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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION

JENNY LISETTE FLORES, *et al.*,

Plaintiffs,

v.

MERRICK GARLAND, Attorney General the United States, *et al.*,

Defendants.

No. CV 85-4544-DMG-AGRx

PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION TO TERMINATE *FLORES* SETTLEMENT AS TO HHS

Hearing: June 21, 2024
Time: 10:00 a.m.
Hon. Dolly M. Gee

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I. INTRODUCTION

For over 25 years the *Flores* Settlement Agreement ("Settlement" or "FSA") has guaranteed independent oversight of the government's treatment of children in federal immigration custody. Defendants now request the Court: (1) modify the Settlement's "licensed program" requirement and (2) partially terminate the Settlement as to the Department of Health and Human Services ("HHS") based on the Unaccompanied Children Program Foundational Rule ("the Rule"), 89 Fed. Reg. 34,384 (Apr. 30, 2024). *See* Defendants' Memorandum of Points and Authorities ("Ds. MPA"). The Court should deny both requests.

In violation of the Settlement, the Office of Refugee Resettlement ("ORR") has operated unlicensed "standard programs" in Texas and Florida since 2021. State licensing is a critical component of the Settlement intended to protect children through independent oversight. When Texas and Florida ceased licensing ORR facilities, Defendants did not seek modification of the Settlement. Instead, HHS indicated it would promulgate federal licensing regulations to provide comparable oversight in these states. But years later, HHS chose to publish the Foundational Rule *before* developing an alternative licensing framework. Rather than creating a durable remedy, Defendants have codified their violations and ask the Court to sanction HHS's unrestricted use of unlicensed facilities. Defendants' proposed modification fails to guarantee meaningul oversight critical to keeping children safe and deprives Plaintiffs of an essential element of their bargain. Modification should be denied.

The Rule also fails to implement HHS's obligations under the Settlement in other ways. The Rule permits indefinite delays in standard placement if a child is apprehended in a remote area or is accused of being a danger to self or others. It also endorses placement in restrictive facilities under circumstances not permitted by the Settlement. Further, the Rule impermissibly exempts out-of-network ("OON") placements from the Settlement's standards, leaving vulnerable children

without any protections.

Finally, Defendants fail to justify partial termination as to HHS. The plain language of the Settlement does not contemplate partial termination. To obtain partial termination on equitable grounds, Defendants must show: (1) full and satisfactory compliance by HHS; (2) that jurisdiction over HHS is not necessary or practicable to ensure compliance by the Department of Homeland Security ("DHS"); and (3) good-faith commitment to the whole of the Settlement. *See Freeman v. Pitts*, 503 U.S. 467, 491 (1992). Defendants cannot—and have not even attempted to—meet this standard. The robust record in this case demonstrates unequivocally that partial termination is inappropriate.

II. ARGUMENT

A. The Foundational Rule Fails to Implement HHS's Obligations Under the Settlement

1. The Rule is Not a Suitably Tailored Modification of the State Licensing Requirement

Defendants seek modification of the Settlement to permit the use of unlicensed "standard programs" in states that refuse to license ORR facilities. Ds. MPA at 21. Defendants fail to establish that this modification is suitably tailored to the changed licensing circumstances in Texas and Florida.

"[A] party seeking modification of a consent decree must establish that a significant change in facts or law warrants revision of the decree and that the proposed modification is suitably tailored to the changed circumstance." *Rufo v. Inmates of Suffolk Cnty. Jail*, 502 U.S. 367, 393 (1992). Defendants bear the burden of satisfying this standard. *Jeff D. v. Kempthorne*, 365 F.3d 844, 851 (9th Cir. 2004); *see also Horne v. Flores*, 557 U.S. 433, 447 (2009) ("The party seeking relief bears the burden of establishing that changed circumstances *warrant relief*") (emphasis added).

"[A] modification of a court order is 'suitably tailored to the changed circumstance' when it 'would return both parties as nearly as possible to where they would have been absent' the changed circumstances." *Kelly v. Wengler*, 822 F.3d 1085, 1098 (9th Cir. 2016) (quoting *Pigford v. Veneman*, 292 F.3d 918, 927 (D.C. Cir. 2002)). To be suitably tailored, a modification "must preserve the essence of the parties' bargain." *Pigford*, 292 F.3d at 927. Defendants' proposed modification deprives Plaintiffs of the essential purpose of their bargain—independent and comprehensive oversight of the treatment of class members.

a. The "standard program" in the Rule is fundamentally inconsistent with the Settlement.

State licensing is a material term of the Settlement. *Flores v. Barr*, 407 F.Supp.3d 909, 919 (C.D. Cal. 2019). The Settlement generally requires that class members be placed in state-licensed programs within three or five days of initial apprehension, or "as expeditiously as possible" in an emergency or influx. FSA ¶ 12.A; *see also id*. ¶¶ 6, 19. Licensed programs must comply with applicable state laws *as well as* specific minimum standards. FSA Ex. 1. This bedrock state licensing requirement is reflected throughout the Settlement. *See, e.g.*, FSA ¶ 7 (child with special needs); ¶ 8 (medium security facility); ¶ 12.C & Ex. 3 (contingency plan for licensed beds). State licensing is so central to the Settlement that "even after its termination, Defendants are obligated to house class members in state-licensed facilities." *Flores v. Barr*, 407 F.Supp.3d at 919 (citing FSA ¶ 40).

With two exceptions,[1] the Rule replaces the Settlement's references to "licensed program" with "standard program." In states that do not license ORR programs, a "standard program" can be unlicensed. 45 C.F.R. § 410.1001. The Rule generally equates standard programs with licensed programs, without *any* preference for licensed over unlicensed placements and without contingency

[1] 45 C.F.R. §§ 410.1103(e), 410.1201(a)(5).

planning specific to licensed beds.[2] *See, e.g.*, 45 C.F.R. §§ 410.1800(a), (b); Ds. App. A [Doc. # 1414-5 at 15].

The sole provision specifically addressing unlicensed standard programs is a general statement that "ORR shall conduct enhanced monitoring [of unlicensed programs], including on-site visits and desk monitoring." 45 C.F.R. § 410.1303(e). The Rule does not explain how this "enhanced monitoring" differs from ORR's ordinary monitoring. *See* 45 C.F.R. § 410.1303(a).

"[T]he purpose of the licensing provision is to provide class members the essential protection of regular and comprehensive oversight by an *independent* child welfare agency." *Flores v. Barr*, 407 F.Supp.3d at 919 (internal citation omitted); *see also Flores v. Lynch,* 828 F.3d 898, 906 (9th Cir. 2016) ("obvious purpose" of state licensing "is to use the existing apparatus of state licensure to independently review detention conditions"); *Flores v. Johnson*, 212 F.Supp.3d 864, 879 (C.D. Cal. 2015) (Defendants agree with Plaintiffs that oversight was the animating concern behind the licensing provision.").

Given the licensing requirement's purpose and centrality to the Parties' bargain, any suitably tailored modification must provide for comparable independent oversight. ORR's undefined "enhanced monitoring" provides even *less* oversight than other substitutes for state licensing the Court previously considered and rejected. *See, e.g.*, *Flores v. Johnson*, 212 F.Supp.3d at 879

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[2] The Rule incorporates Settlement Paragraph 6's requirement that ORR "make reasonable efforts to provide licensed placements in those geographical areas where DHS encounters the majority of unaccompanied children." 45 C.F.R. § 410.1103(e). But this provision mandates only "reasonable efforts" and does not prioritize licensed placements in a non-border state over unlicensed placements. Contrary to Defendants' representation, the Settlement does not *require* placements in Texas and Florida. Ds. MPA at 9, 18. If licensed placements are unavailable, reasonable efforts cannot produce them and the Settlement neither requires nor favors placement in those states.

1 (Defendants proposed inspections by "an independent compliance inspector" and
2 modification "to allow for Plaintiffs to have oversight").
3
4 b. Modification of the state licensing requirement is premature because HHS's actions acknowledge the Rule is not a durable remedy.
5
6 Defendants represent that the Rule is "implementing all the elements of the
7 FSA's licensed placement requirement that ORR could implement." Ds. MPA at
8 22. But HHS's own actions demonstrate the government does not view the Rule as
9 a "durable remedy" and plans to do more. *Horne*, 557 U.S. at 450.
10 In September 2021, HHS stated in a Request for Information ("RFI") that it
11 was considering federal licensure of ORR facilities by "a component outside of
12 ORR." 86 Fed. Reg. 49,549, 49,550. In 2023, HHS stated in the Notice of
13 Proposed Rulemaking on the Foundational Rule that, "in the spirit of current FSA
14 requirements," HHS is developing a separate regulation on federal licensing of
15 ORR care providers in states where licensure is unavailable. 88 Fed. Reg. at 68,916
16 n.52 (Preamble). The Foundational Rule confirms HHS is still developing this
17 regulation but does not indicate its expected release date or any justification for
18 failing to include licensing requirements in this Rule. 89 Fed. Reg. at 34,392 n.61.
19 The Ninth Circuit suggested that non-state licensed facilities "might" be
20 acceptable if regulations allowed for "licensing" similar to the Settlement. *Flores
21 v. Rosen*, 984 F.3d 720, 740 (9th Cir. 2020); Ds. MPA at 24. But the Rule does not
22 provide for licensing. It is merely a temporary stopgap pending future licensing
23 regulations. Until such regulations are published, neither Plaintiffs nor the Court
24 can assess whether they represent a suitably tailored modification. *See Coleman v.
25 Brown*, 922 F.Supp.2d 1004, 1043 (E.D. Cal. 2013) (holding that "it is entirely
26 premature for defendants to seek vacatur" because "[w]hatever resolution
27 defendants contend that they have achieved, that resolution is, without a doubt, not
28 a durable one.").

Defendants' argument that modification is necessary now to avoid violating the Settlement rings hollow. Defendants have been out of compliance with the Settlement in Texas and Florida for years. The Rule merely codifies this dangerous status quo. The Parties have discussed this issue and the importance of alternative independent oversight since 2021. *See* Declaration of Mishan Wroe ¶¶ 23-27, May 31, 2024 ("Wroe Dec."). In a June 2022 meet and confer, Defendants represented that they were planning to propose federal licensing rules to address this problem. Wroe Dec. ¶ 27. Plaintiffs have refrained from filing a Motion to Enforce on this issue to give Defendants time to develop a solution. Plaintiffs remain willing to provide Defendants a reasonable amount of time to develop a durable remedy.[3]

c. The Rule lacks oversight mechanisms necessary to protect children.

The Rule lacks *independent* oversight and any substitute for the essential functions of state licensing. State licensing protects children's safety and well-being by setting comprehensive minimum standards *and* providing the administrative capacity, expertise, and procedures necessary to monitor and enforce those standards. *See* Ex. 1, Declaration of Jill Mason ¶¶ 15-24, 35-38, May 29, 2024 ("Mason Dec."); Ex. 2, Declaration of Larry Bolton ¶¶ 5-12, May 29,

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[3] Plaintiffs reserve the right to enforce the Settlement if Plaintiffs become aware of unsafe conditions in specific unlicensed facilities. *See, e.g.,* Motion to Enforce Settlement re Emergency Intake Sites, September 10, 2021 [Doc. # 1161]. If Defendants insist they suddenly need an immediate solution, Defendants could comply with the Settlement by moving children out of unlicensed facilities "as expeditiously as possible." FSA ¶ 12A. This would not require closing ORR facilities in Texas and Florida. Defendants have instead opted to treat unlicensed programs and licensed programs equally while flouting their obligation to provide comparable oversight. Of course, ORR also had the option to sue Texas and Florida to enjoin their blatant discrimination against the federal government. *See, e.g.*, *United States v. California*, 921 F.3d 865, 878 (9th Cir. 2019). Given these options, Defendants' claim that complying with the Settlement's licensing requirement is "impossible" is palpable hyperbole.

2024 ("Bolton Dec."); Ex. 3, Declaration of Carrie Vander Hoek ¶¶ 11, 13, 15, May 30, 2024 ("Vander Hoek Dec."). Requiring programs to meet state licensing standards without mechanisms necessary to ensure compliance falls inexcusably short of what is required to keep children safe. Vander Hoek Dec. ¶¶ 20-21; Mason Dec. ¶¶ 15-24, 35-38; Bolton Dec. ¶¶ 6, 8-11.

In a comment to the proposed Rule, the attorneys general of 19 states expressed serious concern that the Rule lacked adequate oversight mechanisms for unlicensed facilities "critical to ensure that children are not housed in conditions that are harmful to their health and safety." *See* Ex. 4, Comment of States Attorney General at 12, December 4, 2023. The attorneys general urged ORR to include "minimum monitoring and enforcement functions" in the Rule, including (1) "requirements for inspection, screening, and documentation review prior to the placement of any UACs in a facility"; (2) background check requirements for staff; (3) requirements for the frequency of monitoring visits; "(4) a procedure for receiving, investigating, and responding to complaints within a specified timeframe; and (5) a framework for the enforcement of standards, including procedures for suspension or termination of a facility." *Id.* at 14.

Despite these concerns, the Rule leaves central functions of state licensing completely unaddressed. For example, it does not require vetting and inspection of new facilities to ensure they are capable of meeting minimum standards before accepting children. Nor does the Rule ensure that relevant ORR staff have expertise in state licensing standards. *Cf.* Bolton Dec. ¶¶ 9, 11. Texas licensing, by contrast, requires an on-site inspection to determine compliance with minimum standards and laws *before* issuing a license and requires a facility to demonstrate compliance on a continuing basis for at least three months, with three inspections during this period. *See* 26 Tex. Admin. Code §§ 745.211, 745.339, 745.345, 745.351. Other states similarly verify that facilities can meet minimum standards prior to licensure. *See, e.g.*, Mason Dec. ¶¶ 16-18; Bolton Dec. ¶ 6; Vander Hoek

Dec. ¶ 11; Cal Code Regs tit. 22, §§ 87818, 87820, 87844(a)(1); Del. Code Ann. tit. 14, § 3004A; Fla. Stat. Ann. § 409.175(6)(b); Fla. Admin Code §§ 65C-46.002, 65C-46.003, 65C-46.005.

The Rule's lack of mandatory initial vetting and inspections is especially concerning as the Government Accountability Office ("GAO") previously found that ORR repeatedly failed to take minimum steps to vet its grantees, including failing to: (1) confirm information on applications, (2) adequately verify past state licensing violations, (3) review past performance and incidents of abuse and (4) ensure applicants were state-licensed or eligible for state licensure. Ex. 5, GAO Report at 2, 16-21. The report also found that ORR failed to adhere to its own regulations on auditing facilities and its own policies on monitoring visits. *Id.* at 33-34; *see also id.* at 34 (noting similar findings in 2016).

Perhaps even more concerning, the Rule provides no clear mechanism for children or *anyone* to report abuse, neglect, or standards violations at unlicensed facilities, and no guarantee of follow-up investigations. Texas does not currently investigate reports of abuse or neglect at ORR facilities, and it is unclear what, if any, investigation is done by ORR. Vander Hoek Dec. ¶¶ 16-19. State agencies, by contrast, are required to receive and promptly investigate complaints of licensing violations or maltreatment at licensed facilities. *See, e.g.*, Vander Hoek Dec. ¶¶ 13-15; Mason Dec. ¶¶ 21-24, 33; Bolton Dec. ¶ 9; Fla. Stat. Ann. § 409.175(8)(b); Ill. Admin. Code tit. 89, § 383.35; Mass. Gen. Laws Ann. ch. 15D § 9(c); N.Y. Comp. Codes R. & Regs. tit. 18, § 441.8; Tex. Hum. Res. Code Ann. § 42.044(c). In California, for example, the licensing agency must conduct an onsite inspection of a facility within 10 days of receiving a complaint. *See* Cal. Health & Safety Code § 1538(c)(1). Investigating and responding to complaints requires substantial capacity. *See* Bolton Dec. ¶¶ 5, 9-11. Without timely investigations, children can be left in dangerous situations after allegations of abuse or neglect. Vander Hoek Dec. ¶ 19.

Defendants do not rely on the Ombuds Office in their modification request. Regardless, this office is no substitute for state licensing. The Ombuds "may" receive reports but is not required to investigate or even respond to the reports, much less within any defined period. 45 C.F.R. § 410.2002(a). Moreover, unlike the robust enforcement mechanisms of state licensing, the Ombuds lacks *any* enforcement authority. 45 C.F.R. § 410.2002; *cf.* Mason Dec. ¶ 24; Bolton Dec. ¶¶ 8-10; Cal. Health & Safety Code §§ 1534, 1550; Fla. Stat. Ann. § 409.175(9); 26 Tex. Admin. Code §§ 745.8603, 745.8613.

d. Accreditation is not required by the Rule and is not a substitute for state licensing.

Given the Rule's lack of independent oversight, Defendants rely on accreditation as a substitute. This reliance is misplaced.

First, *accreditation is not actually required by the Rule*. Accreditation is a grant requirement that ORR could change at any time and that ORR retains the discretion to waive. *See* 89 Fed. Reg. at 34,485 (Preamble) (noting that accreditation can be waived). And unlike state licensing, facilities can accept children before receiving accreditation. *See* Declaration of Allison Blake ¶ 19 [Doc. # 1414-3] ("Blake Dec.") (18 programs in Texas and Florida "are in the process of obtaining accreditation"). The Rule therefore allows children to be placed in standard programs without a state license, accreditation, or any equivalent vetting and inspection by anyone.

Moreover, accreditation organizations have private standards and particular areas of focus. *See* Mason Dec. ¶¶ 27, 36; Blake Dec. ¶ 12. Accreditation organizations do not monitor compliance with state licensing standards and cannot substitute for comprehensive state licensing oversight. *See* Mason Dec. ¶¶ 35-36. Accreditation organizations also differ in their level of rigorousness and there are

no clear benchmarks for what it means to be a nationally recognized accreditation agency. Mason Dec. ¶¶ 28-30.[4]

Once a facility is accredited, accreditation agencies do not carry out ongoing oversight and visit programs only once every few years. *See* Mason Dec. ¶¶ 33-35, 37. One of ORR's own grantees raised this concern in response to HHS's RFI on federal licensing, noting that in some instances accreditation requires inspections only every three to five years, which can "create health and safety risks for youth in care at these facilities." *See* Ex. 6, Southwest Key Programs Comment at 6, October 2021. For large organizations, accreditation staff may not even visit every facility. Mason Dec. ¶ 34. Further, accreditation organizations are not charged with investigating complaints and are unable to close facilities that violate standards. Mason Dec. ¶¶ 34, 37-38, 40.

State licensing agencies, by contrast, generally conduct inspections at least annually, and more often if investigating complaints. *See, e.g.*, Mason Dec. ¶¶ 21-23; Cal Code Regs. tit. 22, § 87845(b); Fla. Stat. Ann. § 409.175(8)(a); Ill. Admin. Code tit. 89, § 383.25(c); Mich. Comp. Laws Ann. § 722.118a; Tex. Hum. Res. Code Ann. § 42.044(b); Fla. Stat. Ann. § 409.175(8)(a); 55 Pa. Code § 20.31.

e. Defendants' proposed modification is not in the public interest.

Texas and Florida's refusal to license ORR facilities endangers immigrant children in those states. Despite HHS representing for years that it is working on federal licensing regulations to address this problem, it has yet to create a durable remedy. "[W]hat is certain is that the children who are the beneficiaries of the *Flores* Agreement's protections and who are now in Defendants' custody are

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[4] It is unclear how ORR determines which accreditation organizations to recognize. Some ORR facilities are accredited by Praesidium, Blake Dec. ¶ 19, but this is not one of the organizations mentioned in the Rule's Preamble, 89 Fed. Reg. at 34,486. Praesidium is specifically focused on sexual abuse prevention, not child welfare standards more generally. Mason Dec. ¶ 27.

blameless . . . In implementing the Agreement, their best interests should be paramount." *Flores v. Sessions*, 2018 WL 4945000, at *5 (C.D. Cal. July 9, 2018).

Modification is not in the public interest because—as Defendants themselves acknowledge—licensing oversight is important "to ensure the health, safety, and well-being of children." Ds. MPA at 9. Licensing was a central part of the Parties' bargain and HHS itself has concluded that additional rules on federal licensing are required. Defendants are not entitled to deference under these circumstances.[5] *See Flores v. Barr*, 407 F.Supp.3d at 928. Until Defendants develop a durable remedy that provides independent oversight comparable to state licensing and returns the Parties as nearly as possible to their original bargain, modification is premature. *See Kelly,* 822 F.3d at 1098; *Pigford*, 292 F.3d at 927.

2. The Rule Creates Impermissible Exceptions to "Standard Program" Placement

Even if the Court grants modification of the "licensed program" requirement, the Rule's provisions for standard placement are inconsistent with the Settlement. The Settlement enumerates limited exceptions to prompt licensed placement, such as if a child must be transported from a remote location or if Paragraph 21 applies. FSA ¶ 12.A.

Contrary to the Settlement's requirement that a child apprehended in a remote location be placed in a licensed program within five business days, FSA¶ 12.A(4), the Rule permits indefinite delay in standard placement under these circumstances. 45 C.F.R. § 410.1101(d)(5).

The Rule also unlawfully expands the Settlement's exception for secure placement under Paragraph 21 by permitting indefinite delay in standard placement if "the referring federal agency indicates" that a child "[p]oses a danger to self or

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[5] Providing government officials latitude in "the precise manner of the[] discharge" of their duties, *Frew v. Hawkins*, 540 U.S. 431, 442 (2004), does not require deference to Defendants' disavowal of the *necessity* of independent oversight.

1 others." 45 C.F.R. § 410.1101(d)(6). A generalized indication of "danger to self or
2 others" does not satisfy Paragraph 21 and delay in standard placement based solely
3 on this finding is impermissible. *Flores v. Rosen*, 984 F.3d at 732-33. Further,
4 Settlement Paragraph 23 permits *medium* secure placement only as an alternative
5 for a child who could otherwise be placed in a secure facility under Paragraph 21.
6 But the Rule permits placement in medium secure (re-named "heightened
7 supervision") facilities on grounds not permitted by the Settlement. For example,
8 the Rule permits placement in this restrictive setting for "isolated or petty
9 offenses," 45 C.F.R. § 410.1105(b)(2)(iv), whereas the Settlement specifies that
10 "[p]etty offenses . . . are not considered grounds for stricter means of detention in
11 any case," FSA ¶ 21.A.ii. The Rule also permits heightened supervision placement
12 for a child who is "ready for step-down from a secure facility," without any
13 requirement that the child continue to meet Settlement Paragraph 21 criteria. 45
14 C.F.R. § 410.1105(b)(2)(v). The Settlement has robust criteria for restrictive
15 placement to avoid unnecessary placements in facilities not licensed "for
16 dependent children." FSA ¶ 6; *cf.* 45 C.F.R. § 410.1001.

17 These inconsistencies are unrelated to the lack of licensure in Texas and
18 Florida and cannot be a suitably tailored modification. *See Rufo*, 502 U.S. at 391
19 (court should "do no more" that modification "tailored to resolve the problems
20 created by the change in circumstances.").

21 **3. The Rule Fails to Guarantee the Settlement's Protections for**
22 **Children Placed Out-of-Network**

23 The Rule further fails to implement HHS's obligations by allowing children
24 to be placed long-term in OON facilities that do not meet required standards.

25 The Rule exempts OON placements from Exhibit 1's minimum standards,
26 including basic services and protections against abusive disciplinary practices. *See*
27 FSA Ex. 1; 89 Fed. Reg. at 34,496 (Preamble) ("OON placements are not required
28 to meet the requirements of subpart D as they are not included in ORR's definition

of care provider facilities."); 89 Fed. Reg. at 34,597 ("Subpart D – Minimum Standards and Required Services"); Ds. App. A [Doc. # 1414-5 at 39-51]; *see also* 45 C.F.R. § 410.1001 (OON placements "may include hospitals, restrictive settings, or other settings outside of the ORR network of care" and are not a "standard program"). Because they are not defined as care provider facilities, OON placements are also exempt from the Rule's monitoring provisions. 45 C.F.R. § 410.1303. And although the Rule provides that OON providers be "licensed by an appropriate State agency," it does not mandate they be licensed "for dependent children" as required by Paragraph 6 of the Settlement.[6] 45 C.F.R. § 410.1001.

Plaintiffs raised concerns about the lack of standards for OON placement in a comment to the proposed Rule. Ex. 7, Comment of *Flores* Class Counsel at 11-13. In response, HHS writes in the Preamble that the child's "case manager would monitor the unaccompanied child's care and ensure the unaccompanied child is receiving services," without specifying what services the case manager will be monitoring. 89 Fed. Reg. at 34,409-10. The mere presence of a case manager is plainly insufficient to protect children's rights when they have no legal entitlement to minimum standards. Moreover, the Rule itself does not address the role of a case manager for OON placements.

In the past ORR has failed to provide children placed OON regular contact with their case managers, consistent access to counsel, and language services required to engage in minimum services. *See* Ex. 8, Declaration of Jennifer Vanegas ¶ 12, July 19, 2022 ("Vanegas Dec."); Wroe Dec. ¶¶ 13-15 & Ex. B. Class members have also been hospitalized for weeks or months at a time in unacceptable conditions without services required by the Settlement. *See* Wroe Dec. ¶ 14 & Ex. A; Plaintiffs' Response to Juvenile Coordinators' Interim Reports

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[6] As detailed below, children have been denied minimum services in hospitals that are presumably state-licensed to provide medical care.

1 at 8-9, November 23, 2020 [Doc. # 1039]; Declaration of Class Member at Nexus
2 Children's Hospital at ¶¶ 6, 10-11, November 13, 2020 [Doc. # 1039-9] (child
3 placed at hospital for seven months with little to do during the day and only 1.5
4 hours of class per week); Declaration of Class Member at Nexus Children's
5 Hospital, at ¶¶ 7, 10 [Doc. # 1039-10] (child placed at hospital for six months
6 without educational services).

7 The blanket exemption of OON placements from Settlement requirements is
8 especially troubling as children are routinely placed OON for lengthy periods.[7] As
9 of May 2, 2024, three class members were placed at hospitals for at least 58 days,
10 119 days, and 149 days, respectively. *See* Wroe Dec. ¶ 11. As of the same date, ten
11 class members were held in other OON placements, including five children placed
12 OON for over 130 days and two children for over 320 days. Wroe Dec. ¶ 9.

13 Children who are placed OON tend to be particularly vulnerable in terms of
14 mental or physical health needs. *See* 89 Fed. Reg. at 34,409-11 (Preamble). The
15 Rule inexcusably deprives them of critical protections under the Settlement.

16 **B. <u>Partial Termination of the Settlement is Unjustified</u>**

17 Defendants have not met their burden to demonstrate that partial termination
18 of the Settlement as to HHS is warranted under the Settlement's terms or on
19 equitable grounds.

20 **1. Partial Termination is Inconsistent with the Termination Clause**

21 The Settlement's termination clause provides for full termination based on
22 regulations that implement the entire Settlement. Paragraph 40, as modified,
23 provides that "*All terms* of this Agreement shall terminate 45 days following
24
25
26 [7] Defendants' appendix confusingly places OON facilities alongside Settlement
27 Paragraph 12.A related to initial apprehension. Ds. App. A [Doc # 1414-5 at 12-
13]. If Defendants consider long-term OON placement a placement under
28 Paragraph 12.A, this violates the time limits in Paragraph 12.A. FSA ¶ 12.A;
Flores v. Sessions, 2018 WL 4945000, at *2.

[D]efendants' publication of final regulations implementing this Agreement. Notwithstanding the foregoing, the INS shall continue to house the general population of minors in INS custody in facilities that are state-licensed for the care of dependent minors." (emphasis added).

Defendants appear to propose rewriting the clause as follows: "~~All~~ *Individual* terms of this Agreement shall terminate 45 days following Defendants' publication of final regulations implementing *parts of* this Agreement. Notwithstanding the foregoing, [ORR] shall continue to house the general population of minors in [ORR] custody in facilities that are state-licensed for the care of dependent minors, *provided the state in which ORR chooses to detain such minors agrees to license ORR facilities*."

The Court "must interpret the contract to give effect to the mutual intention of the parties as it existed at the time of contracting." *Gates v. Rowland*, 39 F.3d 1439, 1444 (9th Cir. 1994) (internal citation omited). "[L]ike terms in a contract, distinct provisions of consent decrees are independent obligations, each of which must be satisfied before there can be a finding of substantial compliance." *Rouser v. White*, 825 F.3d 1076, 1081 (9th Cir. 2016). "Accordingly, courts don't release parties from a consent decree unless they have substantially complied with *every one* of its provisions." *Id.*

Here, the parties to the Settlement were Plaintiffs and a *unitary* defendant: the Immigration and Naturalization Service ("INS"). At the time, the INS was divided into regions with the autonomy to adopt separate policies and the original certified class was specific to the Western Region. *See Flores v. Lynch*, 828 F.3d at 901-902. But neither Party contemplated that regulations implementing the Settlement only as to the Western Region would allow that region to exit the agreement, while the remaining regions remained.

The Settlement simply does not contemplate partial termination based on partial implementation. To the contrary, partial termination is inconsistent with the

Settlement's stated goal to "set[] out nationwide policy for the detention, release, and treatment of minors in the custody of the INS." FSA ¶ 9.

2. Defendants Fail to Demonstrate that Partial Termination is Warranted on Equitable Grounds

Nor is partial termination justified on equitable grounds. The Supreme Court held that partial termination of a consent decree based on partial compliance must be informed by three factors: "[1] whether there has been full and satisfactory compliance with the decree in those aspects of the system where supervision is to be withdrawn; [2] whether retention of judicial control is necessary or practicable to achieve compliance with the decree in other facets of the [] system; and [3] whether the [defendant] has demonstrated . . . its good-faith commitment to the whole of the court's decree." *Freeman*, 503 U.S. at 473, 491 (1992). "In considering these factors, a court should give particular attention to the [defendant]'s record of compliance." *Id.* Partial termination is not justified unless the moving party satisfies "*all three parts* of *Freeman*'s three-part test." *Ho. v. San Francisco Unified School Dist.*, 965 F.Supp.1316, 1327 (N.D. Cal. 1997).

The Ninth Circuit has applied this test to the termination of consent decrees in multiple contexts. *See Jeff D. v. Otter*, 643 F.3d 278, 288 (9th Cir. 2011) (requiring consideration of the first and third *Freeman* factors before vacating consent decree in full); *see also Rouser*, 825 F.3d at 1081 ("[T]he court should examine defendants' entire 'record of compliance.'") (quoting *Freeman*, 503 U.S. at 491). Defendants bear the burden of demonstrating that termination is appropriate. *Jeff D. v. Otter*, 643 F.3d at 283-84.

Defendants cite *Freeman* in support of their request for partial termination, Ds. MPA at 25, but make no attempt to satisfy the *Freeman* factors. They instead rely almost exclusively on the Ninth Circuit's statement that Defendants may move

to partially terminate the Settlement. Ds. MPA at 24.[8] Stating that Defendants may *file* a motion to terminate in part is a procedural instruction to Defendants; it in no way directs the Court to grant the motion. Because Defendants did not move to terminate in part in 2019, the legal standard for partial termination was not before this Court or the Ninth Circuit. *Flores v. Rosen*, 984 F.3d at 737. A separate motion was required to allow the Court to consider partial termination on its merits under the applicable legal standard.

In any event, the Ninth Circuit made clear that any motion to terminate in part must demonstrate Defendants' commitment to the *whole* decree, including the rights of accompanied class members in DHS custody. *See Flores v. Rosen*, 984 F.3d at 744 n.12 ("Any motion to terminate the Agreement in part [as to HHS] would have to take into account our holding in *Flores I* that the Agreement protects both unaccompanied and accompanied minors.").[9]

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[8] To the extent Defendants argue that partial termination is justified under *Horne*, they are wrong. Modification based on unexpected changed conditions and partial termination based on partial compliance are two separate requests subject to two different legal standards. The Supreme Court decided *Freeman* just two months after *Rufo* but did not cite *Rufo*, indicating it considered these cases to address separate issues. *See Freeman*, 503 U.S. 467; *Rufo*, 502 U.S. 367; *see also Smith v. Bd. of Educ. of Palestine-Wheatley Sch. Dist.*, 769 F.3d 566, 572 (8th Cir. 2014) (considering the applicability of *Freeman* and *Rufo* and noting "the significant differences between a petition to modify a consent decree on account of changed circumstances, and a petition to terminate all or part of a consent decree because the party subject to the decree has fully complied with its obligations"). Because Defendants seek both modification based on changed factual conditions *and* partial termination based on the Rule's purported implementation of the Settlement, they must satisfy both standards. *Cf. id.* at 574 (modification under *Rufo* did not warrant terminating other provisions unrelated to changed circumstances).

[9] Defendants suggest the Ninth Circuit's holding that the regulations should not be enjoined in full justifies termination in part. *See* Ds. MPA at 25. But, as the Ninth Circuit made clear, the scope of an injunction and the propriety of partial termination are separate issues, and the Settlement can coexist with regulations. *See Flores v. Rosen*, 984 F.3d at 737.

Because Defendants cannot satisfy each of the *Freeman* factors, the motion for partial termination should be denied.

a. HHS has not fully and satisfactorily complied with the Settlement.

Defendants seeking to terminate a consent decree based on satisfaction of the decree must show substantial compliance. *See Jeff D. v. Otter*, 643 F.3d at 283. "[S]ubstantial compliance does imply something less than a strict and literal compliance with the contract provisions but fundamentally it means that the deviation is unintentional and so minor or trivial as not substantially to defeat the object which the parties intend to accomplish." *Id.* at 284 (internal citation omitted). "[O]nly final regulations that implement the *Flores* Agreement, incorporate the relevant and substantive terms, and are consistent with the terms thereof may formally terminate this consent decree." *Flores v. Barr*, 407 F.Supp.3d at 925 (internal citation omitted); *see also Flores v. Rosen*, 984 F.3d at 741.

As discussed above, the Rule's material inconsistencies with the Settlement preclude partial termination. *See* Section II.A, *supra*. Additionally, ORR cannot demonstrate a "consistent pattern of lawful conduct" and "record of compliance" with the Settlement. *See Freeman*, 503 U.S. at 491. The Court has repeatedly found ORR in violation of the Settlement. *See, e.g.*, *Flores v. Barr*, 2020 WL 2758795, at *1-2 (C.D. Cal. May 22, 2020); *Flores v. Barr*, 2020 WL 2758792, at *8-10, *12-13 (C.D. Cal. Apr. 24, 2020); *Flores v. Sessions*, 2018 WL 10162328, at *21 (C.D. Cal. July 30, 2018); *Flores v. Sessions*, 862 F.3d 863 (9th Cir. 2017); *see also L.V.M. v. Lloyd*, 318 F.Supp.3d 601, 613-14 (S.D.N.Y. 2018) (holding that ORR director review policy unnecessarily delayed release).

HHS's belated request for modification does not excuse years of violations by operating unlicensed facilities in Texas and Florida, especially when the proposed modification simply codifies ORR's existing deficient practices. *See* 89 Fed. Reg. at 34,485 (Preamble) (describing response to Texas's actions); *see also Flores v. Rosen*, 984 F.3d at 736 ("[T]he government has apparently disregarded

that right in practice, but it does not follow that we can sanction that disregard."); *Flores v. Sessions*, 2018 WL 4945000, at *2 (noting that "Defendants did not request an alteration of their legal obligations [as to accompanied minors] until many years later"). ORR also placed children in hospitals and other OON placements for weeks or months without access to the minimum services required by Settlement Exhibit 1. *See* Section II.A.3, *supra*.

Further, ORR held thousands of children in unsafe and unsanitary conditions in Emergency Intake Sites ("EISs") in 2021. Plaintiffs moved to enforce the Settlement and the Court later approved an agreement setting minimum standards at EISs. *See* Order Granting Final Approval of Settlement Agreement, September 23, 2022 [Doc. # 1288]; Motion to Enforce Settlement re EISs [Doc. # 1161].

In recent years, Plaintiffs have also met and conferred with Defendants after identifying Settlement violations that did not result in a motion to enforce. In 2022, for example, Plaintiffs learned of unaccompanied children detained by DHS for days or weeks in hotels in highly restrictive and harmful conditions, in violation of Paragraph 12.A and the Court's September 2020 Title 42 order. *See* Wroe Dec. ¶¶ 16-22; Plaintiffs' Response to ICE and CBP Juvenile Coordinators' Reports at 1-3, July 15, 2022 [Doc. # 1268]; *Flores v. Barr*, 2020 WL 5491445, at *8 (C.D. Cal. Sept. 4, 2020); *see also* Ex. 9, Declaration of M. Vaneza Alvarado ¶¶ 6-10, June 24, 2022 ("Alvarado Dec.") (two class members with heightened mental health needs were detained in hotels for over a week with no services and extremely limited access to counsel); Vanegas Dec. ¶¶ 9-11 (describing lack of services and abusive conditions of client's hotel detention).

This prolonged hotel detention was caused by HHS's practice of discharging children from its custody following arrest by local law enforcement and then refusing to timely resume custody, in violation of Paragraphs 12.A and 19 of the Settlement. *See* Wroe Dec. ¶¶ 16-18, 21; Alvarado Dec. ¶¶ 6-9; Vanegas Dec. ¶¶ 8-9, 12. After several months of negotiations between the Parties, ORR eventually

1 issued a new policy related to children arrested by local law enforcement. *See*
2 Wroe Dec. ¶ 22.
3 Defendants clearly have not demonstrated "full and satisfactory compliance"
4 as to HHS. *Freeman*, 503 U.S. at 491.
5 b. Terminating jurisdiction over HHS will compromise effective enforcement of the Settlement as to DHS.
6
7 Defendants fail to make any showing that continued enforcement as to HHS
8 is not "necessary or practicable to achieve compliance with the decree in other
9 facets of the [] system." *Id.* at 491. The obligations of DHS and HHS under the
10 Settlement are "intertwined or synergistic in their relation," *id*. at 497, and
11 continued jurisdiction over HHS is necessary to ensure compliance by DHS.
12 The Settlement applies to *all* children in INS custody and does not delineate
13 separate responsibilities for DHS and HHS. When the Homeland Security Act
14 transferred the INS's functions related to the care and custody of unaccompanied
15 children to ORR, it preserved the Settlement's requirements *in full* as to both DHS
16 and HHS and required ORR to coordinate with DHS agencies. *Flores v. Sessions*,
17 862 F.3d at 870. "Congress did not intend to entirely remove unaccompanied
18 minors from the auspices of authorities outside ORR" and instead "provided for
19 the welfare of unaccompanied minors by ensuring coordination and cooperation
20 among diverse governmenal agencies." *Id.* at 871.
21 Defendants fail to grapple with the interplay between DHS's and HHS's
22 duties under the Settlement and do not explain how the Court could practically
23 enforce the Settlement as to DHS only. DHS's ability to provide safe and sanitary
24 conditions and to expeditiously transfer children to licensed placements requires
25 HHS to timely accept custody of unaccompanied children from DHS. *See* Ds.
26 MPA at 19. This in turn depends on HHS ensuring adequate licensed placements
27 and releasing children from its custody without unnecessary delay to allow for new
28 placements. *See, e.g.*, ORR Juvenile Coordinator Report at 4-8, June 4, 2021 [Doc.

1 # 1124-2] (describing ORR's efforts to increase capacity and expedite releases in
2 response to increased referrals).
3 Section 410.1101 of the Rule illustrates these interrelationships. Subsections
4 (b) and (c) state that ORR will work with the referring federal agency to accept
5 custody of an unaccompanied child. Subsection (d) then lists various "exceptional
6 circumstances" that exempt ORR from timely accepting custody, including an
7 influx, emergency, apprehension in a remote location, and another entity's
8 accusation that a child is a danger to self or others. 45 C.F.R. § 410.1101(d)(2)-(3).
9 There is no requirement that ORR accept custody "as expeditiously as possible" in
10 an influx or emergency. *Cf.* FSA ¶ 12.A.[10] The exceptions for remote locations or
11 alleged dangerousness are inconsistent with the Settlement. *See* Section II.A.2,
12 *supra*.
13 The enforcement problem is clear: DHS could hold an unaccompanied child
14 in violation of Paragraph 12.A on the grounds that HHS has not yet identified a
15 placement. Without jurisdiction over HHS, the Court would be unable to determine
16 whether Defendants are identifying licensed placements as expeditiously as
17 possible. *See Freeman*, 503 U.S. at 497 ("[A] continuing violation in one area may
18 need to be addressed by remedies in another"); *cf. Bobby M. v. Chiles*, 907 F.Supp.
19 368, 372 (N.D. Fla. 1995) (granting partial termination of consent decree as to one
20 of two juvenile facilities only after finding that "Dozier is independent from
21 Eckerd in all pertinent respects").
22 This issue is far from theoretical. In April 2021, the Independent Monitor
23 reported "severe overcrowding" in Customs and Border Protection ("CBP")
24
25 [10] Once a child is *in* ORR custody, the Rule requires standard placement as
26 expeditiously as possible. But the Rule does not obligate ORR to timely *accept*
27 custody from DHS. Remarkably, Defendants assert that Paragraph 12.A's transfer
28 requirements do not apply to ORR, further illustrating their failure to address the
interrelated responsibilities of DHS and HHS. *See* Ds. App. A [Doc. # 1414-5 at
13-14].

facilities that threatened "[v]irtually all the custodial and medical provisions essential to adequate detention conditions." Independent Monitor Report at 4, April 2, 2021 [Doc. # 1103]. In response, *HHS* opened EISs, revised its Covid-19 protocols to accommodate more children, and created expedited release procedures. *Id.* at 12-23. The Court ordered further reporting on CBP conditions and capacity *and* updates on ORR's plans to expand capacity and to transfer minors from EISs. *See* Order re Status Conference at 2-3, May 12, 2021 [Doc. # 1122].

Court-ordered monitoring has also revealed that ORR under-utilized its licensed capacity. *See Flores v. Barr*, 2020 WL 5491445, at *8 (finding Defendants were not placing children in licensed facilities as expeditiously as possible because "ORR shelters were 97% vacant"); Plaintiffs' Response to ORR Juvenile Coordinator's Annual Report, July 15, 2022 [Doc. # 1269] (data on unused beds and history of Parties' meet and confers on this issue).

Relatedly, HHS takes the position that children must pass through DHS custody prior to entering ORR custody—even if the child was previously in ORR custody. *See* Wroe Dec. ¶¶ 16, 21; *see also* Ds. App. A [Doc. # 1414-5 at 18-19] (stating that Settlement Paragraph 16 related to re-assuming legal custody "is not relevant to ORR's Unaccompanied Children Program"). This policy resulted in DHS detaining unaccompanied children in hotels while awaiting HHS placement, in violation of the Settlement and the Court's orders. *See* Section II.B.2.a, *supra*. To resolve non-compliance with the Settlement, Plaintiffs had to meet and confer with representatives of *both* HHS and DHS regarding this issue, and the remedy to DHS's violations involved a change in HHS policy. *See* Wroe Dec. ¶¶ 16-22.

If HHS were not bound by the Settlement, the Court would be severely limited in its ability to monitor Defendants' efforts to timely place children in licensed programs and to order appropriate remedies. *Freeman*, 503 U.S. at 497.

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Defendants' alternative request that the Court terminate those provisions of the Settlement implemented by consistent regulations is similarly unworkable. The Settlement assumes state licensing throughout as an underlying basis of protections for children. Defendants do not identify any specific provisions of the Settlement that are severable from this bedrock requirement.

c. Defendants have not shown a good faith commitment to the whole of the Court's decree.

Finally, Defendants have not demonstrated "an affirmative commitment to comply in good faith with the *entirety* of" the Settlement. *Freeman*, 503 U.S. at 499 (emphasis added); *see also Flores v. Rosen*, 984 F.3d at 744 n.12; *Rouser*, 825 F.3d at 1081. In addition to HHS's violations, Defendants do not—and cannot—demonstrate a good-faith commitment to the Settlement by DHS.

The Ninth Circuit specifically instructed that any motion to terminate in part as to HHS must also account for the rights of *accompanied* minors. *Flores v. Rosen*, 984 F.3d at 744 n.12. Yet Defendants' motion includes no mention of accompanied minors, much less a commitment to compliance by DHS. After promulgating flagrantly inconsistent DHS regulations in 2019, Defendants have not signaled any intent to publish consistent regulations that recognize the rights of accompanied minors. Defendants' willingness to omit DHS's vital obligations reveals a lack of consideration of the whole decree.[11]

DHS cannot show a "consistent pattern of lawful conduct" and "record of compliance" with the Settlement. *See Freeman*, 503 U.S. at 491; *see also Fisher v. Tucson Unified Sch. Dist.*, 652 F.3d 1131, 1143-44 (9th Cir. 2011) (ordering district court "to maintain jurisdiction until it is satisfied that the School District has met its burden by *demonstrating*—not merely promising—its 'good-faith

[11] Notably, Defendants substitute "HHS" for "INS" in describing the Settlement's goals, ignoring DHS entirely. *See* Ds. MPA at 15.

1 compliance . . . over a reasonable period of time.'") (quoting *Freeman*, 503 U.S. at
2 498). Indeed, "the history of this case is replete with findings of Defendants' non-
3 compliance with the Agreement." *Flores v. Barr*, 407 F.Supp.3d at 924. Since
4 Defendants last sought termination, the Court has repeatedly intervened to address
5 new and continuing violations that endanger children's safety. *See, e.g.*, *Flores v.*
6 *Garland*, Order re Plaintiffs' Motion to Enforce Settlement re "Open Air Detention
7 Sites," April 3, 2024 [Doc. # 1406] ("OADS Order"); *Flores v. Barr*, 2020 WL
8 5491445, at *8-11.

9 Defendants also remain in active violation of the Settlement. The Court
10 recently found that class members were detained in unsafe and unsanitary
11 conditions in "Open Air Detention Sites." OADS Order. Despite the dire
12 conditions, Defendants have failed to comply with this Order. *See* Plaintiffs'
13 Response to CBP Juvenile Coordinator Report, May 17, 2024 [Doc. # 1422].

14 Further, Defendants have failed to remedy ongoing Settlement violations in
15 CBP facilities. *See, e.g.*, *Flores v. Sessions*, 394 F.Supp.3d 1041 (C.D. Cal. June
16 27, 2017); *Flores v. Barr*, 2019 WL 2723798 (C.D. Cal. June 28, 2019). Despite a
17 new settlement, Defendants continue to separate families in the Rio Grande Valley
18 and El Paso Sectors without apparent operational necessity and fail to ensure
19 consistent visitation. *See* Juvenile Care Monitor Report at 16, May 6, 2023 [Doc. #
20 1412] ("May 2024 JCM Report"); Juvenile Care Monitor Report at 6, Nov. 13,
21 2023 [Doc. # 1372] ("November 2023 JCM Report"). Additionally, Defendants
22 fail to provide young children with appropriate meals or ensure adequate warm
23 clothing. *See* May 2024 JCM Report at 18; November 2023 JCM Report at 28-29,
24 31. Improvements in some other areas do not excuse this continuing non-
25 compliance. *See Armstrong v. Newsom*, 58 F.4th 1283, 1295-96 (9th Cir. 2023).

