"NEITHER SAFE NOR SECURE"

An Assessment of Indian Detention Facilities

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Introduction

The Bureau of Indian Affairs (BIA) operates or funds detention facilities throughout Indian Country. For many years and in multiple forums, the BIA and the Department of Justice (DOJ) have found these facilities to be understaffed, overcrowded, and underfunded. During the course of other work conducted by the Office of Inspector General (OIG), we received numerous anecdotal reports that reaffirmed these findings – years later. Therefore, as part of the ongoing effort of the OIG to examine law enforcement and security programs within the Department of the Interior (DOI or the Department), BIA's detention program was selected for assessment in 2003.

The OIG, Program Integrity Division, began the assessment of Indian Country detention facilities in September 2003. The focus of our assessment was to determine if Indian Country detention facilities were safe and secure, and if BIA appropriately used the funds it received to operate the detention program. We conducted actual site visits at 27 detention facilities (also referred to as jails), scrutinized hundreds of detention and budget records, and conducted more than 150 interviews with BIA and tribal officials, as well as local and federal detention professionals throughout the United States. We conducted our assessment in accordance with the President's Council on Integrity and Efficiency Quality Standards for Inspections. Accordingly, we included such tests or reviews of records that we considered necessary.

We shared our observations with detention facility personnel during each visit. In addition, we provided regular updates to BIA Law Enforcement Services (BIA-LES) and Department management during the course of the assessment.

Early in our assessment, it became abundantly clear that some facilities we visited were egregiously unsafe, unsanitary, and a hazard to both inmates and staff alike. BIA's detention program is riddled with problems and, in our opinion, is a national disgrace with many facilities having conditions comparable to those found in third-world countries. In short, our assessment found evidence of a continuing crisis of inaction, indifference, and mismanagement throughout the BIA detention program. BIA

appears to have had a laissez-faire attitude about these horrific conditions at its detention facilities. Because many of the conditions were potentially life–threatening, the Inspector General issued an Interim Report to the Secretary in April 2004 describing our most significant findings, and to provide an opportunity for her to take immediate and appropriate action.

This report represents the general status of the detention program and facilities as we found them during our assessment. While recognizing some very recent attempts by the Department and BIA to correct deficiencies, we believe that anything short of strong leadership, rapt attention of senior management, and heroic efforts on the part of BIA personnel will fail to correct the deplorable conditions of Indian Country detention facilities.

Throughout the report, we recommend actions that we believe will improve the security, safety, and efficiency of detention facilities in Indian Country. Our anxiety over the detention program remains heightened, however, not only because of what we found during our site visits but, more importantly, because of what we fear remains undiscovered at the sites we did not visit.

Results in Brief

BIA has failed to provide safe and secure detention facilities throughout Indian Country. Our assessment revealed a long history of neglect and apathy on the part of BIA officials, which has resulted in serious safety, security, and maintenance deficiencies at the majority of the facilities. Despite audits, inspections, reports, and other warnings about the woeful conditions of the detention program, BIA has utterly failed to remedy the problems. Whether it lacks the organizational will, or infrastructure, or both, BIA cannot sustain its focus on the problems at its detention facilities long enough to resolve them. Absent relentless pressure and the unflagging support of senior BIA management, we fear it is unlikely to do so in the future.

Because we found the detention program without a credible reporting structure, or accountability, we also found that BIA was unaware of 98% of the serious incidents – including deaths and suicides – that occurred at the facilities we visited. In fact, our assessment was continuously hampered by BIA or jail officials who supplied us with incorrect, inconsistent, and often erroneous information regarding the detention program.

With very few exceptions, the detention centers we visited are operating at below minimum staffing levels. Some of the understaffing takes facilities to the point of being unsafe; none are staffed at a level that detention managers consider optimal.

The maintenance backlog at these facilities is significant. Jail administrators reported countless stories of neglect and delay on the part of BIA's Office of Facilities Management and Construction (OFMC). Our review of OFMC maintenance logs revealed numerous inaccurate, improper and erroneous entries. We found these logs to be of minimal value and were not surprised to learn that the Government Accountability Office (GAO) reached a similar conclusion when they reviewed the maintenance records in 2003.

We found that detention program funding is haphazardly managed by BIA, and once distributed to the tribes, it becomes virtually unaccounted for. BIA could produce little evidence of basic budget planning, budget execution, or

budgetary controls. Since BIA simply does not track expenditures made by tribes, our attempts to identify the total funding for the detention program proved futile. The neglect and mismanagement of detention program funding has not only exacerbated the systemic problems attendant to the detention program in Indian Country, but has also created an environment in which fraud can be perpetrated with impunity and waste can occur undetected.

Training for detention personnel is inconsistent and unpredictable. The majority of the detention officers at the sites we visited have yet to attend mandatory basic training for detention officers at the Indian Police Academy (IPA) in Artesia, NM. Many officers failed to complete the training within 1 year of being hired, as mandated in BIA policy. We even found officers who had been employed for as long as 12 years without attending the required formal certification training.

Basic jail administration procedures and standards are neither followed nor met at most facilities. Many of the management officials admitted that their detention facilities fail to even "come close" to meeting BIA standards for operation, which are derived from nationally recognized detention standards.[1] In fact, we found the majority of the jails make little or no effort to comply with even the most basic requirements.

Unfortunately, we often found that complacency and resignation were the norm — at all levels of BIA management — with no evidence of a coordinated and comprehensive strategic plan to improve and manage the detention program. Without a dramatic shift in organizational culture and professionalism, any positive change will likely be short lived and the program will remain in a dismal status quo. A comprehensive overhaul necessitates an infusion of leadership that can address issues with creativity, decisiveness, and commitment throughout all levels of the detention program.

We believe it is imperative that BIA take immediate action to alleviate potentially life-threatening situations at its detention facilities. The haphazard response to DOJ, OIG, and other

[1] BIA reported that detention standards were created using industry specific information obtained from the American Correctional Association.

reports must give way to a comprehensive and coordinated approach to address the systemic safety, security, and maintenance issues facing Indian jails. Mindful of other historical failures, however, we fear that once the attention wanes on the issues we identify here, the momentum and interest in the BIA detention program will diminish as quickly as it began. Many improvements and changes were anticipated when BIA published its detention standards in 1996 and when DOJ published its report about the Indian Country law enforcement and detention program in 1997. As this report will reiterate, once again, little has changed.

Background

Age of Indian Country Detention Facilities

- 33.0% (24) are over 30 years old
- 28.0% (20) are 20-30 years old
- 19.5% (14) are 10-20 years old
- 19.5% (14) are under 10 years old

BIA's mission is to fulfill trust responsibilities and promote self-determination on behalf of tribal governments, American Indians, and Alaska Natives. BIA provides services directly and through contracts, grants, or compacts for 1.5 million American Indians and Alaska Natives who are members of 562 federally recognized Indian tribes in the 48 contiguous United States and Alaska. The expansive scope of BIA programs covers the full range of state and local government services, including law enforcement services. BIA is required to provide law enforcement services on reservations under the Indian Law Enforcement Reform Act (ILERA) of 1990 (Public Law 101-379). BIA-LES provides direct assistance to tribes for law enforcement programs, including uniformed patrol, criminal investigations, detention, and dispatch on approximately 56 million acres of Indian Country in 35 states.

As of August 2004, the detention program consisted of 72 detention facilities[2] in Indian Country – 17 of which are operated by BIA-LES, 46 receive BIA funding for detention services under 638 contracts, and 9 are operated by tribes. Of the 72 facilities, 27 house adult inmates, 11 house juveniles, and 34 house a combination of both adults and juveniles.

Most of the older detention facilities were built as holding facilities to accommodate approximately 10-20 inmates for short-term periods (48 hours or less). On average, the newer facilities have been designed to accommodate 60 inmates, with four new facilities having more than 100 beds, along with additional rooms and areas, making the facilities more suitable for longer periods of incarceration (12 months or less). Individuals incarcerated in these facilities usually have committed misdemeanors, such as public intoxication or assault and battery.

[2] BIA-LES has been unable to provide us with an exact number of facilities under its control despite numerous requests for an accurate list. For example, the Chemawa Indian School was originally included in this total; however, it no longer is being used by BIA to detain juveniles and was subsequently removed from its inventory. Similarly, the Mescalero detention facility was closed after we began our assessment.

Individuals who have committed felonies, such as murder and burglary, are routinely incarcerated in state or federal facilities off reservations; however, there are times when felons are held in Indian jails.

The DOJ Bureau of Justice Statistics (BJS) publishes an annual report containing statistical data about Indian Country jails. These reports provide information pertaining to jail populations, crimes committed by inmates, overcrowding, jail capacity versus inmate population, and jails under court orders or consent decrees to improve conditions. These and other DOJ reports have documented overcrowding and inadequate capacity as problems in Indian Country for many years.

Bureau of Justice Statistics
Bulletin

Jails in Indian Country, 2002

Highlights

BJS 2002 report

A number of other reports have also documented such problems in Indian Country jails. As early as 1994, the OIG reported that Indian Country detention facilities were poorly maintained and mismanaged. As a result of the 1994 report, BIA contracted for individual safety and security inspections at each of the jails in 1995. The inspection reports overwhelmingly documented a systemic pattern of overcrowding and poorly maintained and managed jails.

In 1997, DOJ issued a report on Indian Country law enforcement that announced "a public safety crisis in Indian Country." In addition to identifying shortages of law enforcement officers and resources, the DOJ report also noted that "[detention] staffing levels fall far short of those required for adequate inmate supervision, thus creating a threat to welfare of the community, staff and inmates." DOJ recommended that BIA-LES be given line authority for law enforcement services, including the detention program, rather than leaving law enforcement services decentralized and under the supervision of the local BIA superintendent. BIA adopted this recommendation in 1999.

On June 3, 1998, former Assistant Secretary - Indian Affairs Kevin Gover testified before the Senate Committee on Indian Affairs on the Department's Indian Country law enforcement initiative. Gover testified about the lack of adequate detention facilities, their generally decrepit conditions, and the considerable problems in maintaining and staffing the

jails. Gover made note of the lack of juvenile facilities, which resulted in numerous occasions where juveniles were temporarily placed in adult detention facilities because there was no other place to house them.

Gover also testified about restructuring BIA law enforcement services to include detention services under the supervision of BIA-LES officials. The restructuring, which ultimately occurred in 1999, was designed to place these services under the control of law enforcement professionals to ensure that law enforcement services were directed by a central command structure, rather than by area managers with little or no law enforcement background.

During this time period, many proposed that Indian Country law enforcement should be transferred to DOJ. This proposal was revisited in 2001 during the International Association of Chiefs of Police (IACP) summit with tribal communities and their justice systems. In its report, *Improving Safety in Indian Country,* the IACP suggested streamlining the federal agencies involved with law enforcement in Indian Country to improve coordination and delivery of services.[4]

In addition to these outside reports and recommendations, internal BIA inspection reports went on to highlight detention program problems and deficiencies. In 2001, a presentation to senior BIA-LES officials identified specific issues in the jails and provided an action plan to address each problem. According to the author of the presentation, BIA-LES managers appeared disinterested and subsequently no action was taken.

After a thorough review of these previous reports and recommendations, we were disappointed, but not surprised, to find during our assessment that little implementation has taken place and the state of the detention program today is no better, and arguably worse, than what it was a decade ago.

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[4] International Association of Chiefs of Police, *Improving Safety in Indian Country: Recommendations From the IACP 2001 Summit*, Alexandria, VA, October 2001. p.11.

Chapter 1: Oversight and Coordination

Senior BIA-LES officials have acknowledged that the detention program is severely understaffed, that facilities are overcrowded, and that neither has received the attention or funding to adequately address the numerous deficiencies. Not once during our assessment did BIA-LES officials gloss over or deny the dire condition of the program or the profound and serious maintenance issues at the facilities. These officials readily admit that they have placed a higher priority on fighting crime on the reservations and focusing on the policing aspect of law enforcement services after line authority was granted to BIA-LES in 1999. They consistently contend that a lack of funding and staffing has made it impossible to address both law enforcement and detention programs simultaneously.

