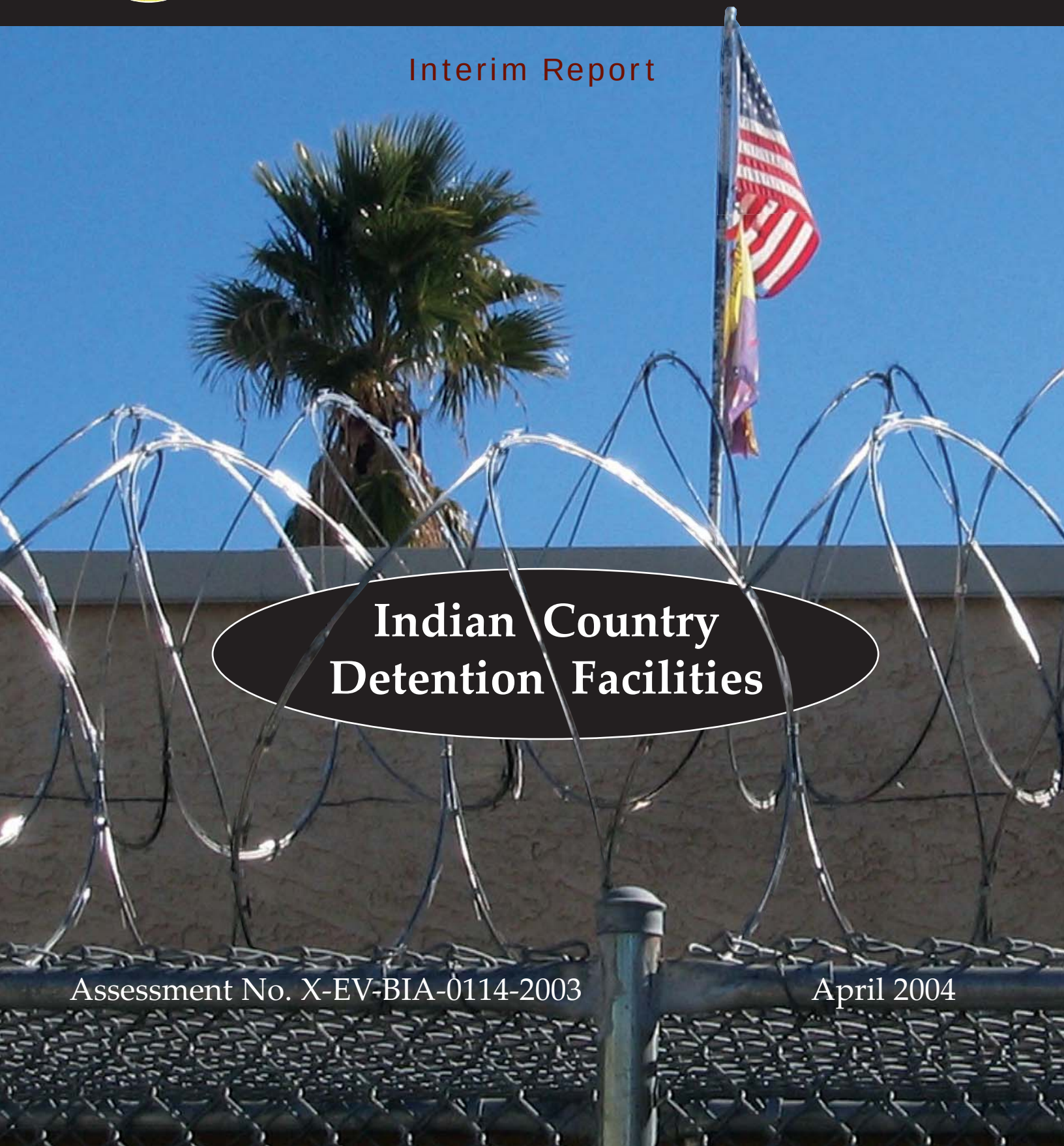
U.S. Department of the Interior

Office of Inspector General

Interim Report



Indian Country Detention Facilities

Assessment No. X-EV-BIA-0114-2003

April 2004

Introduction

In September 2003, we began an assessment of Indian Country detention facilities. Our focus is on whether the funds designated for Indian Country detention facilities were properly expended and whether these facilities are safe and secure. Although this review is scheduled for completion at the end of the summer of 2004, we are compelled to issue an interim report on preliminary findings that are of great concern to us. This is not intended to be a progress report of our review of detention facilities; rather, it is intended to inform the Department of the deplorable conditions existing at some of the facilities that may lead to life-threatening situations. This interim report discusses deaths, suicides, attempted suicides, and escapes of inmates, as well as officer safety issues, at some of the facilities we visited. In fact, we found over 30 deaths, suicides, attempted suicides, and prisoner escapes that were either undocumented or not reported to the Bureau of Indian Affairs' (BIA) Office of Law Enforcement Services (OLES) detention program. We believe it is imperative that BIA takes immediate action to alleviate potentially life-threatening situations at its detention facilities.

Background

Under the Indian Law Enforcement Reform Act of 1990 (Public Law 101-379), BIA is required to provide law enforcement services on reservations. In addition, under the Indian Self-Determination Act (Public Law 96-638), BIA provides funding to tribes for detention services. There are 74 detention facilities in Indian Country; 19 are operated by BIA's OLES, 46 receive BIA funding for detention services under Public Law 96-638, and 9 are operated by tribes. Of the 74 facilities, 28 house adult inmates, 11 house juveniles, and 35 house a combination of both adults and juveniles. Thus far, we have visited 14 detention facilities: 5 were BIA-operated and 8 were contract facilities (hereafter referred to as 638-contract facilities). The facilities we have visited to date are primarily located in the southwestern region of the United States.

For many years the BIA detention program has been characterized as drastically understaffed, under-funded, and poorly managed. BIA's director of law enforcement has oversight authority for BIA-operated and 638-contract detention facilities. The director oversees these facilities through six district commanders. In addition, a program detention manager is assigned to the director's personal staff along with two detention specialists. However, the detention program manager has neither line authority nor direct responsibility for the detention facilities.