26 Despite the Court's specific findings that the Settlement requires access to
27 adequate sleeping conditions, soap, showers, and toothbrushes, class members in
28 the San Diego Sector report the lack of these basic necessities and a lack of privacy

1 in using the bathroom. *See Flores v. Sessions*, 394 F.Supp.3d at 1056, 1060-61;
2 Declaration of KPR ¶¶ 11, 14, April 30, 2024 [Doc. # 1422-2] ("KPR Dec.");
3 Declaration of AFBA ¶ 8, April 30, 2024 [Doc. # 1422-3] ("AFBA Dec.");
4 Declaration of JAF ¶¶ 8-9, April 29, 2024 [Doc. # 1422-8] ("JAF Dec."). Class
5 members also report a lack of "adequate temperature control" and "contact with
6 family members who were arrested with the minor," in violation of Paragraph
7 12.A. KPR Dec. ¶ 15; AFBA Dec. ¶ 12; JAF Dec. ¶¶ 4-5, 9, 13. The Parties met
8 and conferred regarding these violations on May 17, 2024. Wroe Dec. ¶¶ 28-29.
9 Finally, DHS continues to violate the Settlement's speedy release and
10 transfer requirements. *See* May 2024 JCM Report at 10-11 (507 children were held
11 in CBP custody along the Southwest Border for longer than 72 hours in January
12 2024 and 537 children were held for longer than 72 hours in February 2024).
13 Alarmingly, not only does "CBP data reflect[] that . . . many children in families
14 are routinely held for more than 72 hours", but 61 minors in January 2024 and 54
15 minors in February 2024 were in CBP custody for between six and 16 days. *Id.* at
16 11. This occurred "at a time when the census was comfortably below capacity," *id.*,
17 again indicating Defendants' fundamental lack of commitment to complying with
18 the whole of the Settlement.
19
III. CONCLUSION
20 For these reasons, and because termination as to HHS is not in the public
21 interest, Defendants' motion should be denied. *See Flores v. Barr*, 407 F.Supp.3d
22 at 928-929 ("[T]he evidentiary record before this Court overwhelmingly shows
23 that throughout several presidential administrations, the Agreement has been
24 necessary, relevant, and critical to the public interest in maintaining standards for
25 the detention and release of minors arriving at the United States' borders.").
26
27
28

Dated: May 31, 2024

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CERTIFICATE OF COMPLIANCE

I, the undersigned counsel of record for Plaintiffs, certify that this brief contains **7,989** words, which complies with the word limit set in the Court's order granting Plaintiffs' *ex parte* application for leave to extend word limit. Doc # 1419.

Dated: May 31, 2024

/s/ Mishan Wroe
Mishan Wroe

CERTIFICATE OF SERVICE

I hereby certify that on May 31, 2024, I caused a copy of Plaintiffs' Opposition to be served to all counsel through the Court's CM/ECF system.

Dated: May 31, 2024

/s/ Mishan Wroe
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12 UNITED STATES DISTRICT COURT
13 CENTRAL DISTRICT OF CALIFORNIA
14 WESTERN DIVISION
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16 JENNY LISETTE FLORES, *et al.*, 17 Plaintiffs, 18 v. 19 20 MERRICK GARLAND, Attorney General the United States, *et al.*, 21 22 Defendants. 23 24	No. CV 85-4544-DMG-AGRx DECLARATION OF MISHAN WROE IN SUPPORT OF OPPOSITION TO DEFENDANTS' MOTION TO TERMINATE *FLORES* SETTLEMENT AS TO HHS Honorable Dolly M. Gee Chief United States District Judge Hearing: June 21, 2024 Time: 10:00 a.m.

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Declaration of Mishan Wroe

I, Mishan Wroe, declare as follows:

1. This declaration is based on my personal knowledge. If called to testify in this case, I would testify competently about these facts.

2. I am a Senior Attorney at the National Center for Youth Law, and I am counsel of record for Plaintiffs in the above-captioned case. I make this declaration in support of Plaintiffs' Opposition to Defendants' Motion to Terminate the *Flores* Settlement as to the U.S. Department of Health and Human Services ("HHS").

Defendants' Use of Out-of-Network Placements

3. Pursuant to ¶¶ 28 and 29 of the *Flores* Settlement Agreement ("Settlement" or "Agreement"), the Department of Homeland Security ("DHS") and HHS provide monthly data reports to Plaintiffs' counsel regarding class members in their custody. The reports from HHS include information about class members in the custody of the Office of Refugee Resettlement ("ORR").

4. As *Flores* counsel, I received and analyzed the April 2024 HHS Flores Data report ("April 2024 Report") produced to Plaintiffs by Defendants. According to the "Read Me" tab of the April 2024 Report, the "Census," "Out of Network Placements," and "Medical" tabs provide a snapshot of ORR data as of May 2, 2024.

5. The Census tab contains several data fields including, but not limited to, fields for each class member's "Alien_No" and "ORR_Placement_Date."

6. The Out-of-Network (OON) Placements tab contains the following fields: (1) First_Name; (2) Last_Name; (3) Alien_No; (4) DOB; (5) Gender; (6) Age at Time of Out of Network Placement; (7) ORR Admit Date; (8) Assigned Program; (9) Out of Network Facility; (10) Out of Network City; (11) Out of Network State; (12) Out of Network Admit Date; (13) Out of Network Discharge Date; (14) Currently in Out of Network; (15) Calendar Year (Admit); (16) Placement Status; (17) Out of Network Placement Type; and (18) Basis for Placement.

7. The Medical tab contains the following fields: (1) Alien_No; (2) First_Name; (3) Last_Name; (4) DOB; (5) COB; (6) Assigned Program; and (7) Medical Facility.

8. There are ten *Flores* class members listed on the OON Placements tab in the April 2024 Report. Using the date in the "ORR Admit Date" field I calculated each child's length of stay in ORR custody by counting the days between that date and May 2, 2024.[1] The ten class members on the OON Placements tab had the following lengths of stay in ORR custody as of May 2, 2024 (listed from shortest to longest): 80 days, 93 days, 244 days, 251 days, 253 days, 313 days, 329 days, 392 days, 570 days, and 771 days.

9. Using the date in the "Out of Network Admit Date" field I calculated each child's length of stay at an OON placement by counting the days between that date and May 2, 2024.[2] The ten class members on the OON Placements tab had the following lengths of stay at an OON Placement as of May 2, 2024 (listed from shortest to longest with the information in the Out of Network Placement Type field summarized in parentheses): 17 days (OON RTC), 21 days (OON RTC), 31 days (OON Therapeutic LTFC), 56 days (part of this time was at an OON Staff Secure and part of the time was at an OON Therapeutic Group Home), 59 days (OON RTC), 133 days (OON Independent Living Program), 143 days (part of this time was at an OON Staff Secure and part of the time was at an OON Therapeutic Group Home), 147 days (OON Independent Living Program), 329 days (part of

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[1] One child did not have an admit date listed in the "ORR Admit Date" field. I looked for that child using their A-number on the Census tab and found their "ORR Admit Date" on that tab. That is the date I used to make this calculation. Another child had two "ORR Admit Dates" because they had been in custody in 2021 and re-entered custody this year. I used the 2024 admit date to make this calculation.

[2] One child had an Out of Network Admit date that was before their ORR Admit date, which is likely an error. Therefore, that child's calculation results in a longer length of stay in an Out of Network placement than in ORR custody overall.

1 this time was at an OON RTC and part of the time was at an OON Staff Secure),
2 and 421 days (OON RTC).
3 10. There are three *Flores* class members listed on the Medical tab in the April
4 2024 Report. Each of these children are placed at the same hospital. Using each
5 class member's "Alien_No" I found their "ORR_Placement_Date" on the Census
6 tab. Using the date in the "ORR_Placement_Date" field, I calculated each child's
7 length of stay in ORR custody by counting the days between that date and May 2,
8 2024. The three class members on the Medical tab had the following lengths of
9 stay as of May 2, 2024 (listed from shortest to longest): 80 days, 128 days, and 144
10 days.
11 11. Because the Medical tab does not provide the date each class member was
12 placed at their medical placement, I searched prior monthly data reports produced
13 to Plaintiffs by Defendants and found the first date (using the snapshot date
14 reported on each monthly data report) each of the three children on the Medical tab
15 first appeared on that tab. Then, I calculated an approximate minimum length of
16 stay for each child by counting the days between the first date they appeared on the
17 Medical tab and May 2, 2024. Based on this calculation, the three class members
18 on the Medical tab were placed at hospitals for at least the following lengths of
19 time as of May 2, 2024 (listed from shortest to longest): 58 days, 119 days, and
20 149 days.
21
22 **<u>*Flores* Settlement violations at Out-of-Network Placements and Long-Term Hospitalizations</u>**
23 12. Over the last several years, as ORR began increasing its utilization of OON
24 placements, *Flores* counsel increased the number of site visits made to OON
25 placements and continued to monitor compliance with the Settlement at these
26 irregular placements. Settlement compliance at OON placements varies
27 significantly.
28

13. For example, in November 2020, *Flores* counsel conducted a site visit to children placed out of network at Nexus Children's Hospital in Texas, which revealed class members were being denied basic services required by the Settlement and raised serious concerns about their health and safety. *See* Plaintiffs' Response to Juvenile Coordinators' Interim Reports at 8-9, November 23, 2020 [ECF 1039].

14. In March 2022, I was notified of a class member who had spent over a month in a hospital and did not have an appropriate ORR placement despite being ready for discharge. This class member had been denied basic services such as educational services and the ability to go outdoors for over a month. I emailed Ms. Ordin and Dr. Wise for assistance in rectifying this situation to avoid motion practice. *See* email correspondence with *Flores* monitors attached hereto as Exhibit A.

15. That same class member was later inappropriately discharged from ORR custody and detained by U.S. Immigration and Customs Enforcement ("ICE") before being placed by ORR in an OON facility in Florida. Plaintiffs' counsel met with him at that facility and emailed Defendants to raise concerns regarding a lack of consistent case management, language services, and phone calls with counsel and family. Attached hereto as Exhibit B is a true and correct copy of email correspondence with Defendants regarding these Settlement violations.[3]

Meet and Confer discussions regarding class members discharged to local law enforcement custody

16. In 2022, *Flores* counsel became aware of a systemic issue regarding class members discharged from ORR custody after arrest by local law enforcement. As a result of ORR's decision to discharge these youth, despite being under no legal

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[3] I redacted the child's A-number from this exhibit to protect his privacy and because it is not relevant to my declaration.

obligation to do so, class members were often denied access to basic services and access to counsel, and were forced to enter ICE custody before being permitted to re-enter ORR custody.

17. On July 8, 2022, *Flores* counsel sent a letter to Defendants outlining the particular problem of ICE detaining youth in hotels for prolonged periods of time after their discharge from local law enforcement custody. The youth highlighted in this letter, attached hereto as Exhibit C,[4] were denied access to counsel and experienced verbal and physical abuse while detained by ICE in hotels. The letter explained the inappropriateness of hotel detention as a violation of the Settlement and this Court's specific order relating to hotel detention. Plaintiffs further explained the inappropriateness of discharging youth from ORR custody based on their physical placement in local law enforcement custody.

18. We met and conferred with Defendants from both DHS and HHS, as well as their respective counsel, about this issue on July 27, 2022. Following that conversation, we sent a subsequent meet and confer letter dated August 15, 2022. This second letter, attached hereto as Exhibit D,[5] explains in further detail the basis of our legal argument regarding ORR's discharge policy and why it is not permitted by the Settlement.

19. On September 22, 2022, and November 3, 2022, the Parties, including representatives from both DHS and HHS, met and conferred again on these issues and following those discussions, Plaintiffs sent a third meet and confer letter on December 6, 2022, which is attached hereto as Exhibit E. This letter provided recommendations from Plaintiffs to modify ORR's discharge policy and prevent

[4] I redacted children's A-numbers from this exhibit to protect their privacy and because their A-numbers are not relevant to my declaration.

[5] I redacted children's A-numbers from this exhibit to protect their privacy and because their A-numbers are not relevant to my declaration.

calls to local law enforcement to manage behavioral manifestations of disability and detention-fatigue in class members.

20. On January 10, 2023, the Parties met and conferred again to further discuss possible changes to ORR policy to avoid motion practice.

21. Throughout 2023, the Parties exchanged email correspondence regarding possible changes to ORR policy which are memorialized in part, as Exhibit F, attached hereto.[6] Throughout the course of the Parties' meet and confer discussions, Defendants maintained that unaccompanied class members must first pass through DHS custody before ORR can take custody.

22. As seen in Exhibit F, on September 19, 2023, Defendants notified Plaintiffs that updates and changes had been made to the ORR Policy Guide and Manual of Procedures to address, in part, the concerns raised by Plaintiffs.

Meet and Confer discussions regarding lack of state licensing in Texas and Florida

23. In 2021, Texas and Florida began the process of de-licensing or failing to re-license shelters and facilities that hold unaccompanied immigrant children. This created violations of the Settlement across many ORR-contracted facilities.

24. On June 2, 2021, Defendants emailed *Flores* counsel to discuss the impact of Texas's decision to de-license shelters holding unaccompanied immigrant children and its impact on the Government's ability to comply with the *Flores* Settlement Agreement.

25. The Parties met and conferred on June 8, 2021, regarding these issues. Plaintiffs' counsel expressed our concern that the lack of licensing would result in no independent oversight of these facilities, which would put children at risk of abuse and neglect. Defendants articulated their own concerns and assured Plaintiffs

[6] I redacted a child's A-number from this exhibit to protect his privacy and because his A-numbers are not relevant to my declaration.

that they were considering their options to respond to these state actions and would develop a plan to address these issues.

26. In an effort to continue to work with ORR to address this concerning development, I emailed HHS counsel Jonathan Wall in January 2022. I did not receive a response from Mr. Wall. Attached hereto as Exhibit G is that email dated January 14, 2022.

27. Later that year, in June 2022, the Parties met again to discuss ORR's plans to address the lack of state licensed facilities in Texas and Florida. At this meet and confer, Defendants represented that they were working on regulations to provide for federal licensing of programs that were no longer eligible for state licensing based on the actions of the states they were operating in. Defendants noted that a plan for Notice of Proposed Rulemaking (NPRM) regarding federal licensing had been posted in the Unified Regulatory Agenda of the Federal Register[7] and that Plaintiffs would have an opportunity to provide input once this NPRM was published.

Meet and Confer discussions regarding Settlement violations in CBP's San Diego sector

28. On May 10, 2024, Plaintiffs sent Defendants a meet and confer letter regarding violations of the Settlement discovered during our site visit to three Border Patrol Stations in CBP's San Diego Sector. Attached hereto as Exhibit H is a true and correct copy of that meet and confer letter. I have not attached the declarations we shared with Defendants but some of the declarations referenced in the letter were filed with Plaintiffs' Response to CBP Juvenile Coordinator Report on May 17, 2024 [ECF 1422].

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[7] It is my understanding that this was a reference to a posting in the Spring 2022 Unified Agenda after HHS's September 2021 Request for Information. *See also*, 86 Fed. Reg. 49,549, 49,550.

29. On May 17, 2024, the Parties met and conferred regarding the issues raised in the May 10 letter. The Parties agreed to continue discussions of these issues to attempt to resolve the Settlement violations.

I declare under penalty of perjury that the foregoing is true and correct. Executed this 31st day of May, 2024, at Oakland, California.

/s/ Mishan Wroe

Mishan Wroe

EXHIBIT A

Diane de Gramont <ddegramont@youthlaw.org>

Urgent concern re Flores class member hospitalized in MI since February 1, 2022

Mishan Wroe <mwroe@youthlaw.org> Wed, Mar 16, 2022 at 3:35 PM
To: "Paul H. Wise" <pwise@stanford.edu>, Andrea Sheridan Ordin <aordin@strumwooch.com>
Cc: Neha Desai <ndesai@youthlaw.org>, Diane de Gramont <ddegramont@youthlaw.org>, jvanegas@michiganimmigrant.org

Dear Ms. Ordin and Dr. Wise,

We have recently learned of a *Flores* class member, currently placed at Bethany Christian Services Therapeutic Group Home in Michigan, who has been hospitalized since February 1, 2022. Our understanding is that the hospital intends to discharge him (possibly as soon as this week) but ORR has no placement for him and Bethany's Therapeutic Group Home has refused to take custody of him. ORR has failed to find him an appropriate placement and as a result, he has spent over a month admitted to the hospital where he is not receiving the services required by Exhibit 1 of the *Flores* Settlement.

This child is 16 years old and to our knowledge he has nothing to do during the day and is not being allowed any outdoor activity. I've copied his legal service provider, Jennifer Vanegas at Michigan Immigrant Rights Center, who can provide additional details regarding his case.

We would like to try to resolve this situation before we involve the court but the matter is urgent and we are deeply concerned that ORR is considering possible secure placement which would be entirely inappropriate based on what we know about this child's case. We understand he has pending referrals for OON placements but there has been no indication as to when a bed will be available.

Dr. Wise, would you be able to work with the Division of Health and/or with the ORR Juvenile Coordinator or anyone else you think appropriate to determine what ORR's placement plan is for this child and what ORR is doing to ensure placements can meet this child's needs? The child urgently needs an appropriate placement and if we do not have an understanding of what ORR's plan is for placement before the end of the week, we intend to send a meet and confer letter to the government regarding the *Flores* Settlement violations at issue.

Thank you,
Mishan

Mishan Wroe *(Pronouns: she / her / hers)*
Senior Attorney, Immigration & Legal Advocacy
National Center for Youth Law
Phone: 510-920-3512
Fax: 510-835-8099
1212 Broadway, Suite 600, Oakland, CA 94612

EXHIBIT B

Mishan Wroe <mwroe@youthlaw.org>

6/7 Devereux Site Visit

Leecia Welch lwelch@children right org Thu, Jun 9, 2022 at 2 32 PM
To: "Fabian, Sarah B (CIV)" <Sarah.B.Fabian@usdoj.gov>, "Batool, Fizza (CIV)" <Fizza.Batool2@usdoj.gov>
Cc: Diane de Gramont <ddegramont@youthlaw.org>, Andrea Sheridan Ordin <aordin@strumwooch.com>, "Paul H. Wise" <pwise@stanford.edu>, Mishan Wroe <mwroe@youthlaw.org>, Carlos Holguín <crholguin@centerforhumanrights.email>, Neha De ai nde ai@youthlaw org

Hi all - I'm writing to follow up on my 6/7 site visit to Devereux Behavioral Health in Melbourne, FL. During that visit, I had a brief tour of the facility and interviewed EAMF - A# [REDACTED], who was the only UC at the facility at the time of my visit. EAMF has been in ORR custody for nearly 3 years - and has cycled through multiple placements that haven't met his needs. Most recently, he was discharged from ORR (for reasons that are unclear), transferred to ICE where he experienced horrible treatment in a hotel room with MVM contractors, and was then re-admitted to ORR custody and sent to Florida - first to a hospital and then to Devereux.

Given EAMF's mental health needs, his years in custody, and the traumatic experiences he has endured recently - we want to emphasize the need for timely resolution of some concerns we have with his placement at Devereux. Additionally, we are aware that UCs have been placed at Devereux in the past and may be placed there in the future - and we are concerned that these same issues may come up for any other UC placed at Devereux. We are hopeful that by flagging these concerns and working with the provider to address them - other youth will not face similar obstacles to services.

- **Phone calls to counsel and family** - Despite being at Devereux for over a month, a schedule has not been put in place to ensure EAMF has consistent contact with his attorney, family in home country, staff at ORR etc. He reported frequent obstacles in receiving calls from his attorney, case manager, clinician, and other approved callers. Devereux needs to ensure there is a set schedule so that EAMF knows when these calls are happening and his attorney and family have the time set aside to speak with him. With regard to calls with his family, he noted that sometimes the timing does not take into account his family's availability and connectivity challenges due to weather etc.

- **Access to case management** - EAMF is not getting weekly contact with his case manager to update him on developments in his case and does not feel like he is receiving consistent case management. These meetings should also be part of the schedule maintained by Devereux Having weekly updates will help with his understandable anxiety about the status of his case.

- **Language access and discrimination**- EAMF does not have consistent access to Spanish-speaking staff to address his needs There are only 1 2 staff who speak Spanish and they are not always available. Some staff who don't speak Spanish have been unwilling to use interpreters or even interpreter apps when EAMF has requested it Lack of consistent access to Spanish-speaking staff is particularly concerning given that this program is supposed to be therapeutic Not being able to communicate with staff can exacerbate mental health issues for youth - resulting in elevated distress and causing difficult situations that could be avoided with effective communication EAMF has felt discriminated against at times because he is Spanish-speaking, including having to go last for phone calls resulting in calling family at later times that aren't workable for them

- **Inappropriateness of placement** - EAMF's strong preference is to be released to a sponsor - and new family members have recently been identified. He would benefit from more intensive case management to expedite determination of sponsor appropriateness and support the sponsor, as needed. In the meantime, he would prefer to be in an ORR program where there are other Spanish-speaking youth and staff.

Please let us know how we can best ensure these issues are addressed.

Best wishes, Leecia

Leecia Welch | Deputy Legal Director
(She/Her)
Children' Right
2021 Fillmore Street
San Francisco, CA 94115
lwelch@childrensrights.org
www.childrensrights.org

EXHIBIT C

July 8, 2022

Sarah B. Fabian
Office of Immigration Litigation
P.O. Box 868, Ben Franklin Station
Washington, DC 20044

Via email

Re: *Flores*, et al. v. *Garland*, et al., No. CV-85-4544 DMG (ARGx)

Sarah,

Pursuant to paragraph 37 of the *Flores* Settlement Agreement ("Settlement"), Plaintiffs request the Parties meet and confer to discuss Defendants' practice of discharging children in ORR's legal custody to local law enforcement, which is inconsistent with paragraphs 14 and 19 of the Settlement. Plaintiffs would also like to discuss Defendants' subsequent detention of these unaccompanied class members in unlicensed hotels in violation of the district court's September 2020 orders.

Background

ICE census reports indicate that ICE has detained at least three unaccompanied children in hotels for over three days since October 2021.[1] In addition, Plaintiffs are aware of at least two additional unaccompanied class members detained by ICE in hotels for well over three days but never reported on ICE census reports. Specifically, class member G.M.G. (A# [redacted]) was subjected to approximately 20 days of ICE hotel detention in March and April 2022 and class member E.A.M.F. (A# [redacted]) was detained by ICE in hotels from April 12, 2022, through April 18, 2022. *See* Alvarado Decl. ¶¶ 8-9.[2] Neither G.M.G. nor E.A.M.F. appear in the April 2022 ICE census data and Plaintiffs were never informed of their hotel detentions.

G.M.G. and E.A.M.F. both endured unacceptable conditions in ICE hotel detention. G.M.G. was confined to hotel rooms for nearly three weeks without access to any outdoor recreation or even fresh air. Alvarado Decl. ¶ 8. E.A.M.F. was placed in restraints and reported verbal and physical abuse by the ICE security contractors guarding him. *See* Alvarado Decl. ¶ 9. Despite being represented by counsel, both G.M.G. and E.A.M.F. experienced severe limitations on their access to counsel. *See* Alvarado Decl. ¶¶ 8-9.

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[1] The children include J.R.C. (A# [redacted]), detained at the Pear Tree Inn SNA Airport from December 6, 2021 through December 10, 2021, C.V.O. (A# [redacted]), detained at the Pear Tree Inn SNA Airport from December 14, 2021 through December 19, 2021, and B.A.R. (A# [redacted]), detained at the Pear Tree Inn SNA Airport from October 28, 2021, through November 1, 2021.

[2] G.M.G. is listed in the March 2022 ORR census as discharged to local law enforcement on March 19, 2022. He subsequently reappears on the April 2022 ORR census with an ORR placement date of April 11, 2022.

ORR census reports for the relevant months indicate that each of the five above-referenced children was in ORR custody prior to their ICE hotel detention. Specifically, each child was placed by ORR at BCFS San Antonio Staff-Secure, was discharged from ORR custody to local law enforcement, was transferred to ICE custody, and eventually returned to ORR custody. The legal service provider for BCFS San Antonio Staff-Secure reports that it is common practice for children to be discharged from ORR custody after an arrest by local law enforcement. Alvarado Decl. ¶ 6.

Discharges to Local Law Enforcement

There is no legal basis to discharge class members from ORR's legal custody to local law enforcement upon a class member's arrest. Paragraph 19 of the Settlement provides that "[i]n any case in which the INS does not release a minor pursuant to Paragraph 14, the minor shall remain in INS legal custody." Paragraph 14 of the Settlement also does not contemplate discharge to local law enforcement.

Accordingly, class members who are temporarily taken into the physical custody of local law enforcement must remain in ORR's legal custody and must be returned to an ORR care provider once they are released by local law enforcement. Plaintiffs are not aware of any statute requiring or even permitting HHS to discharge children from ORR's legal custody to local law enforcement upon a class member's arrest, but please advise if you have a different understanding.

ICE Hotel Detention

On September 21, 2020, the district court ordered that "DHS shall cease placing minors at hotels", with exceptions for "*brief* hotel stays (not more than 72 hours) as necessary and in good faith to alleviate bottlenecks in the intake processes at licensed facilities." Order re Defendants' *Ex Parte* Application to Stay at 5, Sept. 21, 2020 [Doc. # 990] ("Sept. 21 Order"). The court further ordered that "[w]hen any Class Members are transferred to hotels for this purpose, Defendants shall notify Plaintiffs' counsel and the Independent Monitor, providing the identities and number of minors subject to the hotel placements, and the locations of the hotels." *Id.*

Despite the Court's order, at least five unaccompanied class members were discharged from ORR custody to local law enforcement, transferred to ICE custody, and detained in hotels for over three days, since October 2021. G.M.G. and E.A.M.F. do not appear in the ICE census data and Plaintiffs were not otherwise notified about their hotel placements. We have no way of knowing how many other class members were in a similar situation, but were not reflected on the ICE census.

As described above, G.M.G. and E.A.M.F.'s experiences exemplify the district court's findings that it is unsafe and inappropriate to detain vulnerable children in hotels under the control of contractors that lack child welfare training or qualifications. *See* Order re Plaintiffs'

Motion to Enforce Settlement as to "Title 42" Class Members at 13-15, Sept. 4, 2020 [Doc. # 976]; Sept. 21 Order at 2.

Plaintiffs are deeply concerned that class members in ORR custody continue to be at risk of unnecessary and inappropriate ICE hotel detention as a result of the agency's apparent, and unnecessary, discharge policy. We would like to discuss what steps Defendants will take to ensure future compliance with the Settlement and the district court's orders, including ceasing discharges from ORR legal custody to local law enforcement and immediately notifying Plaintiffs' counsel if a child is transferred to ICE hotel detention.

Please let us know when Defendants are available to meet and confer regarding these issues.

Best,

Mishan Wroe

DECLARATION OF M. VANEZA ALVARADO

I, M. Vaneza Alvarado, declare as follows:

1. I am a resident of the State of Colorado, and I am over the age of 18. I am an attorney licensed to practice in the States of Texas and Colorado.

2. I execute this declaration based on my personal knowledge, except as to those matters based on information and belief, which I believe to be true. If called to testify in this case, I would testify competently about the following facts.

Experience Serving Youth in ORR Custody

3. The Refugee and Immigrant Center for Education and Legal Services (RAICES), is a legal service provider that works primarily with immigrant youth. Since about April of 2020, I have served as Lead Staff Attorney for RAICES representing unaccompanied immigrant youth at the BCFS Staff Secure facility in San Antonio, TX.

4. As of 2018, RAICES is the largest legal aid group of its kind in Texas. RAICES has served unaccompanied children in the legal custody of the Office of Refugee Resettlement ("ORR") who have been placed by ORR at BCFS Staff Secure and other programs within the ORR network of care providers. As of June 2022, RAICES currently serves approximately 442 youth in ORR custody.

1 5. As a legal service provider for ORR shelters, RAICES's attorneys and staff
2 maintain regular contact with the youth at the facilities. We provide ongoing
3 consultations and presentations concerning the legal rights of detained minors. We also
4 provide direct legal representation to youth.

5 Discharges from ORR Custody and ICE Hotel Detention

6 6. In my experience representing children at BCFS Staff Secure, it is common
7 practice for BCFS staff to summon local law enforcement if a minor causes any property
8 damage. When the child is arrested, they are subsequently discharged from ORR custody.
9 Although RAICES is the legal service provider for this facility, I have not been informed
10 why children are discharged from ORR custody upon arrest.

11 7. In one recent case, my client 16-year-old G.M.G., had an upsetting phone call with
12 his abusive mother who was still living in his home country. The shelter disclosed to the
13 mother the child had been transferred to an out-of-network (OON) facility for mental
14 health treatment. The minor's mother understood the minor was sent to a home for "crazy
15 people". Upon returning to Staff Secure after his treatment in the OON facility, G.M.G
16 had an upsetting phone call with his mother, the minor stated on several occasions he did
17 not want to discuss why he was upset and requested a meeting be done later. The shelter
18 staff insisted that they discuss what was bothering him, and did not respect the minor's
19 wishes, which then provoked the minor to throw a chair at a window. Local law
20 enforcement was summoned, and the minor was arrested. The minor was placed in adult
21 detention. After many failed attempts to advocate on his behalf, I finally was able to
22

1 make the appropriate authority understand, the minor was in fact only 16 years old and
2 therefore, unlawfully being held with the adult population. Subsequently, ORR refused to
3 take the minor back into custody when he was released from jail and handed over to ICE.
4 8. G.M.G. was held by ICE in various hotels for approximately 20 days before I was
5 able to advocate that he be transferred back into ORR custody. I was allowed two phone
6 calls with my client while he was being held in ICE custody and at a local hotel in San
7 Antonio, TX. My client told me directly that he was not allowed to leave the hotel room
8 for any recreation activity or just to breath some fresh air. I requested that I be allowed to
9 provide my client with art supplies or swimming trunks, and that request was denied.
10 Despite my efforts to advocate for him, I was not allowed to be involved with which
11 secured facility he would be transferred into. I made a plea that he be placed back into
12 San Antonio Staff Secure so that I could continue legal services. He subsequently was
13 transferred to Children's Village Staff Secure and out of RAICES's area of service.
14 9. A second 16-year-old at BCFS Staff Secure, E.A.M.F., had been in ORR custody
15 since July 15, 2019. Since entering ORR custody, E.A.M.F. had been transferred to
16 various facilities around the country. He was placed in San Antonio Staff Secure in
17 March of 2022, making this his ninth placement in just over two years. On April 9, 2022,
18 E.A.M.F. was arrested and discharged from ORR custody. He was later turned over to
19 ICE officials and detained in a hotel room from April 12, 2022, through April 18, 2022,
20 After many efforts to locate the minor, I was able to finally obtain a phone number to
21 reach him. I worked closely with E.A.M.F.'s attorney at the Michigan Immigrant Rights
22

1 Center, with whom he had built a rapport and trusting relationship. I was extremely
2 concerned about E.A.M.F. because he reported to his attorney that the ICE contractors
3 placed him in restraints and subjected him to verbal abuse and physical assaults. Eight
4 days of this treatment and confinement to a hotel room is not acceptable for a boy already
5 previously diagnosed with various mental health disorders.

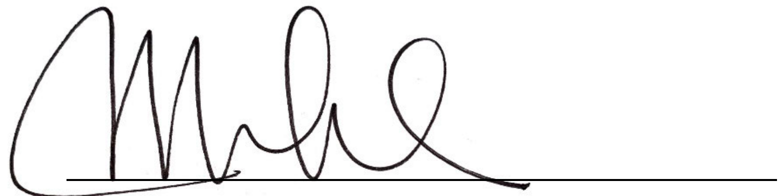
6 10. E.A.M.F.'s arrest was the sixth arrest this year from Staff Secure and the twelfth
7 arrest since about March of 2021. I would estimate that the Staff Secure averages about
8 nine clients a month.

9

10 I declare under penalty of perjury that the foregoing is true and correct. Executed
11 on this 24 day of June 2022, at San Antonio, TX.

12

13

14 

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16 M. Vaneza Alvarado

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EXHIBIT D

August 15, 2022

Sarah B. Fabian
Office of Immigration Litigation
P.O. Box 868, Ben Franklin Station
Washington, DC 20044

Via email

Re: *Flores*, et al. v. *Garland*, et al., No. CV-85-4544 DMG (ARGx)

Sarah,

Plaintiffs are writing to follow up on our July 8, 2022 letter and our July 27, 2022 meet and confer discussion regarding class members whom ORR discharges to local law enforcement and whom ICE thereafter detains in hotels. This letter provides further information on Plaintiffs' position in anticipation of a further meet and confer conversation.

ORR retains legal custody of children it discharges to local law enforcement

Plaintiffs disagree with ORR's argument that it loses legal custody of a child once the child is arrested by local law enforcement. As will be seen, ORR retains legal custody of such children and should therefore resume their physical custody promptly upon their release from the physical custody of state or local law enforcement.

Paragraph 19 of the Settlement provides that "[i]n any case in which the INS does not release a minor pursuant to Paragraph 14, the minor shall remain in INS legal custody." Paragraph 14 provides for the release of class members to a defined set of custodians. Local law enforcement agencies are not among the custodians to whom children may be released.

Similarly, the TVPRA provides that "the care and custody of all unaccompanied [] children, including responsibility for their detention, where appropriate, shall be the responsibility of the Secretary of Health and Human Services." 8 U.S.C. § 1232(b)(1); *see also id.* § 1232(c)(3)(A) ("[A]n unaccompanied alien child may not be placed with a person or entity unless the Secretary of Health and Human Services makes a determination that the proposed custodian is capable of providing for the child's physical and mental well-being."). Neither the Settlement nor the TVPRA authorize ORR to relinquish its responsibility for an unaccompanied child and transfer legal custody to local law enforcement.

The term "legal custody" in the Settlement has the ordinary meaning provided in state family law. *See Flores v. Garland*, 3 F. 4th 1145, 1154-55 (9th Cir. 2021). As the Ninth Circuit explained, "[t]he ordinary meaning of the term 'custody' in family law is the right to make important decisions affecting the child." *Id.*; *see also id.* at 1155 ("California Family Code § 3003 defines 'legal custody' as 'the right and the responsibility to make the decisions relating

to the health, education, and welfare of a child.'"). Legal custody can include joint legal custody. *Id.* at 1155.

Under principles of state family law, a child's parent or other legal custodian does not lose legal custody of a child upon a child's arrest. The same principle applies to children for whom a state child welfare agency acts as *parens patriae*. In Texas, for example, the Department of Family and Protective Services (DFPS) retains legal custody of a foster child involved in the juvenile justice system.[1] Children involved in both the child welfare and juvenile justice systems are considered "dual status" or "crossover youth."[2]

Parents and legal custodians have a critical role in ensuring that a child's rights and welfare are respected after arrest. Specifically, the Texas Family Code requires that a law enforcement officer who takes a child into custody promptly notify "the child's parent, guardian, or custodian." Texas Family Code § 52.02(b). Texas law further provides that a child "is entitled to be accompanied by the child's parent, guardian, or other custodian or by the child's attorney" in the Juvenile Processing Office. Texas Family Code § 52.025(c); ; *see also* Texas Family Code § 52.03(c) (disposition without referral to court can include "a brief conference with the child and his parent, guardian, or custodian" or "referral of the child and the child's parent, guardian, or custodian for services"); Texas Family Code §§ 52.031(f), (g) (child's parent, guardian, or custodian must receive notice and must consent to a child's participation in a first offender program).

Federal law includes similar protections for children detained on allegations of juvenile delinquency. *See, e.g.,* 18 U.S.C. § 5033 (requiring notice to a "juvenile's parents, guardian, or custodian" of a child's arrest, the child's rights, and the charges against them).

Plaintiffs understand that ORR—like any legal custodian—cannot exercise plenary decision-making authority over a child arrested and temporarily detained by local law enforcement, but this does not absolve ORR of its obligations to act as a child's legal custodian until and unless it properly releases the child to an appropriate custodian in accordance with the TVPRA and the Settlement. Indeed, under a contrary interpretation of the law, local law

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[1] *See* Texas Department of Family and Protective Services, *Juvenile Justice Resource Guide* at p. 8, March 2019, http://www.dfps.state.tx.us/handbooks/CPS/Resource_Guides/Juvenile_Justice_Resource_Guide.pdf ("When a youth in DFPS conservatorship becomes involved with the juvenile justice system, DFPS does not relinquish conservatorship."); *see also* American Bar Association, *Criminal Justice Standards: Dual Jurisdiction Youth*, https://www.americanbar.org/groups/criminal_justice/standards/dual_jurisdiction_youth/ ("1.2(l) The child welfare system and agencies should not terminate services or close a youth's dependency case solely because the youth was arrested….").

[2] *See, e.g.,* Texas Children's Commission, *Dual Status Task Force Final Report* at p. 13, December 2021, http://texaschildrenscommission.gov/media/84912/dual-status-task-force-final-report.pdf; Georgetown University Center for Juvenile Justice Reform, *Crossover Youth Practice Model*, https://cjjr.georgetown.edu/our-work/crossover-youth-practice-model/; Robert F. Kennedy National Resource Center for Juvenile Justice, *Dual Status Youth Reform*, https://rfknrcjj.org/resources/dual-status-youth/.

enforcement would be empowered to release the child to his or her parent or other adult independently of ORR's wishes. *See, e.g.,* Texas Family Code § 52.02(1) ("[A] person taking a child into custody" in Texas may "release the child to a parent, guardian, custodian of the child, or other responsible adult upon that person's promise to bring the child before the juvenile court as requested by the court."). This would be clearly inconsistent with the TVPRA. *See* 8 U.S.C. § 1232(c)(3)(A).

ORR is therefore obliged to safeguard the welfare of a child arrested by local law enforcement to the same extent as other legal custodians whose children are arrested. This includes checking in on the child, ensuring the child has access to counsel, and addressing concerns about violations of the child's rights with the relevant local authorities. This is the same role DFPS caseworkers play for Texas foster children in the juvenile justice system.[3] If a child is mistakenly placed in adult detention, for example, it is important that someone advocate for their proper placement. *See* Alvarado Decl. ¶ 7. Critically, ORR should also immediately begin planning for the child's release to ensure that the child can be transferred to an appropriate placement promptly upon the child's release from the physical custody of state or local law enforcement.[4]

Leaving a child in law enforcement custody with no legal custodian deprives them of critical protections and interferes with the child's ability to promptly return to an appropriate placement. Unaccompanied immigrant children are at particular risk in the criminal system because they generally do not speak English and lack an understanding of the U.S. legal system. In addition, many of the children arrested by local law enforcement and discharged from ORR custody are especially vulnerable because of their heightened mental health needs. E.A.M.F. (A# ███████), for example, entered ORR custody over three years ago and has a well-documented history of trauma and mental health challenges. *See* Vanegas Decl. ¶¶ 7, 13. He spent a cumulative total of over 400 days at MercyFirst RTC in 2019-2021. Following his return to ORR custody, E.A.M.F. was placed at an out-of-network RTC. Vanegas Decl. ¶ 12. G.M.G. (A# ███████) spent over a year in ORR custody before his arrest and is also currently placed at an out-of-network RTC. His casefile reflects a serious trauma history, multiple mental health challenges, and a significant intellectual disability.

Although ORR cannot control the actions of local law enforcement, it has an obligation under the Settlement and the TVPRA to maintain legal custody and take the steps within its power to ensure the safety and welfare of these vulnerable children.

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[3] *See* Texas Department of Family and Protective Services, *Juvenile Justice Resource Guide* at pp. 7-8 (child's DFPS caseworker takes steps to ensure an application requesting appointment of counsel is filed and "works cooperatively with law enforcement, juvenile justice officials, and the youth's caregiver to plan appropriately for the youth"). Even after a foster child in Texas is adjudicated delinquent and committed to juvenile justice custody, DFPS continues to be responsible for meeting with the child, ensuring they are receiving appropriate services, and developing a transition plan. *See* Texas Department of Family and Protective Services, *Juvenile Justice Resource Guide* at p. 14.
[4] *See* Texas Department of Family and Protective Services, *Juvenile Justice Resource Guide* at p. 14 (caseworker responsibility for transition planning); *see also id.* at 16 ("When a youth is placed on probation, CPS resumes responsibility for placing the youth in a suitable living arrangement").

Defendants may not subject class members to prolonged detention in hotels

Plaintiffs do not agree with Defendants' position that the district court's orders restricting the detention of class members in hotels and requiring Defendants to report prolonged hotel detentions apply exclusively to class members detained pursuant to Title 42.

Even assuming, *arguendo*, that ORR could relinquish legal custody of class members upon arrest by local law enforcement, ORR would have an obligation to promptly resume custody after the child's release by local authorities. Nothing in the TVPRA requires a child to go through ICE custody before returning to ORR custody and the district court's orders prohibit Defendants from requiring vulnerable children to spend over three days in hotels awaiting ORR placement.

In its September 2020 orders, the district court held that children detained pursuant to Title 42 are class members and therefore entitled to the full protections of the Settlement. Order re Plaintiffs' Motion to Enforce Settlement as to "Title 42" Class Members at 17, Sept. 4, 2020 [Doc. # 976] ("Sept. 4 Order"). In so ruling, the Court rejected Defendants' argument that they may treat children detained under Title 42 with less regard than those they detain under Title 8. Defendants now appear to argue that children they detain under Title 8 are entitled to fewer protections than those they detain under Title 42, a notion that cannot be reconciled with the parity between Title 8 and Title 42 class members the Court's order require.

In any event, the plain language of the district court's September 2020 orders limits ICE hotel detention for *all* class members. *See* Order re Defendants' *Ex Parte* Application to Stay at 5, Sept. 21, 2020 [Doc. # 990] ("Sept. 21 Order") ("DHS shall cease placing minors at hotels", with exceptions for "*brief* hotel stays (not more than 72 hours) as necessary and in good faith to alleviate bottlenecks in the intake processes at licensed facilities."); *id.* ("When *any Class Members* are transferred to hotels for this purpose, Defendants shall notify Plaintiffs' counsel and the Independent Monitor, providing the identities and number of minors subject to the hotel placements, and the locations of the hotels.") (emphasis added).

In its September 4, 2020, order, the district court made clear that children in custody under Title 42 are entitled to the same protections as all other class members. *See* Sept. 4 Order at 17 ("Defendants shall comply with the Agreement with respect to such minors [in Title 42 custody] *to the same degree* as any other minors held in their custody.") (emphasis added). The Court also specifically provided that "[i]f other exigent circumstances arise that necessitate future hotel placements, Defendants shall *immediately* alert Plaintiffs and the Independent Monitor, providing good cause for why such unlicensed placements are necessary." *Id.*

Lastly, Plaintiffs note that the ICE Juvenile Coordinator's Annual Report states, ". . . ICE may have occasion to rely on brief, ad hoc hotel stays for Class Members and their accompanying parents and legal guardians, *subject to the terms set forth in this court's September 4 and September 21, 2020 orders*." ICE Annual Juvenile Coordinator Report at p. 2 [Doc. #1259-2] (emphasis added). If Defendants now contend that they may detain children

arrested pursuant to Title 8 in hotels without regard to the Court's September 2020 orders, they should correct the record on this point.

Plaintiffs are hopeful that the Parties' disagreement over prolonged hotel detentions can be obviated if ORR maintains legal custody of children arrested by local law enforcement and makes reasonable and good faith efforts to plan for the child's return to ORR custody after being released from local law enforcement authorities. If the child remains in ORR's legal custody, the agency need not wait for a re-referral from ICE to begin working on a suitable placement for the child.

Please let us know when Defendants are available for a follow up meet and confer discussion regarding these issues.

Best,

Mishan Wroe

EXHIBIT E

December 6, 2022

Fizza Batool
Office of Immigration Litigation
P.O. Box 868, Ben Franklin Station
Washington, DC 20044

Via email

Re: *Flores*, et al. v. *Garland*, et al., No. CV-85-4544 DMG (ARGx)

Fizza:

Plaintiffs are writing to follow up on our November 3, 2022 meet and confer discussion regarding class members discharged from ORR custody following arrest by local law enforcement, and Defendants' request for specific recommendations on potential ORR guidance addressing this issue.

Introduction

As outlined in our July 8, 2022 and August 15, 2022 meet and confer letters, Plaintiffs maintain that ORR has an obligation under the *Flores* Settlement and the TVPRA to retain legal custody of children arrested by local law enforcement. A child's temporary transfer to the physical custody of local law enforcement does not discharge ORR's legal responsibility for the child and ORR's obligation to ensure the child is placed in the least restrictive setting that is in the best interest of the child, as the Settlement and the TVPRA require. Despite the parties' multiple meet and confer conversations, Defendants have yet to identify any provision of the Settlement or the TVPRA that even permits, let alone requires, discharge of a child from ORR's legal custody upon arrest.[1]

In the interest of finding solutions to safeguard the safety and well-being of class members, however, Plaintiffs offer the following recommendations for future ORR guidance on children arrested by local law enforcement. By providing such recommendations, Plaintiffs are not waiving our legal position and, pending review of any new ORR policy regarding discharge of unaccompanied children after arrest, Plaintiffs will continue to explore the legal remedies available to our class members.

Recommendations

Before discharging a child from ORR's legal custody, ORR and/or the child's assigned care provider shall:

[1] The only TVPRA provision cited by Defendants, 8 U.S.C. 1232(b)(2), relates to referrals of children to ORR custody and does not refer to discharges. Moreover, nothing in this provision bars ORR from directly taking custody of an unaccompanied child.

- Delay discharge for at least 24 hours after arrest to determine whether the child will be detained indefinitely by law enforcement pending delinquency proceedings or returned to the care provider facility.[2] Immediately resume custody if law enforcement releases the child.

- Immediately notify the child's parent or legal guardian, attorney, and Child Advocate, if any, of the child's arrest, current location, law enforcement point of contact, and public defender contact, if known. As detailed in Plaintiffs' August 15, 2022 letter, unaccompanied children arrested by local law enforcement are often particularly vulnerable and at serious risk if left without a legal custodian in an unfamiliar criminal system. If ORR is unwilling to maintain responsibility for the child, it must ensure the child's access to other adult advocates.

  If the child does not have an individual attorney, the legal service provider assigned to the facility should be notified of the child's arrest. ORR could make exceptions to the parent or legal guardian notification requirement if there are specified child welfare reasons not to provide notice. *See, e.g.,* ORR Policy Guide 1.2.4.

- Arrange a face-to-face visit or phone call with the child to explain where the child is and likely next steps in the child's case, including names and numbers of persons the child can contact for assistance (e.g., Child Advocate, public defender's office).

- Notify local law enforcement authorities of information necessary to ensure the child's immediate safety, including the child's status as a minor, the child's preferred language, any current medications or prescriptions, any disability-related accommodation needs (e.g., hearing aids), and whether the child is at documented enhanced risk for suicide. To facilitate representation and advocacy by the child's representatives, ORR should also notify law enforcement authorities of the names of the child's attorney/legal service provider and Child Advocate, if any.

While a child is detained by local law enforcement, ORR shall:

- Immediately begin planning for the child's return to ORR custody, including by determining whether the child can return to their current placement if it is in their best interests to do so, whether additional services could be provided to maintain the current placement, or whether the child needs a different placement. ORR should coordinate with the child's attorney and Child Advocate, if any, to identify and secure an appropriate, least restrictive placement.

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[2] Program staff at Compass Connections Staff Secure informed Plaintiffs' counsel during our recent site visit that they understand ORR's policies to require discharge if a child has been in local law enforcement's physical custody for 24 hours.

- If charges are filed against the child, contact relevant authorities to ensure an application for appointment of a public defender is filed and provide any information necessary to facilitate appointment of a public defender.[3] ORR should also directly notify the local public defender's office of the arrest of an unaccompanied child.

- Coordinate with the child's public defender, including by sharing information necessary to enable representation and working with the public defender to identify placement options if delinquency proceedings are not commenced or are terminated against the child, or if the child is eligible for bail or other alternatives to detention.

Upon a child's release from law enforcement detention, ORR shall:

- Ensure an ORR placement is immediately available for the child. If no long-term placement has been secured by the time of the child's release, ORR should require the child's prior care provider to take the child back at least temporarily while a new placement is secured, unless the prior care provider can demonstrate a valid reason for denial under ORR Policy Guide 1.3.3. ORR could also explore arrangements with existing care providers to provide temporary emergency placements when needed.

- Establish a protocol to ensure that a child's belongings are transferred to the new placement and to coordinate with the child's attorney and Child Advocate, if any.

Conclusion

In Plaintiffs' view, it would be simpler for ORR to plan for a child's release from local law enforcement and take other steps to protect the child's welfare if ORR retains legal custody of the child. As detailed in Plaintiffs' August 15, 2022 letter, retaining legal custody would be in line with state child welfare practice and would promote the best interests of the child. Plaintiffs are nonetheless willing to reach a compromise if ORR delays discharge by at least 24 hours and takes steps to ensure the child's prompt return to ORR custody and placement in the least restrictive setting consistent with the child's best interests. If ORR continues to insist that an ICE referral is required to resume physical custody of a child, it should obtain such a referral without forcing the child to spend time in physical ICE detention.