Despite this candid acknowledgement, these officials argue that the detention program has improved under their direct supervision and point out that BIA-LES is still in its infancy.

Since receiving its authority, we found that BIA-LES has attempted to provide oversight and management for the detention program with very limited success, using a two-pronged approach.

Administratively, the detention program has been coordinated through a Detention Program Manager working out of the BIA-LES Central Office. The manager, a criminal investigator by background, was appointed in 2000, and provided with limited training, virtually no staff, and minimal authority to accomplish his duties.

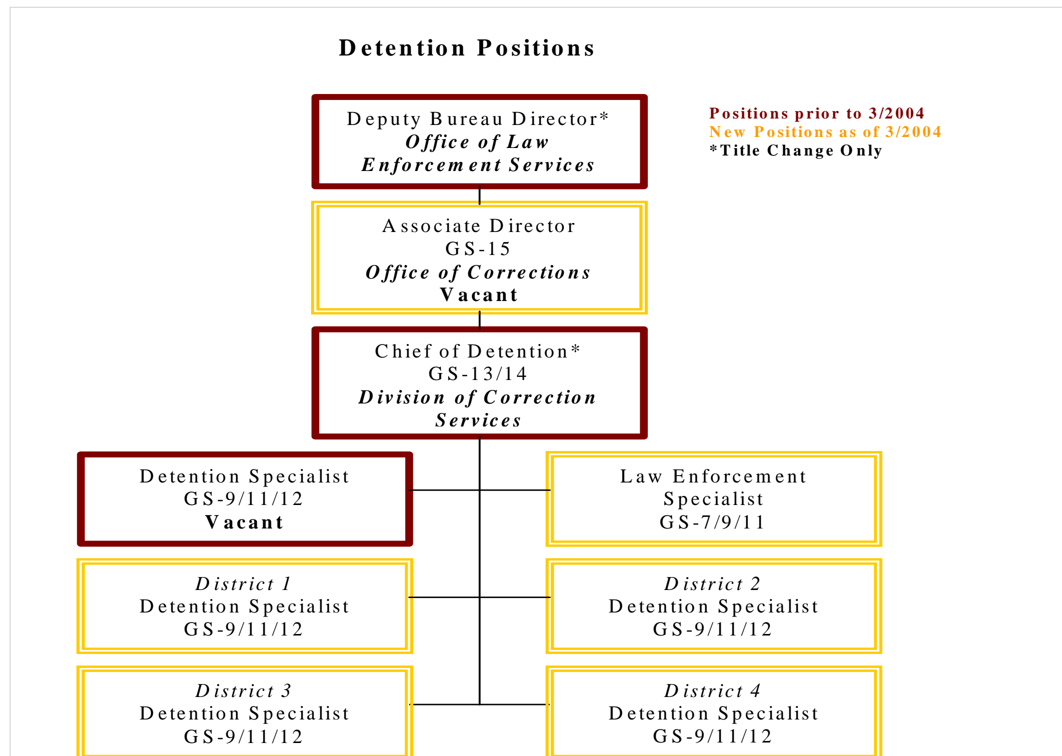
At the outset of our assessment, we discovered that the detention program manager had been assigned as the BIA-LES Acting Deputy Director of Operations. He conceded that much of his time was diverted from the detention program, effectively leaving that program without a functioning manager.

In 2001, a detention specialist was hired as the lone staff member of the program manager. This single detention specialist was expected to provide tribal and BIA jails with technical advice as well as conduct compliance checks. Since the beginning of this assessment, three additional

detention specialists have been added.

Six BIA District Commanders are responsible for managing law enforcement services in their respective districts, and they rely mainly on BIA chiefs of police to oversee these functions on the reservations. Our assessment found the oversight of the detention program by these District Commanders to be virtually non-existent. In fact, several District Commanders had never visited some jails under their command or spoken with the jail administrators. Many of the Commanders acknowledged giving little or no attention to jail issues, but they also pointed out that neither did their superiors raise detention as a priority. One District Commander reported that he could not recall a single discussion on detention issues during any staff meeting or conference call for more than a year.

The tribal 638-contract detention facilities are similarly managed and overseen by a chief of police. We found a greater number of dedicated jail administrators, however, overseeing the larger tribal detention programs. Because these jail administrators tend to be more extensively trained detention professionals, we found their jails to be more efficiently operated and managed than BIA-operated jails.



DOI's Office of Law Enforcement and Security (DOI-OLES) is responsible for overseeing all Department law enforcement and security programs, including detention facilities in Indian Country. Since 2001, DOI-OLES has been responsible for coordinating and establishing departmental law enforcement policies and services. We found no evidence, however, of DOI-OLES providing any oversight of the Indian detention program.

BIA-LES has proven incapable of providing the coordination and oversight of Indian Country jails without assistance. The detention program desperately needs a level of advocacy and support well beyond what BIA-LES is presently able to provide.

In addition to the lack of DOI-OLES involvement, we found senior BIA management outside of law enforcement to be inexplicably uninformed about detention program deficiencies – despite annual funding requests specifically to improve jail facilities. One senior political appointee remarked that the law enforcement deputy director never brought the dismal state of Indian Country jails to the attention of the Assistant Secretary's office.

BIA-LES simply does not have the administrative infrastructure to properly manage and oversee the detention program. Detention staff at many of the 638-contract jails we visited told us that BIA-LES was essentially a non-entity. BIA-LES has failed to provide 638-contract jails with technical support or an accessible point-of-contact. The contempt for BIA was readily apparent in many of the discussions we had with detention staff and tribal members. One jail administrator met our team at the door by exclaiming, "I'll tell you now I am not a fan of BIA."

The lack of a dedicated staff with the capability to develop, implement, and administer policies and procedures is a primary cause of BIA's inability to effect change in the detention program. Absent appropriate staff to monitor compliance, safety issues go unreported and the truly deplorable conditions of the jails remain shrouded in secrecy.

Having chiefs of police manage detention facilities has proven to be an operational failure. High crime rates and poor officer staffing demand the constant attention of the

chiefs. Without a dedicated detention program manager on site, the needs of the jails will always remain secondary to fighting crime.

Another significant challenge for management will be to overcome the frustration, cynicism, and apathy that infect Indian Country detention personnel. The overall mismanagement and neglect of the program has left many personnel with the attitude that management is not interested in the detention program and that nobody cares about the jails, the staff, or the inmates. We believe that BIA-LES management's abdication of responsibility for the detention program significantly contributed to the overall malaise we encountered during our visits. That escapes are not taken seriously, vandalism is tolerated, or that there is little sense of professionalism among detention officers should come as no surprise, given management's inattention to the many serious problems found in the jails.

Recommendations

1. For the purpose of providing the prominence and advocacy vital to ensuring that the focus on improving Indian Country jails does not diminish, the Deputy Assistant Secretary for Law Enforcement should become actively engaged in coordinating the oversight and management of the BIA-LES detention program.

2. The Department should create a senior-level (GS-14/15) full-time equivalent (FTE) position for a detention professional in DOI-OLES to help provide increased coordination and advocacy for the Indian Country detention program.

3. DOI-OLES should conduct compliance inspections at BIA and 638-contract detention facilities on a scheduled and unscheduled basis. For the immediate future, it is recommended that the Department OLES and not BIA-LES be responsible for the compliance oversight of the detention program.

4. BIA-LES should establish a senior-level (GS-15) detention program director with proper detention management credentials to manage the BIA and 638-contract detention facilities. This position should

report directly to the BIA-LES director, coordinate actions with DOI-OLES, and be the BIA-LES liaison with OFMC for detention-related repairs. BIA should provide the appointee with adequate new staff to fulfill these responsibilities. At a minimum, the Central Detention office should be staffed with a Director, Deputy Director, secretary, and three management analysts. The six regions should be staffed with two detention specialists per region.

Chapter 2: Safety and Security

Serious Incidents

"What happens on the reservation stays on the reservation."

We discovered there have been 11 fatalities, 236 attempted suicides, and 631 escapes at Indian Country jails over the last 3 years.[5] We believe these numbers to be conservative given that 98% of these incidents have never been reported to BIA-LES. Our efforts to determine more precise numbers were hindered because local records are often inconsistent or poorly maintained by jail administrators. One jail administrator confirmed our concerns that incidents are underreported when he stated, "What happens on the reservation stays on the reservation."

Fatalities

The number of fatalities reported includes the recent suicide at the jail in Yakama, Washington, as well as the death of Cindy Gilbert, a 16-year old student who died of alcohol poisoning while in a detention cell at the Chemawa Indian School in Oregon.[6]

On December 6, 2003, Gilbert (a.k.a. Cindy Lou Bright Star Gilbert Sohappy) was found dead in one of the school's four cinderblock detention cells. She had been found intoxicated on school grounds and had been placed into a detention cell to sober up. Approximately 3 hours later, the school staff entered her cell, found her to be non-responsive and summoned the local emergency rescue squad. Gilbert was pronounced dead by the rescue staff.

An autopsy determined that Gilbert's death resulted from complications of acute ethanolism. The medical examiner's report indicated Gilbert's blood alcohol level was .37, considerably over the .08 intoxication level for the state.

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[5] We have limited our discussion of serious incidents to deaths and suicides, attempted suicides, and escapes. The statistics cited above were obtained from BIA-LES and site visits. We note, however, that the accuracy of many statistics provided by BIA have proven unreliable when tested.

[6] Although there is some question within BIA regarding supervisory responsibility over the Chemawa Indian School detention facility, BIA-LES included it on the "Inventory of Indian Country Detention Facilities—2003." The school's detention facility had four cells that were used to temporarily detain unruly or intoxicated students. These cells are no longer used.

The OIG initiated an investigation into the death of Gilbert. The investigation, currently under DOJ review, revealed a history of inaction to correct a myriad of policy and safety issues at the school's detention facility. In addition, we found that the school had no policy on having intoxicated students medically screened before incarceration.

According to the Acting Lead Detention Officer, this occurred because the two officers on duty were "more interested in cleaning up the office" than observing inmates.

In December 2003, an inmate at the BIA-operated Haulapai Detention Center in Arizona, who had been 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 an intoxication cell where he would have received frequent monitoring to a single cell where the attempted suicide occurred.

Another death occurred in December 2003 at the San Carlos 638-contract facility in Arizona, when an inebriated inmate was placed in the intoxication cell and subsequently 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 Detention Officer, this occurred because the two officers on duty were "more interested in cleaning up the office" than observing inmates.

Detention officers at the time were "off-line for approximately 30 minutes," handling other duties, and were not properly overseeing the cell population.

In March 2003, a 16-year-old female hanged herself at the 638-contract Zuni Adult and Juvenile Detention Facility in New Mexico. According to the facility administrator, detention officers at the time were "off-line for approximately 30 minutes," handling other duties, and were not properly overseeing the cell population.

In October 2002, a male inmate at the Rosebud jail in South Dakota was found dead in his cell. The inmate had been placed in the holding cell with other inmates the previous evening after he was arrested for public intoxication. Detention logs indicated that officers made regular observations of the cell and noted that the inmate was sleeping. An investigation by tribal investigators concluded that the inmate appeared to have died from asphyxia and/or poisoning after consuming anti-freeze or a similar substance. This death was reported to the FBI but not to BIA.

In July 2002, a male inmate at the Blackfeet Adult Detention Center in Montana, who was arrested for intoxication, died approximately one hour after being placed in a cell. An autopsy ultimately attributed this inmate's death to appendicitis. This death was reported to the FBI but not to BIA.

"There are no written procedures for handling inmate deaths."

In March 2002, an inmate was found dead in his jail cell at the Pine Ridge facility in South Dakota due to an overdose of medication ingested prior to being incarcerated. The victim, along with another man, had been booked for intoxication. During the booking process, the victim informed the detention officer that the man accompanying him had ingested multiple pills. That inmate was immediately taken to the hospital for medical care; however, the victim inmate who remained at the jail had also taken multiple pills and later died.