In most facilities, basic jail administration procedures are not followed and many detention managers and their staff have not received professional, certified training in detention procedures. In fact, BIA OLES officials admitted that none of their detention facilities "come close" to meeting BIA's standards for operation, which derive from nationally recognized detention standards. BIA's detention program is riddled with problems and continues to be a national disgrace with many facilities having conditions comparable to those found in third-world countries. Unfortunately, BIA appears to have a "laissez-faire" attitude in regard to these horrific conditions at its detention facilities.

Based on our visits, we are concerned that serious incidents are not always communicated up the chain of command. Specifically, our review of the serious incident log kept by OLES' detention program and a similar log kept by BIA Internal Affairs revealed that many of the incidents we identified were not on these logs.

While we have only visited 14 facilities, our anxiety is heightened by what we have found and in anticipation of incidents that we have yet to discover. We can only assume that similar incidents have occurred at other detention facilities. The following section chronicles a few examples of the life-threatening situations we have identified to date.

Interim Findings

Our interim findings are based on our 14 site visits, dozens of interviews, and review of hundreds of documents obtained from BIA's OLES and at individual detention facilities.

Deaths and Suicides

We found that six deaths have occurred at six of the facilities visited. This number includes the recent death of Cindy Gilbert, the 16-year old student who died while in a detention cell at the Chemawa Indian School in Oregon. BIA operates the Boarding School and its detention facility[1], which was included on the "Inventory of Indian Country Detention Facilities--2003" document that we received from OLES.

In March 2003, a 15-year-old female inmate hanged herself at the BIA-operated Zuni Adult and Juvenile Detention Facility in New Mexico. According to the facility director, correctional officers at the time were "off-line for approximately 30 minutes," handling other duties, and were not properly overseeing the cell population. BIA Internal Affairs did investigate this incident.

In December 2003, at the BIA-operated Haulapai Detention Center in Arizona, an inmate who was arrested for public intoxication was found hanging in an apparent suicide attempt in his jail cell. Although the inmate was resuscitated, he died 6 days later in the hospital. A preliminary investigation determined that the inmate had been transferred from the intoxication cell to a single cell where the attempted suicide occurred. BIA and the Federal Bureau of Investigation are still investigating this incident.