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[3] *See* Texas Department of Family and Protective Services, *Juvenile Justice Resource Guide* at p. 7, March 2019, http://www.dfps.state.tx.us/handbooks/CPS/Resource_Guides/Juvenile_Justice_Resource_Guide.pdf ("If a criminal attorney has not been appointed for a foster care youth who is charged as a juvenile or as an adult, the caseworker contacts the Regional Attorney and the youth's representatives (attorney ad litem, guardian ad litem and CASA) so that an Application Requesting Appointment of Counsel or a petition to determine indigency can be filed with the appropriate court, if necessary.").

Please provide Defendants availability in December for a follow up meet and confer discussion regarding these issues.

Best,

Mishan Wroe

EXHIBIT F

Mishan Wroe <mwroe@youthlaw.org>

Follow-up on Meet and Confer re Discharges from ORR custody

Batool, Fizza (CIV) Fizza Batool2@u doj gov Tue, Sep 19, 2023 at 9 27 AM
To: Mishan Wroe <mwroe@youthlaw.org>
Cc: "Fabian, Sarah B (CIV)" <Sarah.B.Fabian@usdoj.gov>, Leecia Welch <lwelch@childrensrights.org>, Carlos Holguín <crholguin@centerforhumanrights.email>, Neha Desai <ndesai@youthlaw.org>

Mishan,

My sincere apologies for the delay. ORR has updated the UC Policy Guide & MAP Section 5.8.11. Please find attached the revi ed MAP Section 5 which include the new policie on page 48 49 The new policie can al o be found in the UC Policy Guide here: https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide-section-5.

ORR also plans to update the UC Policy Guide/MAP Section 3 related to behavior management to reiterate that calls to law enforcement are not considered a behavior management strategy and care providers should make every effort to de-escalate a conflict to prevent the need to contact law enforcement. I do not have a timeframe for this development at the moment We will notify Plaintiff when the e are publi hed

Kind regard ,

Fizza

From: Mishan Wroe <mwroe@youthlaw.org>
Sent: Wednesday, September 6, 2023 4:52 PM
To Batool, Fizza (CIV) Fizza Batool2@u doj gov
Cc: Fabian, Sarah B (CIV) <Sarah.B.Fabian@usdoj.gov>; Leecia Welch <lwelch@childrensrights.org>; Carlos Holguín <crholguin@centerforhumanrights.email>; Neha Desai <ndesai@youthlaw.org>
Subject: Re: [EXTERNAL] Follow-up on Meet and Confer re Discharges from ORR custody

Hi Fizza,

I hope you are doing well. I am writing to follow-up on the updates to the MAP regarding discharges to law enforcement. Did tho e change happen in Augu t a e pected? If o, can you plea e hare the MAP with u ?

Thank ,
Mishan

--

Mishan Wroe, she/her
Senior Attorney, Immigration & Legal Advocacy
p: 510.920.3512
youthlaw.org

On Mon, Jun 12, 2023 at 1:25 PM Mishan Wroe <mwroe@youthlaw.org> wrote:

> Fizza,
>
> Thank you for these responses. We look forward to reviewing the MAP when it's updated and we can circle back with any questions we have at that point. Have a great week.
>
> Best,
>
> Mishan
>
> --
>
>
>
> **Mishan Wroe, she/her**
> **Senior Attorney, Immigration & Legal Advocacy**
> p: 510.920.3512
> youthlaw.org
>
>
>
> On Mon, Jun 5, 2023 at 1:03 PM Batool, Fizza (CIV) <Fizza.Batool2@usdoj.gov> wrote:
>
>> Mishan,
>>
>> Below, please find answers in red to Plaintiffs' questions.
>>
>> 1. When does ORR plan to update the Policy Guide and the MAP regarding its discharge policy? ORR endeavor to update the guidance by Augu t 2023
>> 2 Will ORR end Plaintiff the updated MAP portion when they are available? Ye

3. Can you please describe which of Plaintiffs' recommendations ORR is planning to adopt in its update guidance? We are not in a position to share this information at this time given that the agency is in the deliberative stage regarding these changes. However, ORR states that it is serious about taking Plaintiffs' letter recommendation into account

Kind regard ,

Fizza

From: Mishan Wroe <mwroe@youthlaw.org>
Sent: Thursday, June 1, 2023 8:02 PM
To Batool, Fizza (CIV) <Fizza Batool2@u doj gov
Cc: Fabian, Sarah B (CIV) <Sarah.B.Fabian@usdoj.gov>; Leecia Welch <lwelch@childrensrights.org>; Carlos Holguín <crholguin@centerforhumanrights.email>; Neha Desai <ndesai@youthlaw.org>
Subject: Re: [EXTERNAL] Follow-up on Meet and Confer re Discharges from ORR custody

Fizza,

Thank you for sharing this information with us and we are relieved to hear that [redacted] is no longer in ICE custody. At thi time, if we are able to di cu our que tion via email, we agree that we can forgo a meet and confer phone call. Our questions are listed below and we look forward to ORR's response. If you'd prefer to schedule a call, please let us know.

Best,

Mishan

1. When does ORR plan to update the Policy Guide and the MAP regarding its discharge policy?
2. Will ORR send Plaintiffs the updated MAP portions when they are available?
3. Can you please describe which of Plaintiffs' recommendations ORR is planning to adopt in its update guidance?

--

Mishan Wroe, she/her
Senior Attorney, Immigration & Legal Advocacy
p: 510.920.3512
youthlaw org

EXHIBIT G

Mishan Wroe <mwroe@youthlaw.org>

Florida licensing

1 message

Mishan Wroe <mwroe@youthlaw.org> Fri, Jan 14, 2022 at 9:58 AM
To: Jonathan.Wall@hhs.gov
Cc: Neha Desai <ndesai@youthlaw.org>

Jonathan,

I hope you are doing well. We have been closely monitoring the developments with Florida licensing and have been in contact with Florida providers and advocates. We know that you are working on this issue and wanted to reach out to see if there is a way we can be helpful. Might you have some time next week to discuss and explore whether there is any support we can provide to you all as you navigate this issue?

Best,
Mishan

Mishan Wroe *(Pronouns: she / her / hers)*
Senior Attorney, Immigration & Legal Advocacy
National Center for Youth Law
Phone: 510-920-3512
Fax: 510-835-8099
1212 Broadway, Suite 600, Oakland, CA 94612

EXHIBIT H

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Shakti Belway

Fizza Batool
Trial Attorney
Office of Immigration Litigation
fizza.batool2@usdoj.gov

Via email

May 10, 2024

Dear Fizza,

We write to meet and confer regarding violations of the *Flores* Settlement Agreement ("Settlement Agreement" or "FSA") occurring in CBP's San Diego Sector.

Flores counsel recently interviewed class members at the Imperial Beach, Boulevard, and Campo CBP stations in the San Diego Sector. Class members at all three stations reported concerning violations of the Settlement Agreement, which are outlined below. To avoid motion practice, Plaintiffs request a meet and confer call to discuss what steps Defendants will take to remedy these violations and ensure future compliance with the Settlement Agreement in the San Diego Sector.

I. Unsafe and Unsanitary Conditions (FSA ¶ 12A)

CBP is required to hold minors "in facilities that are safe and sanitary and that are consistent with [CBP's] concern for the particular vulnerability of minors." FSA ¶ 12A. Facilities must provide access to "toilets and sinks, drinking water and food as appropriate . . . [and] adequate temperature control." *Id.* Adequate access to hygiene items, including "soap, towels, showers, dry clothing, [and] toothbrushes" fall within the Settlement Agreement's requirement of "safe and sanitary" conditions. *Flores v. Sessions*, 394 F. Supp. 3d 1041, 1057 (C.D. Cal. 2017).

Class members described unsafe and unsanitary conditions arising from a lack of access to basic hygiene services and items, overcrowding, and inadequate temperature control.

Numerous children, including children who had been detained for more than three days, reported no access to showers, hand soap, or toothbrushes and toothpaste. *See, e.g.*, JAF Decl. ¶ 9; PCH Decl. ¶ 10; AFBA Decl. ¶ 8; GMC Decl. ¶ 9; WJVR Decl. ¶ 6. Class members also described unsafe overcrowding in several areas. For example, in family unit areas at Campo, children slept on the floor because there were not enough mats to sleep on or were forced to share a single mat between three children, and there were only two toilets available for more than 50 people. *See* GMC Decl. ¶¶ 5, 9; MANG Decl. ¶ 6; *see also* JAC Decl. ¶ 10.

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info@youthlaw.org | www.youthlaw.org

Children also reported that the cells were dirty, and that there was garbage and leftover food in the cells that they had to clean up. *See, e.g.* PCH Decl. ¶¶ 6, 10, 14; MANG Decl. ¶ 4.

II. Lack of Separated and/or Private Bathrooms (FSA ¶¶ 11, 12A)

In addition to requiring that children be held in "safe and sanitary" conditions, the Settlement Agreement requires CBP to treat "minors in its custody with dignity, respect, and special concern for their particular vulnerability as minors." FSA ¶¶ 11, 12A. However, children routinely reported across all three stations that the only toilets available to them are located in their cells, with no division or separation from their eating and sleeping spaces, creating unsanitary conditions. JAC Decl. ¶ 18; PCH Dec. ¶ 9; JAF Decl. ¶ 8; AFBA Decl. ¶ 8; KPR Decl. ¶¶ 11, 14; BBS Decl. ¶ 9; GBS Decl. ¶ 8; COL Decl. ¶ 9; ES Decl. ¶ 7; MANG Decl. ¶ 5; WJVR Decl. ¶ 6.

The complete lack of privacy to use the bathroom also violates the Settlement Agreement's requirement that minors be treated with "dignity, respect, and special concern for their particular vulnerability." FSA ¶ 11. Children reported that the toilets were open to rest of the cell and within view of cameras. *See* PCH Decl. ¶ 9 ("if you want to use the toilet, everyone can see you and there is also a camera there."); *see also, e.g.*, JAF ¶ 8; AFBA ¶ 8; GMC ¶ 9; ES Decl. ¶ 7. Some children described holding up blankets so that they could have privacy while using the toilet. *See, e.g.*, JAF ¶ 8; GMC ¶ 9; MANG Decl. ¶ 5. The lack of privacy was very distressing to the children we spoke with and failed to account for their particular vulnerability as minors.

III. Lack of Family Visitation or Contact (FSA ¶ 12A)

The Settlement Agreement requires CBP to provide children with "contact with family members who were arrested with the minor." FSA ¶ 12A. *Flores* counsel interviewed several children who were separated from their family members—including from their siblings and parents—and provided no in-person or telephonic contact. *See e.g.*, JAF Decl. ¶ 5; JMRM Decl. ¶¶ 3-4; KPR Decl. ¶¶ 4, 8, 15. For example, a 14-year-old girl at the Imperial Beach Station had no contact with her 12-year-old brother for more than 3 days, until their *Flores* interview. PCH Decl. ¶¶ 4, 8.

IV. Inadequate Temperature Control (FSA ¶ 12A)

Maintaining facilities at a consistently cold temperature is a violation the Settlement Agreement, which requires adequate temperature control in facilities holding children. FSA ¶ 12A; *Flores v. Sessions*, 394 F. Supp. at 1059. Many children reported being very cold or freezing throughout their time in CBP facilities. *See, e.g.*, JAC Decl. ¶ 12; JAF Decl. ¶ 9; PCH Decl. ¶ 11; AFBA Decl. ¶ 12; GBS Decl. ¶ 7. Class members also reported that CBP does not provide additional clothing—or allow children to access additional layers in their own belongings—for children to keep warm. *See, e.g.*, JAC Decl. ¶ 12; JAF Decl. ¶ 9; PCH Decl. ¶ 11; AFBA Decl. ¶ 12; KLRP Decl. ¶ 4; KPR Decl. ¶¶ 13-14. We interviewed some class members and their adult relatives who reported that children were becoming sick from the cold temperatures. *See, e.g.*, KLRP Decl. ¶ 4; ES Decl. ¶ 11.

V. Inadequate Telephone Access (FSA ¶ 12A)

CBP has a responsibility to treat children "with special concern for their particular vulnerability as minors," FSA ¶ 12A, even when a certain condition is not explicitly enumerated in the Settlement Agreement. *Flores v. Sessions,* 394 F. Supp. 3d at 1060 (finding that adequate sleeping conditions were required by the Settlement as part of concern for the particular vulnerability of minors); *Flores v. Barr*, 934 F.3d 910, 915 (9th Cir. 2019) (same). Access to a telephone call is an essential factor of accounting

for the "particular vulnerability of minors," especially unaccompanied minors.[1] One of the most important components to a child's sense of safety and security is connection and access to a trusted adult.[2] For children in CBP custody, phone access may be the only way a child can talk to a caregiving adult they trust. Furthermore, while children may have traveled with a trusted adult, they may also need to talk to another trusted adult who is a parent or primary caregiver who may only be available to them by phone. For these reasons, telephone access is central to providing conditions that are consistent with a "concern for the particular vulnerability of children."

Flores counsel spoke with children, including unaccompanied children, in each of the three stations who had not been permitted to make a telephone call. *See, e.g.*, JAF Decl. ¶ 14; AFBA Decl. ¶ 7; GMC Decl. ¶ 6; MANG Decl. ¶ 11. The inability to make phone calls with loved ones had exacerbated the stress these children experienced in CBP custody. *See, e.g.*, JAF Decl. ¶ 13.

VI. Failure to Expeditiously Process Minors (FSA ¶ 12A)

Under the Settlement Agreement, CBP "shall expeditiously process [ ] minor[s]." FSA ¶ 12A. At the Imperial Beach Station, *Flores* counsel interviewed three children who had been detained there for more than 72 hours. *See* JAF Decl. ¶ 6; PCH Decl. ¶¶ 4, 8 (sibling pair). *Flores* counsel is deeply concerned that class members experience unnecessarily prolonged stays in unsafe detention conditions while waiting to be transferred to licensed placements.

Please provide Defendants' availability for a meet and confer regarding these issues. We request that you provide options for a meeting as soon as possible and no later than May 17, 2024.

Thank you,

Mishan Wroe

Cc: Andrea Sheridan Ordin, aordin@strumwooch.com; Dr. Paul H. Wise, pwise@stanford.edu; Dr. Nancy Ewen Wang, ewen@stanford.edu.

[1] The agency's own TEDS Standards recognize this responsibility and *require* CBP to offer telephone calls to unaccompanied children. *See* U.S. Customs and Border Protection, National Standards on Transport, Escort, Detention, and Search, *Section 4.9 Telephones*, October 2015, https://www.cbp.gov/sites/default/files/assets/documents/2020-Feb/cbp-teds-policy-october2015.pdf.

[2] Center on the Developing Child at Harvard University, "Three Principles to Improve Outcomes for Children and Families," 2021 Update, at 3-4, https://harvardcenter.wpenginepowered.com/wp-content/uploads/2017/10/3Principles_Update2021v2.pdf (describing how responsive relationships with caregivers promote healthy brain development in children and help children deal with stress and regulate emotions).

Jenny L. Flores, et al. v. Merrick Garland, et al.
Case No. CV 85-4544-DMG (AGRx)

Exhibit Index to Plaintiffs' Opposition to Motion to Terminate as to HHS

Exhibit	Exhibit Description
1	Declaration of Jill Mason, May 29, 2024
2	Declaration of Larry Bolton, May 29, 2024
3	Declaration of Carrie Vander Hoek, May 30, 2024
4	Comment of State Attorneys General to Unaccompanied Children Program Foundation Rule, December 4, 2023
5	United States Government Accountability Office, *Unaccompanied Children: Actions Need to Improve Grant Application Reviews and Oversight of Care Facilities*, GAO-20-609, September 2020
6	Comment of Southwest Key Programs, Inc., Response to RFI for Federal Licensing of ORR Facilities, October 2021
7	Comment of *Flores* Class Counsel to Proposed ORR Foundational Rule, December 4, 2023
8	Declaration of Jennifer Vanegas, July 19, 2022
9	Declaration of M. Vaneza Alvarado, June 24, 2022

Previously Filed Declarations

Docket No.	Description
1039-9	Declaration of Class Member at Nexus Children's Hospital, November 13, 2020
1039-10	Declaration of Class Member at Nexus Children's Hospital, November 13, 2020
1422-2	Declaration of KPR, April 30, 2024
1422-3	Declaration of AFBA, April 30, 2024
1422-8	Declaration of JAF, April 29, 2024

EXHIBIT 1

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DECLARATION OF JILL MASON

I, Jill Mason, declare as follows:

1. I am a Licensed Clinical Social Worker (LCSW) with over 25 years of clinical social work experience working with youth in foster care, including executive-level leadership positions. I have served in various leadership and consulting positions at Seneca Family of Agencies for the past 20 years, including acting as the Division Director for Community Based Services and the Project Director for Todo Por Mi Familia. The facts set forth in this declaration are based upon my personal knowledge, and if called to do so, I would competently testify under oath regarding the same.

2. I submit this declaration in support of Plaintiffs' Opposition to Defendants' Motion to Terminate the *Flores* Settlement Agreement as to the Department of Health and Human Services. In preparing this declaration, I reviewed the declaration of Allison Blake in support of Defendants' motion and pages 34485-86 of the preamble to the Foundational Rule.

Background and Qualifications

3. I received a Bachelor of Social Work from Baylor University in 1997 and a Master of Social Work from Virginia Commonwealth University in 1999. I have been a LCSW in California since 2005 and in Arizona since 2007. I began working as a therapist for Seneca's residential treatment program in 1999. I conducted assessments of children and families, provided therapy, and managed cases for foster youth in a residential care setting. I started this work because I wanted to help foster youth and their families with the healing process. My work allowed me to support children in addressing their histories of trauma, abuse, and neglect.

4. Seneca is a nonprofit with a $180 million budget that provides children and families with behavioral health and social services. Many of Seneca's programs serve

children in the child welfare system. I was drawn to Seneca, in particular, because the organization has a focus on helping children unconditionally.

5. Since 2003, I have held various executive leadership and consulting positions with Seneca, including acting as the Division Director for Residential Services, the Division Director for Community Based Services, a Regional Executive Director, a Consulting Executive Director, and the Project Director for Todo Por Mi Familia.

6. As Division Director, I oversaw all aspects of community based programs with a total budget of $35 million and over 500 employees. My responsibilities included program development, fiscal management and oversight, and total clinical and administrative oversight of multiple programs and facilities, including managing various programs and services for youth in foster care.

7. In 2007, in my capacity as Regional Director at Arizona's Children Association, I oversaw a program with Catholic Charities that managed Office of Refugee Resettlement (ORR) placements in Maricopa County, Arizona.

8. As a Consulting Executive Director for Seneca from 2014-2020, I designed a program model for two Short-Term Residential Therapeutic Programs and provided expert consultation regarding start-up implementation, state licensure, and Medicaid billing. I also provided consultation and direction to regional leadership regarding The Joint Commission (TJC) accreditation.

9. From 2020-2022, I acted as the Project Director for Todo Por Mi Familia. Through this national program, Seneca offered over 2,300 parents and children who were forcibly separated at the border mental health services through a $14.5 million time-limited, sole source contract with the U.S. Department of Health and Human Services. This program was the result of a federal court order in the *Ms. JP v. Sessions* lawsuit requiring the government to provide mental health services to families impacted by the government's "Zero Tolerance Policy." The program was ultimately incorporated into the *Ms. L v. ICE* Settlement. Through this work, I

1 learned about the overwhelming mental health needs of many children in ORR
2 custody. I was struck by their profound histories of trauma and abuse.
3 10. Since 2022, I have been a Consultant for Rising Social Strategies assisting
4 public agencies and nonprofits with their goal of supporting and improving child
5 serving systems. I have worked with various governmental entities and nonprofit
6 organizations providing residential and community based services to youth and
7 families. I have provided technical assistance to public child welfare agencies on
8 program design and implementation, state licensure, contracting and budgets. I have
9 also provided expert consultation to multiple nonprofits regarding state licensure and
10 accreditation.
11 11. California requires all residential programs to have a Certified Administrator
12 who is trained in licensing requirements. I developed the curriculum to train
13 California's Certified Administrators about residential licensing requirements, and I
14 have led many of those trainings.
15 12. I also served on Arizona's Foster Care Review Board, where I supported
16 children who had spent long periods in foster care with gaining permanency. I have
17 also served as a CASA in Arizona.
18 13. Through my work at Seneca and consulting with other nonprofit organizations
19 that provide residential care to children in the foster care system, I have developed in-
20 depth knowledge of state licensing, including an understanding of California's
21 detailed regulatory requirements for residential placement. I have led all aspects of
22 the initial licensing process and managed ongoing licensing compliance for many
23 Seneca Programs for over two decades.
24 14. I have also been deeply involved in the accreditation process for Seneca. I,
25 along with two other co-workers, led Seneca's initial accreditation process in the early
26 2000s and established systems to qualify for TJC accreditation. Since then, I have
27 overseen Seneca's programs to make sure that they remain compliant with all
28 accreditation requirements. My work has included obtaining accreditation for new

Seneca programs and helping three previously non-accredited agencies that joined Seneca successfully navigate the accreditation process and prepare for TJC's on-site review surveys that occur every three years.

Role of State Licensing in Ensuring the Health and Safety of Children

15. State licensure systems are critical to protecting children from harm. Licensing standards, ongoing state oversight, and regulatory enforcement are all necessary to safeguard children's health and well-being and to ensure they are being treated with dignity and respect.

16. In the field, we rely on licensing regulations daily as we apply those requirements to our practice. Before a facility can open, organizations must complete an extensive approval process that addresses the population they plan to serve and how they will comply with licensing regulations. The licensing agency conducts site inspections before facilities can begin operating, and during those visits the program must demonstrate that it meets all licensing requirements. To ensure continued compliance with these requirements, organizations must also show that they have ongoing administrative and programmatic systems in place.

17. In California, organizations that apply for licensure must complete a lengthy three-part application. First, the organization must submit a plan of operation comprised of policy and procedure-oriented documents that indicate how the program will comply with licensing regulations. The plan includes all the different processes in place, such as the process for conducting criminal background checks on staff prior to hiring. This plan must articulate the evaluation, accountability, and supervision processes for all staff, including the Board of Directors. The Board of Directors also must sign a statement that they will hold the organization accountable. Second, the organization must develop a Program Statement that explains the concept, goals, and philosophies of the program. Third, the organization must complete a range of

1 administrative forms, such as forms indicating they have sufficient operational
2 funding. In total, licensing applications are generally about 300 pages with detailed
3 explanations of all the licensing compliance mechanisms.
4 18. After an organization submits its licensing application, the licensing agency
5 reviews it and conducts site inspections to ensure the facility meets all the different
6 types of regulations, such as fire clearances. If any issues are identified during the site
7 visit, the organization must make corrections, and only after those corrections are
8 made will the state issue a provisional license. Provisional licenses last for up to 12
9 months during which time the licensing agency conducts further monitoring of the
10 site. After the provisional period, if a site is in full compliance with licensing
11 regulations, the Community Care Licensing Division (CCL) will issue a license.
12 19. Once an application is approved, CCL provides oversight to ensure the
13 organization maintains compliance with licensing standards. If the Program
14 Statement in the application outlines more exacting standards than those required by
15 licensing regulations, CCL will also require the organization to meet those more
16 exacting standards.
17 20. Organizations, like Seneca, will generally start hiring staff after they have been
18 granted a provisional license. To comply with licensing requirements, the hiring
19 process must include a criminal history check, a check of the California Child Abuse
20 Central Index, and an Out of State Child Abuse Check for anyone who lived outside
21 of the state for the past five years. The background check process is vital to children's
22 safety because it helps screen out people with a history of harming children.
23 Background checks need to be comprehensive and pull from all jurisdictions to ensure
24 child safety. If an exemption is sought for a potential employee with a criminal
25 background, the state licensing agency makes the determination whether to grant it. It
26 is important that the licensing agency make this decision because the organization
27 itself is not the right entity to decide whether or not to exempt its own staff.
28

21. CCL inspects facility sites annually in California, but most facilities will have ongoing contact with CCL in response to various types of complaints and incidents reported by the facility as required by regulation. CCL can get complaints from anyone, including children, case workers, parents and even staff working at the facility. By regulation, licensed facilities are required to report standards violations to CCL and submit written incident reports on a wide range of occurrences within codified timeframes. In addition, when someone calls Child Protective Services (CPS) alleging a child in a residential facility or foster home has been abused or neglected, CPS sends that report to CCL to investigate.

22. Each licensed facility and foster care agency has an assigned CCL analyst who investigates complaints. The analyst can play an important role in identifying trends and red flags before a crisis develops. Analysts have the authority to conduct unannounced site visits, review children's charts, and interview children and staff at the facility. CCL prioritizes complaints by risk-level the same way CPS does.

23. When a major report comes in, such as sexual abuse, a specialized team from CCL works with the assigned analyst to investigate. The analyst and team will conduct several visits, almost always unannounced, to complete the investigation and issue findings.

24. After each investigation, the analyst must determine whether the report is substantiated, unsubstantiated, or unfounded using a preponderance of the evidence standard. When a report is substantiated, CCL will take enforcement actions that can include mandated improvements, fines, civil penalties, exclusion of specific staff from ever working in a licensed facility, up to license revocation.

<u>Accreditation Process for Facilities Caring for Children</u>

25. Accreditation is a process whereby organizations who meet standards set by an accreditation agency can seek the agency's approval and demonstrate the quality of

their programs. In order to gain accreditation, organizations must put systems in place to show how they will maintain and improve their programming. Accreditation by a reputable agency demonstrates an organization's commitment to maintaining quality systems.

26. The Joint Commission (TJC) is one of three major accreditation agencies serving foster children. The other two are the Council on Accreditation (COA) and the Commission on Accreditation of Rehabilitation Facilities (CARF).

27. I am not familiar with Praesidium and to my knowledge it is not a major accreditation agency for child welfare facilities. Based on their website this agency appears to focus specifically on sexual abuse prevention.[1]

28. Accreditation agencies are private organizations. There are no formal requirements to create an accreditation agency and no clear benchmarks for what it means to be a nationally recognized accreditation agency. States choose to recognize accreditation agencies that they determine to be reputable.

29. California requires all Short-Term Residential Therapeutic Programs to obtain accreditation from either TJC, COA, or CARF, as well as obtaining licensure.

30. Seneca is accredited through TJC, which is recognized as the leading accreditation agency across hospitals and health care and behavioral health organizations. My understanding is that TJC is the most rigorous and thorough accreditation process for behavioral health organizations.

31. Accreditation agencies were designed to support quality service provision, but they are not a substitute for state licensure. They have infrequent contact with programs; they do not play a monitoring role or investigate complaints; and they have no enforcement authority other than revoking an organization's accreditation.

[1] *See Praesidium Accreditation Standards for Consumer Serving Organizations*, PRAESIDIUM, https://www.praesidiumaccreditation.com/standards/

32. Accreditation agencies analyze organizational systems at a high level. There is no equivalent role to that of a licensing analyst who is able to identify early warning signs of potentially harmful situations for children through regular monitoring of specific facilities. Seneca has a TJC account specialist who acts as a point of contact but that person does not have an oversight role.

33. Accreditation agencies inspect an organization as part of the initial accreditation process, but the inspections are much less rigorous than licensing agencies. In addition, accreditation agencies, like TJC, only conduct site visits every three years as part of the accreditation renewal process. During the three-year surveys, they review organizational policies, procedures, and systems to ensure program quality. The goal of accreditation review is to get an overview of how systems are functioning.

34. Depending on the number of facilities within an organization and the geographic span, accreditation staff may conduct visits at just a few of an organization's sites, rather than visiting every facility. The accreditation review's purpose is to identify any systemic failures or weaknesses and ensure those systems are improved, rather than focus on enforcement or ensure accountability. During the period between on-site surveys, organizations submit aggregated data annual reports to TJC related to census and client demographic information, and information regarding new programs and program closures. Accredited organizations typically only report, on a voluntary basis, very serious events such as death, permanent harm, or severe temporary harm of a child to TJC. TJC has a grievance process, but in my two decades of working at Seneca, I cannot recall a time that TJC did an investigation. I do not know if they ever received any grievances relating to Seneca or how they respond to complaints because I have never seen it occur.

Difference Between State Licensure Oversight System and Accreditation

1 35. The difference between licensing and accreditation is that licensing is designed
2 to ensure regulatory compliance through monitoring and enforcement, while
3 accreditation provides a mechanism to measure program quality and service delivery.
4 Organizations need to have both to ensure children have access to higher quality
5 programs and also have a place to turn when there are problems or safety concerns in
6 their facilities or foster homes. State licensure plays a vital role in child safety that
7 accreditation simply was not designed to address.
8 36. Another key difference is that accreditation entities have their own standards
9 and areas of focus – often proprietary – that they use to evaluate programs. These
10 standards are very different from state licensing regulations, and they are not
11 accessible to the public without paying a significant fee. Because they use their own
12 standards, TJC staff with whom I have interfaced often do not know state licensing
13 requirements. We often have to educate them about various state requirements.
14 37. As discussed above, accreditation and state licensing agencies also differ in the
15 frequency and intensity of site visits and the fact that accreditation agencies do not
16 play an oversight and enforcement role. At Seneca, CCL monitoring contacts of some
17 sort occurred about monthly, but I cannot recall ever seeing staff at an accreditation
18 agency visit Seneca outside of the approval or three-year review visits.
19 38. If ORR were to mandate that all of their programs caring for immigrant children
20 were required to obtain accreditation from a national accreditation organization such
21 as TJC, COA or CARF, that would be a positive step forward. But accreditation
22 without state licensing places children in those facilities at serious risk of harm.
23 Accreditation assumes the baseline requirements and protections of state licensing. If
24 there is no state licensing infrastructure, crucial safety measures will be missed. For
25 example, in California, the accreditation standard for fingerprinting staff requires that
26 the facility follow the state licensing regulation about fingerprinting that pertains to
27 the facility. If there were no state licensing regulation that applied to a facility, the
28 organization could simply develop its own fingerprinting policy, and the accreditation

1 agency would only ask the organization to abide by that internal policy. Moreover,
2 because accreditation agencies are not designed to evaluate compliance with state
3 licensing or play a monitoring and enforcement role, it is unclear what would happen
4 in facilities when there is an allegation of abuse and neglect by staff or when a child's
5 rights are otherwise being violated.
6 39. Based on my review of the regulations and the Declaration of Allison Blake, it
7 is my understanding that the regulations do not mandate accreditation. This is also
8 problematic. ORR acknowledges that 18 programs in Texas and Florida are in the
9 process of obtaining accreditation, but it is unclear if or when they will receive
10 accreditation, what is happening in the meantime, and what happens if they are not
11 ever accredited.
12 40. Even if all of ORR's providers eventually become accredited, accreditation is
13 simply not a substitute for the important functions provided by state licensing
14 oversight and enforcement. The harshest penalty an accreditation agency could invoke
15 would be to revoke accreditation, and that may only happen after a terrible incident
16 had already occurred.
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19 I declare under penalty of perjury under the laws of the United States of America that
20 the foregoing is true and correct. Executed on this 29th day of May 2024 at Chandler,
21 Arizona.
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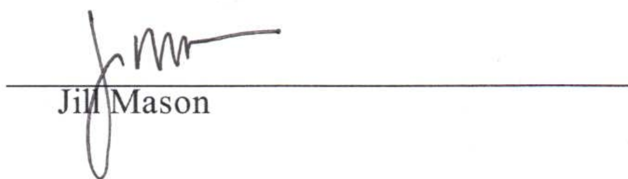
24 
Jill Mason
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EXHIBIT 2

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DECLARATION OF LARRY BOLTON

I, Larry Bolton, declare as follows:

1. I am an attorney, duly licensed to practice law in California. I served as Chief Counsel and Deputy Director for the Legal Division of the California Department of Social Services (CDSS) from 1991 to 2009 and have worked for the state for my entire career. I submit this declaration in support of Plaintiffs' Opposition to Defendants' Motion to Terminate the Flores Settlement Agreement as to the Department of Health and Human Services. The facts set forth in this declaration are based upon my personal knowledge, and if called to do so, I would competently testify under oath regarding the same.

Background and Qualifications

2. I worked as an attorney for the State of California for nearly 50 years, including acting as Chief Counsel and Deputy Director of the Legal Division of CDSS for 18 years. CDSS is the state agency with the authority to supervise every phase of the administration of public social services in California. Among its duties, CDSS is responsible for developing California's statewide foster care plan, supervising the administration of statewide foster care services by the 58 county agencies, and enforcing state law and regulations. The Community Care Licensing Division ("Licensing Division") of CDSS is directly responsible for establishing and maintaining licensing standards for placements for foster youth and for licensing and overseeing such placements. I have dedicated my career to protecting the health, welfare, and safety of foster youth and other vulnerable populations.

3. I graduated from U.C. Davis School of Law in 1973 and was admitted to practice in California later that year. I began working as an attorney for the State of California in 1974, and in 1978 I became the Assistant Chief Counsel of the newly created CDSS. Part of my responsibilities in this role included supervising the

1 attorneys working in support of the Licensing Division. The Licensing Division
2 oversees all Community Care Facilities, including daycare, elder care, and out-of-
3 home care for children. Out-of-home care licensing includes group homes for
4 children and foster family homes. In addition to serving as Chief Counsel for CDSS
5 from 1991 to 2009, I also served as Chief Counsel for the California Health and
6 Human Services Agency (CalHHS) for a period of time. I retired from my position as
7 Chief Counsel at CDSS in 2009, but stayed on as a part-time retired annuitant for
8 another 14 years, during which I acted as a legal advisor to the Chief Counsel of
9 CDSS and CalHHS.
10 4. For more than 30 years I was an active member of the American Association of
11 Public Health and Human Services Attorneys, including serving as the President of
12 the organization. I also served on the faculty of the National Licensing Institute and
13 the California District Attorneys Association, and frequently spoke at national
14 conferences focusing on state licensing legal developments and trends. I presented on
15 the importance of licensing to public safety at Virginia Commonwealth University,
16 Johns Hopkins, and the California County Counsel Association. I was appointed by
17 Attorney General Van De Kamp to the taskforce on child abuse and the California
18 Supreme Court's Blue Ribbon Commission on Foster Care. I also served as legal
19 counsel to the California Child Welfare Council. During my tenure, California has
20 been a leader in establishing rigorous licensing standards for out-of-home placements
21 and expanding its enforcement capacity to ensure adherence to those standards.
22
23 **California's Robust Licensing Infrastructure**
24
25 5. Governor Jerry Brown signed legislation creating CDSS in 1977, which came
26 into effect in 1978. This change was responsible for significantly strengthening
27 licensing protections for children. Around this time, licensing in California radically
28 changed and became a much greater priority for the State of California. The legal

support for the Licensing Division grew from one lawyer who filed less than ten enforcement actions a year to, ultimately, a staff of more than 60 lawyers filing several thousand legal enforcement actions per year. All of California's governors have supported ensuring protections for children in out-of-home placements. I worked for every governor since Governor Brown, and I am thankful that protecting foster children has remained a bipartisan concern.

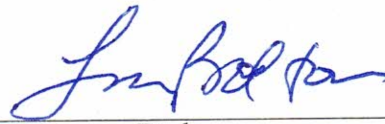
6. Some of the key components of California's licensing infrastructure are (a) detailed standards designed to ensure the health and safety of children in group homes and foster family homes; (b) a process for the approval and renewal of licenses for group homes and foster parents, including a detailed process for verifying the ability of potential licensees to meet minimum standards and fingerprinting to verify criminal background checks; (c) regular compliance procedures, including unannounced facility inspections, complaint investigations, and issuing deficiency notices; and (d) enforcement of licensing standards. Each of these components are crucial to the health and safety of children in foster care, but of utmost importance are ensuring that the people entrusted with caring for children have been screened appropriately, and that there are robust enforcement procedures to ensure corrective actions are taken when licensing standards are not upheld.

7. Over the course of my career, I have been a proponent of ensuring there is a rigorous process to vet foster parents and all staff in facilities who come into contact with foster children. California was one of the first states in the country to require criminal background checks for caregivers and staff working in out-of-home care facilities. Our department was involved in many actions involving abusive foster parents and group home staff over the years, and I learned that licensing authorities play a vital role in reducing the risk of harm to children. In California, the background check process includes conducting a criminal history check and a check of the California Child Abuse Central Index. To ensure CDSS does not inappropriately screen out people who do not pose a risk to children, there is also a

1 process for an applicant to receive a criminal record exemption for some
2 misdemeanors and less serious felonies.
3 8. The enforcement role of the Licensing Division is also crucial. Without
4 rigorous enforcement, the rules may be ignored. There must also be swift
5 consequences for violating licensing standards.
6 9. The Licensing Division is responsible for investigating complaints and taking
7 action when licensees fail to protect the health, safety and personal rights of children
8 in their care or otherwise refuse to comply with licensing laws and regulations.
9 Investigations are conducted by licensing staff, which include trained investigators
10 with expertise in California licensing standards. All complaints are investigated, and
11 complaints involving physical or sexual abuse are investigated right away. This team
12 works closely with law enforcement in these investigations. If investigations raise
13 serious concerns, CDSS can take immediate steps to keep children safe. For example,
14 if CDSS received a complaint that a staff person at an out-of-home care facility had
15 sexually assaulted a child, CDSS could require the facility to place that employee on
16 administrative leave while it conducted an investigation. If there were broader
17 concerns regarding children's safety, CDSS could issue a Temporary Suspension
18 Order resulting in all children in the facility being placed elsewhere.
19 10. Enforcement actions include application denials, compliance plans,
20 probationary licenses, temporary suspension of licenses, and license revocations.
21 Administrative legal actions are filed by the CDSS Legal Division and hearings are
22 held before the State Office of Administrative Hearings and heard by Administrative
23 Law Judges. These legal actions are crucial to children's health and safety because
24 they can result in the revocation of licenses of dangerous facilities or abusive foster
25 parents.
26 11. Having an independent, trained workforce with the capacity to promptly
27 investigate complaints and pursue enforcement actions is vital to the health and safety
28 of children in out-of-home care.

12. In 2000, during my tenure as Chief Counsel, CDSS was sued by Youth Law Center because there were county-run shelter facilities across the state that were caring for foster children in out-of-home care without meeting state licensing standards. In the lawsuit, *Warren v. Saenz*, plaintiffs alleged that many of these county-run facilities were unsafe, overcrowded and chaotic. Plaintiffs alleged that some of these shelters were so overcrowded that children were sleeping and changing clothes in hallways. Plaintiffs also alleged that these shelters violated state licensing laws because children in these facilities were subjected to excessive force, such as the use of restraints; they were not receiving needed mental health services; and their personal rights were being violated, including their right to visit with family, their right to not be locked inside a facility, their right to community activities, and their right to file licensing complaints. As a result of the *Warren v. Saenz* case all of the county-run facilities had to become state licensed in order to continue serving children. There were vast improvements in these places and in children's lives as a result.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed on this 29th day of May 2024 at Sacramento, California.



Larry Bolton

EXHIBIT 3

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Declaration of Carrie Vander Hoek

I, Carrie Vander Hoek, declare as follows:

1. This declaration is based on my personal knowledge. If called to testify in this case, I would testify competently about these facts.

2. I am a Licensed Master Social Worker (LMSW). For the last 17 years I have worked with unaccompanied children in federal custody and children in the state foster care system. In addition to my work with the Young Center for Immigrant Children's Rights (hereinafter "Young Center"), described below, I spent over seven years working for General Dynamics IT (GDIT) pursuant to its work with the Office of Refugee Resettlement (ORR). In that capacity, I provided review, assessment, and third-party release recommendations for children in ORR custody seeking release to family and later supervised 11 bilingual Case Coordinator staff who submitted child welfare-based recommendations on family reunification, transfers, and placements of unaccompanied children in ORR custody.

3. Prior to GDIT, I worked for the Bair Foundation, where I supervised a caseload of foster families to ensure they met the holistic needs of foster children and complied with state standards. In that capacity, I worked with the Texas Department of Family and Protective Services (DFPS), mental health professionals, Court Appointed Special Advocates (CASA), guardians *ad litem*, attorneys, early child development specialists, and schools. I also supervised, mentored, and trained the agency's social service workers.

4. I received my Master of Social Work Degree from the University of New England in 2014, during which time I completed an internship with the Hope Family Health Center, and I received my Bachelor of Social Work from Calvin College in 2007. I am bilingual in Spanish and English.

5. I currently work as a Deputy Program Director of the Young Center's Child Advocate Program. The Young Center is a registered 501(c)(3) organization based

1 in Chicago with programs in nine additional locations including: Phoenix, Arizona;
2 Los Angeles, California; Grand Rapids, Michigan; New York, New York; New
3 Jersey; Harlingen, Texas; Houston, Texas; San Antonio, Texas; and Washington,
4 D.C. The Young Center was founded in 2004 as a pilot project of ORR to create a
5 program to provide independent Child Advocates, akin to best interests guardians
6 *ad litem*, for child trafficking victims and other vulnerable unaccompanied children.
7 The role of the Child Advocate was codified in the Trafficking Victims Protection
8 Reauthorization Act of 2008, 8 U.S.C. § 1232(c)(6)(A).
9 6. Young Center attorneys and social workers are appointed as Child Advocates
10 alongside trained, bilingual volunteers. The role of the independent Child Advocate
11 is to advocate for the best interests of the child. Child Advocates identify a child's
12 best interests by considering the child's expressed wishes, safety, right to family
13 integrity, liberty, developmental needs, and identity. These "best interests factors"
14 are well-established in the child welfare laws of all 50 states and in international
15 law, including the Convention on the Rights of the Child.
16 7. Since its founding, the Young Center has served as the independent Child
17 Advocate for more than 7,000 children in government custody. We are the only
18 organization authorized by ORR to serve in that capacity.
19 8. I have worked at the Young Center for more than five years. From 2019 to
20 2020, I served as a Staff Child Advocate in our Harlingen, Texas, office, providing
21 Child Advocate services for unaccompanied children in ORR custody. In that role, I
22 advocated for children's best interests and developed Best Interests Determinations
23 (BIDs) regarding children's care, custody, release, legal representation, and
24 repatriation. I also provided case consultations and case support for staff on issues
25 involving child welfare, child development, and trauma. I also supervised volunteer
26 Child Advocates who were assigned to meet regularly with children in federal
27 custody. From 2020 to 2021, I served as a Managing Social Worker, supervising
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both staff and volunteer Child Advocates in the Young Center's Harlingen, Texas, office. My role was to ensure our team's best interests advocacy was grounded in child welfare and trauma-informed best practices. I engaged with local stakeholders on all issues impacting children's time in custody, and reviewed BIDs that were submitted in children's cases.

9. Since 2021, I have served as a Deputy Program Director of the Young Center's Child Advocate Program, based out of our Harlingen, Texas, office and more recently out of our Houston, Texas, office. In that capacity, I have overseen Child Advocate staff in our Harlingen, Houston, San Antonio, Washington, DC, and Grand Rapids offices. I serve as a primary point of contact for children, family members, ORR staff, ORR grantees and ORR contractors. I also help to ensure our staff are reporting child abuse and neglect in accordance with state laws governing mandated reporting of child abuse and neglect. I review BIDs for complex cases and ensure our BIDs reflect best practices in child welfare; and I collaborate with colleagues to ensure services for children are child-led and trauma-informed.

State Licensing Provides Essential Oversight of Children's Safety

10. ORR contracts with grantees to operate shelters and other placements for unaccompanied immigrant children and youth all over the United States. Each state provides its own licensing requirements for the care of dependent children.

11. One of the main purposes of state licensing is to provide independent oversight for the care and treatment of children in state or federal custody. This includes ensuring facilities meet minimum standards before they can accept children, conducting investigations after reports of abuse or neglect or violations of minimum standards, conducting random and scheduled inspections of facilities that care for dependent children, and issuing citations, corrective action plans, or even revoking a facility's license when necessary.

12. Texas law requires that I, in my capacity as both a Licensed Social Worker and a Deputy Program Director of Child Advocates, report instances of child abuse or neglect to state child welfare authorities. *See* Tex. Fam. Code § 261.101. During my career working with children, I have made hundreds of reports to state child welfare and licensing authorities about abuse, neglect, or other harm that children have experienced before and during their time in government care. I have made or consulted with Young Center staff on dozens of reports to state child welfare and licensing authorities after children have disclosed abuse, neglect, or other harm that they have experienced while in facilities operated by ORR contractors or grantees. These include disclosures of verbal and physical abuse, the use of inappropriate forms of punishment, and improper use of restraints on children by staff.

13. Under Texas law, when child abuse or neglect in a state-licensed facility is reported to state child welfare authorities, those state child welfare authorities, in coordination with state licensing authorities, are required to conduct a prompt and thorough investigation to determine if any child was abused or neglected; whether any child is at risk of future abuse or neglect; and whether children at the facility are safe. This independent investigation may involve information-gathering about the facility, the facility's activities, or staff at the facility; interviews with the child (or children) who may have been abused or neglected; visual examination of the child for any visible injuries or bruises; photographing any visible injuries or bruises; a medical examination of the child; interviews of other children at the facility, as well as any adults with relevant information or who may have witnessed alleged abuse or neglect; and requesting copies of records related to medical or mental health care the child received due to the abuse or neglect. Once the investigation is complete, state child welfare authorities write up a report of the findings of the investigation and notify various parties, including state licensing authorities, of the investigation findings. When a facility is found to have violated

minimum licensing standards, the state licensing agency is then responsible for taking action as to the facility's license. For instance, the licensing agency may impose a corrective action, which requires the facility to take steps to come into compliance and to undergo more frequent inspections while they are taking these steps. In the most egregious cases, the state licensing agency may impose restrictions on the facility's license or even close down the facility.

14. ORR facilities also have pre-programmed telephones that permit children to directly contact the state child abuse or neglect hotline.

15. Independent investigations of abuse and neglect or other violations of minimum standards are critical to the safety of vulnerable children in immigration custody. Many of the children we work with are understandably hesitant to share their most vulnerable experiences with ORR staff. They tend to be very fearful of the impact that disclosing information could have on their treatment while in ORR custody or on their immigration case. Therefore, when a child discloses abuse or neglect, we carefully explain to the child our obligation to report the abuse or neglect to state child welfare authorities and what we expect will occur as a result of the report, including an investigation by an entity separate and independent from ORR and the ORR facility.

Lack of State Licensing

16. Since 2021, our Child Advocates in Texas have continued to report instances of abuse and neglect to the relevant state authorities because, as mandatory reporters, we are legally mandated to do so. During that time, Young Center staff have reported approximately 10 instances of alleged abuse and neglect, including emotional, verbal, and physical abuse and improper use of restraints that resulted in injury, to DFPS. I have consulted with staff on most of these cases.

17. When we have made these reports, in some cases, DFPS officials told us that they would not investigate the complaint because DFPS did not have jurisdiction over ORR facilities. In other cases, we received no response and were not aware of any actions taken by DFPS or any other state agency to investigate the report. We have also been informed that DFPS is now forwarding reports of abuse and neglect of children in ORR facilities to ORR.

18. If a child calls the state child abuse and neglect hotline from an ORR facility, my understanding is that the child will get the same response.

19. We are not aware of formal procedures put in place by the federal government to replicate the procedures provided under state law after the state of Texas decided to stop licensing ORR facilities and investigating allegations of abuse or neglect in ORR facilities. We continue to report disclosures to the state, and we also notify ORR officials of our reports. We are unaware of whether ORR is conducting timely and thorough investigations of reports of abuse and neglect of children in ORR placements in Texas. If ORR is conducting investigations, we do not know what the outcomes are or what, if any, corrective or accountability measures are implemented if reports of harm are determined to be credible. The lack of any state investigation and lack of clarity about investigation or corrective measures by ORR or any other federal entity are deeply concerning to us as Child Advocates and undermines our ability to advocate for children's safety.

The Final Rule Lacks Critical Independent Oversight Mechanisms

20. The regulations published by the Department of Health and Human Services that seek to replace the *Flores* Settlement Agreement lack critical oversight mechanisms.