In July 2001, an inmate at the Blackfeet Adult Detention Center died as a result of a seizure. The inmate had an extensive history of seizures prior to being incarcerated.

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

Broken light fixture observed during May 2004 Yakama site visit.

A tragic example of BIA's failure to remedy poor conditions at Indian Country detention facilities, despite the attention and publicity surrounding this issue, occurred on June 25, 2004, when a 39-year old inmate at the Yakama detention facility committed suicide. The inmate, who had been incarcerated for violating a domestic violence no-contact order, was placed in isolation after attacking another inmate. He subsequently hanged himself from a broken light fixture in a corner of the cell out of view of a surveillance camera using a blanket and a bucket that had been left in the room. Only one person, a dispatcher, was on duty that night — similar circumstances occurred when another inmate committed suicide at that facility in 1997. Due to the heavy volume of calls for service that night, the dispatcher did not conduct periodic rounds of the cellblock. The inmate's body was not discovered until 8 hours later when jail staff went to check on him.

The inmate's death occurred 1 month after we visited the Yakama site and 2 days after the Inspector General testified before the Senate Committee on Indian Affairs about the deplorable conditions we had discovered during our site visits. The Inspector General referred to his visit to Yakama and the conditions he had personally witnessed there. The OIG's Interim Report of April 2004 specifically addressed life-threatening issues comparable to those found at Yakama, such as poor physical conditions, inadequate staffing, and inattentive management, yet BIA-LES management failed to implement sufficient safeguards to prevent such an incident. According to detention officers, BIA-LES had not visited the Yakama jail in more than 5 years and had also failed to show up for an inspection they had scheduled for June 22, 2004, just 3 days prior to the inmate's death. Detention staff also reported a second BIA inspection scheduled after the inmate's death was cancelled without explanation. BIA detention specialists did not conduct a site inspection of this troubled detention facility until September 15, 2004.

The same light fixture, used in June hanging, was again observed during August 2004 Yakama site visit.

Attempted Suicides

Based on our own findings and observations noted in other reports, suicide attempts appear to be a regular occurrence at many of these facilities. Data obtained from our 27 site visits indicates a total of 236 suicide attempts over a 3-year period. The BJS reported there were 282 suicide attempts in Indian Country jails during the period of June 2001-2002 alone.[7] In addition, BJS further reported that while there had been an increase of jail admissions of 32 percent for the same period, suicide attempts had more than doubled.

On more than one occasion, we found multiple suicide attempts had been made by the same inmate. For instance, a review of the incident log at the BIA-operated Mescalero Detention Facility in New Mexico revealed that from July 2002 to January 2004, 5 of the 15 reported incidents involved the same female 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 facility, would attempt to slash her wrists or hang herself with articles of her clothing.

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[7] Minton, Todd D. "Jails in Indian Country, 2002," *Bureau of Justice Statistics Bulletin,* U.S. Department of Justice, Office of Justice Programs, November 2003.

In spite of the disturbingly high number of suicide attempts at this facility, there are still many occasions where a lone dispatcher is on duty and unable to properly observe inmates.

Incredibly, an individual detained at the Shiprock facility in 2001 attempted to hang himself seven times using articles of clothing and towels left in the cell. According to the facility administrator, the detention officers' response to these attempts was quite elementary -- if the inmate tried to hang himself with his socks, they would take his socks away; if he tried to hang himself with his towel, they would remove the towel - until the inmate remained in his cell without any clothing or towels.

In March 2004, the Yakama detention facility reported that there had been an astounding 53 attempted suicides at the facility in the previous 3 years. In spite of the disturbingly high number of suicide attempts at this facility, there are still many occasions where a lone dispatcher is on duty and unable to properly observe inmates.

Despite the prevalence of suicide attempts, BIA-LES is wholly lacking in procedures for handling and documenting these incidents. Jail administrators at a number of facilities were often unable to determine a precise number of suicide attempts at their respective facilities due to a lack of accurate recordkeeping.

In contrast to most detention facilities in which inmate access to any materials that might be crafted into a weapon is strictly monitored, in the Indian Country detention facilities we visited, we observed a common practice of allowing inmates uncontrolled access to knives as well as other utensils that could readily be used to harm themselves or others.

Kitchen knives are stored in unlocked drawers. Sisseton/Wahpeton, SD

We observed inmates at Tohono O'odham in Arizona and Rosebud in South Dakota using large knives to prepare food in the kitchens while only being supervised by a cook. We also noted that kitchen knives are stored in unlocked drawers at many jails. At Sisseton/Wahpeton in South Dakota, we observed a hammer and a hunting knife on desks that were readily accessible to inmate workers who roamed freely throughout the facility.

In May 2003, a male inmate at the Rosebud jail attempted suicide by slitting his wrists with a knife that he obtained from the jail kitchen. A locking knife cabinet was purchased after this suicide attempt to prevent the theft of knives when jail staff are not present. During our site visit, however, we

observed that the facility continues to allow inmates to use un-tethered knives while working in the kitchen.

Inmate using knife in kitchen.
Rosebud, SD

We could not identify any specific cause for what appears to be an unusually high rate of suicides and attempts in Indian Country jails. We note, however, that many inmates arrive at the jails intoxicated or under the influence of drugs. In the *National Study of Jail Suicides: Seven Years Later*[8] the authors reported that 60.3% of the suicide victims studied had been under the influence of alcohol, drugs, or both at the time of their incarceration. The study also noted that jail suicides are more prevalent when staff supervision is reduced.

This study, as well as others, has shown that careful and thorough screening is necessary to identify suicidal tendencies, and the importance of having properly trained personnel on duty to conduct suicide screening both during intake and in subsequent phases of the inmate's incarceration. Intake screening is not intended to be an in-depth, time-consuming evaluation, but meant to be more of a triage to detect suicidal behavior and medical requirements. At many non-Indian jails, on-duty medical staff conduct the screening, which also serves to detect most medical and mental health problems and classification needs.

Hunting knife on desk.
Sisseton/Wahpeton, SD

During our site visits, we observed that there was no consistent method of screening inmates for suicide or medical purposes. Often times, the inmate was considered too intoxicated to screen at intake and inadequate staffing precluded later screening, thus the facility never was able to gauge any potential suicidal behavior. We also found that none of the 27 jails we visited had medical staff on duty during any time. In addition, we learned that the jails do not have an established threshold for blood alcohol level for detention officers to use in determining the need for medical screening of intoxicated inmates. Several deaths may have been prevented with either on-site medical staff and/or BAC threshold protocols.

Escapes

For the most part, the detention officers at the jails we visited convey stories of inmate escapes with an air of casual inevitability. In fact, our impression is one of collective

[8] Hayes, Lindsay M. and Joseph R. Rowan, *National Study of Jail Suicides: Seven Years Later*, National Center on Institutions and Alternatives, February 1988.

acceptance. In our interviews, detention officers who discussed escapes 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 inmate escapes. This is not only disconcerting, it is irresponsible to allow escaped inmates to freely travel in a community and surrounding areas while the local law enforcement authorities have no information regarding their escapes.

Use of handcuffs over cipher lock in recreation yard. Tohono O'odham, AZ

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 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 topped with barbed wire, there seems to be a universal acceptance among the detention officers that if inmates want to climb over the fence and escape, they will.

Recreation yard. Yakama, WA

For example, male inmates at the BIA-operated Mescalero facility were allowed to exercise in an outside confinement area unobserved. Although this area is surrounded by a 12-foot cyclone fence with two additional feet of concertina barbed wire at the top, one inmate, who wanted to see his girlfriend, merely climbed up the cyclone fence, cutting himself on the concertina wire in the process, and left the premises. Only one detention officer, who was inside the facility, was on duty at the time.

At the Northern Cheyenne jail in Montana, an unguarded inmate escaped from an outdoor recreation yard by climbing a fence topped with barbed wire. The strands of barbed wire were damaged and pulled together by the inmate. No effort has been made to repair the barbed wire or to replace it with concertina wire to prevent additional escapes. A detention officer at Crow Creek in South Dakota stated, "You give inmates some exercise freedom and then they take off. It was easy to get out."

"You give inmates some exercise freedom and then they take off. It was easy to get out."

At the Sisseton/Wahpeton jail, we observed that the recreation yard wall was only topped with poorly maintained strands of barbed wire. The recreation yard contained chairs

and freestanding wooden benches that could be used by inmates to escape over the wall. When we inquired about the escape potential created by these items, we were told of an inmate who had recently escaped over the wall utilizing a chair and a door handle to climb out of the yard. Detention personnel did not appear to be alarmed that additional escapes were likely to occur if the benches and chairs remained in the recreation yard.

Chairs line recreation yard. Sisseton/Wahpeton, SD

Unsupervised inmates at the Medicine Root detention facility in South Dakota escaped from the recreation yard by climbing an electrical conduit onto the roof of the main building, which has no fence or barriers to prevent escape. Detention officers expressed frustration that they could not let inmates use the recreation yard because maintenance personnel have not taken any action to move the conduit or install effective barriers along the roof to prevent future escapes. Another inmate escaped because a door was left open when police officers brought an individual to the jail.

Electrical conduit used to escape. Medicine Root, SD

From weakened and deteriorating locks on cell doors to broken windows in inmate dormitories, the interiors at many of these facilities are in extremely poor condition and do not deter inmates who set out to escape. For example, the wire-meshed windows in many of the cells at the White Buffalo Youth Detention Center in Montana 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 administrator, these "removable windows" have, in the past, provided an avenue of escape for a number of detained youths. As recently as February 2004, three male detainees 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 detention officers.

Loosely encased wire-meshed windows. White Buffalo Home, MT

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 both detention officers and facility administrators alike. At one detention facility, the administrator recounted an incident of a juvenile escaping by stating that they "haven't seen him since." At another facility, the administrator casually attributed several prior escapes to poor perimeter security. A third jail administrator in Arizona simply stated that there are too many escapes to count.

One officer chuckled in response to our question about escapes and said, "Oh yeah, they happen."

One officer at the Shiprock Adult Detention Center chuckled in response to our question about escapes and said, "Oh yeah, they happen." She then recounted a story about an inmate who had escaped from her in June 2003. The inmate escaped on foot and in ankle-shackles while she was ushering a line of inmates from the facility to the courthouse across the courtyard. Since she was the only officer on duty at the time, she could not pursue the fleeing inmate and leave the other inmates unattended. The officer told us that she believed that the inmate had not yet been apprehended. A review of facility logs indicated no record of the escape or of the inmate being returned.

A number of inmates have escaped by just by walking away, yet the jail staffs continue to allow them to work or loiter while unguarded in areas where they can easily escape. We observed unguarded inmate workers at Sisseton/Wahpeton and Medicine Root routinely exit the jails while they work in non-secure areas. At Yakama, we observed an unguarded inmate sitting against a wall outside the jail in an unfenced area adjacent to the parking lot. The inmate remained outside of the jail several hours later. We observed another unguarded inmate loitering outside the front entrance to the jail during a subsequent visit to this facility several months later. At Pine Ridge, we noticed four unguarded inmates loitering outside of the sally port in a non-secure area only a short distance from the highway. A detention officer at Pine Ridge summed the problem up by stating "inmate workers escape a lot — also from the hospital and from the courthouse."

Unguarded inmate outside Yakama jail.

During a visit to the BIA-operated Blackfeet Adult Detention Center, the district commander told our investigators that he had personally seen unsupervised inmates milling about in the recreation yard from which unsupervised inmates had previously escaped; however, he did not seem concerned about this and had done nothing to rectify the situation. At this same facility, in April 2002, an inmate worker, commonly known as a trustee, escaped and committed a murder before he was eventually apprehended.

Several inmates at Rosebud also escaped by climbing through the suspended ceiling in the dining area into a non-secure area and walking out the door. This escape route has not been blocked or corrected although it has been identified for some time. To our amazement, inmates continue to use

the dining area with little or no supervision.

We were told that the exterior door had been propped open because the jail gets "stuffy." Incredibly, we observed the same door that the inmate used to escape was propped open during our visit.