Since 2001, one suicide has occurred at the Shiprock Adult Detention Center, a 638-contract facility, in Shiprock, New Mexico. An inmate was placed in the isolation cell and left unobserved for 2 hours, during which time the inmate hanged himself. According to the facility director, there are no written procedures for handling inmate deaths.

[1] The school's detention facility has four cells that are used to temporarily detain unruly or intoxicated students.

A similar incident occurred in December 2003 at the San Carlos 638-contract facility, when an inebriated inmate was placed in the intoxication cell and died of asphyxiation.

Similarly, at the BIA-operated Hopi Adult and Juvenile Facility in Arizona, an intoxicated inmate died of asphyxiation in 2003. According to the Acting Lead Correctional Officer, this occurred because the two officers on duty were "more interested in cleaning up the office" than observing inmates.

Attempted Suicides

Thus far, it appears that suicide attempts are a regular occurrence at most of these facilities. Often, these suicide attempts are made repeatedly by a single individual. A review of the incident log at the BIA-operated Mescalero Detention Facility, from July 2002 to January 2004, showed 5 of the 15 incidents reviewed involved the same detainee who, on different occasions, attempted to inflict bodily harm on herself. According to the detention officer, the inmate was usually arrested for public intoxication and, after arriving at the detention center, would attempt to slash her wrists or hang herself with articles of her clothing.

During 2001, an individual detained at the Shiprock facility attempted to hang himself seven times using articles of clothing or towels left in the cell. According to the facility director, the officer's response was quite elementary—if the inmate tries to hang himself with his socks, take his socks away; if he tries to hang himself with his towel, take the towel away—until the inmate remained in his cell without any clothing.

Equally disturbing, aside from the actual suicide attempts, is the lack of procedures for both handling and documenting these events. At Tohono O'odham in Arizona, a 638-contract facility, the corrections administrator seemed uncertain of the exact number of suicide attempts, though he stated it was probably around five or six. Likewise, at the BIA-operated Hualapai facility in Arizona, the chief of police, who is also in charge of the detention center, could not state the exact number of suicide attempts, but admitted that there had been "a few instances where inmates tie articles [of clothing] around their necks." In addition, at the Hopi facility, the Acting Lead Correctional Officer admitted there had been several attempts, though she did not know the exact number.

Prisoner Escapes

For the most part, the correctional officers at these facilities convey stories of prisoner escapes with an air of casual inevitability. In fact, our impression is one of collective acceptance. In our interviews, correctional officers who discussed escapes also told us that it is just not possible to prevent inmates from escaping. Since the majority of these facilities function with only a single officer on duty, officers explained that they simply cannot "keep an eye" on everyone. In addition, we found that some facilities do not notify local law enforcement of prisoner escapes. This is not only disconcerting, it is irresponsible to allow escaped prisoners to freely travel in a community and surrounding

areas while the local law enforcement authorities have no information regarding their escapes.

Physically rundown and deplorably maintained, many of the facilities provide ample opportunity for escape. At one facility, the chain-link fence surrounding the outdoor recreation yard was held together and locked by a set of handcuffs because the inmates had learned the combination to the cipher lock on the gate. While many of the recreation yards at these facilities are fenced-in and crowned with barbed wire, there seems to be a universal acceptance among the correctional officers that if an inmate wants to climb over the fence and escape, they will. For example, at the BIA-operated Mescalero facility in New Mexico, the male prisoners were allowed to exercise in an outside confinement area unobserved. This area is surrounded by a 12-foot cyclone fence with two additional feet of concertina barbed wire at the top. One prisoner, who later stated that he wanted to see his girlfriend, merely climbed up the cyclone fence, cutting himself on the concertina wire, and left the premises. The detention officer who was alone on duty was inside the facility at the time. The prisoner was captured 4 days later and returned to the jail.

During a visit to the BIA-operated Blackfeet Adult Detention Center in Montana, the district commander, upon arriving at the facility, told our investigators that he had personally seen prisoners, unsupervised, milling about outside the front of the facility. However, the district commander did not seem concerned about this and did nothing to rectify the situation. At this same facility, in April 2002, a trustee[2] escaped and committed a murder before he was apprehended.