21. Although licensing alone does not ensure the safety of children, it is a prerequisite for ensuring a baseline of core requirements to which facilities must

1 adhere and a vital structure for accountability. Allowing the government to place
2 unaccompanied immigrant children and youth in facilities without independent
3 standards, oversight, inspection, and accountability, particularly at a time when
4 there is no alternative in place, leaves little guarantee that the facilities will be safe.
5
6 I declare under penalty of perjury that the foregoing is true and correct. Executed
7 this 30th day of May, 2024, at Houston, Texas.
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11 Carrie Vander Hoek
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EXHIBIT 4

State of California
Office of the Attorney General

ROB BONTA
ATTORNEY GENERAL

December 4, 2023

Submitted via Federal eRulemaking Portal

The Honorable Xavier Becerra, Secretary
Robin Dunn Marcos, Director
Office of Refugee Resettlement
U.S. Department of Health and Human Services
330 C Street, S.W.
Washington, D.C. 20201

RE: Unaccompanied Children Program Foundational Rule, Document Number 2023-21168, 88 Fed. Reg. 68908

Dear Secretary Becerra and Director Dunn Marcos:

We, the Attorneys General of California, Connecticut, Delaware, District of Columbia, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Vermont, and Washington (States), write in response to the Department of Health and Human Services' (HHS) Unaccompanied Children Program Foundational Rule, 88 Fed. Reg. 68,908 (published Oct. 4, 2023) (Proposed Rule). Protecting immigrant children is important to our States. As of July 2020, 84 facilities licensed in our States were caring for unaccompanied children (UACs) in the custody of the Office of Refugee Resettlement (ORR).[1] Every year, thousands of children are released from immigration custody and reunified with family members or other adult sponsors who are residents of our States. These children become members of our communities, where they live in our neighborhoods, attend our schools, and grow into adults raising their own families. Together, 40 percent of all children who will be released from immigration custody by the federal government this year will come to our States.[2] Indeed, since Fiscal Year 2015, more than 68,000

[1] Gov't Accountability Off., GAO-20-609, *Unaccompanied Children: Actions Needed to Improve Grant Application Reviews and Oversight of Care Facilities* 7 (2020), https://www.gao.gov/assets/gao-20-609.pdf.

[2] Off. of Refugee Resettlement, Unaccompanied Children Released to Sponsors by State (Nov. 8, 2023), https://www.acf.hhs.gov/orr/resource/unaccompanied-alien-children-released-to-sponsors-by-state In Fiscal Years 2022 and 2023, our States received approximately 40 percent of all unaccompanied children released from immigration custody by the federal government. *See id.*

UACs have been released to sponsors in California alone.[3] Each of our States is committed to ensuring that all children who are cared for within our borders, including UACs, are provided with high standards of care in the least restrictive, most family-like conditions.

The States commend HHS on the significant steps it has taken to codify and improve protections for UACs in the custody of ORR. In particular, we welcome provisions in the Proposed Rule that govern language access, improve access to counsel, guarantee access to reproductive health care, emphasize the importance of community-based care, encourage comprehensive post-release services, and require the implementation of positive behavior management strategies. The Proposed Rule represents a significant step forward to improving conditions and care for UACs in ORR custody.

However, the States are concerned with provisions of the Proposed Rule that would permit the placement of UACs in unlicensed facilities.[4] The States urge HHS to amend the Proposed Rule to require that all facilities housing UACs be state-licensed, including both standard programs and emergency and influx facilities. In the alternative, the States urge HHS to (1) require that all facilities that house UACs, including emergency and influx facilities, be state-licensed where licensure for such facilities is available; (2) require that all facilities that house UACs within a state's borders comply with state law and regulations applicable to facilities for the care of dependent children in addition to ORR standards; and (3) implement a more comprehensive regime for federal oversight of unlicensed facilities housing UACs. The States offer these recommendations in consideration of the States' compelling interest in and deep concern for the health, safety, and wellbeing of UACs, both those currently within our borders and those who will one day become members of our communities.

I. The States Support Elements of the Proposed Rule that Provide Enhanced Protections for UACs.

The Proposed Rule improves certain critical protections for UACs consistent with the purpose of the stipulated settlement in *Flores v. Reno*, No. 85-cv-4544 (C.D. Cal. Jan. 17, 1997) (*Flores* Settlement Agreement) and the States' standards for ensuring the rights and well-being of children residing in the States. The States applaud the inclusion of these increased protections and the effort to create comprehensive regulations to govern the placement and care of UACs.

A. Language Access

The States support the strong language access requirements included throughout the Proposed Rule. In particular, the States appreciate the requirements in proposed section 410.1306 that placements "consistently offer" all UACs the option of interpretation and translation services

[3] *Id*.
[4] Currently, Texas and Florida prohibit the licensure of facilities within their borders to care for UACs. 88 Fed. Reg. 68,908, 68,915-16.

in the UAC's native or preferred language and in a way the UAC understands; that language access considerations inform placement decisions; and that placements provide educational instruction, relevant materials, appropriate recreational reading materials, and documents that are part of the educational lessons in a format and language accessible to all UACs.[5] The States also welcome the Proposed Rule's requirement that placements ensure effective communication with UACs with disabilities, including appropriate auxiliary aids and services.[6]

Language access is critical to ensuring UACs are able to participate fully in educational, legal, and other available services. Robust language access requirements are also important to the States. For example, California's Dymally-Alatorre Bilingual Services Act, Cal. Gov. Code § 7290 et seq., seeks to eliminate language barriers that preclude residents of California from having equal access to public services. Language access is also critical to ensure that UACs are able to effectively communicate with their caregivers about their needs and to reduce the isolation that comes with being unable to communicate. The States commend the efforts made to ensure that the Proposed Rule contains robust protections for all UACs who are non-primary English speakers.

B. Access to Counsel

The States appreciate the Proposed Rule's expansion of legal services for UACs. Access to legal services is critical in order for UACs to have information about their rights, legal protections, and available services while in the immigration system. In particular, access to counsel, where possible, is vital to ensure that UACs' due process rights are protected during the course of their immigration case.

In particular, the States strongly support the provisions in proposed section 410.1309, subsections (a)(4) and (b) that would provide ORR with the discretion, subject to available resources, to fund legal services for UACs, including direct immigration legal representation and access to counsel for enumerated non-immigration related matters.[7] Studies have shown that access to counsel is vital for UACs to be able to effectively participate in their immigration cases and leads to just outcomes. According to a 2016 study by the American Immigration Council, detained immigrants with counsel are nearly 11 times more likely to pursue relief than those without representation and are twice as likely to obtain relief than detained immigrants without counsel.[8] Similarly, a 2014 analysis of immigration court data found that 73 percent of UACs with representation were allowed to remain in the United States whereas only 15 percent of

[5] 88 Fed. Reg. 68,908, 68,992-93.
[6] 88 Fed. Reg. 68,908, 68,943.
[7] 88 Fed. Reg. 68,908, 68,995-96.
[8] Am. Immigr. Council, *Access to Counsel in Immigration Court* (Sept. 28, 2016), https://www.americanimmigrationcouncil.org/research/access-counsel-immigration-court.

unrepresented children were allowed to stay.[9] The States urge that resources be allocated to fund legal services for UACs currently or previously in ORR care.

C. Access to Reproductive Care

The States support the provisions in the Proposed Rule that seek to protect UACs' access to medical services that require heightened ORR involvement, including access to abortion care.[10] In particular, the States welcome the provisions of the Proposed Rule that require ORR to, if necessary, provide UACs with transportation across state lines to guarantee access to medical services, including abortion care, regardless of whether ORR is prohibited from paying for the medical care itself.[11] The Proposed Rule also rightly recognizes the importance of considering a UAC's health status, including information regarding the UAC's reproductive health status, in the determination of the most appropriate placement for the UAC.[12] The States also support the requirement that emergency and influx facilities provide family planning services, pregnancy tests, and medical services requiring heightened ORR involvement such as abortion care to UACs.[13] It is critical that UACs in ORR's care have access to timely and appropriate medical care, including the full panoply of reproductive health services. Such access is vital to UACs' physical, mental, and emotional growth and development, as well as their long-term health.

The requirements that ORR ensure that UACs have access to reproductive health services are consistent with the States' similar interests in supporting access to reproductive health care services. Three of the States—California, Michigan, and Vermont— have recently amended their constitutions to protect personal reproductive rights, including the right to abortion.[14] Other States continue to protect the right to abortion by statute.[15] The States strongly support HHS's efforts to ensure ongoing access to these critical health care services for UACs in its care.

D. Post-Release Services

The States also support the Proposed Rule's expansion of post-release services for UACs. This will foster UACs' safe integration into their local communities by assisting them in obtaining critical services, including education, legal services, health insurance, mental health

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[9] TRAC Immigr., *Representation for Unaccompanied Children in Immigration Court* (Nov. 25, 2014), https://trac.syr.edu/immigration/reports/371/.

[10] 88 Fed. Reg. 68,908, 68980, 68,993-94, 68,998-99.

[11] 88 Fed. Reg. 68, 908, 68994.

[12] 88 Fed. Reg. 68,908, 68,921.

[13] 88 Fed. Reg. 68,908, 68,999.

[14] *See* Cal. Const., art. I, § 1.1 (guaranteeing right to reproductive freedom); Mich. Const., art. I, § 28; Vt. Const., ch. I, art. 22. Other States similarly protect personal reproductive rights, including the right to an abortion, through their constitutions.

[15] *See, e.g.*, Del. Code Ann. tit. 24, § 1790; 775 Ill. Comp. Stat. 55/1-15; Me. Rev. Stat. Ann. tit. 22, §§ 1597-A, 1598; N.J. Stat. Ann. § 10:7-2; N.Y. Pub. Health Law § 2599-aa (2019); Wash. Rev. Code § 9.02.100.

services, and counseling.[16] The States particularly welcome the Proposed Rule's expansion of post-release services to any case where a home study is conducted and to UACs with mental health and other needs who would benefit from the ongoing assistance of a community-based service provider even if their case did not involve a home study.[17] The Proposed Rule would rightfully require that providers furnish post-release services that are sensitive to the individual needs of the UAC and in a way that the child effectively understands—regardless of spoken language, reading comprehension, or disability—to ensure meaningful access to all UACs, including those with disabilities or limited English proficiency.[18] This expansion of post-release services will provide much-needed support to UACs as they transition from ORR's care to the care of their sponsors.

E. Community-Based Care

In addition, the States strongly support the Proposed Rule's emphasis on a community-based care model that would allow for the care of UACs in community-based placements that operate in a manner consistent with the States' licensing standards.[19] As ORR notes, a community care model would allow UACs to be integrated into their local communities in the States, attend local schools, and be involved in "extracurricular, enrichment, cultural, and social activities" in their local communities, which would promote the health, safety and best interests of the UACs.[20] The States have a strong interest in ensuring that UACs residing in the States are cared for in a safe and stable placement in the community where they will not suffer further unnecessary trauma. Community-based care has been a part of good child welfare practice for decades.[21] Keeping children in their local communities has positive effects on the child's well-being and allows the child to form critical bonds with individuals in their community and at school.[22]

F. Positive Behavior Supports

The States also support the Proposed Rule's requirement that care provider facilities for UACs use evidence-based, trauma-informed, and culturally sensitive behavior management strategies.[23] This requirement aligns with the States' laws regarding the care of children placed in group care facilities. For example, California law requires staff in group care facilities to employ trauma-informed, evidence-based de-escalation and intervention techniques when responding to the behavior of a child residing in the facility, and law enforcement may only be

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[16] 88 Fed. Reg. 68,908, 68,988.
[17] 88 Fed. Reg. 68,908, 68,933, 68988.
[18] *Id*.
[19] 88 Fed. Reg. 68,908, 68,919-20.
[20] 88 Fed. Reg. 68,908, 68,920.
[21] *See* Child Welfare Information Gateway, *Community-based Resources: Keystone to the System of Care* (Oct. 2009), https://www.childwelfare.gov/pubPDFs/community.pdf.
[22] *Id*.
[23] 88 Fed. Reg. 68,908, 68,991-92.

used as a last resort once all other de-escalation and intervention techniques have been exhausted.[24] California law also requires these facilities to develop protocols that identify and describe collaborative relationships with community-based service organizations that provide culturally relevant and trauma-informed services to the children served by the facility to prevent, or as an alternative to, arrest, detention, and incarceration for system-impacted youth.[25] The States encourage ORR to incorporate these same child welfare standards into the Final Rule.

II. The States Oppose Provisions of the Proposed Rule that Would Permit Placement of UACs in Unlicensed Facilities.

Although the States applaud the provisions of the Proposed Rule that expand and strengthen protections for UACs, the States are deeply concerned about provisions of the Proposed Rule that would permit the placement of UACs in "standard programs" or emergency or influx facilities that are not state-licensed. For nearly twenty-five years, the *Flores* Settlement Agreement has protected UACs in the custody of ORR by ensuring that, with certain limited exceptions, they are placed in facilities licensed by the states. This structure accords with the states' longstanding responsibility to regulate child welfare and to care for the wellbeing of the children in our States. As State Attorneys General, we have a duty to protect the rights of our most vulnerable populations, safeguard their health and safety, and defend state laws. The Proposed Rule undermines the States' protection of UACs by allowing multiple types of unlicensed facilities. Specifically, the Proposed Rule inappropriately (1) defines "standard program" to include facilities that are not licensed in states which have chosen not to license facilities housing UACs, and (2) sanctions the operation of emergency or influx facilities without a state license.

Permitting UACs to be housed in unlicensed facilities would intrude on a traditional area of state regulation and expertise, risks lowering the standards of care for these children, and would create a future risk of sanctioning the operation of secure facilities and family detention facilities that the States have refused to license due to the harms they inflict on children. Animated by a desire to ensure that UACs are housed in conditions that are safe and healthy, that promote children's well-being, and that comply with the standards that the States have developed through long experience, the States urge HHS to require that all facilities housing UACs be state-licensed, including both standard programs and emergency or influx facilities. In the alternative, the States urge HHS to (1) require that all facilities that house UACs, including emergency and influx facilities, be state-licensed where licensure is available; (2) require that all facilities that house UACs within a state's borders comply with state law and regulations applicable to

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[24] Cal. Health & Safety Code, § 1531.6 (b)(1), (3); *see also* 10-148 Me. Code R. ch. 35, §§ 2(3), 5(A)(2)(b),(e); Mich. Comp. Laws § 722.112d (restricting use of restraints and seclusion for youth in licensed care child facilities); Mich. Admin. Code R. 400.8140 (requiring positive methods of discipline for youth in licensed congregate care facilities); N.J. Admin. Code 3A:56-6.13, 6.14, 10.14; Wash. Rev. Code §§ 13.34.420 (requiring qualified residential treatment programs to use trauma-informed treatment model), 13.40.020(6)(c), 72.01.412(10)(c).

[25] Cal. Health & Safety Code § 1531.6 (b)(5).

facilities for the care of dependent children in addition to ORR standards; and (3) put in place a more comprehensive regime for oversight of unlicensed facilities housing UACs.

A. The States have long-standing experience and expertise in the licensing and oversight of residential placements for children.

Ensuring child welfare, including establishing and enforcing standards of care and for licensing of residential placements for children, is a police power vested in the states.[26] States accordingly have a long history of enacting child welfare laws that guide the care and protection of minor children who cannot remain safely at home. Massachusetts passed such a law in 1866.[27] From the first emergence of child welfare systems in this country, states have played an important role in licensing children's residential placements. As historians have recognized, "[r]elated to the development of state systems of child care was the introduction of state policies and procedures for licensing and regulating child care facilities."[28] Accordingly, states have licensed and monitored placements for over a century. By the 1890s, the states understood supervision over child caring agencies to encompass the principles that: (1) the state should know where its dependent children are; and (2) state agents should visit and inspect these institutions and agencies at regular intervals, and full reports should be made to the state.[29] Leaders in the child welfare field have long recognized "the importance of instituting strong regulatory systems, including licensing, service monitoring, and case accountability to protect the interests of children in the child care system."[30]

Over decades of experience in administering their child welfare systems, the States have developed expertise in creating and enforcing standards for the care of youth in children's residential facilities that reflect the States' critical interest in protecting the physical, emotional, and psychological health of all children within their borders.[31] As a result, each of the States has comprehensive standards and licensing procedures to ensure that residential

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[26] *See, e.g.*, *Moore v. Sims*, 442 U.S. 415, 435 (1979) ("Family relations are a traditional area of state concern."); *H.C. ex rel. Gordon v. Koppel*, 203 F.3d 610, 613 (9th Cir. 2000); *Schall v. Martin*, 467 U.S. 253, 265 (1984) (states must "play [their] part as parens patriae" where "parental control falters….").

[27] *See* An Act Concerning the Care and Education of Neglected Children, 1866 Mass. Acts ch. 283; *see also* Mass. Gen. Laws ch. 119, § 1.

[28] Brenda G. McGowan, *Historical Evolution of Child Welfare Services*, in Child Welfare for the Twenty-first Century: A Handbook of Practices, Policies, and Programs at 17 (2005), http://www.garymallon.com/archive/spring2013/cw702/05.McGowanChildWelfareHistory.Final.02.25.2012.pdf.

[29] *Id*. at 17-18 (quoting Grace Abbot, The Child and the State 17-18 (1938)).

[30] *Id*. at 18.

[31] *See*, *e.g.*, *Globe Newspaper Co. v. Super. Ct. for Norfolk Cnty.*, 457 U.S. 596, 607 (1982) (holding that a State's "interest" in "safeguarding the physical and psychological well-being of a minor … is a compelling one"); *Ginsberg v. New York*, 390 U.S. 629, 640 (1968) (noting that a State "has an independent interest in the well-being of its youth," and recognizing "'society's transcendent interest in protecting the welfare of children'" (citation omitted)).

placements for children provide the care and services necessary to support children's healthy development in settings that further their best interests.

For example, each of the States follows a policy of placing children in the least restrictive setting to meet their particular needs.[32] Similarly, each State maintains a comprehensive licensing scheme for all placements used to house children.[33] Each State's comprehensive child welfare system seeks to protect the personal rights, health, and safety of children in residential facilities. For example, California has long maintained a "foster youth bill of rights," which ensures that children in residential facilities have, among other rights, the right to not be locked in any portion of their placement facility; visit and contact siblings and family members; have social contacts with individuals outside the child welfare system; attend religious services; participate in extracurricular activities; be placed in out-of-home care in accordance with their gender identity; attend school in the community; and receive prompt, comprehensive medical care.[34] Each State has a robust system for ensuring meaningful oversight, accountability and enforcement of these licensed placements.[35] And to ensure that all children in the State enjoy the protection of these standards and oversight, each State prohibits the operation of unlicensed children's residential facilities.[36]

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[32] *See*, *e.g*., Cal. Welf. & Inst. Code §§ 706.6(c)(2)(B), (d)(2), 16001.9(a)(4), 16501(j); Mass. Gen. Laws ch. 119 § 32; Del. Code Ann. tit. 29, § 9003(a)(4); D.C. Mun. Regs. tit. 29, § 6201.3; Mich. Comp. Laws § 722.958b(3)(h); Minn. Stat. § 260C.181, subd. 2; Nev. Rev. Stat. § 432B.390; N.J Stat. Ann. § 9:6B-4(g); N.M. Stat. Ann. § 32A-6A-12 (2015); N.Y. Comp. Codes R. & Regs. tit. 18, § 430.11(d); Or. Admin. R. 413-070-0625(1)(g); Wash. Rev. Code § 74.13.065; 11 Pa. Cons. Stat. § 2633(4); N.J. Admin. Code § 3A:12-1.7(b)(14); 20 Ill. Comp. Stat. 505/7.3a(c)(2); 705 Ill. Comp. Stat. 405/2-27-405/2-27.2; Ill. Admin. Code tit. 89, § 301.60(b)(1); Me. Dep't of Health & Human Services, Child and Family Services Manual § 3.4.

[33] *See*, *e.g*., Cal. Code Regs. tit. 22, div. 6; Conn. Gen. Stat. § 17a-145(a); D.C. Code § 4-1303.01a, et seq.; D.C. Code § 7-2101, et seq.; D.C. Mun. Regs. tit. 29, § 6201, et seq.; D.C. Mun. Regs. tit. 29, § 6301, et seq.; Me. Rev. Stat. tit. 22, §§ 7801, 8101 et seq.; Nev. Rev. Stat. §§ 432A.131, 432A.141; N.M. Stat. Ann. §§ 32A-4-8 (2019), 40-7a-1 et seq. (2011); N.Y. Const. art. XVII; N.Y. Soc. Serv. Law §§ 34, 34-a; 62 Pa. Cons. Stat. §§ 901-922, 62 Pa. Cons. Stat. §§ 1001-1088, 55 Pa. Code ch. 3800; Mass. Gen. Laws ch. 15D, §§ 2(c), 6, 7; 606 Mass. Code Regs. 3, 5; Wash. Rev. Code ch. 74.15; Wash. Admin. Code ch. 110-145; N.J. Stat. Ann. §§ 30:4C-27.6 to.7; N.J. Admin. Code §§ 3A:51-2.1 to -2.7; 225 Ill. Comp. Stat. 10/7; 89 Ill. Admin. Code Parts 401-404.

[34] Cal. Welf. & Inst. Code § 16001.9. Other States likewise maintain foster youth bills of rights. *See, e.g.*, Del. Code Ann. tit. 13, § 2522; Nev. Rev. Stat. §§ 432.525, 432.530, 432.535; N.J. Stat. Ann. § 9:6B-4; Or. Rev. Stat. § 418.202; 11 Pa. Cons. Stat. § 2633; R.I. Gen. Laws § 42-72-15; Me. Dep't of Health & Human Services, Child and Family Services Manual § 3.9(VIII)(A).

[35] *See, e.g.*, Cal. Health & Safety Code §§ 1550-1557.5; Me. Rev. Stat. tit. 22, §§ 4099-J to 4099-P; Mass. Gen. Laws ch. 15D; Del. Code Ann. tit. 14, § 3004A; D.C. Code §§ 7-2105 & 7-2108; D.C. Mun. Regs. tit. 29, § 6201, et seq.

[36] *See, e.g.*, Cal. Health & Safety Code § 1509; Mass. Gen. Laws ch. 15D, § 6; Del. Code Ann. tit. 14, § 3004A; D.C. Code § 7-2102; 225 Ill. Comp. Stat. 10/3; Me. Rev. Stat. tit. 22, §§ 7801, 8101; 10-148 Me. Code R. chs. 35, 37; Mich. Comp. Laws § 722.115m(2); Minn. Stat. § 245A.03, subd. 1; Nev. Rev. Stat. § 432A.131; N.Y. Soc. Serv. Law §§ 371, 460-a, 460-b; Or. Rev. Stat. § 418.990(3); 55 Pa. Code §§

The federal government has long relied on the states' collective experience, expertise, and particular interest in maintaining standards of care for children within their borders to ensure that unaccompanied children in federal immigration custody are placed in facilities that are safe and healthy for children. Since 1997, the states' licensing standards have governed residential placements for children in federal immigration custody within each of the states pursuant to the *Flores* Agreement and federal law. *See*, *e.g.*, *Flores v. Lynch*, 828 F.3d 898, 906 (9th Cir. 2016) ("obvious purpose" of requiring placement of unaccompanied immigrant children in state-licensed facilities is to "use the existing apparatus of state licensure to independently review detention conditions"). Consistent with this landscape, the federal government has never—for immigration purposes or in any other child welfare context—licensed facilities for children. Instead, the federal government has appropriately relied on the states' decades of experience in licensing such facilities and enforcing the standards developed by the states.

B. The Proposed Rule fails to adequately describe the standards under which unlicensed facilities would be required to operate, risking placement of UACs in harmful conditions.

The Proposed Rule appropriately recognizes that, in most cases, facilities that house UACs must be licensed by an appropriate state agency.[37] However, the Proposed Rule departs from this general approach for standard programs where "licensure is unavailable to programs providing services to unaccompanied children" in the state in which the facility operates.[38] In such cases, standard programs will be required to meet minimum standards that are outlined in the Proposed Rule and also to "meet other requirements specified by ORR," which are not further described in the Proposed Rule.[39]

Similarly, the Proposed Rule would not require emergency or influx facilities to be state-licensed, instead providing that such facilities "may not be licensed or may be exempted from licensing requirements by State and/or local licensing agencies."[40] The Proposed Rule would require emergency or influx facilities to meet certain minimum standards outlined in the Proposed Rule.[41] The Proposed Rule would permit those standards to be waived for facilities operating for less than six months where ORR determines the standards are operationally infeasible.[42]

20.21, 20.51, 3800.11; R.I. Gen. Laws § 42-72.1-4(a); Wash. Rev. Code § 74.15.150; Wash. Admin. Code § 110-145-1310.

[37] See 88 Fed. Reg. 68,908, 68,981 (standard program definition); 88 Fed. Reg. 68,908, 68,989.

[38] 88 Fed. Reg. 68,908, 68,989.

[39] *Id*.

[40] 88 Fed. Reg. 68,908, 68,979.

[41] 88 Fed. Reg. 68,908, 68,999.

[42] *Id*.

The States commend the improvements in the minimum standards for standard programs and emergency or influx facilities outlined in the Proposed Rule. In particular, the States support the inclusion of requirements that both types of facility provide an individualized needs assessment and an individualized services plan for each child.[43] The States likewise support the requirement that facilities provide services in a manner that is sensitive to the age, culture, native language and needs of each child.[44] And, as discussed in further detail above, the States applaud requirements that standard programs implement trauma-informed positive behavior management systems.[45] These minimum standards represent important protections for UACs in ORR's care and custody.

However, despite these positive elements of the minimum standards outlined in the Proposed Rule, the States are concerned that the minimum standards for both standard programs and emergency or influx facilities do not address all of the issues for which the States have developed licensing standards for children's residential facilities. For example, California's state licensing standards require that facilities maintain minimum staff-to-child ratios; the minimum standards outlined in the Proposed Rule for emergency or influx facilities include no such staffing requirements.[46] Many of the States' licensing schemes include specifications as to the size and maintenance of living quarters that are absent from the minimum standards.[47] Certain of the States' licensing schemes require that children be allowed independence and access to the community, as appropriate, including access to participation in recreational, cultural, and extra-curricular activities outside the facility; the minimum standards do not contain such requirements.[48] Nor is it clear whether other requirements subsequently developed by ORR for unlicensed standard programs would be consistent with or address all issues addressed by the States' standards. The States recommend that the minimum standards and any other requirements that ORR develops for standard programs and emergency or influx facilities address the issues for which the States have developed licensing standards, including but not limited to the examples identified above. The States strongly suggest that ORR look to

[43] 88 Fed. Reg. 68,908, 68,990; 69,000.

[44] *Id*.

[45] 88 Fed. Reg. 68,908, 68,991-92

[46] Cal. Code Regs. tit. 22, § 84065.5; *see also* 606 Mass. Code Regs. 3.07(2).

[47] Cal. Code Regs. tit. 22, § 84087; 606 Mass. Code Regs. 3.08(7); Ill. Admin. Code tit. 89, §§ 402.9, 403.26, 404.44(j); 10-148 Me. Code R. ch. 35, § 5(Q)(18), (21); 10-148 Me. Code R. ch. 37, § 5(P)(16), (19)-(20); Mich. Admin. Code R. 400.8167 (indoor space per child requirement); Mich. Admin. Code R. 400.8380 (maintenance of premises); N.J. Admin. Code § 3A:56-4.1 (initial facility approval requirements), 3A:56-4.4 (maintenance and sanitation requirements); N.Y. Comp. Codes R. & Regs. tit. 18, § 448.3(d)(1)-(9); Wash Rev. Code §§ 43.185C.295, 74.15.030; Wash. Admin. Code ch. 110-145.

[48] Cal. Code Regs. tit. 22, § 89379; Ill. Admin. Code tit. 89, § 404.34; 10-148 Me. Code R. ch. 35, § 5(F)(23); Mich. Admin. Code R. 400.8170 (access to outdoor play); N.J. Admin. Code § 3A:56-6.8(a); N.Y. Comp. Codes R. & Regs. tit. 18, §§ 441.25, 442.20, 448.3(d)(1); Wash. Admin. Code ch. 110-145.

the States' licensing standards and requirements for guidance in developing and elaborating its own standards.[49]

As described above, each of the States have developed comprehensive licensing standards over decades of experience. In order to ensure that UACs in ORR's care and custody are protected by these comprehensive, state-specific standards, the States urge ORR to revise the Proposed Rule to require that all facilities housing UACs be state-licensed. However, should ORR determine to permit the use of unlicensed facilities, with a view to protecting the health and safety of UACs housed in such unlicensed facilities, the States urge that the Proposed Rule be revised to clearly require that standard programs and emergency and influx programs meet both ORR requirements *and* applicable state laws and regulations.

Specifically, the States recommend that proposed section 410.1302, subsection (b), governing standard programs, be revised as follows: "(b) Comply with all applicable State child welfare laws*,* ~~and~~ regulations, *and standards*, ~~and~~ all State and local building, fire, health, and safety codes, ~~or~~ *and* other requirements specified by ORR if licensure is unavailable in their State to care provider facilities providing services to unaccompanied children." The States recommend that proposed section 410.1801, subdivision (b)(15), governing emergency or influx facilities, be revised as follows: "(15) Emergency or influx facilities, whether state-licensed or not, must comply~~, to the greatest extent possible,~~ with *all applicable* State child welfare laws*,* ~~and~~ regulations (such as mandatory reporting of abuse), *and standards,* as well as State and local building, fire, health and safety codes~~, that ORR determines are applicable to non-State licensed facilities~~."

Concerns about the health and safety of UACs detained in unlicensed facilities in the past underscore the importance of ensuring that all facilities housing UACs are state-licensed or, at minimum, required to comply with state licensing regulations. In 2018 and 2019, HHS housed thousands of children in facilities, including in Tornillo, Texas, and Homestead, Florida, that were not licensed for the residential care of children.[50] Conditions at these facilities were inconsistent with the standards required of state-licensed facilities. In Tornillo, "[c]hildren spen[t] weeks crammed 20 to a tent, languishing in the desert, far away from sponsors and attorneys, and without adequate access to basic needs such as schools or a firm roof over their head."[51] Observers at the Tornillo facility noted that facility "felt like a prison or jail."[52] Similarly, "Homestead [had] the feel of a secure detention facility," was "surrounded

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[49] *See* Exec. Order No. 13132, 64 Fed. Reg. 43,255 (Aug. 4, 1999).

[50] *Unaccompanied Alien Children: An Overview*, Congressional Research Service, R43599, Sept. 1, 2021 at 20-22, https://sgp.fas.org/crs/homesec/R43599.pdf.

[51] Sen. Dianne Feinstein, *Letter to Dep't of Homeland Security Re: DHS Docket No. ICEB-2018-0002, RIN 0970-AC42 1653-AA75, Comments in Response to Proposed Rulemaking: Apprehension, Processing, Care, and Custody of Alien Minors and Unaccompanied Alien Children* (Nov. 6, 2018) at 2.

[52] Margaret Hartmann, *Reporters Tour Texas Facility Where Migrant Children are Detained*, New York Magazine (June 14, 2018), https://nymag.com/intelligencer/2018/06/reporter-migrant-children-incarcerated-in-texas-facility.html.

by tall perimeter walls" and had "a 24/7 security patrol"; "[c]hildren [were] not able to leave Homestead freely."[53] Then-Senator Kamala Harris called conditions at the Homestead facility "a human rights abuse."[54] More recently, whistleblowers have described troubling conditions at the Fort Bliss Emergency Intake Site, including crowded conditions that made effective supervision of youth impossible, failure to provide clean bedding or clothing, and delays in providing medical or mental health care.[55] Lengthy stays at the Fort Bliss facility in these conditions caused deterioration in the mental health of unaccompanied children, including increased risk of self-harm.[56]

C. *The Proposed Rule fails to adequately describe the oversight and enforcement regimes that would ensure unlicensed facilities meet minimum standards.*

In addition to the standards for licensing facilities, the States conduct robust oversight to ensure that facilities are continuing to comply with minimum standards. The States would recommend the adoption of similar oversight for any unlicensed facilities housing UACs. For example, California state law requires an initial evaluation visit within 90 days of the initial issuance of a license, provides for unannounced visits and visits on a regular schedule, permits public inspection of all reports and plans of correction for facilities, contains a process for receiving complaints about a facility and resolving such complaints through onsite inspections within ten days of receipt, outlines the process for suspension and revocation of licenses for facilities, and provides for civil penalties for noncompliance.[57] Other States also perform monitoring and enforcement functions.[58] The States' oversight mechanisms and processes are critical to ensure that children are not housed in conditions that are harmful to their health and safety.

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[53] Amnesty Int'l, *No Home for Children: The Homestead "Temporary Emergency" Facility* 21 (2019), https://www.amnestyusa.org/wp-content/uploads/2019/07/Homestead-Report_1072019_AB_compressed.pdf.

[54] Ben Smith, *Kamala Harris: The Waving Meme Moment was "Heartbreaking"*, BuzzFeed News (Aug. 15, 2019), https://www.buzzfeednews.com/article/bensmith/kamala-harris-the-waving-meme-moment-was-heartbreaking?bftwnews&utm_term=4ldqpgc#4ldqpgc.

[55] Gov't Accountability Project, *Letter to House of Representatives, Senate, Office of Special Counsel, and Office of Inspector General, Dep't of Health & Human Services Re: Protected Whistleblower Disclosures of Gross Mismanagement by the Department of Health and Human Services at Fort Bliss, Texas Causing Specific Dangers to Public Health and Safety* (July 7, 2021) at 7-10, https://whistleblower.org/wp-content/uploads/2021/07/070721-Fort-Bliss-Whistleblowers-Disclosure.pdf.

[56] Camilo Montoya-Galvez, *Migrant Children Endure "Despair and Isolation" Inside Tent City in the Texas Desert*, CBS News (June 22, 2021), https://www.cbsnews.com/news/immigration-migrant-children-fort-bliss-tent-city-texas/.

[57] Cal. Health & Safety Code §§ 1534, 1538, 1550-1557; Cal Code Regs. tit. 22, § 87844.

[58] Ill. Admin. Code tit. 89, §§ 383.25-383.85; Mich. Comp. Laws §§ 722.115, 722.118a, 722.120; N.J. Stat. Ann. §§ 30:1-14, 1-15, 30:4C-4, 30-11B-4; N.J. Admin. Code 3A:56-1.1(b), (f), (g); N.Y. Soc. Serv. Law §§ 460-c, 460-d; N.Y. Comp. Codes R. & Regs. tit. 18, § 441.7; Wash. Rev. Code §§ 74.13.031(6), 74.13.260.

Due to the states' expertise in this area, ORR has long relied on the states' oversight and enforcement functions to ensure, in the first instance, that UACs are housed in safe and appropriate conditions. However, ORR has struggled in the past to provide consistent supplemental monitoring of its contracted, state-licensed facilities. For example, in 2016, the Government Accountability Office found that, although contracted state-licensed facilities were largely providing required services, ORR's on-site monitoring visits had been inconsistent and ORR had not received complete case files for review.[59] In September 2020, the Government Accountability Office found that ORR had failed to obtain and review state licensing citations, failed to conduct timely audits and site visits, and experienced months-long delays in providing facilities with monitoring reports and required corrective actions.[60] And in May 2023, HHS's Office of Inspector General found that ORR had failed to ensure that ORR and care provider staff followed required procedures when transferring children due to limitations in ORR's quality control procedures and oversight.[61]

The States appreciate that the Proposed Rule describes general ORR monitoring activities for standard programs. However, the States are concerned that the Proposed Rule does not contain any description of heightened oversight procedures for unlicensed standard programs to replace the oversight that otherwise would have been provided by the relevant state licensing agency.[62] The States are likewise concerned that the Proposed Rule contains no explanation of how ORR will provide oversight to emergency or influx facilities or ensure that such facilities comply with ORR's standards and with state law.[63] And while the States welcome the proposed creation of an Office of the Ombuds, such an office fulfills a different purpose and, by design, lacks enforcement authority. Where a State will not be providing oversight in the first instance, more robust and detailed requirements for ORR's oversight mechanisms is critical. The monitoring regime described in the Proposed Rule is insufficient to replace the oversight provided by state licensing and enforcement agencies, and creates a significant risk that UACs will be placed in facilities that do not meet required minimum standards.

There are also significant concerns that unlicensed ORR emergency and influx facilities have previously operated without requiring criminal or child abuse and neglect background

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[59] Gov't Accountability Off., GAO-16-180, *Unaccompanied Children: HHS Can Take Further Actions to Monitor Their Care* 24-28 (2016), https://www.gao.gov/assets/gao-16-180.pdf.

[60] Gov't Accountability Off., GAO-20-609, *Unaccompanied Children: Actions Needed to Improve Grant Application Reviews and Oversight of Care Facilities* 16-18, 32-36 (2020), https://www.gao.gov/assets/gao-20-609.pdf.

[61] Dep't of Health and Human Services, Off. of Inspector Gen., *The Office of Refugee Resettlement Needs to Improve its Oversight Related to the Placement and Transfer of Unaccompanied Children* (May 2023), https://oig.hhs.gov/oas/reports/region6/62007002.pdf.

[62] 88 Fed. Reg. 68,908, 68,991.

[63] 88 Fed. Reg. 68,908, 68,999-69,000.

checks.[64] The Proposed Rule does not clearly require background checks for staff in emergency or influx facilities. By contrast, California law requires that all staff at licensed children's residential facilities undergo a stringent background check that includes checks of the Federal Bureau of Investigation's and the California Department of Justice's criminal records, the California Child Abuse Central Index, and the state child abuse registry of any state in which a prospective staff member has resided in the past five years.[65] Other States follow similar procedures regarding background checks for facility staff.[66]

The States urge that all facilities housing UACs should be state-licensed to ensure that UACs enjoy the protections of state oversight and enforcement. However, consistent with the States' deep concern for the welfare of UACs, should HHS determine to permit the use of unlicensed facilities, the States recommend that the Proposed Rule be revised to include, at a minimum, the following monitoring and enforcement functions for facilities that are not state-licensed: (1) requirements for inspection, screening, and documentation review prior to the placement of any UACs in a facility; (2) requirements for criminal and child abuse and neglect background checks for all facilities housing UACs in ORR care, including emergency and influx facilities; (3) requirements for frequency of monitoring visits and evaluations, including both scheduled and unannounced visits, and for review of documentation and case files; (4) a procedure for receiving, investigating, and responding to complaints within a specified timeframe; and (5) a framework for the enforcement of standards, including procedures for suspension or termination of a facility for failure to comply with state laws, regulations, and codes or with ORR standards. These minimum monitoring and enforcement functions are critical to protecting the health, safety, and welfare of any UACs in ORR custody.

D. The States strongly oppose any attempt to operate unlicensed facilities within their States, including family detention facilities.

Finally, the States are concerned with the implications of ORR sanctioning the operation of unlicensed facilities within the States. As described above, establishing and enforcing standards of care for licensing of residential placements for children is a core police power vested in the states, which have consistently required that such placements be licensed. In exercising that police power, States have made a considered policy decision *not* to license certain types of facilities. For example, the States generally do not permit "secure" or locked children's

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[64] Off. of Inspector Gen., Dep't of Health & Human Services, *The Tornillo Influx Care Facility: Concerns About Staff Background Checks and Number of Clinicians on Staff (A-12-19-20000)* (Nov. 27, 2018) at 1, 6, https://oig.hhs.gov/oas/reports/region12/121920000.pdf; Amnesty International, *No Home for Children: The Homestead "Temporary Emergency" Facility*, *supra* note 533 at 20-21.

[65] *See* Cal. Health & Safety Code §§ 1522, 1522.1.

[66] *See, e.g.*, Mass. Gen. Laws ch. 15D, § 7(a); Del. Code Ann. tit. 14, § 3004A; 10-148 Me. Code R. ch. 16, at § 2(H); Mich. Comp. Laws § 722.115d; Nev. Rev. Stat. §§ 432A.175, 432A.1755, 432A.1785; N.J. Admin. Code §§ 3A:55-5.1(b)(3), 3A:55-5.6 to -5.9; N.M. Stat. Ann. § 32A-15-3; N.Y. Soc. Serv. Law § 378-a; 55 Pa. Code § 3800.51; R.I. Gen. Laws § 42-72.1-3(e)(9); Wash. Admin. Code § 110-145-1510.

residential facilities, except as necessary for the child's safety or the safety of others, or in connection with a juvenile offense.[67] State licensing standards generally require that children in residential facilities have freedom of egress from these facilities; the independence appropriate to their age, maturity and capability; and the ability to participate in activities in the community.[68]

A Proposed Rule that sanctions ORR's use of unlicensed facilities raises serious concerns that in the future the federal government may seek to expand the use of other types of unlicensed facilities—most saliently, facilities for the detention of families—in the States. This concern is not unfounded: the federal government has attempted to do before. See *Flores v. Rosen*, 984 F.3d 720, 739-40 (9th Cir. 2020) (enjoining proposed regulations that would have permitted family detention in States that did not license family detention facilities). The harms such facilities inflict on children is well documented,[69] and for that reason, the States have uniformly declined to license such facilities. Any plan to employ unlicensed secure facilities, which children are not allowed to leave, including family detention facilities, would harm the States, not only as to their interest in enforcing their duly-enacted laws and regulations, but also in their compelling interest of protecting the welfare of the States' children.

E. The States propose amendments to the Proposed Rule.

For the reasons described above, the States strongly urge HHS to revise the definition of "standard program" to require that all homes and facilities operated by such programs be state-licensed and to update proposed section 410.1302, subsections (a) and (b), consistent with that requirement. The States further urge HHS to revise the definition of "emergency or influx facility" and proposed section 410.1801 to require that emergency or influx facilities be state-licensed.[70]

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[67] *See, e.g.*, Del. Code Ann. tit. 10 § 1007, id. tit. 16, §§ 5001-5011; D.C. Code § 2–1515.01, et seq.; Ill. Admin. Code tit. 89, §§ 411.10, 411.110(g); Mich. Comp. Laws § 712A.15(4); N.Y. Comp. Codes R. & Regs. tit. 9, §§ 180-1.1–180.1.21, 180-3.1–180-3.32, and id. tit. 18 §§ 450.1–450.10; 55 Pa. Code §§ 3800.271–3800.283.

[68] *See, e.g.*, Del. Code Ann. tit. 13, §§ 2502, 2522; 20 Ill. Comp. Stat. 505/7.3a(c)(2), Ill. Admin. Code tit. 89, § 404.34; Mich. Comp. Laws § 722.958b; N.Y. Comp. Codes R. & Regs. tit. 18, § 441.25; Or. Admin. R. 413-200-0335(4), 413-200-0356.

[69] Children who are detained in family detention facilities experience increased Post-Traumatic Stress Disorder (PTSD), elevated emotional problems, increased problems with peers, high rates of anxiety, depression, suicidal behavior, and other behavioral problems, and regressive behavioral changes, including decreased eating, sleep disturbances, clinginess, withdrawal, self-injurious behavior, and aggression. Rhitu Chatterjee, *Lengthy Detention of Migrant Children May Cause Lasting Trauma, Say Researchers*, NPR (Aug. 23, 2019), https://www.npr.org/sections/health-shots/2019/08/23/753757475/lengthy-detention-of-migrant-children-may-create-lasting-trauma-say-researchers; Julie M. Linton et al., *Detention of Immigrant Children*, 139(5) Pediatrics e20170483 (2017), https://publications.aap.org/pediatrics/article/139/5/e20170483/38727/Detention-of-Immigrant-Children.

[70] State licensing for emergency and influx facilities is potentially available in California, for example, where such facilities could seek licensure as group homes or transitional shelters. *See* Cal. Code Regs. tit. 22, § 84000 et seq.; Cal. Health & Safety Code § 1502.3.

However, should HHS retain the proposed definitions of "standard program" and "emergency or influx facility," the States propose alternative recommendations consistent with the States' deep concern with the health and wellbeing of UACs in ORR custody.

First, as discussed above, the States recommend that the Proposed Rule be revised to require facilities operating without a license to comply with all relevant state licensing regulations and standards. Specifically, the States recommend that proposed section 410.1302, subsection (b), be revised as follows: "(b) Comply with all applicable State child welfare laws*,* ~~and~~ regulations, *and standards*, ~~and~~ all State and local building, fire, health, and safety codes, ~~or~~ *and* other requirements specified by ORR if licensure is unavailable in their State to care provider facilities providing services to unaccompanied children."

Second, the States recommend that proposed section 410.1801 be revised to require that an emergency or influx facility be licensed by an appropriate State agency if State licensure is available. The States also recommend that proposed section 410.1801, subdivision (b)(15), governing emergency or influx facilities, be revised as follows: "(15) Emergency or influx facilities, whether state-licensed or not, must comply~~, to the greatest extent possible,~~ with *all applicable* State child welfare laws*,* ~~and~~ regulations (such as mandatory reporting of abuse), *and standards,* as well as State and local building, fire, health and safety codes~~, that ORR determines are applicable to non-State licensed facilities~~."

Third, the States strongly urge that, in the event ORR places children in facilities that are not state-licensed, ORR provide a level of oversight that is commensurate with what would otherwise have been provided by the state. With respect to facilities that are not state-licensed, the States recommend that the Proposed Rule be revised to include, at a minimum, the following monitoring and enforcement functions for facilities that are not state-licensed: (1) requirements for inspection, screening, and documentation review prior to the placement of any UACs in a facility; (2) requirements for criminal and child abuse and neglect background checks for all facilities housing UACs in ORR care, including emergency and influx facilities; (3) requirements for frequency of monitoring visits and evaluations, including both scheduled and unannounced visits, and for review of documentation and case files; (4) a procedure for receiving, investigating, and responding to complaints within a specified timeframe; and (5) a framework for the enforcement of standards, including procedures for suspension or termination of a facility for failure to comply with state laws, regulations, and codes or with ORR standards. And the States urge ORR to allocate sufficient staffing and other resources to ensure that oversight of any unlicensed facilities is as robust as that which would otherwise have been provided by the state in which the facilities are located.

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The States welcome the steps that HHS has taken to develop a comprehensive regulatory regime to govern the care of UACs in the custody of ORR. In particular, the States strongly support provisions of the Proposed Rule that improve UAC's language access and access to counsel and reproductive health care, strengthen post-release services, prioritize community-based care, and require the implementation of positive behavior management systems.

However, the States are opposed to the provisions of the Proposed Rule that would permit UACs to be housed in unlicensed facilities. The licensing and oversight of children's residential facilities is a core police power of the states, and the States have developed comprehensive licensing regimes over the course of many decades to ensure that children housed in these facilities are healthy and safe and that their rights are protected. The States strongly recommend that the Proposed Rule be revised to require that any facilities housing UACs be state-licensed. Should HHS nevertheless determine to permit the use of certain unlicensed facilities, consistent with the States' compelling interest and concern for the health, safety, and well-being of UACs, the States strongly recommend that the Proposed Rule be revised to require that all facilities be licensed where licensure is available and that all facilities be required to comply with all relevant state laws. The States further urge HHS to ensure that comprehensive oversight mechanisms are developed and implemented to ensure that unlicensed facilities are compliant with state law and ORR policy.

Sincerely,

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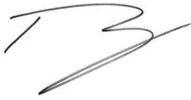

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EXHIBIT 5

Case 2:85-cv-04544-DMG-AGR Document 1427-7 Filed 05/31/24 Page 2 of 70 Page ID #:49943

United States Government Accountability Office

Report to the Chairwoman of the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, Committee on Appropriations, House of Representatives

September 2020

UNACCOMPANIED CHILDREN

Actions Needed to Improve Grant Application Reviews and Oversight of Care Facilities

GAO-20-609

GAO Highlights

Highlights of GAO-20-609, a report to the Chairwoman of the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, Committee on Appropriations, House of Representatives

September 2020

UNACCOMPANIED CHILDREN

Actions Needed to Improve Grant Application Reviews and Oversight of Care Facilities

Why GAO Did This Study

ORR is responsible for the care and placement of unaccompanied children in its custody, which it provides through grants to state-licensed care provider facilities. ORR was appropriated $1.3 billion for this program in fiscal year 2020. GAO was asked to review ORR's grant making process and oversight of its grantees.