Detention personnel at Pine Ridge told us that an inmate escaped the night prior to our visit. The inmate kicked a cell door when it was opened by an officer, ran around the startled officer, and escaped through an unlocked door. We were told that the exterior door had been propped open because the jail gets "stuffy." Incredibly, we observed the same door that the inmate used to escape propped open during our visit. We also learned that unsupervised inmate workers are routinely tasked to conduct work and are allowed to loiter in unfenced areas outside of the jail. The Pine Ridge jail continues to allow this practice despite their high number of escapes.

Of the escapes we were able to document during our assessment, 144 (23%) of the 631 occurred when unguarded inmates simply walked away while awaiting medical treatment at clinics or hospitals. For instance, many of the 37 reported escapes at the Rosebud detention facility occurred when inmates walked away from the hospital.

Door used during escape still propped open.
Pine Ridge, SD

Inmates are regularly left in the care of medical staff or hospital security personnel who are not trained to handle or restrain inmates. An officer at Pine Ridge said, "We don't have enough people to escort them to the hospitals." At the Yakama detention facility, inmates who require medical care, for which the jail cannot afford to pay, are actually released from custody with the hope that they will return on their own after treatment. Not surprisingly, Yakama detention officers commented that inmates have learned to feign illness because they know that they will be released if they claim a need for medical treatment.

Serious Incidents Chart

	Blackfeet, MT (BIA)	Chemawa, OR[1] (BIA)	Crow, MT (BIA)	Crow Creek (Ft. Thompson), SD (BIA)	Gila River Juv, AZ (638)	Gila River Adult, AZ (638)	Haulapai (Peach Springs), AZ (BIA)	Hopi, AZ (BIA)	Kyle Juv (Kiysuska Otipi), SD (638)	Kyle Adult (Medicine Root), SD (638)	Mescalero, NM (BIA)	Nisqually, WA (638)	N.Cheyenne, MT (BIA)	Pine Ridge, SD (638)
Deaths														
Non-Suicide	2	1[1]	0	0	0	0	0	1	0	0	0	0	0	0
Suicide	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Suicide Attempts	9	0	8	2	0	0	4	4	9	1	17	3	41	16
Escapes	64	0	6	17	8	0	2	26	3	116	1	1	11	69
Totals	75	1	14	19	8	0	7	31	12	117	18	4	52	86

	Puyallup, WA (638)	Quinault, WA (Tribal-BIA owned)	Rosebud, SD (638)	Salt River, AZ (638)	San Carlos, AZ (638)	Shiprock, NM (638)	Sisseton, SD (638)	Tohatchi, NM (638)	Tohono O'odham, AZ (638)	Ute Mountain Ute, CO (BIA)	White Buffalo, MT (638)	Yakama, WA (638)	Zuni, NM (638)	Totals
Deaths														
Non-Suicide	0	0	0	0	1	0	0	0	0	0	0	0	0	5
Suicide	0	0	1	0	0	1	0	0	0	0	0	1	1	6
Suicide Attempts	0	0	12	1	4	7	6	3	18	1	12	53	5	236
Escapes	2	2	37	1	184	3	9	0	2	0	19	42	6	631
Totals	2	2	50	2	189	11	15	3	20	1	31	96	12	**878**

[1] Chemawa Indian Boarding School has detention cells and reported by BIA as a Detention Facility.

Legend	
(yellow)	**Incidents reported to OIG from detention facilities.**
(gray)	**No Incidents Discovered.**

Out of the 878 incidents, BIA-LES's Incident Log only reflected 22 of those incidents. Therefore, BIA-LES was unaware of 98% of incidents reported to the OIG.

Revised as of August 2004

Recommendations

5. DOI-OLES should ensure that BIA-LES establishes and implements clear reporting protocols for serious incidents occurring at all BIA and 638-contract detention facilities. At a minimum, all officer safety issues, inmate deaths, attempted suicides, assaults, and escapes should be reported promptly through an established chain of command ending with the Director of BIA with copies to the DOI-OLES.

6. BIA and 638-contract detention administrators should ensure that any escape is immediately reported to surrounding local, tribal, and state law enforcement authorities.

7. BIA-LES criminal investigators should immediately respond and conduct a preliminary inquiry to determine if a full investigation is warranted on any reported serious incident. Their findings, in every case, should then be reported to the Director of BIA-LES with a copy to the DOI-OLES. All death cases at BIA or 638-contract detention facilities, not investigated by the FBI, should be investigated by a BIA-LES criminal investigator.

8. BIA and tribes should explore alternatives to detention for intoxicated inmates. When it is necessary to incarcerate intoxicated inmates, additional detention officers should be on duty to assist with the additional monitoring required.

9. DOI-OLES should work with the tribes and BIA to establish a Memorandum of Understanding (MOU) with the Indian Health Service to provide on-site medical assistance at all detention facilities with more than 20 inmates incarcerated. Detention staffs should be adequately staffed and scheduled to accommodate for medical transport to hospitals when necessary.

Chapter 3: Detention Facility Staffing

Determining the appropriate detention staff ratio for a jail is extremely complex with many variables to consider. No two facilities are exactly alike. Thus, staffing requirements should be determined by considering the physical size and layout of the facility, inmate population, types of inmates, including the need for isolation, length of average stay by inmate, technology available, and the competency of the staff.

When conducting our site visits, we learned that most of the facilities operated below their authorized staffing levels, and they operated below what the managers would consider optimum. We discovered that 79% of the facilities fell below minimum staffing levels on a regular basis. One manager remarked, "We are often down to none" when asked if they ever fell below minimum staffing levels.

One manager remarked, "We are often down to none" when asked if they ever fell below minimum staffing levels.

Most managers and detention professionals we spoke with believe there generally should be a minimum of one detention officer per shift who is dedicated for the sole purpose of providing security and observation of inmates. There are other more scholarly views including an author in one prominent correction publication who writes "The ratio of staff to inmates should not be the central issue. Instead, the issue should be making sure the right number of properly trained staff, are in the right places, at the right time, doing the right things. What is important is the way the staff are trained, assigned, and managed, not just how many there are."[9] The author goes on to remark, "that if the detention staffs are not competent or productive, simply increasing their numbers will not improve facility operations."[10]

In fact, we found that the majority of the detention facilities we visited operated with only one detention officer per shift and often times the officer had several collateral duties that took his/her attention away from the inmates. Even more disturbing was our discovery that a number of jails have shifts with no detention officers on duty. In these instances, dispatchers, cooks, or police officers fill in while continuing to do their primary jobs.

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[9] Krauth, Barbara. *Staff Inmate Ratios: Why It's So Hard to Get to the Bottom Line*, L.I.S.I., September 1988.
[10] *Ibid.*

For example, the dispatcher at the Crow Creek detention facility is regularly called upon to watch the inmates while performing dispatch duties and must prepare meals for the inmates as well. One Crow Creek employee commented, "The dispatcher works as an officer, the dispatcher cooks. Everyone shuffles around. We're jacks of all trades." The Northern Cheyenne detention facility normally has only one detention officer on duty. The cook fills in for the detention officer two or three times weekly when the detention officer transports inmates for medical treatment or court appearances. At the 55-bed Blackfeet Adult Detention Center, the lone detention officer stands in for other personnel several times a week and must physically leave the jail to prepare meals, leaving the inmates unsupervised.

"The dispatcher works as an officer, the dispatcher cooks. Everyone shuffles around. We're jacks of all trades."

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, 7-day a week "lockdown" on inmates. Although lockdown is not unusual as a short-term solution for an acute problem in a detention facility, it could lead to an unsafe and dangerous environment long-term. The 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 place officers and inmates in a potentially life-threatening situation.

Indian Country jails currently range in size from 2 to 120 beds. While we recognize that small jails, which are often no more than temporary holding cells, may be able to operate with one detention officer/dispatcher on duty as long as they are supported by other law enforcement personnel, in most instances, the practice of operating a jail that houses inmates more than 48 hours with only one detention officer on duty is a recipe for disaster.

Detention officers must book and process new inmates brought to the jail, intercede when altercations occur, make regular rounds of the jail to keep inmates under surveillance, manage/watch suicidal or violent inmates, respond to emergencies or injuries, transport inmates for medical care, oversee visitors, log activities, and manage other operational functions of the jail. It is unreasonable to expect one detention officer to perform all of these duties under normal

conditions. During periods of increased inmate population, such as weekends and holidays or when jails are overcrowded, the challenges faced by a single detention officer become overwhelming.

Lone detention officers are also at great risk of being assaulted, injured, or even killed during the performance of their duties. Inmates may be encouraged to attack a lone detention officer since they know that many of these officers have nobody to come to their rescue. Occasionally, other inmates intervene to help a detention officer, as occurred at Mescalero where a lone female detention officer 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 a trustee convinced the intruder to move to another part of the jail and to leave the officer alone. Another inmate then summoned the police. At the Blackfeet Adult Detention Center, a dispatcher was alerted to an assault on the lone detention officer by inmates pounding on the walls. Unfortunately, this incident does not appear to be an exceptional case; the BIA district commander told us, “Every officer here has been assaulted.” Detention officers should not have to place their hopes of being rescued on inmates if they are assaulted or attacked.

Sign indicating staffing shortage.
Crow Creek, SD

Inadequate staffing greatly increases the potential for BIA liability when injuries, deaths, or escapes happen. We believe there is a direct correlation between insufficient staff and the number of serious incidents and escapes that occur at Indian Country jails.

In most cases, Indian Country jail staffing levels are so low that there are no detention officers available to fill in when officers are sick or otherwise unable to be on the job. Many unfilled vacancies further contribute to the inability of jails to have a sufficient number of detention officers on duty and require detention officers to work unsafe levels of overtime. A detention officer at Crow Creek claimed it is not uncommon to work up to 16 hours per day. Detention officers at other jails similarly reported that they must work double shifts when co-workers are sick or vacancies remain unfilled for long periods of time.

Several detention officials reported that it is not uncommon for vacancies to go unfilled because of a lack of qualified

applicants. Not surprisingly, we were told that many applicants are not willing to move to remote areas with poor housing, low pay, and undesirable working conditions.

The National Institute of Corrections (NIC) in Longmont, CO, notes that on average, it takes 5 FTEs to staff one post on an 8-hour shift, 7 days per week. In contrast, BIA jails have approximately one FTE per shift for each jail. BIA management's failure to fill vacancies and/or increase staffing to sufficient levels directly impacts the poor operation and management of the jails for which it has responsibility.

BIA management has been aware of the unsafe conditions created by insufficient staffing for more than 6 years with little evidence to indicate that there has been more than a token effort to take corrective action. In his June 3, 1998 testimony, former Assistant Secretary Gover testified about the danger of inadequate staffing. Gover stated, "Most of the facilities have limited staff on duty at any given time to adequately manage inmates. For example, during a shift, the same person may serve as jailor, dispatcher, receptionist and cook. Clearly, this frequent predicament causes an unreasonably dangerous situation for the employees as well as the inmates." Gover's testimony echoed many of the findings noted in the 1997 DOJ report.

Recommendations

10. Staffing shortages at BIA and 638-contract detention facilities that are related to officer safety should be identified by the BIA-LES and corrected immediately. DOI-OLES should oversee this effort.

11. BIA-LES in collaboration with 638-contract programs should develop staffing models and methodologies for BIA and 638-contract detention facilities. DOI-OLES should oversee this developmental effort.

12. The DOI Law Enforcement and Security Board of Advisors should develop recruiting standards and guidelines for BIA detention officers. BIA-LES should then assist tribal detention programs in developing recruiting standards and guidelines for tribal detention officers.

Chapter 4: Detention Facility Maintenance

Inoperable sinks in cells. Mescalero, NM

We found the condition of the majority of the jails we visited to be abysmal — the result of years of neglect and failure to perform even routine repairs in a timely manner. In contrast, local county jails we visited for benchmarking purposes are in significantly better condition than the Indian Country jails of the same age.[12] In general, the county jails, which received sufficient upkeep, clearly had many more years of service remaining while many of the Indian Country jails are dilapidated to the point of condemnation.