From weakened and deteriorating locks on cell doors to broken windows in inmate dormitories, the interior of many of these facilities is in extremely poor condition and therefore does not deter prisoners who set out to escape. For example, the wire-meshed windows in many of the cells at the White Buffalo Youth Detention Center are loosely encased in a crumbling wall and, with the application of some pressure, can be easily removed from their housing. According to the Acting Director at the detention center, these “removable windows” have, in the past, provided a vehicle of escape for a number of detained youths. As recently as February 2004, three male inmates escaped through one of the windows in the day room of the male dormitory, after obtaining two fire extinguishers and using them to spray the two on-duty correctional officers. Two of the three youths were apprehended immediately afterward; the third eventually returned on his own volition.

Perhaps even more disturbing than the actual circumstances and frequency of inmate escapes at these facilities are the lack of response and importance placed on these incidents by those working at the facilities, both correctional officers and facility directors alike. At one detention facility, the director recounted an incident of a juvenile escaping and concluded by stating that they “haven’t seen him since.” At another facility, one prisoner managed to escape through the vehicle entrance. Two more prisoners managed to escape from the courthouse, on two separate occasions. In one of

[2] A trustee is an inmate who is provided special privileges and responsibilities.

these instances, the correctional officers pursued the fleeing inmate up the side of a vast, rocky precipice above the highway in order to apprehend him. At a third detention facility, the director simply attributed several prior escapes to poor perimeter security.

We visited the Shiprock Adult Detention Center in January 2004. During interviews with the correctional officers, one officer, after being asked about any escapes from the facility, chuckled and said, "Oh yeah, they happen." She then stated that a prisoner had escaped from her in June 2003. She explained that the prisoner had escaped on foot and in ankle-shackles while she was ushering a line of prisoners from the facility to the courthouse across the courtyard. Since she was the only officer on duty at the time, she said that she could not pursue the fleeing inmate and leave the other prisoners unattended. The officer told us that to the best of her knowledge that prisoner had not yet been apprehended.

Officer Safety

One of the most common problems found while visiting these facilities has been a lack of staffing. In many cases, having only one correctional officer on duty per shift is not unusual; it is, in fact, common practice at some of the facilities. Clearly, this is undesirable. An officer working alone, under any circumstances, is at risk.

At Mescalero, a female correctional officer was working alone when she was confronted at knife-point by a former inmate who entered the facility through an unlocked door. Tragedy was averted when the officer locked herself into a detention cell while another prisoner convinced the intruder to leave the officer alone. A second inmate then summoned the police.

The San Carlos facility in Arizona has only four correctional officers on staff to operate what they feel is an overcrowded facility. To address this situation, the facility has placed a 24-hour "lockdown" on inmates. Although a 24-hour, 7-day a week, lockdown may be a short-term solution, it could lead to an unsafe and dangerous environment long-term. At San Carlos, a detention officer on duty has no one for back up if a medical emergency or conduct problem arises. When an officer is working alone, he or she must either wait for assistance or act independently, both of which risk placing themselves or inmates in a potentially life-threatening situation.

At the Blackfeet facility in Montana, staff told us there is "never" more than one correctional officer on duty. Furthermore, twice a week, the officer on duty also functions as the facility cook to prepare inmates' meals, leaving the facility unsupervised during meal preparation time. At this same facility, one of the dispatchers said that her husband, a correctional officer at the facility, had been working alone and was attacked by an inmate. According to the dispatcher, the sound of the other inmates banging on doors was the only thing that alerted her to the incident and prevented a potential fatality. Unfortunately, this incident does not appear to be an exceptional case; the BIA district commander told us, "Every officer here has been assaulted."

Aside from a lack of officers on staff, the current officers at these facilities are, for the most part, poorly trained. This lack of training not only hinders the officers' ability to properly document incidents and follow standard procedures, but also leaves the officers unprepared to prevent physical harm that may be targeted against them or against inmates. In fact, one district commander stated, "We've never received any training on how to operate a detention facility." When asked if his facility followed BIA standards, the commander quipped, "Most BIA standards can't be met, so why even try?"