This report examines (1) how ORR considers state licensing issues and past performance in its review of grant applications; (2) state licensing agencies' oversight of ORR grantees, and how ORR and states share information; and (3) how ORR addresses grantee noncompliance. GAO reviewed ORR grant announcements and applications for fiscal years 2018 and 2019. GAO conducted a survey of 29 state licensing agencies in states with ORR facilities, and reviewed ORR monitoring documentation and corrective action reports. GAO also reviewed ORR guidance and policies, as well as relevant federal laws and regulations, and interviewed ORR officials.

What GAO Recommends

GAO is making eight recommendations to ORR on improving clarity in its grant announcements, communication with state licensing agencies, and monitoring of its grantees. ORR agreed with all eight recommendations.

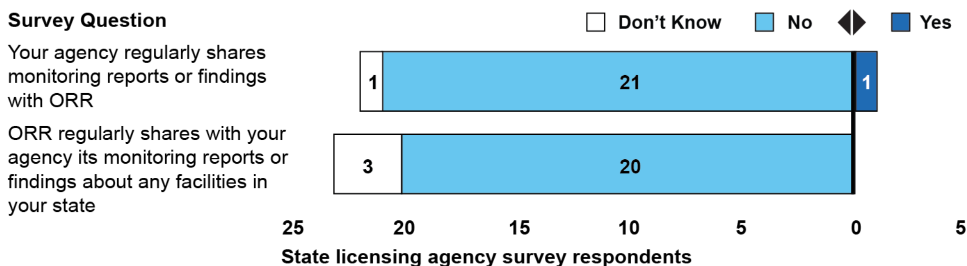
View GAO-20-609. For more information, contact Kathryn A. Larin at (202) 512-7215 or larink@gao.gov.

What GAO Found

The Office of Refugee Resettlement's (ORR) grant announcements soliciting care providers for unaccompanied children—those without lawful immigration status and without a parent or guardian in the U.S. available to provide care and physical custody for them—lack clarity about what state licensing information is required. Further, ORR does not systematically confirm the information submitted by applicants or document a review of their past performance on ORR grants, when applicable, according to GAO's analysis of ORR documents and interviews with ORR officials. The grant announcements do not specify how applicants without a state license should show license eligibility—a criterion for receiving an ORR grant—or specify what past licensing allegations and concerns they must report. In addition, the extent to which ORR staff verify applicants' licensing information is unclear. In fiscal years 2018 and 2019, ORR awarded grants to approximately 14 facilities that were unable to serve children for 12 or more months because they remained unlicensed. In addition, ORR did not provide any documentation that staff conducted a review of past performance for the nearly 70 percent of applicants that previously held ORR grants. Without addressing these issues, ORR risks awarding grants to organizations that cannot obtain a state license or that have a history of poor performance.

State licensing agencies regularly monitor ORR-funded facilities, but according to GAO's survey of these agencies, their information sharing with ORR is limited (see figure). State licensing agencies and ORR staff both said that improved information sharing would benefit their monitoring of facilities. Without such improvements, ORR may lack information about ongoing issues at its facilities.

Key Survey Responses on Information-Sharing with the Office of Refugee Resettlement (ORR) by the 23 State Agencies That Licensed ORR-Funded Facilities in Fall 2019



Source: GAO survey of state agencies that license ORR-funded providers, conducted October 2019 – January 2020. | GAO-20-609

ORR requires grantees to take corrective action to address noncompliance it identifies through monitoring, but ORR has not met some of its monitoring goals or notified grantees of the need for corrective actions in a timely manner. For example, under ORR regulations, each facility is to be audited for compliance with standards to prevent and respond to sexual abuse and harassment of children by February 22, 2019, but by April 2020, only 67 of 133 facilities had been audited. In fiscal years 2018 and 2019, ORR also did not meet its policy goals to visit each facility at least every 2 years, or to submit a report to facilities on any corrective actions identified within 30 days of a visit. Without further action, ORR will continue to not meet its own monitoring goals, which are designed to ensure the safety and well-being of children in its care.

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Abbreviations

ACF	Administration for Children and Families
COVID-19	Coronavirus Disease 2019
FOA	Funding Opportunity Announcement
HHS	Department of Health and Human Services
OGM	Office of Grants Management
OMB	Office of Management and Budget
ORR	Office of Refugee Resettlement
PSA	Prevention of Sexual Abuse

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U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
Washington, DC 20548

September 15, 2020

The Honorable Rosa DeLauro
Chairwoman
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, Committee on Appropriations
House of Representatives

Dear Ms. DeLauro,

The Department of Health and Human Services' (HHS) Office of Refugee Resettlement (ORR) was appropriated $1.3 billion in fiscal year 2020 to carry out a program for the care and placement of unaccompanied alien children—children without lawful immigration status and without a parent or guardian in the United States available to provide care and physical custody for them, including those who have been separated from their parent or guardian.[1] In fiscal year 2019, the latest year for which complete data are available, ORR awarded grants totaling over $1.8 billion to organizations providing shelter and other services to these children.[2] Unaccompanied alien children (referred to in this report as unaccompanied children) are generally referred to ORR for care by the Department of Homeland Security. The numbers of these referrals have fluctuated over time, but increased substantially from almost 14,000 in fiscal year 2012 to more than 69,000 in fiscal year 2019, and decreased

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[1]The term "unaccompanied alien child" refers to a child who (1) has no lawful immigration status in the United States, (2) has not attained 18 years of age, and (3) has no parent or legal guardian in the United States or no parent or legal guardian in the United States available to provide care and physical custody. 6 U.S.C. § 279(g)(2). As such, children traveling with related adults other than a parent or legal guardian—such as a grandparent or sibling—are still deemed unaccompanied alien children. In addition, if the Department of Homeland Security (DHS) determines that children in its custody without lawful immigration status should be separated from their accompanying parents, DHS then considers these children to be unaccompanied and refers them to ORR. For more information on DHS processing of families arriving at the Southwest border and on separations of such families, see GAO, *Southwest Border: Actions Needed to Improve DHS Processing of Families and Coordination between DHS and HHS,* GAO-20-245. (Washington, D.C.: February 19, 2020), GAO, *Southwest Border: Actions Needed to Address Fragmentation in DHS's Processes for Apprehended Family Members,* GAO-20-274. (Washington, D.C.: February 19, 2020), and GAO, *Unaccompanied Children: Agency Efforts to Reunify Children Separated from Parents at the Border,* GAO-19-163. (Washington, D.C.: October 9, 2018).

[2]ORR awards these funds via cooperative agreements; however, for the purposes of this report we refer to them as grants.

significantly in fiscal year 2020. According to ORR officials, as of June 4, 2020, there were 1,123 unaccompanied children in ORR's care.

You asked us to examine ORR's grant making process and oversight of its grantees. This report examines (1) how ORR considers state licensing issues and past performance in its review of grant applications; (2) state licensing agencies' policies and practices for overseeing ORR grantees, and how ORR and states share information on oversight; and (3) ORR policies and practices for addressing grantee noncompliance with grant agreements.

To address our first objective, we reviewed documentation related to ORR grants for fiscal years 2018 and 2019, the most recent years available at the time of our review. We reviewed the eight ORR grant announcements issued during this time, grant applications submitted to ORR in response to these announcements, and ORR funding decision memoranda. To determine whether applicants that received ORR grants in fiscal years 2018 and 2019 were able to obtain a state license and whether they had begun serving children, we compared the 58 applications (that resulted in grant awards) from those two years to data ORR provided on facilities' status as of July 2020.[3] While ORR program officials acknowledged that these data are not always kept up-to-date, we found the data sufficiently reliable for the purpose of providing approximate numbers of facilities that had obtained a license and begun serving children. To address our second research objective, we conducted a survey via email of 29 state licensing agencies in the 26 states, including the District of Columbia, where ORR had awarded grants to operate facilities as of July 2019.[4] We received survey responses from 28 of the 29 agencies.[5] We also conducted interviews with state licensing agency officials in Arizona, Maryland, and Texas. We selected these states based on a combination of criteria including the number of ORR grantee facilities in each state, different types of state licensing agencies, and both border and non-border states. We also analyzed selected quarterly performance reports submitted to ORR from nine facilities in these three states. We selected these facilities based on their number of

[3]We also reviewed data provided by ORR on its facilities as of February 5, 2020.

[4]We administered the survey from October 2019 to January 2020.

[5]Washington State Department of Children, Youth, and Families declined to participate in the survey.

recent ORR and state licensing corrective actions, and to reflect a range of facility types, sizes, and populations served.

To address our third objective, we reviewed ORR summary data on corrective actions issued in fiscal years 2018 and 2019, and reviewed corrective actions issued to our selected facilities by ORR teams involved in monitoring. To assess the reliability of the corrective action data, we obtained information from ORR officials about the data. We found the data to be sufficiently reliable for the purposes of this report. To address all our objectives, we interviewed or requested written responses from ORR officials, including ORR program officials, project officers, federal field specialists, and other staff involved in the grant review process and facility monitoring. We also reviewed relevant federal laws and regulations, and ORR policies, procedures, and guidance.

Further, to incorporate the perspectives of ORR grantees in our review, we sought to interview staff of ORR grantees. However, HHS wanted to have one of its attorneys present at these interviews or take other measures that we believed could have prevented grantees from speaking freely with us about their experiences with ORR. We were unable to reach timely agreement with HHS on procedures for conducting these interviews that would address this concern. As a result, our review is based on information obtained from ORR officials and documents and, where relevant, state documentation and interviews. In addition, we conducted some interviews with ORR officials, but obtained other information through written questions at HHS's request. For further information on our scope and methodology, see appendix I.

We conducted this performance audit from May 2019 to September 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Under federal law, unaccompanied children in the custody of the federal government generally must be transferred to HHS within 72 hours after a determination is made that they are unaccompanied children.[6] ORR, part

[6] 8 U.S.C. § 1232(b)(3).

of the Administration for Children and Families (ACF) within HHS, is responsible for coordinating and implementing the care and placement of these unaccompanied children.[7] Since 2003, ORR has cared for more than 340,000 children.[8] The majority of these children have been 13 to 17 years old, but some have been younger, including infants. ORR is required to promptly place unaccompanied children in its custody in the least restrictive setting that is in the best interest of the child.[9] In addition, the 1997 Flores v. Reno settlement agreement articulated standards for the care of these children, including the provision of proper physical care and maintenance, including suitable living accommodations, and appropriate medical care and educational services.[10] According to ORR, all children in its care receive classroom education appropriate to their level of development, mental and medical health services, case management, recreation, and unification services that facilitate their release to family members or other sponsors who can care for them.[11] For example, in 2016 we reported that 60 percent of unaccompanied

[7]6 U.S.C. § 279.

[8]HHS Latest UAC Data – FY2019, https://www.hhs.gov/programs/social-services/unaccompanied-alien-children/latest-uac-data-fy2019/index.html, downloaded May 31, 2019.

[9]8 U.S.C. § 1232(c)(2)(A).

[10]The court-approved settlement agreement in the case of *Flores v. Reno* was the result of a class action lawsuit filed against the former Immigration and Naturalization Service (INS) challenging the agency's arrest, processing, detention, and release of juveniles in its custody. The agreement sets out nationwide policy for the detention, release, and treatment of minors in the custody of the former INS, the border security and immigration-related functions of which are now performed by U.S. Customs and Border Protection, U.S. Immigration and Customs Enforcement, and U.S. Citizenship and Immigration Services. Stipulated Settlement Agreement, *Flores v. Reno*, No. 85-4544 (C.D. Cal. Jan 17, 1997). A court order prohibiting the implementation of an August 2019 final rule that would have replaced the terms of the *Flores* settlement agreement is currently pending appeal before the U.S. Court of Appeals for the Ninth Circuit. See *Flores v. Barr*, No. 19-56326 (9th Cir. argued May 19, 2020). In addition, the issue of releasing children from ORR-funded facilities during the COVID-19 pandemic continues to be litigated.

[11]ORR also provides grants to organizations to conduct home studies prior to placement with a sponsor in certain cases, such as if the child's safety is in question and funds follow-up services for at-risk children after their release. See 8 U.S.C. § 1232(c)(3)(B) and *ORR Policy Guide: Children Entering the United States Unaccompanied*, sections 2.4 and 6.1, and 6.2.

children were released into the care of a parent who was already living in the United States.[12]

To provide for these children, ORR solicits residential care providers (grantees) through funding opportunity announcements (grant announcements),[13] and typically funds successful applicants through 3-year cooperative agreements (grant agreements).[14] During fiscal years 2018 and 2019, ORR issued eight grant announcements, and awarded funds to applicants in response to seven of them.[15] ORR grantees are private nonprofit and for-profit organizations and businesses. The majority of children in ORR custody are cared for in shelter facilities, but some are cared for in other settings.[16] These include:

- secure shelters for children with an offender history,
- residential treatment centers for children with diagnosed mental health disorders,
- transitional (short-term) foster care, where children receive services at a central facility site but spend nights with a foster family, for younger or more vulnerable children, and

[12]This analysis used ORR data on unaccompanied children from El Salvador, Guatemala, and Honduras who were released from ORR custody from January 7, 2014 through April 17, 2015. See *Unaccompanied Children: HHS Can Take Further Actions to Monitor Their Care,* GAO-16-180 (Washington, D.C.: Feb. 5, 2016).

[13]ORR refers to these as Standing Announcements or Funding Opportunity Announcements.

[14]In this report, we refer to these cooperative agreements as grants or grant agreements. The grants are for a 3-year project period; funds are awarded for the second and third years based on approved continuation applications, subject to satisfactory progress by the grantee and a determination that continued funding would be in the best interest of the federal government.

[15]In this report, we refer to each instance in which ORR issued a grant announcement, reviewed applications, and made award decisions as a funding "round." We identify these funding rounds by the deadline ORR set for grant applications. ORR issued an eighth grant announcement for secure facilities that closed in June 2018, but did not fund any grantees in response to this announcement,

[16]In this report, we refer to these individual care settings as "facilities," regardless of the type of setting. When a grantee is providing transitional or long-term foster care, the "facility" is the grantee's office responsible for finding, vetting, and overseeing individual foster homes (and, in the case of transitional foster care, providing on-site services during the day). Individual licensed foster homes are not considered facilities. One grantee may operate multiple facilities.

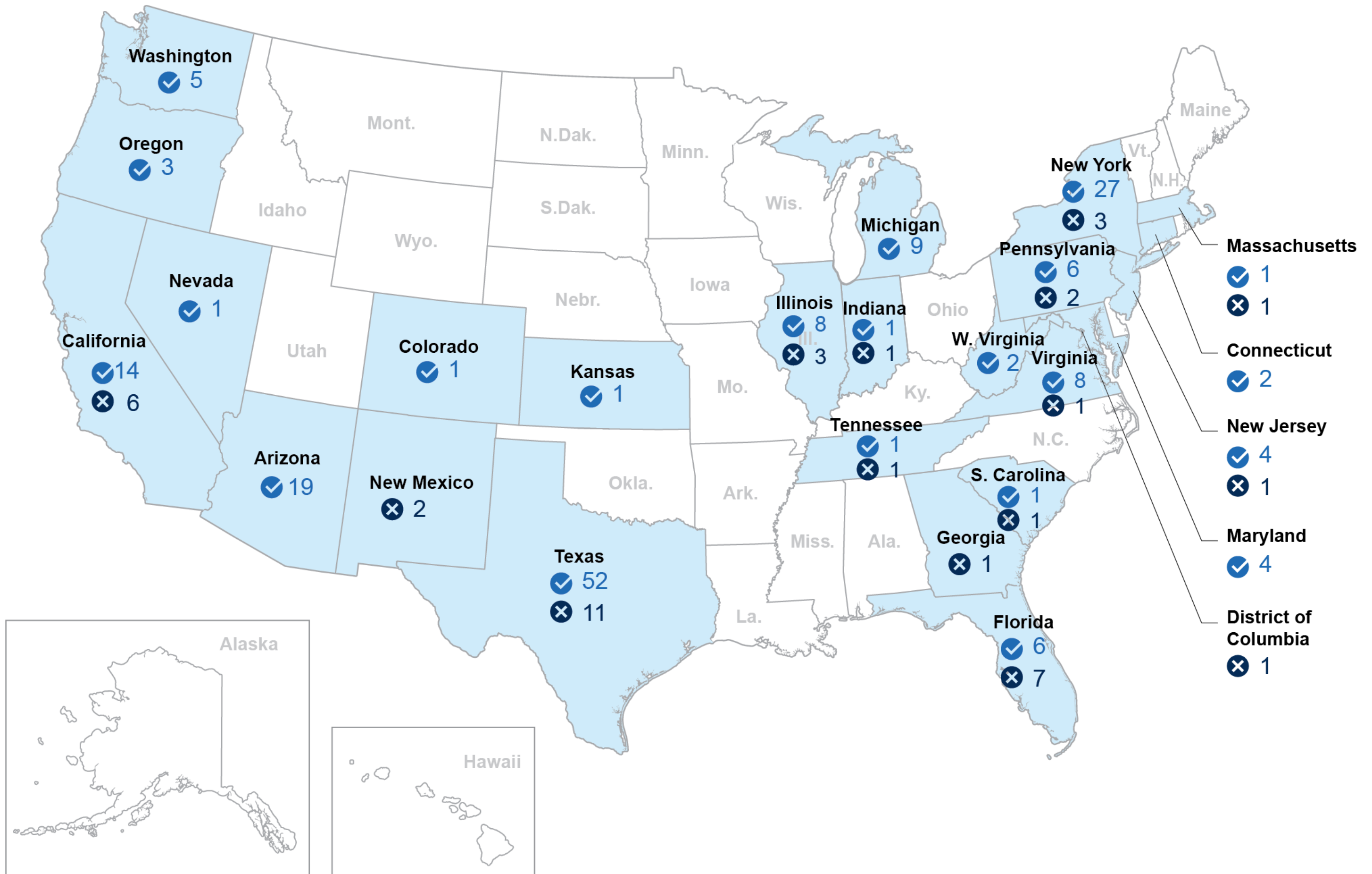
- long-term foster care in single-family or group homes for children whom ORR expects to be eligible for immigration relief and who are expected to have an extended stay within the ORR system.[17]

As of July 2020, ORR grantees were operating 176 facilities in 22 states, and ORR had awarded grants for an additional 43 facilities that were not yet serving children, including facilities in an additional three states (see fig. 1). As a result, ORR's available bed capacity was approximately 13,500, with approximately 5,000 additional beds funded but not yet available for use.[18] Slightly over a third of ORR's available beds were provided by a single grantee. An additional 21 percent were provided by the next two largest grantees. Many other grantees are smaller, operating only one or two facilities or facilities with fewer beds.

[17]There are several types of immigration relief that may be available to these children, for example, asylum or Special Immigrant Juvenile status. ORR has other placement options that it sometimes uses. For more information on types of immigration relief, the types of facilities operated by ORR grantees, and the care provided to children in these settings, see GAO-16-180.

[18]The number of beds funded but not yet available is an estimate based on a spreadsheet ORR project officers use to track the funded capacity of ORR grantees and the number of beds ORR has available. ORR program officials acknowledged that the spreadsheet is not always kept up-to-date, but is currently the only method it has to track this information.

Figure 1: Number of Grantee Facilities Funded by the Office of Refugee Resettlement With and Without Unaccompanied Children in Residence, July 2020



✔ Number of grantee facilities in state serving children (Total=176)

✖ Number of facilities in state awarded a grant but not serving children (Total=43)

States with Office of Refugee Resettlement (ORR)-funded facilities (Total=25)

Source: GAO analysis of ORR data; National Atlas (base map). | GAO-20-609

Note: ORR officials also told us that ORR has two additional facilities, one in Florida and one in Texas, which ORR uses to provide services during influxes of unaccompanied children. Data provided by ORR also included one additional ORR-funded facility, the location of which was still “to be determined” and which was not serving children as of July 1, 2020.

ORR facilities generally must be licensed by a state licensing agency to provide residential, group, or foster care services for dependent children.[19] State licensing agencies generally monitor facilities to ensure they comply with the state's minimum standards of care, and ORR program officials told us this monitoring ensures facilities are adhering to child welfare best practices. States establish their own licensing requirements and monitoring activities, including the frequency of monitoring, and a variety of state agencies may license and monitor ORR-funded facilities.[20]

In addition to state licensing and monitoring, ORR monitors the facilities it funds. When ORR identifies a facility that is not complying with ORR policies, the terms of its grant, or other applicable requirements, it may require the facility to take corrective action. Several ORR teams are involved in monitoring grantee compliance in different ways, and these teams may issue corrective actions for any instances of noncompliance they identify (see table 1). According to its policy guide, ORR may also take other actions to ensure compliance and the safety of children, including removing children from a facility entirely.[21]

[19]ORR also requires its grantees to comply with various other requirements. For example, a recent grant announcement states that "[a]pplicants must describe that the facility/foster home meets all relevant zoning, licensing, fire, safety, and health codes required to operate a residential based social service program." See Administration for Children and Families, Office of Refugee Resettlement, Standing Announcement for Residential (Shelter) Services for Unaccompanied Alien Children, HHS-2017-ACF-ORR-ZU-1132, Due Date: 05/09/2019. See also 45 C.F.R. pt. 75 for HHS's regulations establishing uniform administrative requirements, cost principles, and audit requirements for HHS grant awards.

[20]At times, ORR has operated "influx" facilities—facilities used when the number of unaccompanied children in ORR's care has been exceptionally high. Influx facilities may operate on federally owned or leased properties, and are generally exempt from the requirement to obtain a state license, according to ORR's *Policy Guide*. In June 2020, ORR officials told us ORR was funding the upkeep of two influx facilities so that they can be activated quickly should the need arise. However, these officials said there had been no children in the care of these facilities since August 2019 and that ORR had no plans to reopen them. Influx facilities may be funded via cooperative agreements or contracts, and the HHS Office of the Inspector General is currently reviewing the process by which one of these contracts was awarded.

[21]Under HHS's grant regulations, if a grantee fails to comply with federal statutes, regulations, or the terms and conditions of its award, ORR may impose additional conditions, such as requiring additional financial reports or project monitoring. If ORR determines that additional conditions cannot remedy the noncompliance, it may take other actions as appropriate, including terminating the award. 45 C.F.R. §§ 75.371, 75.207.

Table 1: Roles of ORR Teams Involved in Oversight and Issuing Corrective Actions for Facilities Providing Care for Unaccompanied Children

Team	Roles and key monitoring goals	Areas reviewed/ potential corrective action areas

Monitoring team	• Conduct a review of each ORR-funded facility once every two years, including:
	  • review of policies and procedures, reports, and case files
	  • 5-day site visit and inspection of the facility to review additional documentation, interview staff, children and youth, and stakeholders
		• Program management
		• Services
		• Safety and security
		• Child protection
		• Case management
		• Personnel management
		• Fiscal management

Project officers	• Oversee specific facilities • Conduct desk monitoring through review of all required documents and reports submitted by facilities • Responsible for overseeing facilities' implementation of corrective action plans	• Program Design • Personnel • Compliance with ORR policy and procedures • Any items with budgetary impact • Staffing ratios • Compliance with grants terms and conditions • Licensing standards compliance • Child safety/risk issues
Federal field specialists	• Act as the local ORR liaison with facilities and stakeholders • Generally visit facilities at least once per month and work with contractor field specialists who visit facilities more often • Approve child transfer and release decisions • May help monitor implementation of corrective action plans	• Compliance with ORR policy and procedures • Child safety/risk issues • Licensing standards compliance • Any child-specific issues
Prevention of Sexual Abuse team[a]	• Contracts with outside organization to conduct audits of all facilities' compliance with ORR regulations and policy on preventing and addressing sexual abuse and harassment, within 3 years of February 22, 2016, and then every three years	• Compliance with Interim Final Rule on *Standards To Prevent, Detect, and Respond to Sexual Abuse and Sexual Harassment Involving Unaccompanied Children* • Related ORR policies and procedures

Source: Office of Refugee Resettlement (ORR) Policy Guide, Department of Health and Human Services regulations, and interviews with ORR officials. | GAO-20-609

Note: During periods when ORR funds influx facilities via contracts, Contracting Officer's Representatives are also involved in monitoring facilities. ORR officials told us that these officials serve a role similar to project officers. ORR officials confirmed that as of June 2020, they were funding only one influx facility via contract, which was inactive and not caring for any children.

[a]In December 2014, ORR published an Interim Final Rule establishing standards to prevent, detect, and respond to sexual abuse and sexual harassment in certain ORR-funded facilities that house unaccompanied children, in response to a requirement in the Violence Against Women Reauthorization Act of 2013. 79 Fed. Reg. 77,768 (Dec. 24, 2014). Among other things, the rule provides that each facility that houses unaccompanied children will be audited at least once within 3 years of February 22, 2016, and during each three-year period thereafter. 45 C.F.R. § 411.111(a). The rule does not apply to secure care provider facilities or individual foster care homes.

In 2016, we found that some ORR facilities were not maintaining complete case files on children in their care, and that ORR was not able to complete in-depth monitoring visits on schedule, with some facilities going years without such a visit. As a result, we recommended ORR review its monitoring program to ensure timely visits and proper documentation of services.[22] ORR agreed with the recommendation and subsequently provided documentation showing that it had increased its monitoring visits and standardized its monitoring tools. In addition, in 2019, the HHS Office of Inspector General (OIG) reported on concerns it identified as a result of its review of 45 ORR-funded facilities, including that some facilities did not have evidence of background checks on file for all employees, hired staff who did not meet ORR's education requirements, and experienced challenges employing mental health clinicians and accessing external mental health providers.[23] In 2020, the HHS OIG reported that at 39 of 40 ORR-funded facilities reviewed, inspection checklists used by the facilities to monitor their own security measures did not include checks for all measures required by ORR.[24] The HHS OIG has also reported on problems it identified at individual ORR-funded facilities, ranging from claiming unallowable expenditures to failing to document that the facility met ORR health and safety standards.[25]

[22]GAO-16-180.

[23]HHS, Office of Inspector General, *Unaccompanied Alien Children Care Provider Facilities Generally Conducted Required Background Checks but Faced Challenges in Hiring, Screening, and Retaining Employees,* A-12-19-20001, September 2019; and *Care Provider Facilities Described Challenges Addressing Mental Health Needs of Children in HHS Custody,* OEI-09-18-00431, September 2019.

[24]HHS, OIG, *Unaccompanied Alien Children Program Care Provider Facilities Do Not Include All Required Security Measures in Their Checklists,* OEI-05-19-00210, June 2020.

[25]See https://oig.hhs.gov/reports-and-publications/featured-topics/uac/ for links to HHS OIG reports on this topic.

ORR's Grant Announcements Lack Clarity on How Applicants Should Report State Licensing Issues and ORR Does Not Document Review of Grantees' Past Performance

ORR's Grant Announcements Lack Clarity and Grant Applicants Inconsistently Report State Licensing Information

We found that ORR's grant announcements to solicit facilities to provide care for unaccompanied children are unclear about the information applicants must submit on state licensing, and applicants provide inconsistent information. Two specific areas of ambiguity are the status of state licenses and information about past state licensing allegations and concerns.

State Licensing Status

ORR's recent grant announcements specify that applicants must be state licensed or eligible for a license and able to obtain one within 75 days of their grant award.[26] The grant announcements also state that applicants must include proof of their license or license eligibility. While ORR program officials told us that many applicants apply to operate a new facility before it is licensed, the grant announcements do not specify how they should demonstrate that they are eligible for a license in their application. ORR project officers, who review applications as part of ORR's multi-step grant review process, also could not cite specific

[26]For example, see Administration for Children and Families, Office of Refugee Resettlement, Standing Announcement for Residential (Shelter) Services for Unaccompanied Alien Children, HHS-2017-ACF-ORR-ZU-1132, Due Date: 05/09/2019. Section III.1. Eligible Applicants, which states that "Care providers are required to be licensed or license eligible (temporary, provisional or an equivalent license) with license being issued, by a state licensing agency, within 75 days of award to provide residential, group or foster care services for dependent children." The announcement further states that applicants must provide "detailed information regarding type of state licensure, including information on capacity, age/gender permitted, and length of stay allowable." ORR changed its required timeframe for obtaining a license from 60 days to 75 days beginning with its November 2018 funding announcement.

information or documents they would expect to see as proof of eligibility for a license (for more information on ORR's grant review and approval process, see appendix II).

We reviewed all grant applications approved by ORR in fiscal years 2018 and 2019 and found that the majority did not include copies of state licenses for the facilities proposed in the applications. Approximately three-quarters of those 58 applications included a copy of a state license, but 22 of them included licenses that did not cover all facilities proposed in the applications.[27] (See sidebar for information on continuation applications.) For example, in some of those cases, the licenses were for facilities located in a different city than that proposed in the application.

Continuation Applications for ORR Facilities Providing Care for Unaccompanied Children

ORR requires grantees to submit a continuation application between years 1 and 2 and years 2 and 3 of their grant performance period to continue receiving funding for years 2 and 3. According to fiscal year 2018 and 2019 grant agreements we reviewed, the grantees are required to submit a copy of their state license as part of the continuation applications. We reviewed 13 continuation applications submitted in fiscal years 2018 and 2019 for nine selected facilities, and none of these applications included a copy of a state license.

Source: GAO review of Office of Refugee Resettlement (ORR) grant agreements and GAO analysis of continuation applications. | GAO-20-609

Having obtained a state license in the past or for a different facility does not guarantee an organization is eligible for, or will obtain, a state license for a new facility. For example, according to information provided by ORR, four of the 22 grantees that included a copy of a license in their application that was not for the facilities proposed in the application, had been unable to obtain a license for one or more of their proposed facilities as of July 1, 2020. Therefore, none of these grantees were serving children at those sites as of that date.[28] ORR program officials told us that some states are taking longer to approve applications for state licenses than they used to. However, these grantees had been unable to obtain a license for 12 months or longer, significantly more than the timeframe required in ORR's grant announcement.[29]

[27]For an additional six applications that included licenses, it was unclear whether the licenses included in the application were for all facilities proposed in the application or not. ORR approved 58 grant applications during fiscal year 2018 and 2019. In some cases, a single organization received more than one grant. Additionally, some applications included proposals for more than one facility.

[28]We previously reviewed ORR data on facility status as of February 5, 2020. At that time, nine of these 22 grantees had not yet been able to obtain a state license for all facilities proposed in their applications. Between February and July, five of these nine had obtained the required licenses. It took these five grantees at least 7 months to obtain licenses for all facilities in their grant applications. Grantees may not have been able to obtain a license for a variety of reasons, and even though the grantees had not received a license as of July 2020 this does not mean they are ineligible for a license or will never receive one. However, it does indicate that they were unable to obtain a state license within the required timeframe in ORR's grant announcement.

[29]The last grant announcement issued by ORR in fiscal year 2019 closed on May 19, 2019 and ORR finalized its funding decisions on July 15, 2019.

In most cases in which a state license was not included in the application, the applicant provided some information about the status of its licensing application, but many did not obtain a license within 75 days of receiving a grant award. Several applicants stated they would seek licensing once ORR awarded them the grant, indicating they had not yet begun the licensing process. Others stated they had participated in a pre-licensing workshop, had been in contact with the state licensing agency, or had submitted applications for licensing. As of July 1, 2020—12 months after ORR made funding decisions for the last fiscal year 2019 funding round—approximately 14 facilities that ORR approved in fiscal years 2018 and 2019 had not yet been able to obtain a state license, including several that had indicated that they were eligible for a license in their application.[30]

State Licensing Allegations and Concerns

ORR's fiscal year 2018 and 2019 grant announcements also specify that applicants must report "any and all documented state licensing allegations/concerns."[31] However, the announcements do not define this phrase and our review of these announcements found a lack of clarity regarding the information ORR expects applicants to provide. For example, the announcements do not make clear for what time period any such allegations and concerns should be reported. The announcements also do not specify whether applicants operating multiple facilities should report allegations and concerns that have occurred at any of them, or only those at the specific facilities in the application.

[30]The last round of funding decisions for fiscal year 2019 were approved by ACF on July 15, 2019. Some of these 14 facilities were approved in prior funding rounds. In some cases, a single grantee had been able to obtain licenses for some but not all of the facilities proposed in its application. In other cases, the grantee was unable to obtain licenses for any facility proposed in its application. We determined whether a facility was licensed and serving children based on a spreadsheet provided by ORR and used by ORR project officers to track the funded capacity of ORR grantees and the number of beds ORR has available. ORR program officials acknowledged that the spreadsheet is not always kept up-to-date, but is currently the only method it has to track this information. ORR program officials also told us that ORR is in the process of developing a new system to manage information related to its unaccompanied children program. The agency is exploring, with the contractor developing the system, ways that this system might be used to better track its bed capacity and related facility information.

[31]For example, see Administration for Children and Families, Office of Refugee Resettlement, Standing Announcement for Residential (Shelter) Services for Unaccompanied Alien Children, HHS-2017-ACF-ORR-ZU-1132, Due Date: 05/09/2019. Background - Program Structure.

ORR program officials told us that ORR's grant announcement language is intentionally broad regarding the time frame and facility location for which state licensing allegations and concerns should be reported in applications because ORR wants to know this information regardless of when or where such issues occurred.[32] We asked the 11 project officers who reviewed grant applications in one funding round in fiscal year 2019 what information on state licensing allegations and concerns they would expect to see in applications. These project officers said that all allegations and concerns should be reported. They also said that applicants should include state licensing and monitoring reports showing that the applicant has adequately addressed all allegations and concerns.[33] However, we found inconsistent reporting of state licensing allegations and concerns in the 58 applications we reviewed (see fig. 2). Fifteen of the 58 applications included information about whether there were state licensing allegations or concerns.[34] The remaining 43 applications did not reference any licensing allegations or concerns, despite ORR program officials stating that all facilities receive state licensing citations at some point. Further, we found that several applicants had received state licensing citations in the past and one had previously had its state license revoked, but that information was not reported in their applications.[35]

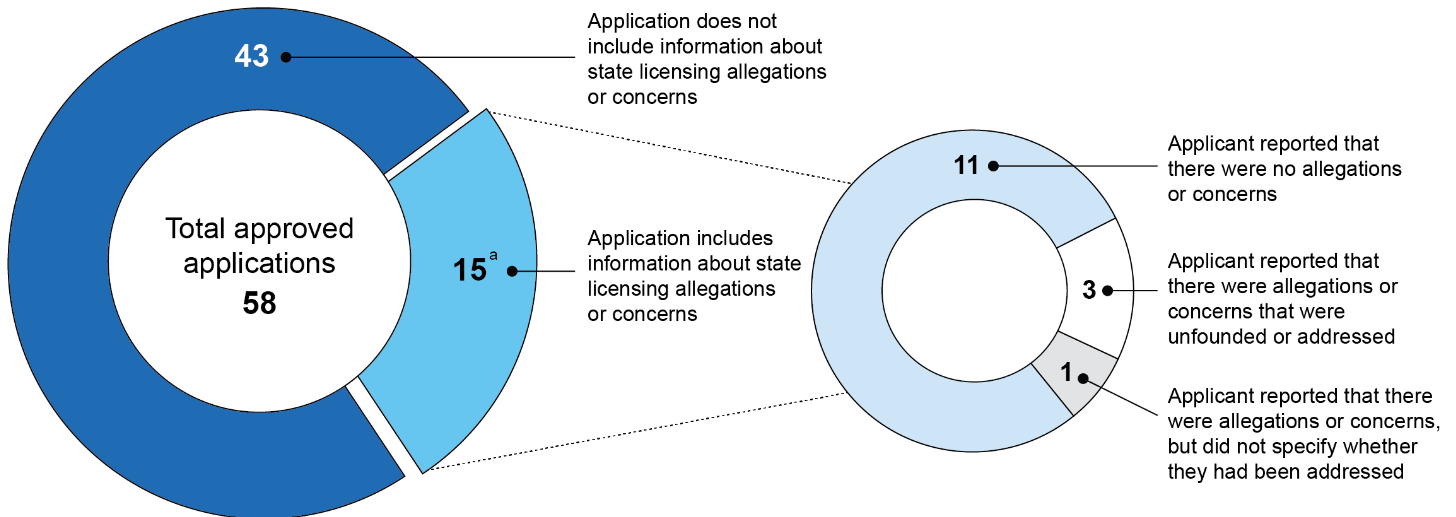
[32]Initially, program officials told us that applicants are not required to report all past allegations and concerns because allegations may be unfounded. The officials said they would expect applicants to report only "serious citations" from state monitors, language not included in the grant announcement and that conflicts with information provided by project officers who review grant applications. However, in June 2020, program officials told us that applicants should report all allegations and concerns in their grant applications.

[33]We provided written questions to ORR for the 11 project officers that reviewed grant applications in one funding round in fiscal year 2019. ORR provided written answers to these questions in a single document.

[34]Two of these 15 applications, although they did not specifically mention the term "licensing allegations or concerns," did report on state monitoring findings.

[35]We did not attempt to determine the extent to which all grant applicants that did not report state licensing citations in their grant applications had received licensing citations in the past. However, we identified, through media reports, several grant applicants that had had state licensing issues. We followed up with state licensing agencies in those states to corroborate those media reports and obtain additional information about the specific licensing citations received by those applicants.

Figure 2: State Licensing Allegations and Concerns Reported in Applications for Office of Refugee Resettlement (ORR) Grants to Provide Care for Unaccompanied Children, Fiscal Years 2018 and 2019.



Source: GAO analysis of applications for ORR grants. | GAO-20-609

[a]Two of these 15 applications, although they did not specifically mention the term “licensing allegations or concerns,” did report on state monitoring findings.

Unless ORR clarifies in its grant announcements the specific information and supporting documentation required from applicants on state licensing issues, it may not receive the information it needs to avoid awarding grants to organizations that will be unable to obtain a state license, have issues that could affect their license status, or that are unqualified to care for vulnerable children. HHS regulations state that the awarding agency’s grant announcements must address the criteria it will use to evaluate grant applications and should clearly describe all such criteria.[36] In addition, federal standards for internal control state that agencies should communicate quality information externally and use quality information to achieve their objectives.[37] Our work has shown that effective oversight

[36]45 C.F.R. pt. 75, app. I, sec. (E)(1).

[37]GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: Sept, 10, 2014).

and internal control are important to provide reasonable assurance to federal managers and taxpayers that grants are awarded properly.[38]

Verifying State Licensing Information

The extent to which ORR verifies the information provided by grant applicants with respect to state licensing as part of its grant review process is also unclear. ORR program officials told us that when reviewing grant applications, project officers search state licensing websites for information about applicants for ORR grants, such as monitoring findings. However, we reviewed the websites of the seven state licensing agencies we interviewed that licensed ORR-funded facilities and found that three of them did not make applicable licensing information publicly available on their website.[39] ORR program officials also said ORR has well-established relationships with state licensing agencies and that project officers would reach out to these agencies for information they could not obtain online. The 11 project officers who reviewed grant applications in one funding round in fiscal year 2019 said they review state licensing and monitoring information if states make it available, usually on state licensing websites. The project officers provided conflicting information about whether they communicate with state licensing agencies during the application review process. Initially, project officers told us that they sometimes, but not always, communicate with state licensing agencies by phone or email during the grant review process; however, in subsequent responses they told us they do not communicate with state licensing agencies during their review. Only two of the 23 state agencies that licensed ORR-funded facilities reported in our survey that ORR contacts them about potential grantees during the application reviews.

With respect to applicants who do not already have a state license, ORR could reduce the risk of awarding grants to applicants that will not be able to obtain a state license by verifying relevant information during the application review process. In our review, we identified two applicants that

[38]GAO. *Grants Management: Observations on Challenges and Opportunities for Reform*, GAO-18-676T (Washington, D.C.: July 25, 2018) and *Federal Grants: Improvements Needed in Oversight and Accountability Processes*, GAO-11-773T (Washington, D.C.: June 23, 2011).

[39]In addition, ORR program officials told us that project officers would typically only look for state license information or licensing allegations or citations against an applicant in the state in which the applicant sought a new grant. Therefore, ORR could be unaware of licensing issues the applicant may have in other states. Because we did not receive a response from ORR to our written questions on which states with ORR facilities make licensing information available online, it is unclear whether ORR officials are aware of this information.

received ORR grants in fiscal years 2018 and 2019 that were either ineligible for, or subsequently denied, a state license due to past licensing issues that ORR did not identify prior to awarding the grant, and which the applicants did not report in their applications.

- During the November 2018 funding round, an applicant included a copy of a previously revoked license in its grant application. The revocation by the state licensing agency made the applicant ineligible for a state license for five years, according to state officials. ORR program officials told us that the applicant did not know that it was ineligible for a state license because the revoked license was a different type from the new one for which it applied. Nevertheless, given the language in ORR's grant application that applicants must report "any and all documented state licensing allegations/concerns" and ORR's position that this language is to be broadly interpreted, it is likely the revocation should have been reported in the application.[40] ORR awarded this applicant a grant and the applicant received grant funds.[41] Although information about the revocation was available on the state licensing agency's website, ORR officials said that at the time they approved the application for funding, they were unaware the applicant was ineligible for a state license. ORR project officers told us that they did not contact state licensing agency officials prior to awarding this grant.
- In the May 2019 funding round, ORR awarded a grant and provided grant funds to an applicant that was subsequently unable to obtain a state license, according to state officials. State licensing agency officials we spoke with said the applicant was ineligible because it provided information to the state licensing agency on a prior facility that did not accurately reflect its compliance history, which included health, safety, and welfare violations. Among the undisclosed citations, according to these officials, were multiple incidents of physical discipline of children. ORR officials we interviewed said they were unaware that this grantee was ineligible for a state license. ORR awarded this applicant five separate grants for facilities in five states in fiscal years 2018 and 2019. As of July 1, 2020, only one of these

[40]The revoked license was a Mental Health license rather than the Residential Care license required for a grantee to operate a shelter for unaccompanied children, according to ORR officials.

[41]In February 2020, ORR program officials said that ORR was in the process of terminating this grant and would recover the grant funds.

facilities had received a state license, and it had provided less than half the beds proposed in its application.

ORR program officials told us that after the agency discovered it had awarded a grant in November 2018 to the applicant whose license had been revoked, ORR instructed project officers to start researching information about applicants' state licensing status prior to grant approvals. ORR provided an internal guidance document officials said was implemented in November 2019. The document includes questions project officers should research about licensing and zoning, among other issues. However, the guidance does not specify that the process by which project officers review grant applications should include contacting state licensing agency officials to verify licensing information submitted by applicants.

While we found no instances of ORR placing children in unlicensed facilities, ORR has awarded grants, and provided grant funds, to several applicants that had difficulty obtaining the required state license within 75 days, and to at least two applicants that were ineligible for, or ultimately unable to obtain, a state license. Without ensuring that project officers have a process to verify state licensing information provided by ORR grant applicants prior to approving grant applications, ORR may continue to provide funds to organizations that do not meet its requirements and may be unable to provide the services delineated in their application.

ORR Does Not Document Review of Applicants' Past Performance as an ORR Grantee When Considering Applications

ORR's grant review process does not include a documented review of the past performance of applicants that have previously received ORR grants, and ORR does not have written guidance on how project officers should review grantees' past performance when reviewing new grant applications. According to ORR officials, nearly 70 percent (72 of 104) of the applications for ORR grants submitted during fiscal years 2018 and 2019 were from organizations that were currently, or had previously been, ORR grantees. According to ORR program officials, project officers have access to quarterly and annual performance reports, as well as monitoring reports, for applicants that have previously provided care to unaccompanied children and are expected to review applicants' past performance.[42] However, at the time of our review, ORR had no written

[42] As part of ORR's grant review process, a panel of outside experts score applications against criteria in the ORR grant announcement. According to our review of FY2018 and 2019 grant announcements, while applicants are expected to describe their organization's qualifications and history, and document their relevant experience providing services, the criteria do not explicitly include applicants' past performance on ORR grants, such as the results of ORR performance and monitoring reports.

guidance requiring project officers to conduct this review, or describing how project officers should conduct or document it.

Project officers that reviewed grant applications during the grant round ending in November 2018 told us they review past performance and monitoring reports and note concerns they identify in their initial assessment review. However, neither project officers nor ORR program officials could provide documentation of such a review, and program officials said that project officers generate no documentation of reviews they conduct. In February 2020, ORR program officials said that ORR is completing guidance that would require project officers to conduct a review of past performance, but provided no additional information about the content of the guidance or how the reviews should be documented.

We identified some ORR grantees with a history of significant incidents related to the safety and well-being of children in their care that subsequently received new or continuation grants. For example, among our nine selected facilities, ORR monitored one grantee in March 2018 and found, among other deficiencies, that the grantee had placed a child in a foster home in which one of the foster parents was under investigation for sexual abuse of another unaccompanied child, according to the ORR monitoring report.[43] Although the grantee removed all children from that particular home three days after the ORR monitor visited it, ORR did not formally notify the grantee of all its monitoring findings, and ask them to take corrective actions, until November 2018.[44] In the meantime, ORR awarded the grantee a new grant in the funding round that ended June 2018.

[43]Some of the other deficiencies identified during this ORR onsite monitoring visit were: a child placed in a foster home in which a tenant without a Federal Bureau of Investigation fingerprint check was living on site, a child in a foster home with a strong smell of cat urine and feces, unaccompanied children reporting that they did not receive science or social studies classes in the grantee's school, and unaccompanied children not receiving proper group counseling sessions. Other deficiencies included children not knowing they were allowed to send or receive mail and medical and mental health staff reporting that they never received specialized training on working with victims of sexual abuse or harassment.

[44]According to ORR officials, the ORR monitor shared the findings with both the grantee and ORR staff assigned to the program during the visit. However, we found that the grantee did not take action on many of the corrective actions until after it received the report, 8 months after the monitoring visit and 5 months after ORR awarded the grantee a new grant.

In addition, in September 2018, a state licensing agency that licensed facilities operated by a another ORR grantee formally notified this grantee of its intent to revoke state licenses for all that grantee's facilities operated in that state. The state licensing agency took these actions based on its findings that multiple facilities had failed to properly document fingerprint background checks for all employees. In October 2018, the licensing agency reached a settlement agreement with the grantee, which allowed most of the facilities to keep their licenses.[45] Prior to these state licensing actions, in 2017, one of this grantee's facilities reported substantiated cases of sexual abuse of unaccompanied children to ORR, leading ORR to provide additional oversight of this grantee and facility, according to an HHS report.[46] In addition, an employee of another facility operated by this same grantee in the same state was convicted of sexually abusing a child in 2015 at the facility, according to media reports. In September 2019, ORR awarded two continuation grants for facilities operated by this grantee in the state. ORR would not comment on whether, or how, it considered these issues when it awarded these continuation grants.

We identified one instance in which ORR rejected an applicant that scored above the cutoff score established by ORR leadership due to its performance on a previous grant.[47] ORR approved funding for that same applicant in a new funding round four months later. ORR project officers told us that the organization's new application was recommended for funding because it would be working with experienced subcontractors, giving ORR confidence that the organization would be able to perform successfully. However, our review of the organization's applications from

[45]This settlement agreement resulted in two of the grantee's facilities voluntarily relinquishing their state licenses and the grantee paying monetary fines, among other stipulations.

[46]According to the HHS report, the additional oversight included monitoring both the care provider facility and the grantee's corporate offices to review internal policies and reporting structures, supervisory response to events, available video footage, and the care provider facility practices. ORR issued corrective actions to the facility, including a requirement to retrain all staff. In addition, ORR temporarily removed all children from the facility and stopped placing additional children there. *Report on Sexual Abuse and Sexual Harassment Involving Unaccompanied Alien Children: 2017*. https://www.hhs.gov/programs/social-services/unaccompanied-alien-children/uac-sexual-abuse-report-2017/index.html, downloaded July 8, 2020.

[47]According to ORR's grant documentation, ORR chose not to fund this applicant because, under a previous grant with ORR, the applicant had engaged in the poor child welfare practice of allowing employees to serve as foster parents for unaccompanied children. It also had failed to deliver the number of beds proposed in its application.

the two funding rounds found that of the three proposed sites that were the same in both applications, five of the six subcontractor partners were the same as in the application that was rejected. ORR may have reasons for continuing to work with grantees that have had serious performance issues in the past. However, without ensuring that the grant process includes a review of applicants' past performance and documentation that a systematic review has been conducted, it is unclear what information ORR considers when making these decisions.