Records reflect that BIA and the tribes have consistently failed to maintain their detention facilities. In the OIG Audit Report, *Maintenance of Detention Facilities, Bureau of Indian Affairs*, issued in August 1994, the findings reflected, in part:

Ten years from our earlier audit, conditions remain the same.

"The Bureau of Indian Affairs and Indian tribes have not adequately maintained detention facilities or corrected hazardous health and safety conditions at these detention facilities. Most of the facilities we visited were in unsanitary conditions and/or disrepair."

The 1994 audit determined the lack of maintenance and repairs at the facilities were attributed to BIA and the tribes not (1) having established and implemented preventive maintenance programs, (2) specifically assigning and holding personnel accountable for correcting deficiencies at BIA-operated facilities, or (3) adequately monitoring tribal contractors to ensure proper maintenance of tribally operated facilities. The audit also reported that the conditions and lack of attention had been on-going for several years prior to the audit.

Broken glass in cell window. Hopi, AZ

BIA OFMC is responsible for the maintenance and repair of BIA-owned detention facilities. OFMC is tasked to manage maintenance funding and to coordinate repairs for all structures owned by BIA. OFMC operates independently of BIA-LES; consequently, jail administrators have no direct authority over local maintenance personnel and do not have the authority to prioritize maintenance and repair work at

[12] We visited seven jails in nearby communities off the reservation.

their facilities. OFMC personnel determine repair scheduling and prioritization for all BIA buildings with little thought of the unique needs of detention facilities. This diminishes any sense of ownership that jail administrators and detention officers have for the maintenance and upkeep of their facility.

Missing pump/leaking water.
Medicine Root Jail, SD

The prevailing attitude of the detention personnel we encountered is that problems reported to OFMC, once made, are no longer their concern. This results in little, if any, follow-up to determine prioritization or repair status. Additionally, few jail administrators conduct formal weekly or even monthly inspections of their facilities as required under current BIA standards for operation. These are the very standards that were implemented to address and respond to the findings of the 1994 OIG Audit.

Unless this trend is reversed, many of the newer jails in Indian Country will prematurely deteriorate due to a similar lack of upkeep and maintenance. Relatively new jails we visited are already showing signs of accelerated aging and wear due to delay of necessary repairs. For instance, the main control panel for monitoring access at the 4-year-old Ute Mountain detention facility has not worked for more than 2 years. Although this problem was reported to OFMC 2 years ago, it is still broken.

We noted that many of the maintenance shortcomings have a direct impact upon officer and inmate safety; yet there is little indication that OFMC or detention personnel place any emphasis on expediting repairs affecting safety.

An egregious example of a deteriorating newer jail was found at the juvenile detention facility at the Kiyuska O'Tipi Reintegration Center, which was constructed in 1995. Door lock indicator lights do not function properly, failed hot water heaters have not been replaced, trim pulled from the roof by a storm has gone unrepaired for several years leaving parts of the structure exposed to the elements, the entry gate to the jail compound is non-functional, a leaking water recirculation pump leaves puddles of water in a utility room, external security light fixtures remain broken, and showers and fire sprinkler heads damaged by inmates are in disrepair.

We noted that many of the maintenance shortcomings have a direct impact upon officer and inmate safety; yet there is little indication that OFMC or detention personnel place any emphasis on expediting such repairs. For example, virtually all of the Plexiglas in the jails at Rosebud and at Zuni in New Mexico, as well as other locations, has been scratched, burned, and damaged to the point that it is extremely difficult for detention officers to see into cells to check on inmates

prior to entry. According to Rosebud personnel, this condition has been reported to OFMC for years, but nothing has been done to repair the Plexiglas.

Scratched and burned Plexiglas. Rosebud Sioux, SD

Fire sprinkler heads at a number of facilities were inoperable. Even more disturbing, detention officers at Yakama reported the entire fire suppression system had not functioned for years. We observed that some fire extinguishers at Yakama had not been inspected since 2001. We also discovered that many cameras and inmate monitoring systems did not work or worked poorly. At Tohono O'odham, the camera monitoring a cell for high risk inmates is pointed to the ceiling while at the Crow jail, several cameras cease functioning on an intermittent basis. In addition, the keys to the cells at Tohono O'odham are so worn that they do not reliably unlock or lock the cell doors. This could easily result in a tragedy in the event of a fire.

We also found that many maintenance shortcomings impacted sanitation. In all too many instances we observed toilets that do not flush, showers and sinks that do not work, and inoperative hot water heaters that have not been replaced. At Pine Ridge, the toilet in the "drunk tank" has been inoperable for months. This situation causes sanitation concerns because intoxicated inmates in the "drunk tank" frequently need to urinate and may not be able to wait until officers can move them to other cells. This also places detention officers at risk because they must frequently move inmates to other occupied cells. According to detention personnel at both Pine Ridge and Crow detention facilities, they experience instances in which waste flushed down one toilet surfaces in another toilet. The plumbing issues at Shiprock are so severe that health inspectors closed the jail for several months in 2003. We learned that the Shiprock jail was again closed for sanitation reasons in June 2004. Health inspectors have since allowed a small portion of the jail to be reopened.

Camera in high-risk cell faces ceiling. Tohono O'odham, AZ

We encountered numerous instances in which even routine maintenance was not being accomplished. It was not uncommon for us to observe broken light fixtures, peeling paint, broken door locks, inoperable or malfunctioning kitchen equipment, and ventilation problems at many of the detention centers. We noted that several air vents at Northern Cheyenne and Crow Creek were so clogged with dust and debris that little air could flow through them.

Detention personnel at the Kiyuska O'Tipi Reintegration Center reported that a replacement water recirculation pump sat uninstalled for almost 6 months while a malfunctioning pump continued to leak water into a utility room. We were also told that a commercial grade toaster and fryer have remained unused since the jail was constructed in 1995 because OFMC personnel have not installed a 220-volt circuit.

Maintenance Funding

...BIA had the means to accomplish additional repairs, but not the will.

There is an enormous backlog of items that require repair, but little to no effort has been made to correct the majority of these problems. BIA officials originally reported that they had approximately $1.4 million available in FY2004 for facility upkeep but had identified approximately $30 million in necessary repairs. BIA subsequently reprogrammed funds to increase the money available for detention facility maintenance to approximately $4 million to address maintenance issues and deficiencies publicized as a result of media attention from our interim assessment.[13] This not only demonstrates that BIA failed to take a proactive approach in managing the detention program prior to OIG interest, it also confirms that BIA had the means to accomplish additional repairs, but not the will.

Our examination of the Facility Management Information System (FMIS) found that there are many duplicate and inaccurate entries. We found that the data provided to us, which OFMC personnel claimed represented jail repair and maintenance needs, included new construction data. For example, we discovered one entry in FMIS in the amount of $979,802 was for the construction of a new jail. We further found there were monetary values attributed to facility maintenance, such as a jail's failure to have a written evacuation plan, inadequate staffing, no fire drills, fire extinguisher training for staff, security study, and overcrowding that are clearly more operational than maintenance issues.

Our review of the FMIS data that was initially provided to us disclosed outstanding maintenance requirements totaling $30.4 million. Subsequent to our request for this data, BIA OFMC personnel began to analyze its information and provided revised FMIS data showing outstanding

[13] Anderson, David W., Hearing on Indian Tribal Detention Facilities, Statement to U.S. Senate Committee on Indian Affairs, June 23, 2004.

maintenance backlog costs of $27.8 million and eventually $26.6 million. This $3.8 million discrepancy represents, yet again, BIA's neglect and mismanagement of the detention program.

We discussed our concerns about these inaccuracies with senior OFMC personnel and provided them with examples of questionable entries attributed to maintenance or repair. In response, OFMC provided revised data approximately 1 week later showing maintenance and repair backlog costs of $23.2 million reducing the total yet another $3.4 million. We believe that additional analysis of FMIS would result in a further reduction of the estimated maintenance costs by another $1 or $2 million. Regardless, the many inconsistent and questionable entries significantly diminish the value of FMIS as a management tool for OFMC and for BIA-LES.

In July 2003, GAO expressed concerns about the quality of data being entered into FMIS. In its report on Indian School Maintenance, GAO observed that "most measures for controlling the quality of new data BIA employees are entering into the system for individual schools are not working well" and that "nearly half of the proposed data entries coming through the system are inaccurate and incomplete."[14] Given that our own examination of FMIS identified so many inaccuracies, we must conclude that BIA management simply does not have an accurate accounting of the maintenance needs or estimated repair costs. Our findings also indicate that BIA is clearly not effectively addressing GAO's recommendations that "BIA establish better guidance and performance expectations for employees who are responsible for entering and reviewing the accuracy and completeness of FMIS data" and "periodically analyze the extent and type of data errors being found during review in order to identify training needs and other strategies for addressing any continuing problems."[15]

It remains clear that BIA does not have sufficient funds to correct known maintenance deficiencies. With appropriate management and oversight, however, many of the identified problems might have been prevented and the severity of many others could have been reduced if repairs were made in

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[14] Government Accountability Office, *Bureau of Indian Affairs Schools, New Facilities Management Information System Promising, but Improved Data Accuracy Needed*, GAO-03-692, Washington, DC, July 2003.
[15] *Ibid.*

a timely manner.

Maintenance Accountability

The poor coordination and communication between BIA-LES and OFMC personnel at all levels leaves maintenance at detention facilities an orphan. Clearly, the unique maintenance needs at the jails has not been recognized. For example, jail administrators at Pine Ridge purchased gun lockers months ago for police to secure their firearms before entering the jail. Detention personnel advised that the gun lockers still remain uninstalled, and police officers who bring prisoners to the jail have nowhere to secure their weapons.

One jail administrator commented that "the staff sets the atmosphere" at the jail.

Vandalism by inmates has caused a significant amount of the maintenance issues reported by jail staff. This destruction of property is costly, adversely impacts the safety of inmates and staff, and diminishes the comfort and cleanliness of the facility. Rarely are inmates who cause damages held accountable. With no consequences for their actions, inmates are not deterred from causing further damage. There is no incentive for inmates to change their behavior. In contrast, we observed that local county jails we visited had virtually no graffiti or noticeable damage because inmates knew there were consequences for damaging the facility. The sheer volume of damage caused by inmates at Indian Country jails indicates that vandalism is accepted and cannot be prevented. We found no indication that BIA management held jail administrators or detention staff accountable for preventing vandalism damage.

We noted a few facilities, such as Ute Mountain, Gila River, and Salt River, where little or no vandalism was observed. The management at these facilities required detention staff and prisoners to keep the facility clean and to properly dispose of trash. One administrator commented that "the staff sets the atmosphere" at the jail.

Recommendations

13. BIA OFMC and BIA-LES should immediately establish an effective system for prioritizing repairs that have any impact on inmate or detention officer safety. They should also review FMIS to identify and remedy inaccurate and redundant entries and implement quality control measures to reduce the risk and occurrence of improper entries.

Chapter 5: Funding of the Detention Program

Detention Program Supplemental Funding

Presidential Initiative:

- FY 1999 - $1.8 million
- FY 2000 - $4.0 million
- FY 2001 - $4.2 million

$10 million

***New Facilities Funding*:**

- FY 2002 - $ 5.0 million
- FY 2003 - $ 5.1 million
- FY 2004 - $11.4 million

$21.5 million

TOTAL **$31.5 million**

Bureau of Indian Affairs Law Enforcement Services Annual Funds

- FY 2001 - $149 million
- FY 2002 - $158 million
- FY 2003 - $160 million
- FY 2004 - $170 million

BIA is required to provide law enforcement services on reservations under the Indian Law Enforcement Reform Act of 1990 (Public Law 101-379). Detention facilities are operated and funded by the BIA, tribes, or a combination of both. BIA and 638-contract programs are funded under the law enforcement budget through the Department's annual appropriation.