During our visit to the Shiprock facility, we learned that a correctional officer who was hired in 1999 has not yet attended BIA detention officer training at the Artesia Training Academy in New Mexico. According to BIA requirements, correctional officers must attend this training within their first year of employment in order to become certified. At the Tohatchi facility in New Mexico, we were told that it takes about 2 to 3 years for an officer to receive training at Artesia. Currently, four employees have not been certified because they have not had their background investigations completed. One of those officers has been working at the facility for 3 years. At the Hopi facility, there was only one officer on duty during our visit. This officer, who was named Acting Lead Correctional Officer, had been at the facility for 3 years and so far has not attended the Artesia training academy. Finally, at the Hualapai facility in Arizona, one officer stated that she had been a correctional officer at the facility for 12 years, and had only recently received her certification in October 2003.

In addition to officer safety, the safety of the inmates themselves must be considered. Officers who are improperly trained or who have not undergone thorough background investigations may become a liability. Recently, a correctional officer working at the White Buffalo Youth Detention Center was convicted of raping a 17-year-old female inmate while transporting her from the facility to receive medical treatment.

Recommendations

While this assessment is still underway, we believe these findings are significant enough to be addressed immediately. By doing so, BIA may be able to prevent further incidents like those chronicled here. If BIA fails to implement our recommendations, we believe other life-threatening incidents will be inevitable.

We recommend that:

1. BIA immediately develops and implements clear reporting protocols for serious incidents occurring at all BIA and 638-contract detention facilities. At a minimum, all inmate deaths, suicides, attempted suicides, escapes and officer safety issues should be reported promptly up an established chain of command ending with the Director of Bureau of Indian Affairs.

2. Any escape from custody should be immediately reported by the detention facility to appropriate local or state law enforcement authorities.

3. BIA OLES should immediately respond and conduct a preliminary inquiry to determine if a full investigation is warranted on any serious incident reported. Their findings, in every case, should then be reported to DOI OLES with a copy provided to the Director of Bureau of Indian Affairs.

4. Detention staffing shortages related to officer safety should be identified by BIA and corrected immediately.

While we have every expectation of finding additional serious incidents, our final report will also provide the Department with recommendations regarding funding, detention standards and policies, detention facility maintenance, health care and social services at the detention facilities, and training and hiring practices of detention personnel.

Reports of Serious Incidents

Indian Country Detention Facilities

		Blackfeet (BIA)	Chemawa [1] (BIA)	Gila River (638)	Haulapai (BIA)	Hopi (BIA)	Mescalero (BIA)	San Carlos (638)	Shiprock (638)	Ute Mountain Ute (BIA)	Tohatchi (638)	Tohono O'odham (638)	Salt River (638)	White Buffalo (638)	Zuni (638)	Totals
Deaths	*Non-Suicide*	0	**1** [2]	0	0	**1** [3]	0	0	0	0	0	0	0	0	0	2
	Suicide	0	0	0	**1**	0	0	**1**	**1**	0	0	0	0	0	**1**	4
Suicide Attempts		**1**	0	0	**2**	**--** [5]	**5**	**4**	**7**	0	**3**	**6**	0	**2**	0	30
Escapes		**3** [4]	0	0	**1**	**1**	**1**	**--** [5]	**2**	0	0	**1**	0	**3**	0	12
Totals		4	1	0	4	2	6	5	10	0	3	7	0	5	1	**48**

NOT Reported to BIA OLES Detention Program Manager. (60%)
Reported to BIA OLES Detention Program Manager. (40%)
No Incidents Discovered.

- Reported incidents occurred within the last 3 years.
- Information was collected from BIA OLES Detention staff and from site visits to facilities.

[1] Chemawa Indian Boarding School has detention cells and reported by BIA as a Detention Facility.
[2] Death attributed to alcohol poisoning.
[3] Death attributed to asphyxiation.
[4] BIA Detention Program aware of only 1 of 3 escapes.
[5] Facility could not provide exact amount, but stated "several escapes."

Attachment 1

Issues Relevant to Escapes and Officer Safety

Handcuffs are used because inmates know the combination.

Wire-meshed windows in a crumbling wall.

Door handle falls off when used.

Unable to see into cells due to scratched Plexiglas.

Gates left open during inmate transfer.

Camera for high-risk inmates in isolation cell faces ceiling.

Overcrowded female cell.

Female inmates sleep on floors due to lack of bed space.