Our work has shown that the use of information on past performance can inform and improve the selection process for grant recipients.[48] In addition, HHS regulations state that the awarding agency must have a framework in place for evaluating the risks posed by applicants before they receive an award.[49] In evaluating such risks, the agency may consider the applicant's history of performance if it is a prior recipient of federal awards.[50] ORR has relevant past performance information on a high percentage of grant applicants because they have previously received ORR grants. If ORR does not systematically consider this information and document how this review informs its funding decisions, it risks awarding grants to applicants with a history of poor performance, which could potentially put children at risk.

State Licensing Agencies Regularly Monitor ORR Grantees, but Information Sharing between ORR and States is Limited

[48]GAO. *Grants Management: Enhancing Performance Accountability Provisions Could Lead to Better Results*. GAO-06-1046 (Washington, D.C.: Sept. 29, 2006).

[49]45 C.F.R. § 75.205(b).

[50]45 C.F.R. § 75.205(c)(3). Specifically, the regulations provide that the agency may consider the applicant's record in managing federal awards, including timeliness of compliance with applicable reporting requirements, conformance to the terms and conditions of previous federal awards, and if applicable, the extent to which any previously awarded amounts will be expended prior to future awards.

State Licensing Agencies Conduct Oversight of ORR Grantee Facilities, and About Half That Monitor These Facilities Identified Significant Deficiencies in Fiscal Years 2018 and 2019

According to our survey, 23 state licensing agencies in 21 states conducted oversight and monitoring of ORR-funded facilities in fall 2019 (see fig. 3).[51] Most of these licensing agencies were within their state's department of human services, child and/or family services, or child safety. State licensing officials we interviewed said their monitoring and oversight of ORR-funded facilities is the same as for other types of facilities they license. In addition to conducting regularly scheduled monitoring activities for established facilities, they reported conducting a site visit or inspection and reviewing other documentation during a facility's initial license approval process. These officials also said their agencies conduct investigations if an incident occurs at a facility or they receive a complaint that could indicate noncompliance with state licensing standards.[52]

[51]The 21 states included the District of Columbia. We surveyed four additional state agencies in states where ORR had awarded grants for one or more facilities, but these facilities were not yet licensed or serving children. In addition, while information provided by ORR indicated that two different state agencies license ORR-funded facilities in New Jersey, only one of these two agencies responded in our survey that they do so. Officials from the other agency told us they provide technical assistance to the licensing agency, but do not directly license any ORR-funded facilities. For more information on our survey methodology, see app. I.

[52]Officials at all four agencies said allegations of abuse or neglect at facilities they license are investigated by another state agency, the child protection agency. However, they said that the state licensing agencies are notified of these investigations.

Figure 3: State Licensing Agency Monitoring Practices for Office of Refugee Resettlement-Funded Facilities Providing Care for Unaccompanied Children, based on Survey Responses in 2019 from 23 Agencies

Monitoring Frequency

Key Monitoring Activities

On-site inspections (23 agencies)
Examples of on-site monitoring activities

- Inspection for compliance with state licensing requirements
- Interviews with staff
- Interviews with children
- Review licensing history for ongoing issues

Review of documentation (22 agencies)
Examples of documents reviewed

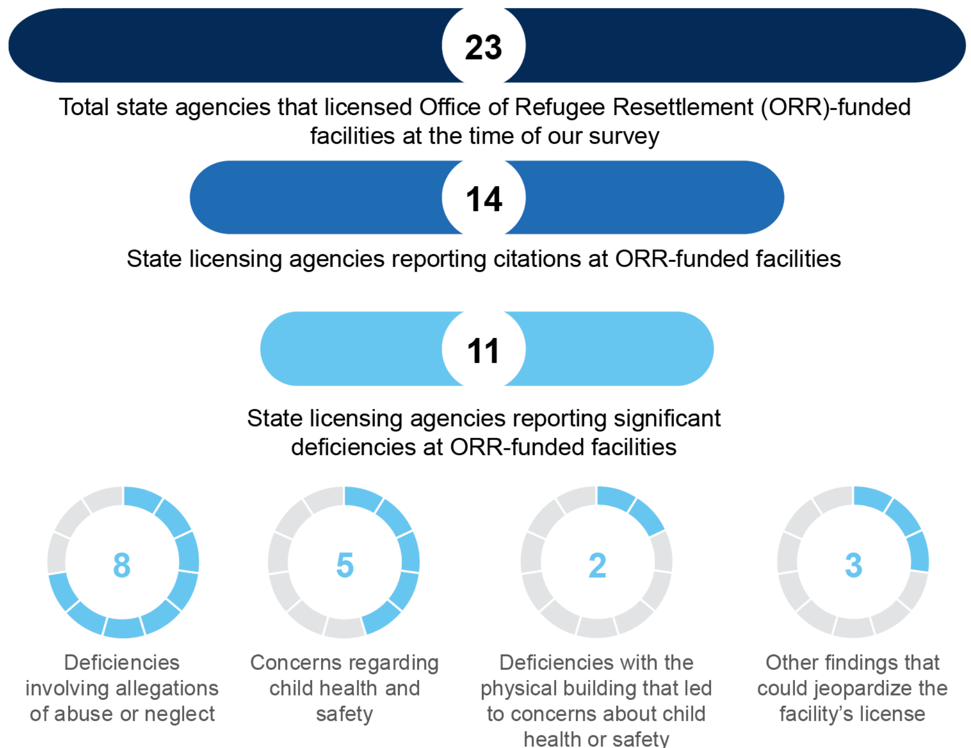
- Staff documentation (background checks, trainings)
- Children's case files

Source: GAO survey of state agencies that license Office of Refugee Resettlement-funded providers, conducted October 2019 – January 2020. | GAO-20-609

Of the 23 agencies that licensed ORR-funded facilities at the time of our survey, 14 reported that in fiscal year 2018 or 2019 they found deficiencies in at least one of the ORR-funded facilities in their state.[53] State licensing agency officials we interviewed said licensing deficiencies can range from administrative or recordkeeping issues to threats to children's health or safety. State licensing officials we interviewed reported that they typically note deficiencies in monitoring reports, issue citations, and then require facilities to take corrective action. Eleven state agencies—or about half of the 23 that licensed ORR-funded facilities—stated that some of the deficiencies they found were significant, defined in our survey as deficiencies that involved child health and safety concerns, allegations of abuse or neglect, deficiencies with the physical building that raised health or safety concerns, or other issues that could jeopardize the facility's license (see fig. 4). Officials from those 11 agencies stated that these deficiencies have been resolved, or the facility has plans in place to do so.

[53]State licensing agencies used varying terminology to refer to issues they identify at facilities, including citation, deficiency, and violation. Here we use "deficiency" to refer to the issue identified, and "citation" to refer to the state licensing agency's official notice to the facility requiring them to address the deficiency.

Figure 4: State Licensing Agency Survey Responses on Deficiencies They Found at ORR-Funded Facilities during Fiscal Years 2018 through 2019



Source: GAO survey of state agencies that license ORR-funded providers, conducted October 2019 – January 2020. | GAO-20-609

Note: For purposes of our survey, we defined significant deficiencies as those involving child health and safety concerns, allegations of abuse or neglect, deficiencies with the physical building that raised health or safety concerns, or other issues that could jeopardize the facility's license. We followed up with the 11 states that reported finding significant deficiencies, all of which told us in March or April 2020 that all of those deficiencies had been resolved or the facility had plans in place to do so.

ORR's Instructions to Grantees Lack Clarity on Reporting of State Licensing Citations and ORR Staff Reported Inconsistent Understanding of Requirements

We found two areas lacking clarity regarding grantees' reporting of state licensing citations to ORR. First, ORR does not provide clear instructions to grantees on whether and how they should include state licensing citations in their quarterly performance reports to ORR. Second, some ORR project officers did not have a clear understanding of what grantees should report to them about state licensing citations.

Instructions for Quarterly Performance Reports

ORR considers state licensing citations to be a performance indicator, but we found that grantees are not given clear instruction on whether or how to submit this information in the quarterly performance reports that are required under their grant agreements. ORR policy states that grantees are required to evaluate their program's strengths and weaknesses based on specified performance indicators, one of which is adverse state licensing citations.[54] However, ORR has not provided instructions or guidance to grantees stating that state licensing citations are to be included in the quarterly performance reports, or what level of detail to include. ORR requires grantees to use an ACF form to submit their quarterly performance report, but the form's instructions do not include specific information on where to include state licensing citations or how much detail to provide, and project officers stated they do not provide additional guidance to grantees on completing performance reports.

Our analysis of quarterly performance reports submitted to ORR by the grantees that operated our nine selected facilities in fiscal years 2018 and 2019 found variation in the level of detail reported on state licensing activity, including in descriptions of deficiencies identified by state licensing agencies. The reports for three of our nine selected facilities included state monitoring citations and additional information on state licensing activity, including dates of on-site inspections, number of records reviewed, number of interviews conducted, and corrective action plans to remedy deficiencies. However, not all reports for our selected facilities included such information. For example, the reports for three selected facilities in two states, operated by the same grantee, did not include any information on more than 70 citations issued by their state licensing agencies to these three facilities during fiscal years 2018 and 2019.[55] The state agency that licensed two of those facilities began the legal process of revoking their licenses in September 2018 due to non-compliance with state fingerprinting and training requirements for facility personnel. According to ORR officials and state licensing officials, ORR was aware of these state licensing actions. The state agency and grantee reached a settlement agreement in October 2018, allowing most of the grantee's facilities in the state to maintain their licenses. However, the

[54]Office of Refugee Resettlement, *ORR Guide: Children Entering the United States Unaccompanied,* Section 5.5.5, accessed June 1, 2020, https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-5#5.5.

[55]We identified these citations through publicly available information from licensing agencies in these two states.

grantee did not document any state licensing citations or revocation notifications in its quarterly reports during fiscal years 2018 and 2019.

Project Officers' Understanding of Reporting Requirements

We also found that not all project officers understood what grantees should report to them regarding state licensing citations. ORR grant agreements require grantees to notify their ORR project officer within 24 hours if any of their facilities receive a citation from a state licensing agency. However, three of the five ORR project officers with oversight of our nine selected facilities said that grantees are not required to report state licensing citations issued to their facilities and grantees do not report this information to them. The other two project officers said that grantees are required to report state licensing citations. ORR officials told us that project officers do not receive guidance regarding reporting of state licensing citations beyond what is stated in the grant agreements.

ORR project officers, who have primary responsibility within ORR for reviewing the quarterly performance reports, also had different understandings of whether or how grantees should include state licensing citations in their performance reports.[56] ORR program officials we interviewed said that grantees should report state licensing citations in their quarterly reports. While two of the five project officers overseeing our selected facilities agreed, the same three project officers who said grantees were not required to report state licensing citations to them also said they were not required to include these citations in their quarterly performance reports and may not do so. Two of those three project officers had oversight of the three selected facilities which we found did not include this information in their quarterly reports.

HHS grant regulations state that the awarding agency should provide grant recipients with clear performance indicators, and that reporting

[56]ORR policy states that project officers review quarterly performance reports. In addition, according to this policy, ACF's Office of Grants Management also reviews these reports.

requirements are to be clearly articulated.[57] In addition, federal standards for internal control state that management should internally and externally communicate the necessary quality information to achieve objectives.[58] Without clearer instructions on how grantees should report state licensing agency citations to ORR in their quarterly performance reports, and in what level of detail, ORR officials, including project officers reviewing future grant applications or grant continuation applications from existing grantees, will not have a complete record of identified state licensing deficiencies and whether they were addressed. In addition, if ORR does not take steps—such as through guidance or training—to clarify project officers' understanding of what grantees are required to report to them regarding state licensing citations, project officers may not provide effective oversight to the facilities they oversee.

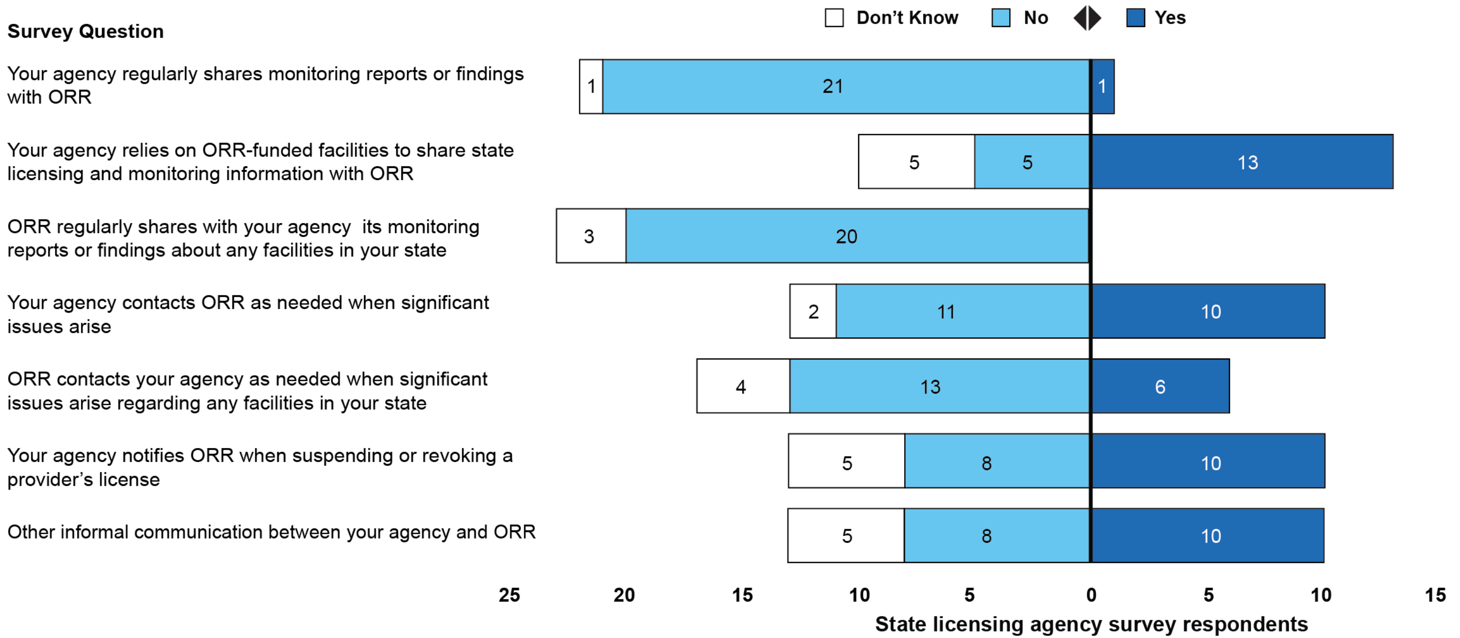
ORR Staff and State Licensing Agencies Reported Limited Information Sharing, and That More Information Would Benefit Their Monitoring

According to our survey of state licensing agencies, there is limited information sharing between ORR and state agencies. For example, 21 of the 23 state licensing agencies that were monitoring ORR-funded facilities in their state responded to our survey that they did not regularly share monitoring reports or findings with ORR, and 11 stated that they did not contact ORR when significant issues arose (see fig. 5). None of the 23 state licensing agencies monitoring ORR-funded facilities said in our survey that ORR regularly shares its monitoring reports. ORR program officials said they would share copies of ORR monitoring reports if a state licensing agency made a formal request to the department, and that they typically share facility census information with state licensing agencies.

[57]Specifically, the regulations provide that the federal award may include specific performance goals, indicators, milestones, or expected outcomes, and that reporting requirements "must be clearly articulated such that, where appropriate, performance during the execution of the Federal award has a standard against which non–Federal entity performance can be measured. " 45 C.F.R. § 75.210(d). See also 45 C.F.R. § 75.301, which states that "[t]he HHS awarding agency should provide recipients with clear performance goals, indicators, and milestones as described in § 75.210. Performance reporting frequency and content should be established to not only allow the HHS awarding agency to understand the recipient progress but also to facilitate identification of promising practices among recipients and build the evidence upon which the HHS awarding agency's program and performance decisions are made."

[58] GAO-14-704G.

Figure 5: Communication between Office of Refugee Resettlement (ORR) and State Licensing Agencies about Facilities Providing Care for Unaccompanied Children



Source: GAO survey of state agencies that license ORR-funded providers, conducted October 2019 – January 2020. | GAO-20-609

Several state licensing agency officials we interviewed and many we surveyed reported they had some contact with ORR, but said this contact was irregular. For example, officials at the state licensing agency that began the process to revoke an ORR grantee's license in September 2018 told us they were only contacted by ORR officials about the deficiencies they had found after media reports were published on cases of abuse at some of the grantee's facilities. An official at another state licensing agency told us that ORR reaches out if the agency is notified that a state licensing citation involves serious allegations. ORR staff also reported limited contact with state licensing officials. ORR guidance states that compliance with state licensing standards is one of the areas that should be monitored by project officers and field staff.[59] However, three of the five ORR project officers for our selected facilities reported no contact with state licensing agency officials.

[59]Office of Refugee Resettlement, *ORR Guide: Children Entering the United States Unaccompanied,* Section 5.5.2, accessed June 1, 2020, https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-5#5.2.

In addition, most state licensing agencies do not have a point of contact with ORR. Officials from 20 of the 28 state agencies that responded to our survey said they did not have an established ORR point of contact. An official from one state licensing agency said they would likely ask staff at ORR-funded facilities in their state for a point of contact, or would search the internet for a contact within ORR if they needed to contact the agency. Another state licensing official told us their agency has no way of notifying ORR if a state license should be revoked, or if there is an immediate need to remove a child as a result of abuse or neglect. Officials from three state agencies told us that they had previously attempted to contact ORR to resolve issues with facilities. According to these officials, one agency made repeated attempts before hearing from ORR, one never received a response, and one was told that ORR could not confirm or share information. Establishing points of contact would facilitate the sharing of key information between ORR and state licensing agencies in a timely way, and ensure ORR has information about ongoing issues at its facilities, including any issues that may put children at risk.

Selected State Licensing Agency Officials' Views on Benefits of Additional Information Sharing with ORR

"The more knowledge we have about issues, concerns, and problems at the entities we regulate, as well as their record of compliance with other regulatory entities, the better able and more effective we are when it comes to ensuring child safety and well-being. It is also good to know what other regulatory entities require, so that we can inform those regulatory entities if we become aware of a situation where their requirements are not being met. We partner closely with other in-state government entities with regulatory and contractual oversight of private child-caring agencies, and it would be beneficial to have a similar relationship with ORR."

"ORR should be aware of licensing concerns since these represent bottom line expectations regarding health and safety."

"It would be beneficial if a state is notified by ORR when a provider within the state receives a grant award…and what services the grant will provide. This would alleviate future confusion if the state later hears that there is an ORR provider in their state."

Source: Written responses to GAO survey from selected state licensing agencies about the Office of Refugee Resettlement (ORR). | GAO-20-609

Officials at state licensing agencies said their monitoring of facilities would benefit from improved information sharing with ORR (see sidebar). Of the 28 state agencies that responded to our survey, including agencies that did not yet license ORR-funded facilities, 25 reported they would find it useful to receive additional information from ORR. For example, one licensing agency reported in survey follow-up communication that it was not aware that a facility in the state had recently been awarded an ORR grant and was required to obtain a license. Ten state licensing agencies responded that it would be helpful to receive ORR's monitoring reports on facilities in their state, which one respondent said would help identify compliance issues for its own monitoring visits. Eight state licensing agencies responded that they would find it helpful to receive notification when ORR awards a grant to a facility in their state. Officials at one state licensing agency noted that such notification would help it ensure unaccompanied children receive all services available in the state. Types of information state licensing agency officials reported would be useful included a list of ORR-funded facilities in their state, copies of grantee cooperative agreements, and ORR policies and guidance for funded facilities.

Officials at six state licensing agencies reported in our survey that they would like to share additional information with ORR, including state monitoring reports. Officials from ORR stated that state licensing reports and information on corrective actions would greatly assist ORR in its own oversight of funded facilities; however, not all state licensing agencies

have been willing to share this information. Four of the five ORR project officers for our selected facilities said that additional information sharing with state licensing agencies would be beneficial to their monitoring of grantees. For example, one project officer said additional communication would help ensure consistency in state and ORR monitoring.

ORR program officials told us at the time of our review that they were exploring the development of a standard operating procedure on communication with state licensing agencies, but did not provide further details, such as when they will decide whether to develop such procedures and whether state licensing agencies would be involved in this effort. Federal standards for internal control state that agencies should communicate quality information externally, and use quality information to achieve their objectives.[60] Without improved communication with state licensing agencies, ORR may not be fully informed about issues at its grantees' facilities. By working with state licensing agencies to develop a plan for mutual information sharing, ORR can maximize the benefits of such communication for both states and ORR.

ORR Primarily Addresses Grantee Noncompliance by Requiring Corrective Actions, but Monitoring and Corrective Actions Have Not Always Been Timely

[60] GAO-14-704G.

ORR is Developing a New Database for Tracking Corrective Actions Issued to Address Noncompliance

ORR policy states that corrective actions are the cornerstone of ORR's monitoring policy for facilities providing care for unaccompanied children, and may be issued at any time as a result of ORR's various monitoring activities.[61] However, it has been difficult for ORR staff to access comprehensive information on past corrective actions. Until recently, only one of the four teams that can issue corrective actions to facilities—the monitoring team that conducts week-long on-site monitoring visits—maintained centralized data on the corrective actions it issued to facilities, according to ORR officials. All four teams (the monitoring team, project officers, federal field specialists, and Prevention of Sexual Abuse team) generally saved documentation of the corrective actions they issued in a shared electronic folder, according to ORR officials, but this system did not allow ORR staff to easily identify the full history and status of a facility. For example, one of the eight field specialists for our selected facilities said that when first assigned to their facility, they would have had difficulty finding information on the shared folder about the facility's past history had they not had the assistance of the past field specialist. Two of the other specialists for our selected facilities said they did not review past corrective actions at all when first assigned to their facilities. In addition, while the field specialists generally said that project officers and monitoring team staff inform them when issuing corrective actions to facilities that the field specialist oversees, three of the eight said this is not always the case.[62]

Because only one of the four teams centrally tracked the corrective actions it issued, ORR's reporting to Congress and others who requested information on corrective actions was incomplete. ORR program officials said they used the monitoring team's tracking data to respond to

[61]Office of Refugee Resettlement, *ORR Guide: Children Entering the United States Unaccompanied,* Section 5.5, accessed June 1, 2020, https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-5#5.5.

[62]HHS's Office of Inspector General also recently found that ORR's reporting system for significant incidents of a sexual nature involving children lacked designated fields that would allow ORR to effectively track such incidents and ensure they are addressed appropriately. This analysis found that ORR's current system for reporting such incidents requires field specialists and other ORR staff to conduct potentially time-consuming manual reviews of narrative summaries in order to identify key information. The Office of Inspector General recommended that ORR assess its current system and identify changes that will allow ORR to conduct more efficient and effective oversight in order to protect the children in ORR's care. See HHS, 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,* June 2020.

information requests, including requests from Congress. However, we reviewed a report provided to Congress in May 2019, which did not specify that data presented on corrective actions was limited to those issued by the monitoring team.[63]

In October 2019, as we conducted our review, ORR awarded a contract to improve its corrective action data tracking and reporting by developing a database to track corrective actions by all four teams that issue them, according to ORR program officials.[64] ORR officials said the contractor had met with all teams that will use the database to learn their data and reporting needs. Officials said they tentatively plan for the new database, which will become part of ORR's new case management system, to be partially operational by November 2020 and fully operational by late 2021.

ORR Has Not Met Some Monitoring Goals and Has Not Notified Some Facilities of the Need for Corrective Actions until Months after Noncompliance Was Identified

Audits on Preventing Sexual Abuse and Harassment

ORR has not ensured the facilities it funds are audited for compliance with standards to prevent and respond to sexual abuse and sexual harassment of children in their care, as required by ORR regulations. In December 2014, ORR published an Interim Final Rule entitled *Standards*

[63]HHS, Administration for Children and Families, *Report to Congress on Unaccompanied Alien Children Program Facility Oversight.* This report presents data on corrective actions issued in fiscal year 2018, noting that some monitoring reports and corrective actions stemming from fiscal year 2018 monitoring visits were still pending at the time of the report. The report indicates that the data on corrective actions come from the site visit team, but also states that the data represent "all corrective actions ORR issued in FY 2018," even though they do not include those issued by other ORR teams.

[64]ORR's position description for the contractor states that their duties include enhancing the collection and analysis of program performance data, including processes that yield reliable and informative data and better capture and communicate corrective actions. The officials said they also intend for the database to include corrective actions issued by Contracting Officer's Representatives during periods when ORR funds facilities via contract.

To Prevent, Detect, and Respond to Sexual Abuse and Sexual Harassment Involving Unaccompanied Children, in response to a requirement in the Violence Against Women Reauthorization Act of 2013.[65] The rule stated that each facility caring for unaccompanied children would be audited for compliance with the standards by February 22, 2019, and every three years thereafter.[66] ORR's Prevention of Sexual Abuse (PSA) team contracted with an outside organization to conduct these audits, according to program officials.

ORR program officials said that the PSA team's contractor began conducting the audits in January 2019. In a report submitted to Congress in May 2019, ORR stated that each facility it funded would receive a PSA team audit by the end of fiscal year 2019 (September 30, 2019).[67] ORR program officials said the PSA team's contractor had audited 67 facilities—out of 133 that were in operation when the audit process was implemented—by April 30, 2020, when the contract ended. Program officials said the contractor was unable to audit all facilities during this time because they had only a one-year contract and began the audits later than expected. They said ORR was working with the General Services Administration to re-compete the contract as a five-year contract and that the new contractor will begin the remaining audits in October 2020. They estimate that the remaining 66 facilities will be audited in fiscal year 2021. Under this new plan, ORR will have missed the audit deadline for those facilities by over a year and a half, and audits will be further delayed for newer facilities that have opened since the audit process began.

[65] 79 Fed. Reg. 77,768 (Dec. 24, 2014). Specifically, section 1101(c) of the Act directed the Secretary of HHS to issue "a final rule adopting national standards for the detection, prevention, reduction, and punishment of rape and sexual assault in facilities that maintain custody" of unaccompanied children. Pub. L. No. 113–4, § 1101(c), 27 Stat. 54, 134-35 (codified at 34 U.S.C. § 30307(d)).

[66] 45 C.F.R. § 411.111(a). The rule does not apply to secure care provider facilities and individual foster care homes. Secure care provider facilities are subject to the Department of Justice's National Standards to Prevent, Detect, and Respond to Prison Rape, 28 C.F.R. pt. 115. According to the rule, unaccompanied children placed in traditional foster care reside in licensed foster homes, attend public school, and receive community-based services, and ORR stated that it therefore was not practicable or necessary to extend the standards to traditional foster care homes.

[67] HHS, Administration for Children and Families, *Report to Congress on Unaccompanied Alien Children Program Facility Oversight.*

Site Visits and Corrective Actions

ORR has not adhered to its policy to conduct a monitoring site visit of each facility at least every two years, and provide a monitoring report to the facility on any corrective actions identified during the site visit within 30 days. According to the policy, site visits involve a comprehensive review of each program's compliance with ORR requirements for program management, services, safety and security, child protection, case management, and personnel and fiscal management. However, according to ORR records, there were 23 facilities in fiscal years 2018 and 2019 that had not received a site visit for more than two years.[68] In 2016, we found that ORR was not able to complete all planned site visits for fiscal years 2014 and 2015 due to resource constraints. We recommended that ORR review its monitoring program to ensure that it conducted site visits in a timely manner.[69]

ORR policy further states that the monitoring team should send a monitoring report documenting any necessary corrective actions to a facility within 30 days after the site visit, but the monitoring team did not meet this timeframe for many of the facilities that received site visits in fiscal years 2018 and 2019.[70] Specifically, these teams averaged over 55 business days—11 weeks—to provide reports in fiscal years 2018 and 2019, according to data from ORR's tracking system. Our analysis of these data found that monitoring teams took more than 30 business days to send reports to 77 percent of facilities they visited in fiscal year 2018

[68]It is possible there were additional facilities for which ORR did not meet the 2-year site visit goal. We reviewed internal ORR tracking documents indicating there were 22 facilities that had not received a site visit for more than 2 years, but ORR officials later said the monitoring team had identified an additional facility for which they had not met the goal.

[69]See GAO-16-180. In August 2017, ORR officials provided documentation showing ORR met its monitoring goals for fiscal year 2016. ORR officials told us in May 2019 that they had completed all but five of the scheduled monitoring visits for fiscal years 2017 and 2018, and provided monitoring plans for the next 2-year cycle. The ORR records we obtained for this review showed that 18 of the 23 facilities for which ORR did not meet the 2-year monitoring goal in fiscal years 2018 and 2019 had been scheduled for visits in fiscal year 2019.

[70]Office of Refugee Resettlement, *ORR Guide: Children Entering the United States Unaccompanied,* Section 5.5.1, accessed June 1, 2020, https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-5#5.5. Although the policy does not specify business or calendar days, ORR officials said that they interpret it to mean business days. After receiving the report, facilities typically have 30 days to provide ORR with a corrective action plan. Once the plan is received, ORR officials said that staff follow up as needed to confirm that all issues are resolved.

and 78 percent of facilities they visited in fiscal year 2019.[71] Some reports took much longer; one report for a site visit conducted in fiscal year 2018 was not sent to the facility until early 2020, well over a year after the site visit.

Monitoring team staff said they conduct exit meetings at the end of each visit in which they inform facility staff of the corrective actions they plan to issue. However, they said they sometimes identify additional corrective actions after the visit, and this was echoed by three field specialists who said that monitoring staff do not always notify facility staff of all corrective actions at these meetings. Monitoring team staff also said that after a visit they debrief the relevant project officer and field specialist on their findings so they can start working with the facility on any corrective actions before they receive the report. However, as previously mentioned, some field specialists told us monitoring staff do not always inform them of corrective actions, which means facilities may not know about some needed actions until receiving their monitoring report months later.

Corrective action plans from several of our selected facilities support this, indicating that the facility did not respond to some corrective actions resulting from their site visit until receiving the monitoring report. None of our selected facilities received their monitoring report within 30 days of the site visit, and the longest delay among them was for one facility overseeing multiple foster care homes, visited by ORR in March 2018, which did not receive its monitoring report listing all corrective actions until 8 months later (November 2018). While the facility's response noted some actions that were completed during or shortly after the site visit, others, which included improving foster parent training, providing access to religious services, and informing children that they were allowed to send and receive mail, were not implemented until more than 9 months after the visit. ORR staff did not confirm completion of all corrective actions until early March 2019, nearly a year after the site visit.

ORR officials said that limited resources and staff prevented the monitoring team from meeting its goals to visit each facility every 2 years and provide facilities with a monitoring report within 30 days of the visit. Monitoring team staff also said that that reports involving many or more complex corrective actions took longer to write and review. They said

[71]Numbers for fiscal year 2018 do not include three facilities that ORR staff visited, but the facilities closed before they could send the monitoring report. Median business days between the end of the site visit and when the facility received the report were 43 for fiscal year 2018 and 57 for fiscal year 2019.

shifting ORR priorities sometimes hampered their efforts to meet these goals, such as when staff were pulled from the team to help with efforts related to reunifying separated families or to fill vacancies on other ORR teams. In addition, Coronavirus Disease 2019 (COVID-19) has recently impeded ORR's progress in conducting monitoring site visits. ORR program officials told us in June 2020 that at that time, the monitoring team was not conducting site visits and that the longer the COVID-19 pandemic lasts, the more challenging it will be for the monitoring team to conduct all site visits it planned for fiscal year 2020.[72]

ORR program officials said that they planned to hire six additional monitoring team staff in spring 2020. In March 2020, these officials told us that this would be sufficient for ORR to meet its monitoring goals in fiscal year 2020. As of June 2020, they said ORR had hired two additional staff for the monitoring team and the hiring process was ongoing. Monitoring team staff who responded to our written questions said their ability to meet monitoring goals going forward would be contingent on hiring and maintaining full staffing levels. They also described some actions that ORR had taken in an effort to reduce delays, including tracking monitoring report timelines starting in May 2019 and transferring monitoring report approval authority from the ORR Director to the Deputy Director. Monitoring team staff said they anticipated that these steps would reduce the amount of time it takes to submit reports, but were uncertain about whether they would be able to meet the 30-day timeframe called for in ORR policy.

Project Officer and Field Staff Workloads

In addition to the staffing and resource limitations described by monitoring team members, some project officers we interviewed said that ORR did not have enough staff in these roles. The four project officers who were overseeing our selected facilities said they were responsible for more facilities than they considered manageable. They said a manageable workload was between five and 12 facilities, depending on the size and type, but their current workloads ranged from 14 to 20 facilities. ORR program officials said as of June 2020 they had hired six additional project officers and planned to hire three more project officers and two

[72]According to these officials, the monitoring team attempted in late March 2020 to conduct remote monitoring of facilities through phone calls and video walkthroughs; however, this effort was put on hold to allow facilities to focus on COVID-19 issues. In June 2020, ORR program officials told us that the monitoring team was assessing weekly whether remote and/or on-site monitoring could resume and was looking for ways to streamline the monitoring process for future site visits.

senior project officers. Officials said they expected these new hires to lower project officer workloads to 12 to 15 facilities each.

In addition, two field specialists said that ORR did not have sufficient numbers of field staff, while a third specialist said that ORR recently hired more field staff which had helped improve field staffing levels. ORR program officials told us in March 2020 that they were hiring 18 field specialists and two supervisors, and expected the additional staff would allow this team to perform more site visits and develop strategies for process improvement. As of June 2020, they said ORR had hired three new specialists and that the hiring process was ongoing.

While additional ORR staff may help address staff shortages that have contributed to delays, a plan—including roles, responsibilities, and timeframes—to guide and focus its monitoring efforts could help ensure that ORR adheres to its own monitoring goals. Timely monitoring visits and prompt follow-up with corrective action reports are necessary to ensure that facilities are in compliance with all applicable grant requirements and ORR policies, including those that help ensure unaccompanied children are safe and provided appropriate services.

ORR Has Additional Options for Responding to More Serious Grantee Noncompliance

ORR policy states that ORR may discontinue funding, halt placements, or remove children completely from facilities that fail to implement corrective actions in a timely and effective manner,[73] and ORR used these options to respond to some instances of noncompliance in fiscal years 2018 and 2019. An ORR-provided list showed that in fiscal years 2018 and 2019, ORR stopped the placement of children in at least 18 facilities (out of 165 grantee facilities ORR funded during that time) and removed children from two of those facilities. In addition, ORR removed children from at least two other facilities where they did not stop placements.[74] According to ORR officials, they took actions against 16 of these 20 facilities for performance or noncompliance issues, most commonly staffing concerns,

[73]Office of Refugee Resettlement, *ORR Guide: Children Entering the United States Unaccompanied,* Section 5.5, accessed June 1, 2020, https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-5#5.5.

[74]It is possible that ORR stopped placement and/or removed children from additional facilities during this time. ORR program officials said they do not systematically track these actions, but compiled the list by surveying project officers. ORR amended the list they provided after we alerted them to an additional stop placement that a field specialist told us about that was not included in ORR's initial list.

such as issues with staff background checks. In two of the four other cases, ORR stopped placements because the facility was preparing to close. In the other two cases, individual children were moved to a different facility due to behavioral challenges. ORR officials said they may also stop placement or remove children for other reasons not related to compliance, such as an outbreak of illness at a facility.[75]

Four of our nine selected facilities were among the 20 in which ORR stopped placement or removed children during this time period. For example, in March 2018, an ORR monitoring team found multiple health and safety issues at one of these facilities, a foster care program, according to the site visit report. Among other issues, the report identified three unaccompanied children living in a foster home where one of the foster parents was under investigation for sexually abusing another minor. ORR staff ensured that all unaccompanied children were removed from the home where the foster parent was under investigation, according to their report. The project officer overseeing this facility said from November 2018 to January 2019, 8 to 10 months after the ORR site visit, the facility staff visited the facility's other foster homes to ensure there were no further health and safety concerns that had gone undetected. In addition, ORR staff also found that the same facility had been without a program director for several months, a position required by ORR, and that facility staff reported inadequate supervision from the acting director. The facility hired a permanent program director about 2 months after the monitoring visit. ORR officials said they did not consider stopping the placement of children at this facility during this two-month period because ORR had provided the grantee with technical assistance that was sufficient to address the identified problems.

As previously mentioned, in September 2018, a state licensing agency issued notices that it intended to revoke the licenses of all eight ORR-funded facilities that were operated by one of ORR's largest grantees in that state, including two of our selected facilities. According to these notices and a letter the state agency sent to the grantee, the state agency took this step due to persistent deficiencies including the grantee's failure to comply with state fingerprinting and minimum training requirements for

[75]ORR program officials told us in June 2020 that they had stopped placing children at all facilities in California, New York, and Washington states since the outbreak of COVID-19, due to the number of COVID-19 cases in those states and the need to limit long distance travel from the border, but were allowing foster care facilities in those states to place a limited number of children in foster homes. The officials said they had not removed any children from facilities due to COVID-19.

facility employees. In October 2018, the state agency and the grantee reached a settlement agreement in which the grantee agreed to voluntarily close two of its facilities, pay a monetary penalty, and submit to additional state monitoring in exchange for keeping its licenses for the remaining facilities.

Once the grantee and state licensing agency reached this agreement, ORR removed children from the two facilities that closed under the settlement agreement and temporarily stopped placing children at the remaining six facilities. The ORR project officer who was overseeing these facilities at the time said that ORR did not consider a stop placement earlier, although the state licensing agency had expressed serious concerns to the grantee a month prior. ORR resumed placing children at the facilities once the state agency approved them to return to full capacity. Internal ORR communications note that in the months following the settlement agreement, the grantee met weekly with ORR project officers and field specialists. However, current and former ORR field specialists with oversight of two of these facilities could not provide examples of any additional steps they took to monitor them following these events, such as increasing the frequency of visits to these facilities. One of the facilities was cited by an ORR site visit team in July 2019 for not meeting ORR's background check requirements and ORR has required corrective action. When we asked if ORR considered taking further enforcement action, the project officer with oversight of the facility cited general ORR policy on corrective action follow-up and enforcement actions but did not provide any specific information on whether ORR considered other actions.

As part of any enforcement actions and under HHS grants policy, ORR may recover any funds that it determines were misspent or spent for purposes that are not allowed. According to ORR officials, ORR required three grantees to return funds to the agency in fiscal years 2018 and 2019:

- The grantee that had some of its licenses nearly revoked in 2018 was required to return over $5 million to ORR in July 2019. According to a letter sent by ORR to this grantee, the agency took this action because of issues including financial conflicts of interest by executives at the organization that violated HHS regulations, and this action was unrelated to the grantee's state licensing issues.
- A second grantee, in October 2019, was required to return over $15 million as a result of drawing down funds in excess of their

expenditures. ORR program officials said the grantee returned the funds to HHS, and these funds were available to the grantee for allowable expenditures during the budget year.

- A third grantee was required, in February 2018, to return nearly $20 million due to excessive executive compensation and various other costs that ORR determined were not allowed under the terms of the grant and HHS regulations. ORR terminated its agreement and closed all facilities operated by this grantee in March 2018. The grantee appealed the requirement that they return funds to the HHS Departmental Appeals Board and as of June 2020, ORR was awaiting the Board's decision.

ORR did not require that funds be returned by the other grantees at whose facilities it had stopped placements or removed children for performance-related reasons in fiscal years 2018 and 2019. According to officials at the Office of Grants Management, HHS takes steps to recover funds from grantees whenever it determines the grantee has not complied with their grant agreements or relevant laws and regulations in ways that have monetary implications. They said they may recover funds from a facility where ORR stops the placement of children for performance-related reasons, for example if the reasons for the stop placement included unallowable expenditures by the grantee, or resulted in the discontinuation of grant funding.

In addition, ORR officials said that from fiscal years 2014 through 2019 there was one grantee for which the agency declined to award a new grant at the end of its 3-year grant period. ORR declined to award this organization a new grant in February 2019, but in July 2019 awarded a subsequent grant to the same organization. ORR officials said they awarded the organization a new grant because it submitted a new application indicating it would be working with experienced subcontractors, increasing ORR's confidence that the organization would perform successfully.[76]

Conclusions

ORR provides grants to organizations to care for children in federal custody without lawful immigration status until they can find an appropriate sponsor available to care for them. These grantees are responsible for the health, safety, and well-being of this vulnerable population. ORR has policies and procedures in place to aid them in

[76]However, as previously noted, our review of the two applications found that of the three proposed sites that were the same in both applications, five of the six subcontractor partners were the same as in the application that was rejected.

awarding grants to the best-qualified organizations and to monitor grantees to ensure that they comply with their grant requirements and the children receive the care they need. However, several significant lapses in the implementation of these policies and procedures could affect the quality of care provided to these children. For example, we found a lack of clarity in grant announcements regarding information applicants are required to provide to ORR, including information related to their state licensing status and any state licensing allegations and concerns. Improving the clarity of these grant announcements could help ensure that applicants provide more complete information to assist ORR in making sound funding decisions.

Additionally, while ORR has conducted outreach in some cases to state licensing agencies to obtain key information about its grantees, information sharing is generally limited between ORR and state agencies. This lack of regular communication between ORR and state licensing agencies could limit the effectiveness of both state and ORR monitoring, increasing the possibility that some children may not receive the care and services they need and placing their safety at risk. Further, most state agencies we surveyed reported that they would like additional information about ORR-funded facilities in their state.

In addition, while ORR has taken steps to more centrally track corrective actions and regularly monitor the facilities it funds, it has not met its own specific targets for the frequency of its monitoring site visits, as well as audits related to the prevention of sexual abuse. Following its monitoring site visits, ORR does not consistently provide grantees with timely information on changes they need to make to comply with ORR policy. Addressing these issues would better ensure the well-being of unaccompanied children and that federal funds are provided to the most qualified organizations.

Recommendations for Executive Action

We are making the following eight recommendations to ORR:

The Director of ORR should clarify in its grant announcements the information and supporting documentation applicants are required to provide in their grant applications with respect to their state licensing status, eligibility, and allegations and concerns. (Recommendation 1).

The Director of ORR should take steps to develop, and ensure that officials reviewing grant applications implement, a process to verify the accuracy and completeness of information reported by grant applicants

on state licensing status, eligibility, allegations and concerns. (Recommendation 2).

The Director of ORR should ensure that the grant review process includes a documented review of applicants' past performance on ORR grants for those that have previously received grants to care for unaccompanied children. This could include, for example, a systematic review of previous quarterly and annual performance reports and a review of corrective actions issued by all ORR monitoring staff to all ORR-funded facilities previously operated by the applicant. (Recommendation 3).

The Director of ORR should clarify in its instructions to grantees the information they are required to report on state licensing citations in their quarterly performance reports. (Recommendation 4).

The Director of ORR should take steps, such as through guidance or training, to ensure that project officers clearly understand the requirement that grantees report state licensing citations at any of their facilities within 24 hours and include state licensing citations in their quarterly performance reports. (Recommendation 5).

The Director of ORR should work with state agencies that license ORR-funded facilities to develop a plan for mutual information sharing, including processes for ORR outreach to states during the grant application review process and ongoing information sharing on ORR and state monitoring processes and identified deficiencies. (Recommendation 6).

The Director of ORR should ensure that ORR provides and maintains a current point of contact for each state agency that licenses ORR grantees to facilitate information sharing regarding ORR-funded facilities. (Recommendation 7).

The Director of ORR should develop a plan—including roles, responsibilities, and timeframes—to guide and focus ORR's efforts to meet its goals to:

- conduct an audit of each facility's compliance with ORR standards on preventing and responding to sexual assault, as required under the Interim Final Rule,
- conduct on-site monitoring visits to each facility at least every 2 years in accordance with ORR policy, and

- report any noncompliance to the facility within 30 days of the site visit, in accordance with ORR policy.

(Recommendation 8).

Agency Comments and Our Evaluation

We provided a draft of this product to the Department of Health and Human Services (HHS) for review and comment. We received written comments from HHS, which are reproduced in appendix III. HHS also provided technical comments, which we incorporated as appropriate.

HHS concurred with all of our recommendations and outlined steps that ORR plans to take to address them. In its response to our first recommendation, HHS stated that in June and July 2020, ORR published four new grant announcements, which it updated to require that applicants be licensed at the time of their application and provide documentation of their license in order to be considered for a grant. These new announcements also require applicants to report any allegations/concerns of abuse and/or neglect, as well as any denial, suspension, and/or revocation of their license.[77] HHS stated that ORR would continue to assess whether the requirement to be licensed at the time of application is reasonable and should be applied to future funding cycles. We reviewed these grant announcements and believe that the updated language is a promising first step toward clarifying the information applicants must provide regarding their state licensing status and any allegations or concerns, as we recommended. However, we found that these grant announcements did not include clarification on two key points: the time period for which any allegations or concerns should be reported, and whether applicants operating multiple facilities should report allegations and concerns that have occurred at any of their facilities, or only those at facilities specified in the application. In addition, if ORR decides not to retain the new requirement to be licensed prior to applying in future grant announcements, it should clarify how applicants that have not yet obtained a license should demonstrate license eligibility in their application.

In concurring with our second and third recommendations, HHS noted that ORR project officers currently assess the accuracy and completeness of grant applicants' state licensing information and consider

[77]In its official response to our recommendations, HHS stated that the grant announcements require awardees to report allegations and concerns. However, HHS later clarified that this sentence should be updated to read applicants, not awardees, consistent with the grant announcements.

past grant performance in their reviews, but that ORR would develop guidance and training in an effort to standardize those elements of their reviews.[78] We agree that guidance and training are needed, given our finding that the 11 project officers provided conflicting accounts of whether they communicate with state licensing agencies during the application review process, and could not provide documentation of their reviews of past performance. In response to our fourth and fifth recommendations, HHS stated that ORR would work with the Office of Management and Budget to add a reporting requirement on state licensing citations to grantees' quarterly performance reports, and would develop guidance and training to ensure project officers understand grantee reporting requirements regarding state licensing citations.

With respect to our sixth recommendation, HHS stated that information sharing between ORR and state licensing agencies would benefit both parties, but noted that implementation of the recommendation would depend on the state agencies' willingness and ability to share information. HHS said that ORR will reach out to other ACF program offices and state licensing agencies, and will work to identify information sharing goals and potential mechanisms to facilitate communication. We recognize that states may vary in their interest and ability to share information with ORR. However, most states we surveyed were interested in some additional information sharing. We encourage ORR to work with each state individually to develop a mutually beneficial information sharing relationship. Regarding our seventh recommendation, HHS noted that ORR will develop and maintain a list of points of contact for each state agency that licenses an ORR-funded facility.

Finally, HHS outlined several steps ORR planned to take in response to our eighth recommendation on monitoring. With respect to auditing facilities' compliance with ORR standards on preventing and responding to sexual assault, as required under the Interim Final Rule, HHS reiterated ORR's plans to solicit a new contract for these audits, but did not state the timeline for publishing the contract solicitation. We urge ORR to work as expeditiously as possible to ensure the remaining audits are carried out, given that it has already missed the initial deadline by over a year. With respect to conducting monitoring visits to each facility every 2 years in accordance with ORR policy, HHS stated that the suspension of these visits due to COVID-19 makes it unlikely that ORR's

[78]HHS stated that, under the department's grants policy, ORR is unable to require the panel of outside reviewers to verify the accuracy and completeness of information provided; however, ORR project officers may perform such an assessment.

monitoring team will be able to visit all facilities originally scheduled for fiscal year 2020. HHS stated that ORR plans to hire additional staff to ensure that the team can catch up on these visits once it is safe to resume them. We recognize the real challenges caused by the current pandemic and that it will likely be very difficult to meet the 2-year goal for fiscal year 2020. With respect to future efforts, in addition to its current hiring plans, we encourage ORR to continue monitoring the team's staffing levels to ensure it can consistently meet its goals going forward. Finally, with respect to reporting noncompliance to facilities within 30 days of the site visit in accordance with ORR policy, HHS stated that ORR is in the process of developing a best practice resource guide for monitoring staff to further improve the timeliness of report submissions.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies of this report to relevant congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, this report will be available at no charge on GAO's website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512–7215 or larink@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.