In the last 4 years, BIA received $637 million for law enforcement services. In addition, since 1999, BIA-LES has also received supplemental funding totaling $31.5 million specifically designated for hiring detention officers and preparing new facilities for operation. This supplemental funding includes $10 million allocated from FY1999 to FY2001 to hire an additional 305 detention officers as a result of the Presidential Initiative for Law Enforcement in Indian Country; $5 million in FY2002, to hire detention staff needed for new facilities; $5.1 million in FY2003 was reprogrammed by BIA-LES; and an additional $11.4 million in FY2004 to prepare new facilities for operation.

We discovered that BIA-operated facilities actually only received $3 million of the $10 million allocated to hire 94 additional detention officers. They had only hired 58 officers as of the end of FY2001. BIA was unable to determine if the remaining $7 million, which was specifically designated for hiring additional detention officers for the 638-contract and self-governed facilities, was in fact used for that purpose.

Since 2002, BIA has only filled a mere 13 positions at BIA-operated facilities. Furthermore, BIA-LES told us funds remaining from budgeted but unfilled positions are ultimately absorbed into the law enforcement program for non-detention activities.

BIA-LES failed to provide us with their budget submissions for the last 3 years when we requested them. BIA-LES officials indicated that they were unable to locate documents or documentation pertaining to their budget requests. An inquiry with BIA budget personnel revealed that they also

could not locate any budget requests or projections for BIA-LES. A BIA budget official advised BIA-LES may not have submitted budget proposals if they were not requesting an increase in their budget. We later learned that BIA-LES managers use historical funding levels with little or no increases for their budget requests. BIA-LES managers indicated that there has been no change in the level of their operating funds for the last 3 years with the exception of increases associated with new facilities.

Budget Projections and Planning

BIA-LES does not seek to obtain accurate or realistic budget projections or plans from responsible local officials, such as police chiefs or detention administrators. We found that most jail administrators and police chiefs we interviewed make no effort to conduct an accurate budget analysis or construct a realistic budget projection. They simply expect to receive the same level of funding that was received in prior years with little or no variation. For instance, an official at one BIA-operated facility stated that they look at the previous years' funding to figure out the current budget because "the funds stay the same each year — there are no increases." Another official stated, "They give us what they want to give us."

"The funds stay the same each year -- there are no increases."

BIA's failure to make any effort to assess the true cost of operations or to create an accurate budget projection becomes a self-fulfilling prophecy. This failure not only impacts the detention program but also impacts the other three components that fall under BIA's law enforcement budget. We believe that the true operational cost of the BIA detention and law enforcement programs is much greater than their current appropriations. BIA cannot address any of its funding difficulties without advocacy. Successful advocacy requires accurate cost assessments and budget projections.

Fund Designation

Our efforts to determine the percentage or amount of BIA-LES funding used for detention were unsuccessful because BIA-LES does not designate separate budget line items for detention. We found that funding is allocated to local officials by BIA-LES, usually to police chiefs, who determine the amount of funding to provide to each of the programs under their responsibility. Typically, no methodology is applied to the percentage allocated to each program nor is there an accurate recording of how the money is used. In most instances, the largest percentage of the funds are used for uniformed police and criminal investigation

leaving inadequate funds for detention operations.

"We wind up on the short end of the allocation table."

An official at the 638-contract Rosebud detention facility reported that only 16% of the local law enforcement budget is allocated for detention services. Most of that funding supports personnel costs, leaving very little money for other needs such as food for inmates and training for detention officers. One chief of police, who is also responsible for detention services, told us that 90% of the funds his department receives support salaries, with the remaining funds used for major needs such as equipment. This same chief also noted that if he had to choose between his police department or detention needs, he would most likely fulfill the police department's needs first. A detention officer at San Carlos in Arizona summed his plight up well by stating, "We wind up on the short end of the allocation table."

We find it troubling that BIA-LES management exercises so little oversight of these budgeted monies and simply distributes funds without any guidelines to ensure that all the programs for which they are responsible receive sufficient and balanced funding. Although we recognize the difficulty of balancing the funding needs of a police department with the needs of a detention program, the gross inequities that we observed at many locations incapacitates detention managers to adequately staff, operate, and maintain their facilities. We believe that the designation of specific funds for detention is imperative for the efficient and effective operation of detention facilities.

New Facility Funding

New Facility Funding
FY 1997-2003

1997 - 2
1998 - 2
1999 - 13
2001 - 2
2002 - 3
2003 - 2

Beds in New Facilities

30%	1-35 beds
40%	35- 70 beds
15%	70-105 beds
5%	105-130 beds
10%	130-160 beds

Since 1997, DOJ has provided over $150 million in construction grants to tribes for building new detention facilities. These grants cover facility construction only. BIA is then responsible for funding a facility's operational requirements. As noted earlier, BIA-LES has received $21.5 million since 2002 for staffing and operating new facilities. Given the poor coordination and planning of new jails between BIA and DOJ, however, facilities have been built that cannot be opened.

According to an April 2004 status report, DOJ was scheduled to have completed 13 jails; yet today only 2 of those completed jails are actually opened and occupied. Nine completed jails are not occupied because of staffing shortfalls. For example, a new jail at San Carlos was completed in May 2004, but remains unoccupied. BIA-LES

managers reported that it will be another 6 to 10 months before this jail can be utilized even though San Carlos received $2.7 million in FY2004 to fund facility operations.

The Ute Mountain detention facility, which is less than 5 years old, was constructed with 54 beds for adult inmates and 22 beds for juvenile inmates. We found the juvenile section of this facility vacant and unused due to lack of staffing. When we inquired about this idle facility, BIA-LES management reported that they plan to open the juvenile section in the next few months.

The Eastern Nevada detention center in Owyhee, Idaho, which was built under a $4.2 million DOJ grant, remains vacant because it failed, unexplainably, to be built to Federal standards. An additional $250,000 was awarded by DOJ in September 2003 to correct deficiencies related to fire walls, sprinkler systems, and alarm systems. BIA detention staff that had been hired for this facility are being utilized at other jails until the facility can be opened. We believe that BIA-LES management's lack of a comprehensive plan to recruit, hire, and train staff for these new facilities, along with failing to properly supervise construction of new facilities, further illustrates their overall indifference to the detention program.

BIA-LES could not provide us with expenditure data for $9.8 million of the $11.4 million received in 2004 for opening new facilities.

BIA-LES officials complained that once DOJ became involved in constructing new facilities, BIA priorities for these jails were not considered. According to them, new jails went to the best grant writers, not those with the most need. In addition, BIA officials also noted the lack of coordination between DOJ, BIA, and the tribes. The lack of cooperation and communication between DOJ and DOI was further emphasized in the IACP Indian Country summit comment and recommendation that both Departments should improve and strengthen their interagency cooperation and communication to provide more effective services in Indian Country.[16]

In August 2003, BIA reprogrammed $5.1 million to tribes that were currently constructing detention facilities using DOJ grants. These funds were distributed so that the tribes could prepare the facilities for occupation. BIA specifically noted that the funds would be tracked to ensure that they were used exclusively for hiring detention staff and

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[16] *Improving Safety in Indian Country*, p. 11.

purchasing the necessary equipment to open facilities in a timely manner. When asked, BIA-LES was unable to provide data showing how the reprogrammed funds were spent because they had not actually tracked the funds. Additionally, BIA-LES could not provide us with expenditure data for $9.8 million of the $11.4 million received in 2004 allocated for opening new facilities.

One BIA-LES official noted, "It would probably be a good idea to track those funds, wouldn't it?"

BIA-LES management officials stated that tribes under 638-contracts and self-governance tribes have never been required to provide BIA with reports on how any law enforcement funds are spent. As a result, BIA does not know whether funding designated for pre-occupancy needs for new jails was actually used for the detention program. One BIA-LES official noted, "It would probably be a good idea to track those funds, wouldn't it?" in response to our inquiries. We are gravely concerned that this failure to provide oversight has or will result in the actual misuse of the funds.

Internal Controls

We are also concerned about internal controls in this area. We noted several inconsistencies in reported amounts of expenses between BIA-LES and the detention facilities when reviewing BIA-operated facility records. Moreover, when comparing expense data obtained from individual facilities with BIA-LES information, we found that none of the facility amounts were consistent with the BIA-LES figures for 2002 and only one amount matched 2003 data.

We further found that BIA was unable to accurately determine if $7 million of the $10 million of supplemental monies it received from FY1999 to FY2001 to hire additional detention officers was actually used for its intended purpose. BIA-LES managers indicated that, once again, they had not required contract or self-governed detention facilities to document or report how these funds were used. Even more disturbing, BIA-LES managers also told us that if any of the funded positions are not filled, the money is automatically absorbed into the law enforcement program for other uses, which is, of course, contrary to the designated appropriation specified by the Congress.

Theft and misuse of funds historically occur when there are no internal controls and the threat of discovery is minimal. From an accounting standpoint, BIA-LES does not use sound business practices for planning, accounting for, and

monitoring the use of detention funds, nor is anyone held accountable for the proper management of detention program funds. This overall neglect of detention program funding oversight has created an environment in which fraud can be perpetrated with impunity and waste can continue undiscovered, because nobody at BIA is paying attention. Without the implementation of an internal control system where detention funding and expenditures can be accurately tracked and reported on a regular basis, misuse or theft of designated funds will likely, or may already have, occurred. We find no excuse for BIA-LES' inattention to funding issues and yet another unfortunate example of inattention and neglect of the detention program.

Public Law 93-638 Contract Funding

Of the 72 detention facilities in Indian Country, 46 receive funding for law enforcement services under Public Law 93-638. During our assessment, we reviewed 16 detention facilities that are operated under 638-contracts. We found that funds for the detention program are not specified and contract terms and conditions are not always enforced. Tribal agencies are often not held accountable for failing to comply with contract terms and conditions. For example, a FY2001 Single Audit Report for the Rosebud Sioux Tribe identified $2.5 million in questionable costs regarding federal funds used for tribal programs that were not in compliance with the contract agreement and related laws and regulations. The report recommended that specific terms or controls and procedures be implemented to ensure that these funds were safeguarded from unauthorized use.

In another similar situation, a BIA contracting officer reported that she was unable to enforce the terms of a contract because the tribe refused to allow her access to their juvenile facility for 7 years. Only after the contracting officer threatened to withhold funding was she allowed to conduct this review. We find it remarkable that no action was taken for 7 years and that BIA-LES took no action to intervene on her behalf.

We are equally concerned that BIA's failure to enforce the terms of the contracts or to provide adequate oversight over 638-contract funds has created an environment in which fraud can thrive and exacerbates the potential liability for BIA and the Department. During our visit to the White Buffalo Home, a detention officer reported that the Tribal Council Chairman authorized the use of 638-contract money

in November 2003 to fund a horse trip for students who were not detainees or affiliated with the detention facility in any way. We subsequently found support for the officer's allegation when we discovered a check written on the White Buffalo Home account for the event.

We also found that a male detention officer at the White Buffalo Home raped a 17-year old female inmate in October 2002 when he was tasked to transport her for medical treatment. The detention officer was convicted after confessing to the crime. According to the report of investigation, the perpetrator had a prior criminal record but an "appropriate background investigation" had not been conducted according to the requirements of the contract. We learned that the perpetrator was related to a tribal council member. BIA's ineffective oversight of this particular contract is especially disturbing since BIA had to take over control of the nearby adult jail and police department due to serious problems associated with the tribe's operation of the law enforcement and detention programs.

Funding for detention services is generally not specified in the terms and conditions of 638-contracts. A review of the sixteen 638-contracts determined that the BIA had allocated at least $61 million for law enforcement program management from FY2001 through FY2003. However, we were only able to trace funds totaling about $7 million (11%), which had been budgeted for contract-managed detention facilities.

In our opinion, language used in the majority of 638-contracts directly contributes to the inadequate funding and operation of detention programs. BIA cannot ensure that necessary detention services are provided for without establishing and implementing specific funding, expenditure, and operational requirements. Specific contract requirements would not only improve the ability of BIA to monitor these programs and to verify that designated funds were actually used for detention services but would also prevent tribes from reallocating much needed detention program funds or exerting undue influence on the operation of the program.

Recommendations

14. BIA should establish and implement a single line item budget for all BIA-LES detention facilities and expenses. BIA-LES should require 638-contract detention facilities to implement similar cost tracking practices.

15. BIA should utilize accurate budget projections that incorporate future funding requirements when preparing funding requests rather than just using historical data. As part of future funding requirements, BIA-LES senior officials and local detention administrators should identify any existing needs and/or deficiencies so that these issues can be properly addressed.

16. DOI-OLES should work with BIA, tribes, and DOJ to develop strategic plans for jail replacement and renovation. DOI-OLES should assist BIA-LES with developing a comprehensive needs assessment to ensure that jails are built and sized appropriately.

17. BIA should implement internal control procedures and proper management oversight to ensure that BIA funding and expenditures are accurately tracked and reported on a regular basis.

18. A standard law enforcement and detention service clause should be developed and used in each and every Public Law 93-638 contract for BIA law enforcement and detention services. The clause should require at a minimum that: (1) law enforcement and detention funding be accounted for and used for its intended purpose and (2) serious incidents be promptly reported to BIA-LES as a condition of the contract.

Chapter 6: Detention Program Training

Sign restricting firearms into the Yakama cell area.

Providing detention officers with certified training is also a critical element in ensuring that detention facilities are able to operate safely and securely, in addition to reducing potential liability for acts of untrained personnel. Specifically, we found that 52% of all the detention officers at the sites we visited had not received detention officer training. We also discovered numerous situations where detention officers were working for long periods of time without having attended the required IPA detention officer training. Examples of BIA-LES management's disregard for timely training include instances where one detention officer at Haulapai and one detention officer at the Kiyuska O'Tipi Reintegration Center (juvenile) in Kyle, SD, who were employed for 12 years and 7 years respectively before either attended detention officer training, and a detention officer at Shiprock, who was hired in 1999 and still has not attended detention officer training.

With few exceptions, there seems to be an overall lack of emphasis on formal certification training of detention officers. We found that many jail administrators place little importance on sending newly hired personnel to training at the IPA. We also found there is hardly any emphasis on refresher training or skills enhancement training for detention officers. The prevailing attitude in most instances is that no additional training is necessary after an officer attends basic detention officer training. One exception to this attitude was found at the Tohono O'odham detention facility where they have a Field Training Officer (FTO) program, along with a FTO manual.

Yakama jail supervisor carrying firearm into the cell area.

Utilization of untrained or poorly trained personnel places inmates and officers at great risk and obviously raises concern about the overall safety and security of many of the detention facilities. For example, detention personnel at Yakama and Pine Ridge allow police officers to enter the jail cellblocks with their firearms contrary to nationally accepted standards and common sense. Furthermore, we observed the detention supervisor at Yakama carry his firearm into the main cellblock despite posted signs prohibiting them. This practice, which we believe is attributable to lack of training

and lackadaisical attitude, places everyone within the jail at significant risk.

"We've never received any training on how to operate a detention facility."

We received conflicting information regarding the availability of basic training at the IPA. Several jail administrators claimed that they are unable to send new personnel to the IPA for training because classes are infrequent and are often full; however, IPA personnel indicated that they routinely have vacancies for these classes and hold regional or local training sessions when asked to provide them. According to IPA officials, the IPA attempts to hold three detention program courses per year although only two were held last year due to budgetary constraints.

We learned there are two detention programs offered at the IPA - one for officers working in an adult facility and another for officers working in juvenile facilities. We noted that much of the curriculum is the same; however, IPA requires that a detention officer who has completed one course attend the other entire course in order to be certified in that program. This is often seen as an increased burden for officers who work at facilities that provide both adult and juvenile detention services. We also find it wasteful to require a detention officer to attend a second course that repeats most of the information taught in the original course when a shorter, supplemental course that covers the differences between adult and juvenile detention could easily be developed. Another option would be to combine both courses and develop one certification program.

"Most BIA standards can't be met, so why even try?"

We also noticed consistent problems with proper documentation and adherence to standards at detention facilities. Some administrators have attributed this to a lack of training. One District Commander stated, "We've never received any training on how to operate a detention facility." When asked if their facility followed BIA standards, that same individual quipped, "Most BIA standards can't be met, so why even try?"

Our assessment determined that the poor management of many of the Indian Country jails can be directly attributed to the failure of BIA-LES to provide and require that jail administrators receive supervisory and financial management training. Most jail administrators we interviewed had received little or no training beyond basic detention officer training; however, there were some notable exceptions. We

found that the jail administrators at the more proficiently run facilities, such as Salt River, Gila River, and Tohono O'odham in Arizona and Ute Mountain in Colorado, had experience and formal training obtained from working in other detention programs.

At Salt River, for example we interviewed the jail administrator who has an extensive detention management background with numerous professional certifications. The manager, who is a non-Indian, explained that he viewed his responsibilities to include training and preparing his Native American staff to eventually take his place.

NIC holds one or two training conferences per year for Indian Country jail administrators to attend at no cost other than transportation and lodging. We found that only 25 jails were represented at the most recent conference in May 2004. NIC personnel and attendees indicated that it is usually the same one third of the Indian Country jail administrator population that participates in these conferences.

NIC also maintains a comprehensive library of reference and training material, which includes workbooks for budget planning, jail staffing analysis, and many other pertinent issues. NIC has published a bibliography of all library holdings about or referencing Indian Country jails. We were surprised to learn that many of the BIA detention specialists we spoke to did not know about the bibliography and few jail administrators had taken advantage of this learning opportunity.

Recommendations

19. BIA-LES and the IPA should take immediate action to identify and train all current detention officers who have not received the basic IPA detention officer training.

20. Appropriate measures to track and ensure compliance/certification of training by detention officers should be developed by DOI-OLES, BIA-LES, and tribes.

21. DOI-OLES should work with BIA-LES and the IPA to develop training standards and modules for BIA and tribal detention officers that would, at a minimum, eliminate the need for separate adult and juvenile detention courses.

Chapter 7: Other Issues

Juveniles Housed at Adult Facilities

The placement of juveniles in adult detention facilities is limited by the Juvenile Justice and Delinquency Prevention Act of 1974.[17] The Act states in part, "…juveniles alleged to be or found to be delinquent…shall not be detained or confined in any institution in which they have contact with adult[s] incarcerated because they have been convicted of a crime or are awaiting trial on criminal charges…"

The Act allows for combined adult/juvenile jails if the juvenile and adult inmates cannot see each other and no conversation between them is possible.[18] This requirement is commonly referred to as "sight and sound separation."

"One inmate raped another inmate in 1997. It was due to understaffing and the guard was not certified. The boy was 13… The boy should not have been there."

During our site visits, we were troubled to learn of instances where juveniles were being housed with adults or held in adult facilities. This unlawful practice not only creates significant potential liability concerns, it significantly increases the likelihood that juveniles will be harmed by others or themselves. No matter what the reason or the duration of confinement, this practice would make major media headlines were it happening elsewhere in America.

A detention officer at one facility stated, "One inmate raped another inmate in 1997. It was due to understaffing and the guard was not certified. The boy was 13….The boy should not have been there." The officer added that the 13-year-old victim was being held in the jail for social services because there was no other place to hold him.[19]

According to officials at the Rosebud adult detention facility, juveniles are routinely held in violation of the sight and sound separation mandate because there is no juvenile facility on the reservation and staffing shortages prohibit detention staff or police from transporting juveniles off the reservation.

[17] The Act exempts juveniles held in secure adult facilities if being tried as an adult.
[18] Modification to the Act, effective December 1996, clarified the sight and sound separation requirement and provided that brief and inadvertent or accidental contact in non-residential areas is not a reportable violation.
[19] BIA records indicate the settlement in the case was for $150,000.

Hallway and bench used to hold juveniles. Sisseton/Wahpeton, SD

In addition, we were told that while the juveniles are physically separated from the adult population, they are still able to hear and communicate with adults in other parts of the jail. Detention officials attempt to comply with the spirit of the law by holding and feeding the juveniles in their individual cells because they cannot be taken to the central dining area without passing through the adult cellblock. Rosebud personnel also attempt to work with the tribal courts to keep the duration of juvenile stays to a minimum amount of time, usually a few days. We note that the Rosebud Sioux tribe is constructing a new juvenile facility at another location on the reservation under a DOJ grant. The new juvenile facility is expected to open later this year.

At the Sisseton/Wahpeton detention facility, juveniles are held in a locked hallway between the police department and the jail's outdoor recreation area. This hallway was not intended to house inmates, has no toilet facilities, and has glass doors that could easily be broken with one of the many chairs in the hallway. Recently a juvenile detainee attempted to escape from this hallway by climbing into the jail attic through an access panel in the ceiling. Detention personnel were able to apprehend her before she could manage to escape from the jail. As a result, however, juveniles are now shackled to a bench in the hallway to prevent future escapes. One officer stated "We're not supposed to hold juveniles… but sometimes we have to." Detention personnel indicated that they have no choice but to hold arrested juveniles since there is no juvenile facility on the reservation and they do not have enough personnel to transport juveniles to other locations without advance planning. One officer advised that juveniles are usually only held for a few hours until they can be released to relatives or social services personnel. There are occasions, however, when a juvenile is held overnight because relatives cannot be contacted.

"We're not supposed to hold juveniles... but sometimes we have to."

Overcrowding

Frequently, many of the jails in Indian Country operate at, or over, their intended capacity. Of the facilities visited, 53% of jail personnel remarked they were habitually overcrowded, whereas the others only became overcrowded on holiday weekends or during tribal events. At some of the facilities, overcrowding has become a health and sanitary issue. Many inmates sleep on mats on the floor because the jails hold two or three times their rated capacity on a regular, recurring basis. For example, the Tohono O'odham jail has a rated capacity of 34 but routinely holds more than 110 inmates. Consequently, more than half the inmates at this jail sleep on

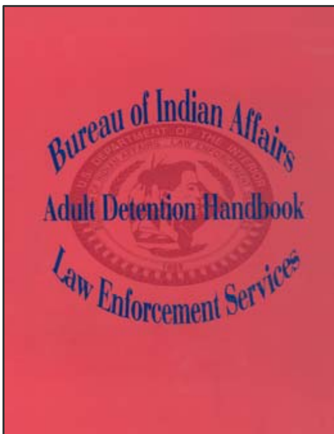
mats on the cell floors, increasing the potential for altercations and injuries because inmates cannot move without stepping over and around one another. Only a handful of jails transport inmate to other facilities to alleviate overcrowding. Most simply pack more and more inmates into the cells and hope that the overcrowding does not last too long. Some jail administrators we interviewed discussed the potential benefits of having a regional jail or jails within Indian Country as one option to alleviate overcrowding. For example, we learned that the Ute Mountain detention facility, which often has more beds than inmates, has been accepting inmates from the Mescalero Apache Tribe in order to gain the most use of the facility. Additionally, BIA-LES officials indicated that they have been researching the concept of constructing regional detention facilities to house long-term inmates which would have the added benefit of reducing the inmate populations at local jails.

Overcrowded cells. Tohono O'odham, AZ.

During our site visits, we discussed the benefit of building regional jails. We found that there was varying support for the concept; however, the most common impediment to a regional concept noted was the resulting loss of tribal identity. Others expressed no concern for mixing members of different tribes together in a regional facility.

Policies and Procedures

By their own admission, BIA managers have failed to follow their own guidelines for the detention program. In October 1996, BIA published detention facility handbooks, which established policies and procedures for Indian Country jails. The policies and procedures were derived from national corrections industry standards. The handbooks initially established 48 mandatory standards for adult facilities and 47 mandatory standards for juvenile facilities. Detention facilities were required to comply with mandatory standards by the end of 1998. The remaining 201 adult standards and 219 juvenile standards were designed to be phased-in over an 8-year period after publication so that by the end of 2005, detention facilities would be 90 percent compliant with all of the published standards. Alarmingly, we found that none of the jails we visited were compliant with the original mandatory standards, let alone the remaining ones. We also found BIA managers made little effort to adhere to the compliance schedule or ensure that jails even worked toward compliance with the original mandatory standards.