Sincerely yours,

Kathryn A. Larin, Director
Education, Workforce, and Income Security Issues

Appendix I: Scope and Methodology

This report examines the federal Office of Refugee Resettlement's (ORR) grant making process and oversight of its grantees that care for unaccompanied children. It addresses (1) how ORR considers state licensing issues and past performance in its review of grant applications; (2) state licensing agencies' policies and practices for overseeing ORR grantees, and how ORR and states share information on oversight; and (3) ORR policies and practices for addressing grantee noncompliance with grant agreements.

We used several approaches to address our objectives, including reviewing relevant federal laws and regulations and ORR policies, procedures, and guidance. In addition, we reviewed documents related to ORR's grants, including grant applications approved for funding in fiscal years 2018 and 2019, conducted a survey of 29 state licensing agencies in states where ORR had awarded grants to operate facilities as of July 2019, and reviewed information grantees submit to ORR on monitoring by state licensing agencies. We also reviewed federal internal control standards on using and communicating quality information. In addition, we reviewed ORR monitoring documentation and corrective action data.

In addition, we interviewed or submitted written questions to relevant ORR and Administration for Children and Families (ACF) officials. Specifically, we collected information from ORR program officials, project officers responsible for reviewing grant applications and monitoring, and ORR federal field specialists, among others. We also collected information from ACF Office of Grants Management (OGM) officials. While we conducted some interviews with these officials, we obtained other information through written questions at the request of the Department of Health and Human Services (HHS). In addition, we interviewed state licensing agency officials in selected states.

Further, to incorporate the perspectives of ORR grantees in our review, we sought to interview staff of ORR grantees. However, HHS wanted to have one of its attorneys present at these interviews or take other measures that we believed could have prevented grantees from speaking freely with us about their experiences with ORR. We were unable to reach timely agreement with HHS on procedures for conducting these interviews that would address this concern. As a result, our review is based on information obtained from ORR officials and documents and, where relevant, state documentation and interviews.

Review of ORR Grants Documentation

To address our first objective, we reviewed documents related to ORR grants made in fiscal years 2018 and 2019, the most recent years available at the time of our review. We reviewed all eight ORR grant announcements with due dates during these two fiscal years and all seven funding decision memoranda issued by ORR during this time.[1] To assess the reliability of grant award data in ORR's funding decision memoranda, we obtained information from ORR officials knowledgeable about the data and reviewed the user manual for the data system that generated the data. We found these data to be sufficiently reliable for our reporting purposes.

In addition, we reviewed all 58 applications from applicants to whom ORR awarded grants during these two fiscal years. We analyzed these approved grant applications to determine what information applicants included about state licensing and past performance on ORR grants, where applicable, among other information. To determine whether applicants that received ORR grants in fiscal years 2018 and 2019 were able to obtain a state license and whether they had begun serving children, we compared the 58 applications that ORR awarded grants to with data ORR provided on facilities' status as of July 2020.[2] We assessed the reliability of the data provided by ORR on its facilities by obtaining information from ORR officials with knowledge of the data. While ORR program officials acknowledged that these data are not always kept up-to-date, we found the data sufficiently reliable for the purpose of providing approximate numbers of facilities that had obtained a license and begun serving children. We also reviewed other ORR and ACF documents related to the grant process, including checklists and training materials, summary reports from the outside panel that reviews applications, internal guidance for project officers' application review, notices of awards, and grant agreements.

Survey of State Licensing Agencies

To learn about state licensing agencies' oversight policies and practices for ORR-funded facilities, and how these agencies share information with ORR, we conducted a Microsoft Word-based survey of 29 licensing agencies in 26 states, including the District of Columbia, where ORR had awarded grants to operate facilities as of July 2019. Our survey included

[1]ORR issued a funding announcement for secure shelter providers with a due date of June 29, 2018. According to ORR officials, either ORR did not receive any applications in response to this grant announcement or ORR's contractor screened out all applicants during its initial review. Therefore, ORR did not fund any applicants in this round and did not issue a funding decision memorandum.

[2]We also reviewed data provided by ORR on its facilities as of February 5, 2020.

questions about whether a state licensing agency currently licensed ORR-funded facilities, its ongoing oversight practices, any deficiencies it found at ORR-funded facilities, and information sharing with ORR. We administered the survey from October 2019 to January 2020.

Because we surveyed all relevant state licensing agencies, our survey had no sampling error. We took several steps to minimize nonsampling error, including using methods to ensure we sent the survey to the appropriate agencies and officials. We identified agencies to survey through a combination of ORR-provided information and online research, and confirmed that they were the appropriate licensing agency and point of contact prior to distribution of the survey. Some of these officials directed us to other officials at their agency. We also conducted pretests with three state licensing agencies, chosen to reflect a variety of state experiences with licensing ORR-funded facilities, to check for the clarity of questions and flow of the survey. We made revisions to the survey based on feedback from the pretests.

We sent the survey by e-mail in an attached Microsoft Word form that respondents could return electronically after marking checkboxes or entering responses into open answer boxes. Finally, we contacted all respondents who had not returned the questionnaire by email and phone. We followed up with respondents who submitted surveys with missing question responses via email and phone to clarify their answers.

To supplement the survey and obtain further supporting information on survey responses, we emailed state agency officials who responded to questions on whether additional information from ORR would be useful. We also emailed all state licensing agencies who responded to our survey and asked if they had a point of contact at ORR.

We received completed responses from 28 of the 29 state licensing agencies we surveyed. Washington State Department of Children, Youth, and Families declined to participate in the survey.

Interviews with State Licensing Agencies

To obtain further information on state licensing policies and practices, as well as on their information-sharing with ORR, we conducted semi-structured interviews with state licensing agency officials in Arizona, Maryland, and Texas. We selected these states based on a combination of criteria, including the number of ORR grantee facilities in each state, a mix of types of state licensing agencies, and border and non-border states (see table 2). We also selected Arizona in part because it has two different agencies that license ORR grantee facilities.

Table 2: States and Licensing Agencies Selected for In-Depth Interviews, with Key Selection Characteristics

State	Number of ORR-funded facilities located in the state[a]	Licensing agency(ies)	Border state?
Arizona	21	Department of Child Safety Department of Health Services	Yes
Maryland	4	Department of Human Services	No
Texas	60	Department of Family and Protective Services	Yes

Source: List of facilities provided by the Office of Refugee Resettlement (ORR) and state licensing agency information. | GAO-20-609

[a]Based on a list provided by ORR as of July 30, 2019. Some facilities were not yet open, according to this ORR data.

At each of these agencies, we interviewed state licensing officials at various levels, including agency leadership and officials who monitor facilities, to ensure we obtained a range of views. Additionally, we reviewed each agency's responses to the survey to determine if there were answers that necessitated additional discussion or clarification. We also conducted more limited survey follow-up interviews with officials from New York's Office of Children and Family Services, Georgia's Department of Human Services, and North Carolina's Department of Health and Human Services. We chose these states based on their survey responses and licensing challenges at ORR-funded facilities identified by news media reports and other federal agencies.

Review of Quarterly Performance Reports

To learn what information grantees report to ORR regarding state licensing citations at their facilities, we reviewed quarterly performance reports submitted to ORR by the grantees that operated nine selected facilities in our three states. We selected these facilities based on the number of corrective actions received on their last ORR monitoring visit, number of corrective actions received from their state licensing agency in the past year (if known), and to reflect a range of facility types, sizes, and populations served (see table 3).[3]

[3]The two facilities we selected in Maryland, and two of the four facilities we selected in Texas, consisted of a shelter and foster care facility that were operated out of the same location. Three of the nine facilities—one in Texas and two in Arizona—were operated by the same ORR grantee.

Table 3: Office of Refugee Resettlement-Funded Facilities Selected by GAO for Review of Quarterly Performance Reports

State	Facility	Type	Population served[a]	Size (bed capacity)[a]	Number of ORR corrective actions issued as a result of ORR's most recent monitoring site visit	Number of state licensing corrective actions issued in FY 2019
Arizona	A	Shelter	Males and females 6-17	304	7	17
	B	Shelter	Males and females 0-17	300	9	9
	C	Shelter	Males, 12-17	78	31	Information not available[b]
Maryland	D	Shelter	Males, 9-17	50	14	4
	E	Transitional and long-term foster care	Males 9-17 (Transitional Foster Care); Males and females 2-17, pregnant and parenting teens, youth with special needs (Long Term Foster Care)	15	34	5
Texas	F	Shelter	Males 0-17, females 0-12, parenting teens 12-17	400	12	22
	G	Shelter	Males and females 8-17, pregnant and parenting teens	100	NA[c]	12
	H	Shelter	Males and females 12-17, pregnant teens in their first trimester	110	18	10
	I	Transitional foster care	Males and females 0-17, pregnant teens	50	43	14

Source: List of facilities provided by the Office of Refugee Resettlement (ORR) and state licensing agency information. | GAO-20-609

[a]Based on a list provided by ORR as of July 30, 2019.

[b]State licensing agency did not make monitoring reports publicly available.

[c]Not applicable because facility had not yet received an ORR monitoring site visit

We reviewed all 37 quarterly performance reports that were submitted to ORR by the grantees that operated these nine facilities in fiscal years 2018 and 2019 for quarters in which they received a state licensing citation. To determine whether these grantees reported state licensing citations in their quarterly reports on those nine facilities, we compared them to publicly available state licensing reports. We were unable to

conduct this analysis for one of the facilities we selected in Arizona, which is licensed by a state agency that does not make information on its citations publicly available and did not respond to our requests for this information.

Analysis of Corrective Actions and Monitoring

To evaluate the timeliness of reports sent by the ORR monitoring team to facilities they visited, we analyzed information from the team's spreadsheets that tracked visits conducted in fiscal years 2018 and 2019. Specifically, we calculated the number of business days between the conclusion of each site visit and the date the team sent the monitoring report detailing any needed corrective actions to the facility.[4] To assess the reliability of the data in these spreadsheets, we obtained information from ORR officials on their processes for maintaining the data. We also compared the dates in the spreadsheets against another spreadsheet that monitoring team managers use to assess the timeliness of monitoring reports, and against monitoring reports for our selected facilities. We identified a few inconsistencies and corrected the data using revised dates provided by ORR. After taking these steps, we determined the data were sufficiently reliable for our purposes.

To identify examples of corrective actions issued by various teams at ORR, and the timing of facilities' responses to those corrective actions, we also reviewed monitoring reports and other corrective actions issued to the nine selected facilities described above. In addition, we obtained information from ORR on the number of facilities in fiscal years 2018 and 2019 that had not had a site visit in over two years, which is the minimum frequency set forth in ORR policy.[5] Finally, we asked ORR program officials for written responses to our questions on the status of audits for compliance with standards to prevent and respond to sexual abuse and sexual harassment of unaccompanied children in ORR-funded facilities.[6]

We conducted our work from May 2019 to September 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain

[4]ORR policy specifies that these reports be sent within 30 days. We calculated business days because ORR officials told us they interpret the policy to refer to business days.

[5]Office of Refugee Resettlement, *ORR Guide: Children Entering the United States Unaccompanied,* Section 5.5.1, accessed June 1, 2020, https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-5#5.5.

[6]See Standards to Prevent, Detect, and Respond to Sexual Abuse and Sexual Harassment Involving Unaccompanied Children, 79 Fed. Reg. 77,768 (Dec. 24, 2014).

sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II: Office of Refugee Resettlement (ORR) Grant Review Process

ORR uses a multi-step process when it reviews new grant applications to provide care to unaccompanied children. The process consists of an initial review by an ORR contractor, a review by a non-governmental panel (outside review panel), and a review by an ORR project officer. After these reviews, either ORR leadership or the Administration for Children and Families' (ACF) Assistant Secretary makes the final funding decisions. ACF's Office of Grants Management conducts a business review of the approved applications (see fig. 6).

Figure 6: Grant Application Review Process

Source: Interviews with, and documents from, ORR and ACF Office of Grants Management. | GAO-20-609

The following information on ORR's grant review process was provided by ACF officials, ORR program officials and project officers, or obtained through our review of documentation related to this process.

- **Contractor review.** ORR's contractor, F2 Solutions, conducts an initial review of all applications for completeness and to make sure they meet certain requirements laid out in ORR's grant announcement. For example, the contractor confirms that the organization or business applying for the grant is eligible for ORR grants and that the application is complete. If the application fails to meet the requirements of the contractor review, the contractor deems the application ineligible and no further reviews are conducted. If the contractor determines that the applicant has met all requirements, the application is forwarded to the outside review panel.
- **Panel review.** The outside review panel scores applications against criteria laid out in the grant announcement. The panel is comprised of three reviewers and a Panel Chair, who acts as a liaison between the

panel and ORR.[1] According to ORR officials, reviewers are selected from outside of the federal government and typically have backgrounds in social work or child welfare. Each of the three panel members independently review and score each of their assigned applications. The panel chair then sends ORR the average of the three reviewers' scores for each application.

- **Application cutoff score.** As part of deciding which applicants will be awarded a grant to care for unaccompanied children, ORR's leadership establishes an application cutoff score after receiving scores from the review panels. When determining the cutoff score, ORR officials said they look for a natural breakpoint in the scores, at the range of application scores during the particular funding round, and ORR's capacity needs.
- **ORR project officer review.** According to ORR program officials and project officers, an ORR project officer reviews each application that has a score above the cutoff established by ORR leadership to assess whether the applicant has a viable plan to provide services and a reasonable budget proposal. The project officer makes funding recommendations to ORR leadership. ORR does not typically review applications that score below the cutoff score; however, ORR project officers receive the list of such applicants and can recommend funding for those applicants. ORR projects officers said that this rarely happens.
- **ORR leadership.** ORR leadership makes funding decisions. In cases in which ORR decides to fund all applicants scoring above the cutoff score, the ORR Director signs off on the decision. In cases in which ORR decides not to fund an applicant whose application scored above the cutoff score, the ACF Assistant Secretary reviews the reasoning for this recommendation and must agree. ORR refers to these cases as out of rank order decisions. They occur when ORR decides to "skip" funding an application that received a higher score and instead fund a lower scoring applicant.
- **ACF Office of Grants Management (OGM) review.** OGM conducts a business review of each application that ORR has approved to confirm it meets the business and financial requirements listed in the grant announcement. As part of that review, OGM also reviews the applicant's budget proposal, and may assist ORR project officers in budget negotiations with approved grantees. The Associate Deputy Assistant Secretary for Grants within OGM gives final approval of

[1]According to ORR, F2 Solutions is responsible for soliciting reviewers and ORR must approve them.

funding decisions if applications were approved in the order they were scored by the outside panel. In cases in which ORR approves applications out of order, the Assistant Secretary of ACF gives final approval.

During fiscal years 2018 and 2019, ORR funded applicants in seven funding rounds (see table 4).[2] There was only one funding round during these 2 years in which ORR did not fund all applications that scored above the cutoff score.[3]

[2]ORR issued an eighth grant announcement for secure facilities that closed in June 2018, but did not fund any grantees in response to this announcement.

[3]ORR leadership set a cutoff score in only three of the seven funding rounds in FY2018 and FY2019. In three of the other four rounds, ORR funded all applicants that passed the initial contractor review. In the fourth, ORR funded the two highest scoring applicants, deferred funding for an additional seven applicants, and four applicants did not pass the initial contractor review. ORR officials said that no cutoff score was required in the other four funding rounds because all applicants either received high scores from the outside panel or were screened out by the ORR contractor. In one funding round, ORR did not fund all applications that scored above the cutoff score. It chose not to fund two applications from the same organization because the organization had not met its obligations under a previous ORR grant and a third application because the applicant was unable to provide evidence that it had a lease or an address for a shelter space and ORR deemed its budget to be unreasonable.

Table 4: Grant Applications and Outcomes for Applicants Seeking Office of Refugee Resettlement (ORR) Grants to Provide Care of Unaccompanied Children, FY2018 and FY2019 Funding Rounds

Facility type	Announcement closing date	Number of applications	Number of applications approved	Number of applications not approved[a]	Cutoff score[b]	Range of scores	Range of scores for funded applications	Number of applications scoring above cutoff score that were not selected for funding
Shelter	May 9, 2019	26	20	6	60	4-100	82-100	0
Shelter	November 26, 2018	18	9	9	50	0-95	69-94	3
Secure	November 26, 2018	1	1	0	no cutoff score	95[c]	95	0
Staff Secure	June 29, 2018	5	4	1	no cutoff score	83-97	83-97	0
Shelter	June 29, 2018	37	20	17	65	0-98	68-98	0
Therapeutic Shelter	June 29, 2018	4	2	2	no cutoff score	77-83	77-83	0
Long Term Foster Care	June 29, 2018	13	2	4	no cutoff score	78-99	95-99	0
Total		**104**	**58**	**39**				

Source: GAO review of ORR funding decision memoranda. | GAO-20-609

Note: Seven applications to provide Long Term Foster Care in the June 29, 2018 round were deferred. Range of scores for all applications and funded applications are rounded to the nearest whole number.

[a]Applications that were not approved included applications that did not pass the initial ORR contractor review, those that passed the initial contractor review but ORR did not fund because they were below the cutoff score, and those that scored above the cutoff score but were not selected for funding. They do not include applications that were deferred.

[b]ORR officials said that no cutoff score was required in the other four funding rounds because all applicants either received high scores from the outside panel or were screened out by the ORR contractor.

[c]ORR received only one application in response to this funding announcement.

Appendix III: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

August 24, 2020

Kathryn A. Larin
Director, Education, Workforce & Income Security Issues
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Larin:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, *"Unaccompanied Children: Actions Needed to Improve Grant Application Reviews and Oversight of Care Facilities"* (Job code 103557/ GAO-20-609).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Sarah C. Arbes -S Digitally signed by Sarah C. Arbes -S Date: 2020.08.25 10:43:36 -04'00'

Sarah C. Arbes
Assistant Secretary for Legislation

Attachment

Case 2:85-cv-04544-DMG-AGR Document 1427-7 Filed 05/31/24 Page 64 of 70 Page ID #:50005

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED — UNACCOMPANIED CHILDREN: ACTIONS NEEDED TO IMPROVE GRANT APPLICATION REVIEWS AN OVERSIGHT OF CARE FACILITIES (GAO-20-609)

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report.

Recommendation 1: The Director of ORR should clarify in its grant announcements the information and supporting documentation applicants are required to provide in their grant applications with respect to their state, eligibility, and allegations and concerns.

HHS Response: HHS concurs with this recommendation.

ORR recently updated four of its Funding Opportunity Announcements (FOA) to require that applicants be licensed at the time of application in order to be considered for a grant and provide documentation of state licensure, including information on capacity, age/sex permitted, and allowable length of stay. The FOA also requires awardees to report any allegations/concerns of abuse and/or neglect; and any denial, suspension, and/or revocation of their and, if applicable, any subrecipient(s)' licensing to provide child welfare related services. These requirements are included in the FOAs for secure, staff secure, therapeutic, and long term foster care beds published by ORR in June and July 2020. ORR has not determined whether the requirement to be licensed at the time of application will remain in future shelter FOAs. ORR will continue to assess whether or not this requirement is reasonable throughout this next funding and onboarding cycle.

Recommendation 2: The Director of ORR should take steps to develop, and ensure that officials reviewing grant applications implement, a process to verify the accuracy and completeness of information reported by grant applicants on state licensing status, eligibility, allegations and concerns.

HHS Response: HHS concurs with this recommendation.

ORR grant applications are reviewed and scored by independent subject matter experts in the child welfare industry. To ensure a fair and objective merit review process as required by HHS grants policy, reviewers are restricted from seeking any additional information not included in the application. Therefore, ORR is unable to require reviewers to verify the accuracy and completeness of information provided. However, an assessment of the accuracy and completeness of information reported by the applicant on state licensing status, eligibility, allegations and concerns may be performed by ORR Project Officers. Currently, this assessment occurs after applications have been scored by reviewers and before an award is made. In addition, Project Officers are trained to engage awardees throughout the negotiation and on-boarding process to ensure programs meet all FOA requirements and award special conditions. ORR will develop guidance to standardize the Project Officer assessment of the accuracy and completeness of information reported by the applicant on state licensing status, eligibility, allegations and concerns and incorporate this guidance into existing training curriculum for Project Officers.

Recommendation 3: The Director of ORR should ensure that the grant review process includes a documented review of applicants' past performance on ORR grants for those that have previously received grants to care for unaccompanied children. This could include, for example, a systematic review of previous quarterly and annual performance reports and a review of corrective actions issued by all ORR monitoring staff to all ORR-funded facilities previously operated by the applicant.

Page **1** of **3**

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED — UNACCOMPANIED CHILDREN: ACTIONS NEEDED TO IMPROVE GRANT APPLICATION REVIEWS AN OVERSIGHT OF CARE FACILITIES (GAO-20-609)

HHS Response: HHS concurs with this recommendation.

ORR takes past performance into consideration for all grant award decisions. This may include information obtained through review of annual reports, findings form monitoring visits/reports, and other knowledge obtained through field staff or through grant monitoring. ORR will expand upon its requirement to review past performance by developing guidance that specifies what documents must be reviewed and how to document the review. Once finalized, ORR will incorporate this guidance into its existing training curriculum for Project Officers for grant applications.

Recommendation 4: The Director of ORR should clarify in its instructions to grantees the information they are required to report on state licensing citations in their quarterly performance reports.

HHS Response: HHS concurs with this recommendation.

ORR will collaborate with the Office of Management and Budget to add a reporting requirement to grantees' quarterly Performance Progress Reports for state licensing citations. ORR will also revise Project Officer monitoring tools accordingly.

Recommendation 5: The Director of ORR should take steps, such as through guidance or training, to ensure that project officers clearly understand the requirement that grantees report state licensing citations at any of their facilities within 24 hours and include state licensing citations in their quarterly performance reports.

HHS Response: HHS concurs with this recommendation.

ORR has begun the development of various standard operating procedures related to the grant award process and will include guidance on the requirement that grantees report state licensing citations at any of their facilities within 24 hours and include state licensing citations in their quarterly performance reports. ORR will also incorporate this guidance into its existing training curriculum for Project Officers.

Recommendation 6: The Director of ORR should work with state agencies that license ORR-funded facilities to develop a plan for mutual information sharing, including processes for ORR outreach to states during the grant application review process and ongoing information sharing on ORR and state monitoring processes and identified deficiencies.

HHS Response: HHS concurs with this recommendation.

HHS believes that information sharing between ORR and state licensing agencies would benefit both parties. However, each state has various licensing agencies with their own regulations and procedures. Therefore, implementation of this recommendation is dependent upon each state agency's willingness and ability to engage in information sharing with ORR and may require the assistance of other Administration for Children and Families (ACF) program offices, such as Children's Bureau. ORR will identify information sharing goals and potential mechanisms to facilitate communication between ORR and state agencies. ORR will also conduct outreach to other ACF program offices and state licensing agencies.

Recommendation 7
The Director of ORR should ensure that ORR provides and maintains a current point of contact for each state agency that licenses ORR grantees to facilitate information sharing regarding ORR-funded facilities.

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED — UNACCOMPANIED CHILDREN: ACTIONS NEEDED TO IMPROVE GRANT APPLICATION REVIEWS AN OVERSIGHT OF CARE FACILITIES (GAO-20-609)

HHS Response: HHS concurs with this recommendation.

ORR will develop and maintain a list of points of contact for each state agency that licenses an ORR grantee facility.

Recommendation 8: The Director of ORR should develop a plan—including roles, responsibilities, and timeframes—to guide and focus ORR's efforts to meet its goals to:

- Conduct an audit of each facility's compliance with ORR standards on preventing and responding to sexual assault, as required under the Interim Final Rule.
- Conduct on-site monitoring visits to each facility at least every two years in accordance with ORR policy, and
- Report any noncompliance to the facility within 30 days of the site visit, in accordance with ORR policy.

HHS Response: HHS concurs with this recommendation.

ORR will publish a five-year contract solicitation to manage and execute efficient and high quality prevention of sexual abuse (PSA) audits to ensure compliance with the Interim Final Rule and relevant ORR policies and procedures. Within the first year of the contract, the contractor is require to complete PSA audits for all the remaining facilities open and operating in 2019 that did not receive an initial audit. After the first year of the contract, the contractor shall conduct approximately 50 to 70 audits per year, prioritizing the deadlines outlined in the IFR. The ORR PSA Team will work closely with the contractor, to ensure the contractor is meeting the PSA audit timelines outlined in the contract and the IFR.

In order to prioritize the health and safety of children, grantee staff, and ORR staff during the COVID-19 pandemic, ORR has temporarily suspended on-site monitoring. As a result, it is unlikely that the UAC Monitoring Team will be able to conduct on-site monitoring for all facilities due for a biennial monitoring visit in FY 2020. Once it is safe to resume on-site monitoring, ORR will hire additional monitors to ensure that by the end of FY 2021 ORR is able to monitor facilities due for monitoring in FY 2020 where the site visit was postponed in addition to facilities due for monitoring in FY 2021. To meet this goal, ORR estimates that it will need approximately one monitor per every 14-16 facilities due for a biennial visit. ORR has 12 monitors on staff and plans to hire a minimum of four additional monitors.

During FY 2020, ORR has made significant progress in narrowing the gap between actual submission times and the 30-day timeframe outlined in ORR policy. This is evidenced by an analysis ORR conducted of FY 2020 year-to-date monitoring report submissions, which showed that it took an average of 36 business days to submit the report to the care provider facility (24 business days to write the report, 11 business days to route the report for internal ORR clearance and receive approval, and 1 business day to send the approved report to the facility). ORR will continue to track monitor, and analyze reporting timelines. In addition, ORR is in the process of developing a best practice resource guide for UAC monitors to further improve the timeliness of report submissions with the goal of bringing all report submissions into compliance with the 30 day timeframe.

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Appendix IV: GAO Contacts and Staff Acknowledgments

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Staff Acknowledgments

In addition to the contacts named above, Elizabeth Morrison (Assistant Director), Lauren Gilbertson (Analyst-in-Charge), David Barish, and Matthew Dobratz made key contributions to this report. In addition, key support was provided by Susan Aschoff, Sarah Cornetto, Helen Desaulniers, Margaret Hettinger, Thomas James, Kelsey Kreider, Amy E. MacDonald, Sheila R. McCoy, Jean McSween, Almeta Spencer, and Curtia Taylor.

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EXHIBIT 6

INTRODUCTION

Southwest Key Programs, Inc. (SWK) is a private, non-profit agency that has positively impacted the lives of at-risk children, youth, and families for 34 years. SWK was established in 1987 with the specific aim of providing community-based services as an alternative to detention and long-term incarceration for youth involved in the juvenile justice system. Our organization has since expanded its program models to include immigrant children's services, residential and emergency shelters for immigrant youth, juvenile delinquency prevention programs, child welfare preventive programs, immediate intervention services for at-risk youth and families, wraparound services, mental health and substance abuse treatment, evening support programs, mentoring programs, and alternative education schools. Today, with a mission of "*Opening doors to opportunity so individuals can achieve their dreams*", SWK is a nationally recognized leader in the provision of caring and effective programming for at-risk children, youth and families in partnership with dozens of federal, state, and local agencies across Arizona, California, Florida, Georgia, New York, and Texas.

SWK began providing shelter care services to Unaccompanied Alien Children (UAC) in Arizona and Texas in 1996 under the direction of the U.S. Department of Justice (USDOJ), Immigration and Naturalization Services (INS), and subsequently in partnership with the Office of Refugee Resettlement (ORR) from 2003 to the present. SWK is currently one of the largest providers of shelter care services to UAC in the United States. Under the supervision of ORR, SWK currently operates 27 shelter programs and one (1) home study/post-release program throughout Arizona, California, and Texas, providing beds to thousands of unaccompanied minors daily with the largest program having a capacity to serve 1,200 UAC. SWK works with the federal government to fulfill the U.S. Supreme Court's mandate on the appropriate care of unaccompanied children from all over the world.

Provided below are SWK's responses to questions posed by the Health and Human Services (HHS) Department through its Request for Information (RFI) regarding Federal Licensing of Office of Refugee Resettlement Facilities. SWK's responses include specific input regarding options for a Federal licensure process to ensure continued program operations of shelters serving UAC and are intended to inform a strategic and impactful plan for the administration of facilities.

QUESTIONS TO THE INDUSTRY

1. What challenges do facilities face in complying with the State-based licensing scheme as currently operating around the country?

Organizations with facilities face an array of challenges in complying with state-based licensing schemes currently operating around the United States. First, in the delivery of shelter care for UAC, entities are required to comply with requirements from both state-based licensing entities and ORR. Meeting requirements at both a state and federal level ultimately causes unforeseen

delays in opening and operating facilities. Additionally, adhering to both state and federal licensing standards requires that facilities operate multiple, at minimum two, database systems including a system for the state licensing entity as well as the UAC database portal system. Having two or more database systems can lead to user error and inaccuracies.

Another challenge faced by facilities is fully understanding licensing requirements. Most states do not articulate licensing requirements in a clear and concise manner, making it difficult for facilities to adhere to such requirements. A well-defined articulation and documentation of requirements by licensing entities, including lists, would enhance organizations' awareness and adherence to facility requisites.

This challenge is particularly difficult for entities that operate facilities in different states as there is no uniform or aligned method for licensure or oversight across states. Where one state may require strict rules around supervision and staffing, another state my not. Additionally, state licensing entities have varying requirements for signing off on professional documents. There are also differing licensing standards regionally and within states depending upon what entity oversees facility licensure. Having consistent licensing requirements within and across states would assist organizations in ensuring that facilities meet all necessary standards of operation. The creation of aligned compliance requisites across states or by the federal government would create consistency and would assist in supporting health and safety outcomes for youth. Further, having one overarching regulatory body providing oversight would enhance facilities' overall operational uniformity, efficiency, and effectiveness.

2. What sort of independent entity do you see as best positioned to provide the services currently provided by State licensing entities?

SWK foresees that one federal independent entity overseeing licensing of facilities across all states would prove most effective in providing the services currently offered by State licensing entities.

3. Comments on having one entity responsible for issuing licenses and a second entity responsible for investigations and inspections.

Having provided shelter care for UAC for the past 25 years, it is SWK's opinion that having one entity performing both licensing and investigations/inspections would prove most effective in the licensing and oversight of ORR facilities. It has been our organization's experience that having these responsibilities separated across two entities will lend to different interpretations of licensing standards and requirements. There is less likely to be conflicting interpretations if one federal entity maintains responsibility for interpreting licensing rules and conducting investigations and inspections. Having one entity responsible for these duties will also assist in the alignment of licensing requirements across all states.

4. When should a provider seek a Federal license as opposed to a State license?

Seeking federal or state licensure is dependent upon whether the vendor operates ORR facilities in one state or multiple states. If a vendor maintains ORR contracts in one state, the vendor should seek a state license. However, if a vendor maintains ORR contracts in more than one state, federal licensure of facilities should be sought.

Referring sources will also inform whether state or federal licensure should be sought. For example, if a vendor is accepting UAC from a state entity such as a foster care system, it may be beneficial to maintain state licensure to coincide with referring source requirements.

Finally, to maintain consistency across states, professional licenses for staff should be federal.

5. Views on the possibility of dual (State and Federal) licensure and/or Federal accreditation of State licensed facilities to ensure compliance with minimum Federal standards?

It is the opinion of SWK that having dual licensure (state and federal) would put ORR vendors in a difficult situation as there may be conflicting requirements among licensing entities. Maintaining a single federal licensure and/or federal accreditation entity responsible for ensuring compliance with minimum federal standards would ensure continuity and alignment of ORR facilities across states nationwide.

6. Suggestions on how to improve information sharing between State and Federal partners?

As an ORR contractor, SWK is well aware of the difficulties in information sharing between state and federal partners. Creating one central database shared between state and federal entities would be most effective in enhancing bi-directional communication. A central database would enable providers to both upload and download pertinent client information made available from other providers and sources in a more timely and efficient manner.

7. What challenges would be posed to existing ORR facilities if ORR were to seek a Federal license on a facility's behalf?

ORR seeking a federal license on a facility’s behalf would pose several challenges. First, it would result in increased scrutiny on the facility and operating organization by media and other external sources. Additionally, there may be significant pushback from states regarding regulatory oversight of facilities. States may be reluctant to pass this regulatory oversight onto federal authorities.

8. What types of standards should be adopted for licensure (the list is non-exhaustive, and commenters should please include recommendations on additional categories)?

SWK agrees that the standards for licensure should consist of categories similar to those currently in place including, but not limited to, the following:

- ✓ Minimum standards for facilities
- ✓ Admission, orientation, reunification, and release processes
- ✓ Child rights
- ✓ Services, including needs assessment, development of care plans, developmental and educational
- ✓ services, and legal services
- ✓ Organization and administration
- ✓ Reporting and recordkeeping
- ✓ Training
- ✓ Monitoring and oversight
- ✓ Caregiver-to-child staffing ratios
- ✓ Medical and dental care, family planning services, and emergency healthcare services
- ✓ Mental health and behavior management
- ✓ Visitation and contact with family members
- ✓ Safeguarding children
- ✓ Physical plant
- ✓ Rescission and denial of licenses

A single federal licensing process with comprehensive standards and requirements would enhance the consistency of licensed facilities across all states.

9. How would an independent licensing entity best provide independence and objectivity from ORR in performing its critical task of monitoring compliance with all existing standards?

While ORR currently provides a high level of oversight and monitoring of facilities and services, interpretations of ORR rules vary by state and even within states depending on which agency monitors compliance. Shifting the responsibility and task of monitoring compliance with all existing standards to an independent licensing entity would enhance objectivity, assist in aligning standards, and reduce varying interpretation of standards among monitoring entities.

10. What proposed rules and processes should be applied for an independent investigatory agency to investigate and inspect federally licensed facilities?

For an independent agency to investigate and inspect federally licensed facilities, SWK recommends that entities follow rules and processes similar to those required for accreditation with set standards, aligned processes, and central measures. It is also recommended that the investigatory agency develop a guide for licensing standard requirements as well as an interpretation guide on how the entity will construe requirements to ensure there are no discrepancies or room for misinterpretation. These standards should be made public so that vendors are well informed of all required measures for licensure.

11. What are some possible benefits of Federal licensure?

As discussed, having consistent federal licensing requirements within and across states would assist organizations in ensuring that facilities meet all necessary standards of operation. Federal licensure would result in multiple benefits including, but not limited to, the following:

- ✓ Enhanced consistency of standards and requirements across states
- ✓ Enhanced consistency of staff requirements across states (licensure, training, etc.)
- ✓ Aligned and consistent new employee and ongoing training across states

Federal licensure would also enhance operational uniformity and consistency nationwide, thus enhancing the care, health, and safety outcomes for youth staying in these facilities.

12. What are some possible challenges of Federal licensure?

Challenges of federal licensure would include, but not be limited to, pushback from current state regulatory agencies that may not wish to relinquish this oversight of facilities.

13. How would Federal licensure impact operations and other requirements, such as grant/contract or insurance requirements?

SWK does not foresee that federal licensure would impact grant or contract requirements, with the exception of possibly speeding up the licensing process for facilities. As such, facilities would be able to open and receive youth in a more timely manner.

14. What agency or entity should investigate and inspect federally licensed facilities?

While SWK does not have a specific recommendation of an entity to investigate and inspect federally licensed facilities, it is our opinion that an entity with similar monitoring and investigative experience conduct this work. Additionally, SWK recommends that the entity chosen to perform these duties research and become fully knowledgeable in investigations, monitoring, and inspection of ORR facilities so that they are fully aware of all licensure requirements.

15. Comments regarding a Federal licensing scheme versus a Federal accreditation plan.

A federal licensing scheme would ensure that monitoring of facilities is conducted on a more consistent basis in alignment with predetermined standards. To adhere to federal licensing requirements, monitoring and investigating of facilities would be more frequent to validate that youth in care are receiving the highest quality of services in a safe and healthy environment. More formalized oversight and monitoring through federal licensure would ensure optimal shelter and care for youth in facilities.

The challenge of a federal accreditation plan for facilities is that the frequency of oversight is less timely than with licensure. For example, in some instances federal accreditation only requires that facilities be inspected every 3 to 5 years. As such, facilities may operate without adhering to standards for a period of time before any pertinent issues are identified. This can, in turn, create health and safety risks for youth in care at these facilities.

16. How can considerations for an ORR Federal licensing, accreditation, and/or monitoring scheme inform additional or aligned guidance and standards for other full-time child-caring facilities supported by ORR or HHS?

Considerations for an ORR federal licensing, accreditation, and/or monitoring scheme can inform aligned guidance and standards for other full-time child-caring facilities supported by ORR or HHS. However, to inform guidance and standards across other child-caring facilities, the ORR federal licensing, accreditation, or monitoring scheme must create uniform and consistent language and standards that can be broad enough to cover other types of facilities as well as those overseen by state organizations. As such, language and standards must allow some minor flexibility of interpretation as long as facilities can demonstrate that they are meeting basic standards and mandates. At the same time, language cannot be so ambiguous that it can be randomly interpreted.

17. What information should ORR provide to the public on ORR-funded or ORR-licensed shelter facilities?

It is the opinion of SWK that ORR should be transparent when providing information to the public on ORR-funded or ORR licensed shelter facilities. First, SWK recommends that ORR make public the standards of care for which licensed facilities are currently required to adhere to. In alignment with transparency, it is recommended that ORR also disclose general information on facilities with identified deficiencies in standards of care while also providing more details on minor deficiencies. The goal of providing this information would be to demonstrate that although deficiencies were noted, the facility still meets overall standards of care.

SWK also recommends that the government create a list of optimal standards of licensure to which ORR-funded or ORR-licensed facilities should strive to achieve, such as a 'gold star standard'. ORR can, in turn, provide information to the public about facilities that not only meet standards, but also exceed standards – achieving a gold star standard of care.

Finally, SWK recommends that ORR create a webpage in which performance information for each ORR-funded or ORR-licensed shelter facility is posted. This webpage would allow the public to view and compare performance of each facility and enable organizations to benchmark how they are performing in contrast to competitors.

18. What resources should ORR consider if it develops a Federal licensing, accreditation, and/or monitoring program?

Licensing of facilities is a lengthy and timely process. As such, ORR should maintain significant resources to ensure that steps required to meet licensing requirements takes place in a time-efficient manner. For example, because background checks of facility staff oftentimes cause major delays in the licensing process, SWK recommends that ORR create a system to more quickly conduct background checks. Moving responsibilities of background clearances within the federal entity could also minimize delays.

SWK also recommends that ORR provide reasonable timeframes for vendors to complete the licensing process.

19. Would a Federal licensing or accreditation program need to work differently in different care environments, such as residential childcare institutions, group homes, and child behavioral health facilities?

A federal licensing or accreditation program would need to work differently depending upon the target population, including the mental and physical needs of youth served. While some aspects of residential care institutions, group homes, and child behavioral health facilities may be similar, federal licensing standards and requirements must be differentiated by youths' needs, particularly their physical health and mental health capacities as these youth would require a different realm of services, supervision, and care. This would greatly affect several categories pertinent to licensing standards such as, but not limited to, development of care plans, developmental and educational services, caregiver-to-child staffing ratios, medical care, mental health and behavior management, etc.

20. Would you recommend any alternatives to a Federal licensing or accreditation scheme?

Not applicable. SWK recommends a federal licensing scheme with one federal independent entity overseeing licensing of facilities across the United States. It is SWK's opinion that a federal licensing scheme would prove most effective in enhancing and improving the licensing processes currently offered by State licensing entities.

EXHIBIT 7

Flores Counsel Comments to Proposed ORR Foundational Rule

I. INTRODUCTION

Dec. 4, 2023

Submitted via Federal eRulemaking Portal

Toby Biswas
Director of Policy, Unaccompanied Children Program
Office of Refugee Resettlement
Administration for Children and Families
Department of Health and Human Services
Washington, DC

Re: HHS Docket No. ACF-2023-0009, Comments in Response to Proposed Rulemaking: Unaccompanied Children Program Foundational Rule (RIN 0970-AC93)

Dear Mr. Biswas:

We write on behalf of class counsel in *Flores v. Garland*, Case No. 85-4544 (C.D. Cal.), to address inconsistencies between the Office of Refugee Resettlement's Notice of Proposed Rulemaking on the Unaccompanied Children Program Foundational Rule ("Proposed Rule") and the *Flores* Settlement Agreement ("FSA" or "Settlement").

The Proposed Rule, to be codified at 45 C.F.R. Part 410, fails to discharge ORR's obligations under Paragraphs 9 and 40 of the FSA "to publish the relevant and substantive terms of this Agreement as a Service regulation." *See also* FSA ¶ 9 ("The final regulations shall not be inconsistent with the terms of this Agreement."). The Commenting Parties, as *Flores* counsel, are intimately familiar with the rights and protections guaranteed by the FSA and urge ORR to reformulate the Proposed Rule to be consistent with the Settlement.

As discussed below, the Proposed Rule dismantles the FSA's state licensing requirements, which is a core protection guaranteed to class members under the FSA. *See, e.g.*, Proposed Rule §§ 410.1001, 410.1101, 410.1103, 410.1201. The Proposed Rule permits children to be placed in unlicensed facilities that are only required to meet undefined "other requirements specified by ORR," without any guarantee of expeditious transfer to a state-licensed placement. *See, e.g.*, Proposed Rule § 410.1001. By omitting references to licensed facilities throughout the Proposed Rule, the Proposed Rule undermines the FSA's substantive terms. Further, the Proposed Rule allows programs to avoid state licensure requirements even where a state has a licensing framework available and undermines other protections for children under state law. *See, e.g.*, Proposed Rule §§ 410.1001; 410.1302(a). Without requiring state licensing, the Proposed Rule falls far short of the requirements of the FSA and is, on its face, inconsistent with the FSA.

Other provisions in the Proposed Rule are also inconsistent with the FSA. For example, certain provisions would permit a delay in licensed placement under circumstances that are inconsistent with Paragraph 19 of the FSA. *See* Proposed Rule §§ 410.1001, 410.1101(d)(7), 410.1800(b). Additionally, parts of the Proposed Rule would allow ORR to deny release to certain sponsors for reasons inconsistent with Paragraph 14 of the FSA. *See* Proposed Rule § 410.1202(d). Another provision of the Proposed Rule fails to protect critical due process rights for children in bond hearings. *See* Proposed Rule § 410.1903. Expeditious placement in licensed facilities, prompt release to appropriate sponsors, and fair bond hearings are among the vital protections guaranteed by the FSA. It is imperative that the Final Rule include these protections, as well as others detailed below.

To implement the FSA and be consistent with its substantive terms, the Final Rule must remedy the deficiencies identified in this comment, including by ensuring state licensing and meaningful independent oversight. Moreover, ORR should take this opportunity to go beyond the floor set by the Settlement and enshrine greater protections for unaccompanied children in ORR custody.

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II. COMMENTING PARTIES

The **National Center for Youth Law ("NCYL")** is a non-profit law firm that has fought to protect the rights of children and youth for over fifty years. Headquartered in Oakland, California, NCYL leads high impact campaigns that weave together litigation, research, policy development, and technical assistance. NCYL also collaborates with public agencies to develop policies and practices to better support children and families. NCYL's Immigration Team works to ensure that immigrant children are able to live in communities rather than in government custody and have the resources they need to heal and thrive. NCYL is counsel to the plaintiff classes in *Flores v. Garland* and *Lucas R. v. Becerra.*

The **Center for Human Rights and Constitutional Law ("CHRCL")** is a non-profit, public interest law foundation dedicated to furthering the legal, civil, human, and constitutional rights of immigrants, refugees, children, indigenous peoples, and the indigent. CHRCL is counsel to the plaintiff classes in *Flores v. Garland* and *Lucas R. v. Becerra.* CHRCL has nationally recognized expertise in law and policy affecting its target populations. CHRCL devotes a majority of its resources to major class action litigation. CHRCL also conducts administrative and legislative advocacy, and policy analysis on behalf of its target populations. CHRCL also serves as a resource for policy makers, advocacy coalitions, and community-based organizations in the areas of migration, refugees, labor-related immigration law and policy.

Children's Rights ("CR") is a national advocacy organization dedicated to improving the lives of children living in or impacted by America's child welfare, juvenile legal, immigration, education, and healthcare systems. CR uses civil rights impact litigation, advocacy and policy expertise, and public education to hold governments accountable for keeping kids safe and healthy. CR's work centers on creating lasting systemic change that will advance the rights of children for generations.

III. COMMENTS ON PROPOSED RULE

A. The Proposed Rule Dismantles State Licensing Requirements in Clear Violation of the FSA

1. The State Licensing Requirement is a Material Term of the FSA

For more than 80 years, there has been consensus within the child welfare field that facilities that care for children must be licensed by state authorities to ensure that such facilities meet fundamental health and safety requirements.[1] Over the past eight decades, states have developed capacity and expertise to license these facilities—capacity and expertise that the federal government lacks. This critical state-based licensing requirement was a central feature in negotiating and agreeing to protections for immigrant children in federal custody. Under the *Flores* Settlement Agreement that resulted from these negotiations, immigrant children must generally be placed in state-licensed facilities and these facilities must "comply with all applicable state child welfare laws and regulations" and abide by other minimum standards. FSA ¶¶ 12(A), 19, Ex. 1.

State licensing agencies have the independence, administrative infrastructure, specialized expertise, and enforcement authority to monitor facilities housing immigrant children and ensure they meet state child welfare standards.[2] The federal district court for the Central District of California and the Court of Appeals for the Ninth Circuit have each recognized that the Settlement's state licensing requirement is a material term of the agreement. *Flores v. Johnson*, 212 F. Supp. 3d 864, 879-80 (C.D. Cal. 2015), *aff'd in part, rev'd in part sub nom. Flores v. Lynch*, 828 F.3d 898, 906, 910 (9th Cir. 2016). As the Ninth Circuit Court of Appeals explained, the purpose of the state licensing requirement is to "use the existing apparatus of state licensure to independently review detention conditions." *Lynch*, 828 F.3d at 906.

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[1] Neha Desai, Emma McGinn, & Laura Alvarez, *Correcting Course: Restoring the critical protection of placement in licensed facilities for children in federal immigration custody*, Apr. 2023, at 6, https://youthlaw.org/resources/correcting-course; *see also National Database of Child Care Licensing Regulations*, CHILD CARE TECHNICAL ASSISTANCE NETWORK, https://licensingregulations.acf.hhs.gov/ (last visited Nov. 30, 2023).

[2] *Id.* at 7; *see also* CAL. CODE REGS. tit. 22, §§ 101169, 101200, 101206; FLA. ADMIN. CODE ANN. R. 65C-46.003(5), 65C-46.005(1); FLA. STAT. ANN. §§ 409.175, 409.176; 26 TEX. ADMIN. CODE §§ 745.211, 745.8407, 745.8603 (state regulations as examples of what licensing requirements encompass).

State licensing is such an essential protection for children that it is the only requirement that both the plaintiffs and the government agreed should survive even after the termination of the Settlement. A 2001 amendment to the FSA states that "[a]ll terms of this Agreement shall terminate 45 days following defendants' publication of final regulations implementing this Agreement. Notwithstanding the foregoing, the INS shall continue to house the general population of minors in INS custody in facilities that are state-licensed for the care of dependent minors." *Flores v. Barr*, 407 F. Supp. 3d 909, 915 (C.D. Cal. 2019) (quoting Dec. 7, 2001 Stipulation amending the FSA).

Of course, licensing alone does not ensure the safety of children, but it is a prerequisite for ensuring a baseline of core requirements to which facilities must adhere and is also a vital structure for accountability. Far more must be done to ensure the well-being of children placed in these facilities, but all of it must be built upon the core infrastructure that state licensing provides.

2. The Proposed Rule Violates the FSA's State Licensing Requirement

Paragraph 6 of the FSA defines a "licensed program" as "any program, agency or organization that is *licensed by an appropriate State agency* to provide residential, group, or foster care services for dependent children, including a program operating group homes, foster homes, or facilities for special needs minors." FSA ¶ 6 (emphasis added). The language in the FSA makes clear that the state's role in licensure is key to the licensing scheme. Proposed Rule Section 410.1001 would replace the "licensed program" of the FSA with a "standard program." Under this Proposed Rule, "[s]tandard program means any program, agency, or organization that is licensed by an appropriate State agency, *or that meets other requirements specified by ORR if licensure is unavailable in the State* to programs providing services to unaccompanied children, to provide residential, group, or transitional or long-term home care services for dependent children, including a program operating family or group homes, or facilities for special needs unaccompanied children." Proposed Rule § 410.1001 (emphasis added).

According to the Preamble to the Proposed Rule, "[t]he proposed definition of 'standard program' is broader in scope to account for circumstances wherein licensure is unavailable in the state to childcare facilities that provide residential, group, or home care services for UC." Preamble (p. 68,967). The proposed definition of "standard program" cannot replace the FSA's requirement of a "licensed program." The Proposed Rule's reference to "other requirements specified by ORR" is vague and in no way substitutes for the child welfare standards or independent oversight provided by

state licensure. *See Flores v. Barr*, 407 F. Supp. 3d at 919 (holding that placing *Flores* class members in facilities that follow federal standards instead of state licensure "is more than a minor or formalistic deviation from the provisions of the *Flores* Agreement, as '[t]he purpose of the licensing provision is to provide class members the essential protection of regular and comprehensive oversight by an *independent* child welfare agency.'" (quoting Order re Pls.' Mot to Enforce at 14 [Doc. # 177])).

The Proposed Rule also eliminates the FSA's "licensed program" requirement in provisions that relate to release rather than ORR placement. Proposed Rule Section 410.1201 details the order of preference for release of a minor from ORR custody. The language mirrors that of Paragraph 14 of the FSA, except that subsection (5) of the Proposed Rule refers to "a standard program willing to accept legal custody" as opposed to "a licensed program willing to accept legal custody." This alteration means that an unaccompanied child could be released from ORR custody for long-term placement in a facility that is not licensed or monitored by any state. Moreover, it is not even clear what "a standard program willing to accept legal custody" means in the release context because the Proposed Rule defines "standard program" within the framework of ORR care providers.

The Final Rule must reintroduce a state licensing requirement in every provision of the Proposed Rule where the FSA requires state-licensed placement. The definition of "standard program" must be expanded to require state licensing. This alone would be insufficient to make the Proposed Rule consistent with the FSA, however, as the Proposed Rule sometimes replaces the term "licensed placement" with other terms such as "appropriate placement" or simply "placement."

For example, Paragraph 12(A) of the FSA states that "[t]he INS will transfer a minor from a placement under this paragraph to *a placement under Paragraph 19*. . ." within a certain timeframe, unless one of the listed exceptions applies. FSA ¶ 12(A) (emphasis added). Paragraph 19 of the FSA establishes the requirement of placement in a licensed program. Proposed Rule Section 410.1101(b) replaces this FSA language with the following: "ORR identifies an *appropriate placement* for the unaccompanied child…." (emphasis added). By replacing "placement under Paragraph 19"—which refers to placement in a licensed facility—with "appropriate placement," the Proposed Rule violates the FSA's state licensing requirement.

As another example, the language in Proposed Rule Section 410.1103(e) not only violates the state licensing requirement of the FSA, but could lead to unlicensed placements being favored over state-licensed placements. Paragraph 6 of the FSA

provides that the government "shall make reasonable efforts to provide *licensed placements* in those geographic areas where the majority of minors are apprehended, such as southern California, southeast Texas, southern Florida and the northeast corridor." FSA ¶ 6 (emphasis added). Proposed Rule Section 410.1103(e), by contrast, states that "ORR shall make reasonable efforts to provide *placements* in those geographical areas where DHS encounters the majority of unaccompanied children." Proposed Rule § 410.1103(e) (emphasis added). By omitting the term "licensed" from this provision, the Proposed Rule violates the FSA state licensing requirement. Further, because the Proposed Rule includes no preference for state-licensed placements over unlicensed standard programs, this provision could have the effect of prioritizing unlicensed placements in Texas over licensed placements in other geographic areas. This undermines the purpose of Paragraph 6 and the FSA as a whole.

3. The Proposed Rule Allows Programs to Avoid State Licensure Requirements Even Where a State has a Licensing Framework Available

Several provisions of the Proposed Rule allow programs to avoid state licensing requirements, even in states that have a licensing framework available. This is inconsistent with the state licensing requirement of the FSA. *See* FSA ¶ 6.

Proposed Rule Section 410.1302(a) states that standard programs shall "[b]e licensed by an appropriate State or Federal agency, or meet other requirements specified by ORR if licensure is unavailable to programs providing services to unaccompanied children in their State, to provide residential, group, or foster care services for dependent children." This language seems to permit programs to choose between three options: (1) state licensing, (2) federal licensing, or (3) "if licensure is unavailable" to programs in a certain state, then the program is required to "meet other requirements specified by ORR." Proposed Rule § 410.1302(a).

As explained above, the "other requirements specified by ORR" are not a substitute for state licensing as required by the FSA. Further, Proposed Rule Section 410.1302(a) permits federal licensing as an alternative to state licensing even in states that have a licensing framework available to ORR grantees. This is a clear violation of FSA licensing requirements.

It is unclear from the drafting of this subsection how the contemplated federal licensure scheme will interact with the "other requirements specified by ORR." [3] In a footnote in the Preamble, ORR states that "[s]eparate from this notice of proposed rulemaking and *in the spirit of* current FSA requirements, ACF is currently developing a notice of proposed rulemaking that would describe the creation of a Federal licensing scheme for ORR care providers located in states where licensure is unavailable to programs serving unaccompanied children." Preamble (p. 68,916 n.52) (emphasis added). The Proposed Rule does not offer *any* detail regarding this potential federal licensing scheme or any assurances that federal licensing will incorporate the minimum standards and oversight mechanisms of state licensure. Without information on federal licensing or any detail on the "other requirements specified by ORR," *Flores* counsel and other stakeholders cannot fully and adequately respond to the Proposed Rule. In any event, substituting federal licensure for state licensure is inconsistent with the FSA.

4. *The Proposed Rule Impermissibly Allows ORR and Care Providers to Violate State Law*

The FSA requires that licensed programs "comply with all applicable state child welfare laws and regulations and all state and local building, fire, health and safety codes." FSA Ex. 1. Proposed Rule Section 410.1302(b), by contrast, allows programs to abide by federal requirements instead of following state law if licensure is unavailable in their state. There is no justification for this exception. Even if it were permissible to operate standard programs without state licenses, there is no reason those programs should not be required to follow state child welfare laws and state and local building, fire, health, and safety codes. ORR has no expertise in topics such as building and fire safety and no authority to authorize care providers to violate state and local law. If state or local laws deprive an unaccompanied child of a right they would enjoy in another state, ORR should transfer the child to a state that better protects their rights.

In addition, the Proposed Rule includes several federal preemption provisions stating that "[i]f there is a potential conflict between ORR's regulations and State law, ORR will review the circumstances to determine how to ensure that it is able to meet its statutory responsibilities. It is important to note, however, that if a State law or license, registration, certification, or other requirement conflicts with an ORR employee's duties within the scope of their ORR employment, the ORR employee is required to abide by their Federal duties." *See* Proposed Rule §§ 410.1302(b), 410.1307(c)(2), 410.1401(d),

[3] In fact, no provision in the Proposed Rule makes clear what the "other requirements specified by ORR" will include. *See* Sections 410.1001, 410.1302(a)-(b).

410.1801(b)(15). There is no parallel language in the FSA. These provisions could be interpreted broadly to give ORR discretion to ignore state licensing requirements if the agency perceives a conflict. Such an interpretation would be inconsistent with the FSA's state licensing scheme. This federal preemption language should be followed by qualifying language stating: (1) state licensure is required, and (2) if a conflict between ORR's policies or regulations and state law arises, the state-licensed program must still follow state licensure requirements.

Further, Proposed Rule Section 410.1001 (definition of "Standard Program") requires all homes and facilities to be "non-secure," whereas Paragraph 6 of the FSA requires them to be "non-secure as required under state law." The omission of "as required under state law" allows for a departure from state law requirements even in states that license ORR facilities. Even if it were permissible to operate standard programs without state licenses, the state law definition of "non-secure" should still control because states have greater expertise on the specific requirements of non-secure facilities in the child welfare context. Without the "as required under state law" clause, ORR could adopt a definition of non-secure that permits much more restrictive conditions than are currently permissible. *Cf. Flores v. Barr*, 407 F. Supp. 3d at 920 (rejecting DHS definition of "non-secure").

For the same reasons, if ORR chooses to retain the reference to "a facility for special needs unaccompanied children" in the definition of "standard program" in Proposed Rule Section 410.1001,[4] it would be impermissible to replace the FSA's Paragraph 6 reference to the "level of security permitted under State law" with undefined "requirements specified by ORR if licensure is unavailable in the State."

5. *The Proposed Rule Contemplates Placement in Out of Network (OON) Facilities That Are Not Defined as Meeting Either State Licensing or "Standard Program" Requirements*

The Proposed Rule introduces the term "care provider facility," which is defined as "any physical site that houses unaccompanied children in ORR custody, operated by an ORR-funded program that provides residential services for children, including but not limited to a program of shelters, group homes, individual family homes, residential treatment centers, secure or heightened supervision facilities, and emergency or influx facilities." Proposed Rule § 410.1001. Notably, the definition states that "[o]ut of

[4] As explained below, *Flores* counsel supports omitting the term "special needs unaccompanied child" from the Final Rule.

network ("OON") facilities are not included within this definition." An OON facility is defined as "a facility that provides physical care and services for individual unaccompanied children as requested by ORR on a case-by-case basis, that operates under a single case agreement for care of a specific child between ORR and the OON provider. OON may include hospitals, restrictive settings, or other settings outside of the ORR network of care." Proposed Rule § 410.1001.

Pursuant to this definition, not all OON facilities are secure placements, yet the Proposed Rule does not specify that OON placements must abide by state licensing requirements, or even that they must follow the requirements of a standard program. Proposed Rule Section 410.1302 identifies the minimum standards that are required in standard programs, but the Proposed Rule does not currently mandate these minimum services at OON facilities.

These gaps in the Proposed Rule undermine the rights of children in OON placements and leave room for ORR to forgo these minimum standards. In the past, some unaccompanied children placed in OON facilities have not received the minimum services required by Exhibit 1 of the FSA.[5] Indeed, we have seen that care and treatment provided by OON facilities can vary widely, in both positive and negative ways, which is why it is so imperative that the Final Rule explicitly state that OON facilities must abide by these minimum standards. For consistency with the FSA, the Final Rule must provide that any OON placement shall be state-licensed and meet the other requirements for licensed facilities outlined in the FSA, including the minimum standards in Exhibit 1.

Further, Proposed Rule Section 410.1105(c)(2) provides criteria for OON RTC placements, but the Proposed Rule does not provide criteria for any other OON placements. To ensure unaccompanied children placed in OON facilities have the same protections as other unaccompanied children, the Final Rule must state that a child may

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[5] *See* Decl. of Class Member at Nexus Children's Hospital, at ¶ 10-11,
Ex. I, Plaintiffs' Response to Juvenile Coordinators' Interim Reports, ECF No. 1039-9, *Flores v. Barr*, Case No. 85-4544 (C.D. Cal. Nov. 23, 2020) ("I spend eight hours a day in my room . . . I have school once a week on Wednesdays. A teacher comes in for an hour and a half and we go over math, English, and language arts."); *Id.*, Decl. of Class Member at Nexus Children's Hospital, at ¶ 10, Ex. J, ECF No. 1039-10 ("I do not have school here. I have not had any school at Nexus the entire time I have been here.")

be placed in an OON program only if it is the least restrictive placement appropriate, *see* FSA ¶ 11, and that any secure OON placement must satisfy the secure placement criteria in Paragraph 21 of the FSA.

6. The Proposed Rule Permits Unlicensed Placement Without the Safeguards of FSA Paragraph 12A

Paragraph 12A of the FSA provides that "minors shall be separated from delinquent offenders." This protection does not appear in the Proposed Rule. The Preamble (p. 68,922) to the Proposed Rule states that this provision was not included because Paragraph 12A relates to the initial apprehension or encounter of unaccompanied children. However, Paragraph 12A is not limited to initial apprehension. Rather, it covers situations where "there is no one to whom the INS may release the minor pursuant to Paragraph 14, and no appropriate licensed program is immediately available for placement pursuant to Paragraph 19."

The definition of licensed program in Paragraph 6 of the FSA specifies that a licensed program must be "licensed by an appropriate State agency to provide residential, group, or foster care services for *dependent* children" (emphasis added). These two paragraphs of the FSA work together: prior to licensed placement, unaccompanied children must be separated from minors adjudicated delinquent; after licensed placement, children must be placed in a facility licensed by the state to serve dependent (rather than delinquent) children.

The Proposed Rule permits children to be placed in "standard programs" that lack state licensure as well as in unlicensed emergency and influx facilities, yet it offers no assurances that unaccompanied children in these placements will be treated as dependent minors. Moreover, as noted above, the Proposed Rule does not specify any required standards for OON facilities or any placement criteria for non-RTC OONs. This would permit ORR to place children in OON facilities that are licensed for minors adjudicated delinquent, in violation of the FSA.

The Final Rule must specify that until an unaccompanied child is placed in a program licensed by the state to provide services for dependent children, the child "shall be separated from delinquent offenders" (except as provided in Paragraph 21 of the FSA).

B. The Ombuds Office Is Insufficient as an Enforcement and Oversight Mechanism to Ensure that Facilities Meet Required Standards

Proposed Rule Section 410.2000 establishes the UC Office of the Ombuds. ORR does not appear to see the Office of the Ombuds as a replacement for state licensing. *See* Preamble to Proposed Rule (p. 68,962) (referring to the Office of the Ombuds as serving "a similar function as the oversight currently provided by the *Flores* monitor"). Nor could it be, since the Office of the Ombuds as outlined in the Proposed Rule will not have sufficient administrative infrastructure or expertise to monitor facilities in the way that state licensing agencies do. And, as ORR acknowledges, "an ombud's office would not have authority to compel ORR to take certain actions." *Id.* Unlike state licensing agencies that are empowered to close programs and take other enforcement actions, the Office of the Ombuds would be able to issue only non-binding recommendations and refer matters to other agencies. *See* Proposed Rule § 410.2002. Importantly, without a requirement for state licensing, the Office of the Ombuds would not be able to refer matters to state licensing agencies for investigation and enforcement.

The Proposed Rule thus creates a vacuum where facilities would be able to operate without the independent oversight and accountability provided by state licensing or any other meaningful oversight mechanism given the lack of independence and insufficient enforcement authority provided to the Office of the Ombuds.

Additionally, Proposed Rule 410.2002(a) states that "[t]he UC Office of the Ombuds may engage in activities consistent with § 410.2100 . . . ." However, the Proposed Rule does not include a Section 410.2100. Without the text of this provision, *Flores* counsel and other stakeholders cannot fully and adequately respond to the Proposed Rule.

C. The Proposed Rule Undermines the FSA's Placement Requirements

1. *Proposed Rule Sections 410.1101 and 410.1800 Permit a Delay in Licensed Placement Under Circumstances Inconsistent with the FSA*

The FSA requires that the INS transfer a minor to a licensed placement under Paragraph 19 within a certain time frame, except: (1) if the minor is treated as an adult under Paragraph 13 or eligible for secure placement under Paragraph 21; (2) "as

otherwise required by any court decree or court-approved settlement"; (3) "in the event of an emergency or influx of minors into the United States, in which case the INS shall place all minors pursuant to Paragraph 19 as expeditiously as possible"; or (4) "where individuals must be transported from remote areas for processing or speak unusual languages such that the INS must locate interpreters in order to complete processing, in which case the INS shall place all such minors pursuant to Paragraph 19 within five (5) business days." FSA ¶ 12(A).

As detailed in the section above, the Proposed Rule impermissibly replaces "licensed program" with "standard program." The definition of "standard program" permits ORR to place unaccompanied children in non-licensed programs without any obligation to expeditiously transfer them to a licensed program. *See, e.g.*, Proposed Rule § 410.1001 (definition of "standard program"). This violates the requirements of Paragraph 12(A) of the FSA.

Further, Proposed Rule Section 410.1101(d)(7) would introduce an additional exception that allows the agency to deny placement to even a standard program upon the occurrence of "an act or event that could not be reasonably foreseen that prevents the placement of or accepting transfer of custody of an unaccompanied child within the timeframes in paragraph (b) or (c) of this section." This language is overly broad and would allow the agency to make placement decisions that are inconsistent with the FSA. Although the government has been bound by the FSA's requirements since 1997, the Proposed Rule does not identify any specific circumstances not already covered by the FSA's current exceptions that required a delay in placement in the past. ORR must eliminate this additional exception for consistency with the FSA.

Similarly, Proposed Rule Section 410.1800(b) introduces qualifying language that would permit a delay in licensed placement under circumstances inconsistent with the FSA. As explained above, one of the five exceptions in the FSA for licensed placement includes "in the event of an emergency or influx of minors into the United States, in which case the INS shall place all minors pursuant to Paragraph 19 as expeditiously as possible." FSA ¶ 12(A)(3). Proposed Rule Section 410.1800 states that "[i]n the event of an emergency or influx that prevents the prompt placement of unaccompanied children in standard programs, ORR shall *make all reasonable efforts* to place each unaccompanied child in a standard program as expeditiously as possible" (emphasis added). The FSA's reference to licensed placement "as expeditiously as possible" already provides ORR with leeway to delay licensed placement when it is operationally

infeasible to place children within the FSA's time limits. The additional qualifying language—"make all reasonable efforts"—weakens the "as expeditiously as possible" requirement for placement in a licensed program. ORR must eliminate this additional qualifying language in order to comply with the requirements of the FSA.

2. The Proposed Rule is Inconsistent with the FSA Because it Eliminates Safeguards Against Secure Placement

The FSA requires that "[a]ll determinations to place a minor in a secure facility will be reviewed and approved by the regional juvenile coordinator." FSA ¶ 23. Proposed Rule Section 410.1104 does not include this requirement and is therefore inconsistent with the FSA. Although Proposed Rule Sections 410.1900 and 410.1902 outline a Placement Review Panel ("PRP") process, the PRP is not a substitute for the FSA's mandatory juvenile coordinator review. The PRP provides the child the opportunity to contest their placement *after* they are placed in a restrictive setting, whereas the FSA requires automatic juvenile coordinator review and approval for all secure placements. The latter is an important safeguard against erroneous initial placement in a secure setting and eliminates the burden on the child to contest their placement in cases where an error could have been identified by the juvenile coordinator. The Final Rule should include this requirement.

Further, the FSA states that minors will not be placed in a secure facility "if there are less restrictive alternatives that are available and appropriate in the circumstances, such as transfer to (a) a medium security facility which would provide intensive staff supervision and counseling services or (b) another licensed program." FSA ¶ 23. Proposed Rule Section 410.1105(a)(2) states that "ORR will not place an unaccompanied child in a secure facility (that is not an RTC) if less restrictive alternatives in the best interests of the unaccompanied child are available and appropriate under the circumstances. ORR may place an unaccompanied child in a heightened supervision facility or other non-secure care provider facility as an alternative, provided that the unaccompanied child does not pose a danger to self or others."

Because "danger to self or others" is already a requirement for secure placement, *see* Proposed Rule §§ 410.1105(a)(3), (c), the additional clause ("provided that the unaccompanied child does not pose a danger to self or others") renders Section 410.1105(a)(2) meaningless. Further, this additional language is unnecessary

because FSA Paragraph 23 and Proposed Rule Section 410.1105(a)(2) already limit alternative placements to those that are "available and appropriate under the circumstances." ORR is not required to make an unsafe placement because such a placement would not be "appropriate." But a child who poses a danger to self or others at one point in time can sometimes be safely and appropriately placed in a less restrictive setting with reasonable modifications that mitigate danger.

The Final Rule should mirror the language of FSA Paragraph 23 and eliminate the superfluous "provided that the unaccompanied child does not pose a danger to self or others" language.

D. Proposed Rule Section 410.1302(c) Lacks Privacy Protections Required by the FSA

Proposed Rule Section 410.1302(c) regarding minimum standards in standard programs lacks a guarantee of a reasonable right to privacy required by the FSA. Pursuant to Exhibit 1 of the FSA, this guarantee "shall include the right to: (a) wear his or her own clothes, when available; (b) retain a private space in the residential facility, group or foster home for the storage of personal belongings; (c) talk privately on the phone, as permitted by the house rules and regulations; (d) visit privately with guests, as permitted by the house rules and regulations; and (e) receive and send uncensored mail unless there is a reasonable belief that the mail contains contraband." FSA Ex. 1, A(12). Proposed Rule Section 410.1801(b)(12) includes this requirement for children placed in emergency or influx facilities, but Proposed Rule Section 410.1302(c) does not include this requirement for standard programs. A reasonable right to privacy is required by the FSA and must be incorporated into Section 410.1302(c) in the Final Rule.

E. The Proposed Rule Undermines FSA Protections by Eliminating Mention of the Right to Judicial Review

Paragraph 24 of the FSA provides for judicial review of facility placement and conditions, stating that "[a]ny minor who disagrees with the INS's determination to place that minor in a particular type of facility, or who asserts that the licensed program in which he or she has been placed does not comply with the standards set forth in Exhibit 1 attached hereto, may seek judicial review in any United States District Court with jurisdiction and venue over the matter to challenge that placement determination

or to allege noncompliance with the standards set forth in Exhibit 1." FSA ¶ 24(B). The FSA also requires notice of the right to judicial review. FSA Ex. 6.

Proposed Rule Section 410.1109(a)(2) provides for a notice of rights that includes some language similar to Exhibit 6 but omits the right to ask a federal judge to review the child's case. The Preamble states that the Proposed Rule does not expressly provide for judicial review of placement or compliance because a regulation cannot confer jurisdiction on a federal court. Preamble (p. 68,975). This limitation is not an obstacle, however, to informing children of their right to potential judicial review in a court with jurisdiction and venue. The Final Rule should thus include a statement informing the unaccompanied child of the right to seek review of a placement determination or noncompliance with Exhibit 1 standards in a United States District Court with jurisdiction.

F. Proposed Rule Section 410.1202 Would Allow ORR to Disregard the Fourth and Sixth Release Preferences in the FSA

The FSA requires that minors shall be released "without unnecessary delay" to sponsors in an order of preference that includes a fourth preference for "an adult individual or entity designated by the parent or legal guardian as capable and willing to care for the minor's well-being," FSA ¶ 14(D), and a sixth preference for "an adult individual or entity seeking custody, in the discretion of the INS, when it appears that there is no other likely alternative to long term detention and family reunification does not appear to be a reasonable possibility," FSA ¶ 14(F). Proposed Rule Section 410.1201(a) mirrors this order of placement preference. Proposed Rule §§ 410.1201(a)(1)-(6). Proposed Rule Section 410.1202(d), however, includes a blanket allowance for denial of release to an unrelated individual with whom the unaccompanied child does not have a pre-existing relationship. This provision is inconsistent with the FSA, is not needed to ensure safe placement, and could result in unnecessary delays to release.

The Preamble to the Proposed Rule explains that the list of potential sponsors in order of release preference "reflects [ORR's] strong belief that, generally, placement with a vetted and approved family member or other vetted and approved sponsor, as opposed to in an ORR care provider facility, whenever feasible, is in the best interests of unaccompanied children." Preamble (p. 68,928). *Flores* counsel strongly agrees with this principle, which is central to the FSA.

The FSA's fourth and sixth placement preferences each contemplate release to a non-relative and do not require a pre-existing relationship with the child. Although the FSA gives priority to a parent, legal guardian, or adult relative, some unaccompanied children lack an available relative sponsor. For those children, the fourth and sixth placement preferences may be their only opportunity for release from ORR custody into a community placement. This is especially critical for children who are denied placement by long-term foster care or other licensed community-based programs.

Pursuant to Proposed Rule Section 410.1202(d), however, "ORR may deny release to unrelated individuals who have applied to be a sponsor but who have no pre-existing relationship with the child or the child's family prior to the child's entry into ORR custody." Proposed Rule § 410.1202(d). This language appears to permit ORR to deny a sponsor *solely* based on the lack of a pre-existing relationship without requiring any individualized evaluation of sponsor fitness. This is inconsistent with the FSA because it would make the release priorities in Paragraph 14(D) and 14(F) optional for ORR. Although the sixth release preference in the FSA refers to release "in the discretion of the INS," the fourth release preference does not include any discretionary language. This suggests that the fourth release preference is not within ORR's discretion.

While it is true that ORR may determine that an unrelated sponsor (or any sponsor) is not a safe placement after individualized consideration, *see* FSA ¶ 17, Proposed Rule § 410.1203(e), the FSA does not permit ORR to decline to *consider* a sponsor because of a lack of a pre-existing relationship with the child. As noted above, this is especially important for children seeking release to an unrelated sponsor under FSA Paragraphs 14(D) or (F) who likely have no other release options. To the extent Proposed Rule Section 410.1202 is intended to include a pre-existing relationship as just one factor in ORR's suitability evaluation rather than an automatic disqualifying factor, the Final Rule must make that clear.

The Preamble to the Proposed Rule recognizes that release to an unrelated sponsor without a pre-existing relationship with the child may be appropriate, noting that "[p]ossible scenarios in which ORR envisions [the sixth release preference] may be applicable include, for example, foster parents or other adults who have built or are building a relationship with an unaccompanied child while in ORR care, such as a teacher or coach, and in which it is possible to ensure that a healthy and viable relationship exists between the unaccompanied child and proposed sponsor." Preamble (p. 68,928). The Preamble further states that "under proposed § 410.1202(e), ORR would consider . . . the opportunity for the potential sponsor and unaccompanied

child to have the opportunity to build a healthy relationship while the child is in ORR care." Preamble (p. 68,929). This is consistent with ORR's current policy. *See* ORR Policy Guide § 2.2.4. Despite the explanation in the Preamble, Section 410.1202(e) of the Proposed Rule does not reference the opportunity for a potential sponsor to build a relationship with the unaccompanied child.

For consistency with the FSA, the Preamble, and ORR's current policy, the Final Rule should explicitly state that a lack of a pre-existing relationship will not automatically disqualify a sponsor from consideration and, if necessary to ensure a safe release, that ORR will provide an opportunity for a potential sponsor to establish a relationship with an unaccompanied child while the child is in ORR custody.

G. Proposed Rule Section 410.1903 Fails to Protect Critical Due Process Rights for Children in Bond Hearings

Paragraph 24(A) of the FSA requires that "[a] minor in deportation proceedings shall be afforded a bond redetermination hearing before an immigration judge in every case, unless the minor indicates on the Notice of Custody Determination form that he or she refuses such a hearing." FSA ¶ 24(A). Proposed Rule Section 410.1903 establishes a risk determination hearing process for unaccompanied children in restrictive placements, but the proposed process falls short of the protections required to safeguard children's rights by (1) not making clear that children denied release based on a finding of danger to self can challenge that determination, (2) not placing on the government the burden of establishing whether a child is a danger to the community, (3) not clearly stating that a child has a right to review evidence in advance of a hearing, and (4) failing to establish recurring risk determination hearings.

1. The Final Rule Must Make Clear that Children Denied Release Based on a Finding of Danger to Self Can Challenge that Determination in a Risk Determination Hearing

The Ninth Circuit has interpreted the *Flores* bond hearing to include a consideration of whether a child is a danger to themself as well as to the community. *See Flores v. Sessions*, 862 F.3d 863, 871 (9th Cir. 2017) (explaining that the Trafficking Victims Protection Reauthorization Act "requires that children not be placed in secure facilities absent a determination that the child poses a danger to self or others or has been charged with having committed a criminal offense. This is, significantly, precisely the determination that can best be made in a bond hearing.") (internal citation

omitted); *see also id.* at 873-74 (noting that class member was determined not to pose a danger to himself or others at the bond hearing). The risk determination hearing process established in Proposed Rule Section 410.1903 references dangerousness determinations but does not provide that these procedures are available to children determined by ORR to pose a danger to *self*, rather than just those children determined to pose a danger to the *community*. Proposed Rule § 410.1903(a) ("All unaccompanied children in restrictive placements shall be afforded a hearing before an independent HHS hearing officer to determine . . . whether the unaccompanied child would present a risk of danger *to the community*.") (emphasis added).

To be clear, a child should never be denied release to a sponsor based solely on danger to self. ORR should instead affirmatively support potential sponsors in accessing post-release community-based services for children with serious mental health needs. *See* Proposed Rule § 410.1311(e)(2). The Final Rule should therefore include language that makes explicit that ORR will not deny release based on danger to self. If ORR does place a child in a restrictive setting or deny release based on danger to self, however, that child must have access to a risk determination hearing under this section to challenge that determination, just as a child whom ORR determines to be a risk to the community must have access to such a hearing.

2. *The Government Must Bear the Burden of Establishing Whether a Child is a Danger to the Community*

The Ninth Circuit has interpreted the bond redetermination hearing to afford "critical due process rights," including: "(a) the 'right to be represented by counsel'; (b) the 'right to make an oral statement'; (c) the right to 'examine and rebut the government's evidence'; (d) the right to 'create an evidentiary record'; (e) the right 'to have the merits of [the minor's] detention assessed by an independent' adjudicator; and (f) the right to appeal the adjudicator's decision." *Flores v. Rosen*, 984 F.3d 720, 734 (9th Cir. 2020) (citing *Flores v. Sessions*, 862 F.3d at 867-68, 879). Proposed Rule Section 410.1903 fails to fully protect children's due process rights. Although the Ninth Circuit upheld the bond hearing provision of the 2019 Final Rule except as to the lack of automatic hearings, ORR should take this opportunity to strengthen the minimal protections in the Final Rule to better safeguard these critical due process rights.

The Ninth Circuit has explained that *Flores* bond hearings "compel [ORR] to provide its justifications and specific legal grounds for holding a given minor." *Flores v.*

Sessions, 862 F.3d at 868. Proposed Rule Section 410.1903(b), however, places "[t]he burden of persuasion . . . on the unaccompanied child to show that they will not be a danger to the community if released, using a preponderance of the evidence standard." Proposed Rule § 410.1903(b).

This is inconsistent with the FSA's mandate that minors be placed in the least restrictive placement and be treated with special concern for their particular vulnerabilities. FSA ¶ 11. Further, because children whom ORR contends are a danger to self or others are generally placed in restrictive settings, due process requires that ORR, not the child, bear the burden of proof by clear and convincing evidence that a child must remain detained. *See, e.g.*, *Lucas R. v. Becerra*, Case No. 18-5741, 2022 WL 2177454, at *20 (C.D. Cal. Mar. 11, 2022).

The Final Rule must place on the government the burden of establishing, by clear and convincing evidence, that a child is a danger to the community.

3. *The Final Rule Must Clearly State that a Child has a Right to Review Evidence in Advance of a Hearing*

As mentioned above, Paragraph 24(A) of the FSA has been interpreted by the Ninth Circuit to include the right to examine and rebut the government's evidence. *Flores v. Rosen*, 984 F.3d at 734. However, the Proposed Rule does not require ORR to provide the child with the right to examine evidence in advance of the bond hearing. Rather, Proposed Rule Section 410.1903(c) states that "[t]he unaccompanied child may present oral and written evidence to the hearing officer and may appear by video or teleconference," and that "ORR may also present evidence at the hearing, whether in writing, or by appearing in person or by video or teleconference." This leaves unaccompanied children in the untenable position of being required to prove a negative, without the opportunity to adequately prepare a rebuttal of the government's evidence.

For consistency with the Ninth Circuit's interpretation of Paragraph 24(A) of the FSA, the Final Rule must include unambiguous language stating that a child has a right to review ORR's evidence within a reasonable time in advance of a hearing. Alternatively, the Final Rule could specify that ORR's evidence at the bond hearing will be limited to the evidence provided to the child as part of their Notice of Placement.

4. *Proposed Rule Section 410.1903(f) Undermines the FSA's Policy Favoring Release by Failing to Establish Recurring Risk Determination Hearings for Children Detained for Long Periods of Time*

Paragraph 14 of the FSA clearly states that there is a general policy favoring release. Given this policy, children should have the right to recurring bond hearings if they remain detained for long periods of time. Proposed Rule Section 410.1903(f) undermines this policy by allowing an unaccompanied child who was determined to pose a danger to the community if released to seek another hearing *only if* the child can demonstrate "a material change in circumstances." Such a narrow basis for requesting another hearing permits long-term detention of children in violation of the FSA's stated policy favoring release.

Moreover, the Proposed Rule provides that "[s]imilarly, ORR may request the hearing officer to make a new determination under this section if at least one month has passed since the original decision, and/or ORR can show that a material change in circumstances means the unaccompanied child should no longer be released due to presenting a danger to the community." Proposed Rule § 410.1903(f). There is no justification for permitting ORR to request reconsideration of a child's danger to the community every month while barring the child from requesting reconsideration absent a material change in circumstances, especially in light of the FSA's policy favoring release.

The Final Rule should establish a right to recurring bond hearings for children detained long-term. At the very least, the Final Rule should permit unaccompanied children to request another hearing on the same bases that ORR is permitted to request a new determination: if at least one month has passed since the original decision, and/or a showing of a material change in circumstances.

H. The Final Rule Must Clarify Provisions Relating to Children with Individualized Needs

Paragraph 7 of the FSA defines the term "special needs minor" and provides that the government "shall assess minors to determine if they have special needs and, if so, shall place such minors, whenever possible, in licensed programs in which the INS places children without special needs, but which provide services and treatment for such special needs."

The Preamble (p. 68,915-16, 68,920-21, 68,925) to the Proposed Rule notes that ORR is considering not defining and not using the term "special needs unaccompanied child" and instead referring to children's individualized needs. *Flores* counsel agrees that the language of "special needs" has become stigmatized and further agrees that omitting the defined term "special needs unaccompanied child" from the Final Rule will not materially affect children's rights under the FSA.

The Proposed Rule, however, does not fully implement the protections of Paragraph 7 of the FSA. Specifically, FSA Paragraph 7 requires that children with individualized needs be placed in integrated placements "which provide services and treatment for such [individualized] needs." Proposed Rule Section 410.1106 does not include this language and instead refers to reasonable modifications for children with disabilities. As recognized in the Preamble (p. 68,925), these terms are not synonymous and not every child with individualized needs is a child with a disability. For consistency with the FSA, the Final Rule should separately address children with individualized needs and children with disabilities.

I. The FSA Does Not Require Consideration of Immigration Enforcement Factors in Determining Runaway Risk and Neither Should the Final Rule

Paragraph 22 of the FSA defines "escape-risk" as "a serious risk that the minor will attempt to escape from custody" and lists factors to consider when making this determination. Proposed Rule Section 410.1001 defines "runaway risk" as a situation where it is "highly probable or reasonably certain that an unaccompanied child will attempt to abscond from ORR care. Such determinations must be made in view of a totality of the circumstances and should not be based solely on a past attempt to run away." Proposed Rule Section 410.1107 lists factors to consider when determining whether an unaccompanied child is a runaway risk but omits the FSA's reference to voluntary departure based on ORR's experience that "this factor has not been relevant in determining whether the child is a runaway risk." *See* Preamble (p. 68,926).

Flores counsel agrees that the updated language in Proposed Rule Section 410.1001's definition of "runaway risk" is consistent with the FSA and supports the Proposed Rule's clarification that this determination must consider the totality of the circumstances.

Additionally, the "factors to consider" listed in Paragraph 22 of the FSA are merely aides to assess the likelihood that a child will attempt to abscond from ORR custody and are not determinative. If a factor is not useful in predicting whether it is

highly probable or reasonably certain that a child will attempt to abscond from ORR custody, there is no need to include it in the Final Rule. For this reason, *Flores* counsel supports the Proposed Rule's omission of voluntary departure as a risk factor.

Other immigration enforcement-related factors in Proposed Rule Section 410.1107 should similarly be removed from the Final Rule. Factors such as a prior breach of bond, a prior failure to appear before DHS or the immigration court, indebtedness to a smuggler, and a prior removal from the United States are generally outside the control of children and are not predictive of their likelihood of absconding. These considerations are unnecessary as they reflect the immigration enforcement role of the former INS and are not appropriate to ORR's distinct role as a custodian of unaccompanied children.

J. The Proposed Rule Uses Present Tense Language that is Likely to Create Confusion as to its Mandatory Nature

The Proposed Rule alternates—sometimes within the same section—between outlining what ORR *shall* do and stating what ORR *does* in the present tense. *Compare* Proposed Rule § 410.1003(a) ("Within all placements, unaccompanied children *shall* be treated with dignity, respect, and special concern for their particular vulnerability.") (emphasis added), *with* Proposed Rule § 410.1003(f) ("In making placement determinations, ORR *places* each unaccompanied child in the least restrictive setting that is in the best interests of the child, giving consideration to the child's danger to self, danger to others, and runaway risk") (emphasis added), *and* Proposed Rule § 410.1104 ("ORR *places* all unaccompanied children in standard programs that are not restrictive placements, except in the following circumstances . . .") (emphasis added). The Proposed Rule's selective use of present tense language is likely to create confusion among regulated parties, children, and other stakeholders as to whether these provisions are in fact mandatory.

For clarity and consistency with the mandatory obligations of the FSA, the Final Rule should consistently use "shall" rather than the present tense.

EXHIBIT 8

DECLARATION OF JENNIFER VANEGAS, JD

I, Jennifer Vanegas, declare as follows:

1. I am a resident of the State of Michigan and I am over the age of 18. I am an attorney licensed to practice in the State of Michigan.

2. I execute this declaration based on my personal knowledge, except as to those matters based on information and belief, which I believe to be true. If called to testify in this case, I would testify competently about the following facts.

Experience Serving Youth in ORR Custody

3. The Michigan Immigrant Rights Center ("MIRC"), founded in 2009, is a legal resource center for immigrants and immigration advocates across Michigan. MIRC's work includes direct representation, pro bono referrals, impact litigation, training, coalition building, advocacy, technical support and more. MIRC is part of Michigan Statewide Advocacy Services ("MSAS"), a non-profit law firm whose administrative services are provided by the Michigan Advocacy Program ("MAP").

4. Since 2017, MIRC, through a contract with the Vera Institute for Justice ("Vera"), has served every unaccompanied child in the legal custody of the Office of Refugee Resettlement ("ORR") placed with ORR sub-contractors in Michigan.

5. Since April 1, 2019, I have been an attorney at Michigan Immigrant Rights Center ("MIRC") working with unaccompanied immigrant children. Since June 1, 2021, I have been a Supervising Attorney on MIRC's Unaccompanied Children's Team, responsible for overseeing the portion of our work involving children in short term custody at ORR facilities in Michigan. This includes foster care, shelter, group home, and emergency intake site placements with Bethany Christian Services ("BCS"), Samaritas (formerly Lutheran Social Services), and an Emergency Intake Site managed by PAE.

6. As the primary legal service provider for immigrant children in ORR custody in Michigan, MIRC's attorneys and staff maintain regular contact with the youth at the facilities. MIRC meets with all children detained at ORR facilities in Michigan, providing group presentations about the rights of detained children and individualized legal screenings. We provide direct legal representation to youth ORR places into long-term custody in Michigan, as well as youth in short-term custody who have no identified sponsor, are considering voluntary departure or are particularly vulnerable and in need of representation. Over the last year, MIRC has served over 1200 youth in ORR custody.

Inappropriate and Prolonged Hotel Detention

7. I represent E-, a 17-year old child who has been held in ORR custody since at least July 15, 2019. During his time in ORR custody, E- has been transferred between ORR contract facilities and out of network placements at least ten times. E- was placed at the BCS Residential Therapeutic Shelter in Michigan between September 2021 and March 22, 2022.

8. E- was transferred to BCFS Staff Secure in San Antonio, Texas on March 22, 2022. On April 9, 2022, BCFS staff called police to the facility following an incident in which E-was accused of pushing a staff member. Police transported E-to Bexar County Juvenile Detention facility, and he was discharged from ORR custody. I was not informed why E- was discharged from ORR custody.

9. E- was turned over to ICE officials on April 11 or 12, 2022. On April 12, 2022, ICE transported E-to a hotel in San Antonio and placed him in a hotel room under the watch of private security contractors employed by G4S and MVM, Inc. From April 12-18, 2022, E-was held in a hotel room in San Antonio, Texas under the guard of private contractors employed by G4S and MVM, Inc. During that time, E- was not permitted to leave the hotel room, and was not offered educational or mental health services, recreation beyond a television, or any access to the outdoors.

1 10. On the evening of April 12, 2022, E-'s attorney at the Michigan Immigrant Rights
2 Center spoke with E- by phone. During that conversation, E-reported that the private
3 security contractors had, that evening, verbally insulted him, physically assaulted him,
4 and applied physical restraints to his arms and legs. E- explained that the private security
5 contractors had made anti-immigrant comments to him, saying things like, "Why are you
6 here? You don't belong. You should just go back home," and calling him offensive
7 names. E- also reported them saying "there are no cameras here, who is going to believe
8 you?" E- became upset and responded by throwing a container of juice. In response, the
9 security contractors grabbed E- and tackled him onto the bed, putting their body weight
10 on him, with one putting his elbow between E-'s legs. In E-'s words, it felt "as though
11 they were raping [him]." While the security contractors were physically restraining E-,
12 they compressed his chest. E-was also forced to put a mask on as he was being pushed
13 into the mattress, and he told them that he "couldn't breathe." The security contractors
14 then applied restraints to E-'s wrists and ankles. They left E- restrained in this manner for
15 approximately an hour, and he was then handcuffed at either the ankles or wrists for
16 another hour or two. E- explained that after the incident, a female supervisor came to his
17 hotel room and he explained to her what happened. To my knowledge, the only action
18 taken after E- complained to staff was that he was taken out of restraints. He remained
19 under MVM custody and was placed in restraints several more times by security
20 contractors during the hotel stay.
21 11. Throughout his custody with MVM, E- was deprived of confidential conversations
22 with counsel. I spent countless hours trying to contact anyone whom I could identify as
23 potentially having the ability to help him and it still took several days to challenge his
24 treatment while being held by ICE/MVM.
25 12. Only after extensive advocacy from MIRC and the Young Center, E- was re-
26 admitted to ORR custody and sent to an out-of-network care provider, Devereaux
27 Advanced Behavioral Health in Orlando, Florida in late April. There, E- has faced
28 significant language barriers and a delay in receiving personal belonging such as

eyeglasses. At present, E- continues to be marginalized at Devereaux because he lacks meaningful language access and also lacks consistent or confidential access to counsel.

13. In my view, the manner in which E- behaved was wholly consistent with his known trauma history as well as mental health challenges that are well documented in his ORR file. The aggressive treatment that he experienced while in MVM custody just created a new sense of trauma, fear, and isolation. I noted an increased sense of desperation and hopelessness in E- following this experience.

14. I cannot overstate the amount of added, long-term trauma that the confusion, poor communication, and punitive responses to E- have caused him. To be sure, E-'s history of trauma impacts his experience in ORR custody, but the continued response of keeping him in increasingly restrictive conditions with little hope of improving the situation or feeling better understood has compounded the existing trauma and created new devastation in his young life.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this 19 day of July, 2022, at Kalamazoo, Michigan.

Jennifer Vanegas, JD
Supervising Attorney,
Michigan Immigrant Rights Center

EXHIBIT 9

DECLARATION OF M. VANEZA ALVARADO

I, M. Vaneza Alvarado, declare as follows:

1. I am a resident of the State of Colorado, and I am over the age of 18. I am an attorney licensed to practice in the States of Texas and Colorado.

2. I execute this declaration based on my personal knowledge, except as to those matters based on information and belief, which I believe to be true. If called to testify in this case, I would testify competently about the following facts.

Experience Serving Youth in ORR Custody

3. The Refugee and Immigrant Center for Education and Legal Services (RAICES), is a legal service provider that works primarily with immigrant youth. Since about April of 2020, I have served as Lead Staff Attorney for RAICES representing unaccompanied immigrant youth at the BCFS Staff Secure facility in San Antonio, TX.

4. As of 2018, RAICES is the largest legal aid group of its kind in Texas. RAICES has served unaccompanied children in the legal custody of the Office of Refugee Resettlement ("ORR") who have been placed by ORR at BCFS Staff Secure and other programs within the ORR network of care providers. As of June 2022, RAICES currently serves approximately 442 youth in ORR custody.

5. As a legal service provider for ORR shelters, RAICES's attorneys and staff maintain regular contact with the youth at the facilities. We provide ongoing consultations and presentations concerning the legal rights of detained minors. We also provide direct legal representation to youth.

Discharges from ORR Custody and ICE Hotel Detention

6. In my experience representing children at BCFS Staff Secure, it is common practice for BCFS staff to summon local law enforcement if a minor causes any property damage. When the child is arrested, they are subsequently discharged from ORR custody. Although RAICES is the legal service provider for this facility, I have not been informed why children are discharged from ORR custody upon arrest.

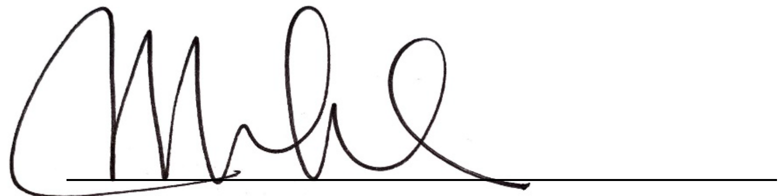
7. In one recent case, my client 16-year-old G.M.G., had an upsetting phone call with his abusive mother who was still living in his home country. The shelter disclosed to the mother the child had been transferred to an out-of-network (OON) facility for mental health treatment. The minor's mother understood the minor was sent to a home for "crazy people". Upon returning to Staff Secure after his treatment in the OON facility, G.M.G had an upsetting phone call with his mother, the minor stated on several occasions he did not want to discuss why he was upset and requested a meeting be done later. The shelter staff insisted that they discuss what was bothering him, and did not respect the minor's wishes, which then provoked the minor to throw a chair at a window. Local law enforcement was summoned, and the minor was arrested. The minor was placed in adult detention. After many failed attempts to advocate on his behalf, I finally was able to

1 make the appropriate authority understand, the minor was in fact only 16 years old and
2 therefore, unlawfully being held with the adult population. Subsequently, ORR refused to
3 take the minor back into custody when he was released from jail and handed over to ICE.
4 8. G.M.G. was held by ICE in various hotels for approximately 20 days before I was
5 able to advocate that he be transferred back into ORR custody. I was allowed two phone
6 calls with my client while he was being held in ICE custody and at a local hotel in San
7 Antonio, TX. My client told me directly that he was not allowed to leave the hotel room
8 for any recreation activity or just to breath some fresh air. I requested that I be allowed to
9 provide my client with art supplies or swimming trunks, and that request was denied.
10 Despite my efforts to advocate for him, I was not allowed to be involved with which
11 secured facility he would be transferred into. I made a plea that he be placed back into
12 San Antonio Staff Secure so that I could continue legal services. He subsequently was
13 transferred to Children's Village Staff Secure and out of RAICES's area of service.
14 9. A second 16-year-old at BCFS Staff Secure, E.A.M.F., had been in ORR custody
15 since July 15, 2019. Since entering ORR custody, E.A.M.F. had been transferred to
16 various facilities around the country. He was placed in San Antonio Staff Secure in
17 March of 2022, making this his ninth placement in just over two years. On April 9, 2022,
18 E.A.M.F. was arrested and discharged from ORR custody. He was later turned over to
19 ICE officials and detained in a hotel room from April 12, 2022, through April 18, 2022,
20 After many efforts to locate the minor, I was able to finally obtain a phone number to
21 reach him. I worked closely with E.A.M.F.'s attorney at the Michigan Immigrant Rights
22

Center, with whom he had built a rapport and trusting relationship. I was extremely concerned about E.A.M.F. because he reported to his attorney that the ICE contractors placed him in restraints and subjected him to verbal abuse and physical assaults. Eight days of this treatment and confinement to a hotel room is not acceptable for a boy already previously diagnosed with various mental health disorders.

10. E.A.M.F.'s arrest was the sixth arrest this year from Staff Secure and the twelfth arrest since about March of 2021. I would estimate that the Staff Secure averages about nine clients a month.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this 24 day of June 2022, at San Antonio, TX.



M. Vaneza Alvarado