BIA's approach to development and implementation of its

detention standards held all BIA-operated and 638-contract jails accountable for each of the standards without regard for the size and operation of individual facilities. This flawed plan required that a jail with ten beds be held to the same standards as a jail ten times its size, unnecessarily overloading smaller facilities with needless and inappropriate requirements in a situation where simple, basic detention procedures should be sufficient.

Under the compliance schedule published in the detention handbooks, these jails were held to the same implementation timetable regardless of operational considerations, staff size, or inmate population. It appears that BIA simply adopted American Correctional Association (ACA) jail standards without giving any consideration to the variety of detention facilities under its jurisdiction.

Liability

BIA's neglect and mismanagement of the detention program increases the liability potential to BIA and to the Department. BIA has paid out $855,000 to settle several lawsuits in the last 3 years alone and there is another $11 million claim pending. We believe that federal, state, or county jails operating under the same conditions we discovered at Indian Country detention facilities would be inundated with legal actions and most would likely have been shut down by court order long ago.

We also found that detention officers at the majority of the jails we visited are dispensing prescription medications to inmates with little, if any, training, inadequate safeguards, and no formal process to ensure legal and medical requirements are met.

BIA is sitting on a liability time bomb and must act to diffuse it now so that modest funds available can be used for their intended purpose, instead of potentially being consumed by legal fees, fines, and judgments.

Recommendations

22. DOI-OLES should conduct routine scheduled and unscheduled inspections to determine compliance with the juvenile sight and sound restriction wherever adult and juvenile offenders are co-located.

23. DOI-OLES should assist BIA-LES with the development and implementation of appropriate standards for Indian Country detention facilities. Consideration for size, capacity, and type of facility should be taken into account. Standards should, at a minimum, identify core health and safety requirements that would be applicable to all jails regardless of size and capacity.

24. DOI-OLES and BIA-LES should consult with the tribes and continue to explore using regional detention facilities to accommodate longer-term inmates and to reduce overcrowding at smaller facilities.

Chapter 8: Positive Findings in the Detention Program

As a result of our Interim report, the Secretary immediately charged a senior Department official with overseeing BIA actions to remedy the conditions at Indian Country jails. The Secretary also promptly requested assistance from the DOJ, Bureau of Prisons (BOP), which resulted in a senior-level detention professional being detailed to the Department to assist BIA-LES senior management with the identification and implementation of actions to correct the deficiencies we discovered during our assessment.

BIA-LES senior officials readily acknowledged the deplorable conditions at the detention facilities and expressed grave concern over our findings. They have already made management and staffing changes at various levels of the detention program.

In early September 2004, BIA-LES conducted a strategic planning conference to deal with the significant deficiencies noted in our April 2004 Interim report. BIA-LES subsequently published the Indian Country Detention Strategic Planning Summary, which contained a task management plan when, if implemented as designed, may address some of the safety, security, and health-related concerns we observed during our site visits.

BIA-LES has assigned a number of its own personnel to accomplish these tasks and has either requested outside resources to assist them in addressing these issues or has developed a plan to obtain outside assistance from professional corrections organizations, such as the Bureau of Prisons, American Correctional Association, American Jail Association (AJA), and Nation Institute of Corrections. In addition, BIA-LES is in the process of developing plans to ensure that health, safety and maintenance issues are promptly communicated and addressed by OFMC as well as an inspection process to confirm that these issues are being dealt with promptly.

In response to our concerns about overall non-compliance with standards that were voiced in our Interim Report, BIA-LES began to review its current standards as they applied to

each type of facility. BIA-LES reported that they are working with ACA and AJA to develop new standards that will apply to detention facilities based upon their size, staff, and inmate population and which will be implemented through a gradual compliance schedule.

It should also be noted that during our assessment we did discover some instances in which detention personnel were being proactive and had implemented procedures with a goal of managing jails more effectively and where positive results have truly been achieved.

As previously noted, the Tohono O'odham detention facility has established a Field Training Officer program to ensure that new detention officers are mentored and veteran detention officers are provided with refresher and skills enhancement training.

The Gila River juvenile detention facility has established a program in which juveniles receive counseling and education as they progress through a program of self-improvement. Additionally, inmates are held accountable for their behavior with established consequences for vandalism and for upkeep of uniforms, furniture, and other equipment issued to them.

The White Buffalo Home juvenile detention facility obtained a grant to establish a home detention program to reduce the detainee population while encouraging rehabilitation of first-time offenders. The program has been so successful that they hope to extend the program by obtaining another grant.

We also found that the detention facility at the Nisqually reservation in Washington was constructed as a minimum security jail utilizing modular buildings, resulting in significant cost savings over traditional construction methods.

We were also surprised to discover that all of the positive innovations noted above occurred at detention facilities operated by the tribes under the 638-contract programs. We found that the Tohono O'odham and White Buffalo facilities share many of the maintenance problems and staff shortages found at other jails, yet they still managed to make program improvements and achieve meaningful results.

Another positive effort was noted in Arizona where detention

personnel from the Hualapai Indian Nation, San Carlos Apache Tribe, Gila River Indian Community, Salt River Pima-Maricopa Indian Community, and the Tohono O'Odham Nation created the Arizona Tribal Justice and Rehabilitation Coalition (ATJRC). ATJRC was formed to benefit member tribes through cooperative initiatives involving resource development, education, and coordination of detention and related services. Presently, 12 of the 22 Arizona tribes are members of ATJRC.[20] The coalition holds regular meetings where detention issues are discussed and members share experiences and best practices.

Recommendation

25. BIA-LES should facilitate regular regional meetings for all BIA and tribal detention administrators to encourage collaborative efforts and discussions on detention best practices.

[20] Only two of the four BIA-operated jails in Arizona are members of this organization.

Conclusion

BIA has failed their responsibility for providing safe and secure detention facilities. The detention program has essentially been ignored by BIA-LES managers and allowed to languish while attention and funds have been focused on other more traditional law enforcement operations.

At the beginning of this assessment, BIA indicated that the majority of their problems could be attributed to a lack of funding. While we believe that more funding is needed, we also believe that BIA is not effectively utilizing the funds it is being given now. BIA must get its fiscal house in order through establishment of sound budget and accounting practices as well as oversight processes before any additional funds are sought or given.

We firmly believe that BIA must overcome the self-imposed paralysis that results from the often-used excuse that BIA simply needs more money. Much can be accomplished when managers and staff apply a sensible attitude to overcome challenges. Oversight has minimal costs and, if practiced, would correct many of the deficiencies that were found. Simply put, a little attention goes a long way.

The responsibility for the conditions and failings we have found at Indian Country detention facilities cannot be attributed to any particular individual or administration. Some of these problems are decades old. Thus, the solutions will not be easy to achieve and may take considerable time, effort and funding. However, nothing less than Herculean effort to turn these conditions around would be morally acceptable.

Appendix 1

REPORT RECOMMENDATIONS

No	Recommendations	Page
1.	For the purpose of providing the prominence and advocacy vital to ensuring that the focus on improving Indian Country jails does not diminish, the Deputy Assistant Secretary for Law Enforcement should become actively engaged in coordinating the oversight and management of the BIA-LES detention program.	12
2.	The Department should create a senior-level (GS-14/15) full-time equivalent (FTE) position for a detention professional in DOI-OLES to help provide increased coordination and advocacy for the Indian Country detention program.	12
3.	DOI-OLES should conduct compliance inspections at BIA and 638-contract detention facilities on a scheduled and unscheduled basis. For the immediate future, it is recommended that the Department OLES and not BIA-LES be responsible for the compliance oversight of the detention program.	12
4.	BIA-LES should establish a senior-level (GS-15) detention program director with proper detention management credentials to manage the BIA and 638- contract detention facilities. This position should report directly to the BIA-LES director, coordinate actions with DOI-OLES, and be the BIA-LES liaison with OFMC for detention-related repairs. BIA should provide the appointee with adequate new staff to fulfill these responsibilities. At a minimum, the Central Detention office should be staffed with a Director, Deputy Director, secretary, and three management analysts. The six regions should be staffed with two detention specialists per region.	12
5.	DOI-OLES should ensure that BIA-LES establishes and implements clear reporting protocols for serious incidents occurring at all BIA and 638-contract detention facilities. At a minimum, all officer safety issues, inmate deaths, attempted suicides, assaults, and escapes should be reported promptly through an established chain of command ending with the Director of BIA with copies to the DOI-OLES.	24

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6.	**BIA and 638-contract detention administrators should ensure that any escape is immediately reported to surrounding local, tribal and state law enforcement authorities.**	**24**
7.	**BIA-LES criminal investigators should immediately respond and conduct a preliminary inquiry to determine if a full investigation is warranted on any reported serious incident. Their findings, in every case, should then be reported to the Director of BIA-LES with a copy to the DOI-OLES. All death cases at BIA or 638-contract detention facilities, not investigated by the FBI, should be investigated by a BIA-LES criminal investigator.**	**24**
8.	**BIA and tribes should explore alternatives to detention for intoxicated inmates. When it is necessary to incarcerate intoxicated inmates, additional detention officers should be on-duty to assist with the additional monitoring required.**	**25**
9.	**DOI-OLES should work with the tribes and BIA to establish a Memorandum of Understanding (MOU) with the Indian Health Service to provide on-site medical assistance at all detention facilities with more than 20 inmates incarcerated. Detention staffs should be adequately staffed and scheduled to accommodate for medical transport to hospitals when necessary.**	**25**
10.	**Staffing shortages at BIA and 638-contract detention facilities that are related to officer safety should be identified by the BIA-LES and corrected immediately. DOI-OLES should oversee this effort.**	**29**
11.	**BIA-LES in collaboration with 638-contract programs should develop staffing models and methodologies for BIA and 638-contract detention facilities. DOI-OLES should oversee this developmental effort.**	**29**
12.	**The DOI Law Enforcement and Security Board of Advisors should develop recruiting standards and guidelines for BIA detention officers. BIA-LES should then assist tribal detention programs in developing standards and guidelines for tribal detention officers.**	**30**

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13.	**BIA OFMC and BIA-LES should immediately establish an effective system for prioritizing repairs that have any impact on inmate or detention officer safety. They should also review FMIS to identify and remedy inaccurate and redundant entries and implement quality control measures to reduce the risk and occurrence of improper entries.**	**36**
14.	**BIA should establish and implement a single line item budget for all BIA-LES detention facilities and expenses. BIA-LES should require 638-contract detention facilities to implement similar cost tracking practices.**	**44**
15.	**BIA should utilize accurate budget projections that incorporate future funding requirements when preparing funding requests rather than just using historical data. As part of future funding requirements, BIA-LES senior officials and local detention administrators should identify any existing needs and/or deficiencies so that these issues can be properly addressed.**	**44**
16.	**DOI-OLES should work with BIA, tribes and DOJ to develop strategic plans for jail replacement and renovation. DOI-OLES should assist BIA-LES with developing a comprehensive needs assessment to ensure that jails are built and sized appropriately.**	**44**
17.	**BIA should implement internal control procedures and proper management oversight to ensure that BIA funding and expenditures are accurately tracked and reported on a regular basis.**	**44**
18.	**A standard law enforcement and detention service clause should be developed and used in each and every Public Law 93-638 contract for BIA law enforcement and detention services. The clause should require at a minimum that: (1) law enforcement and detention funding be accounted for and used for its intended purpose and (2) serious incidents be promptly reported to BIA-LES as a condition of the contract.**	**44**
19.	**BIA-LES and the IPA should take immediate action to identify and train all current detention officers who have not received the basic IPA detention officer training.**	**47**

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20.	**Appropriate measures to track and ensure compliance/certification of training by detention officers should be developed by DOI-OLES, BIA-LES and tribes.**	**47**
21.	**DOI-OLES should work with BIA-LES and the IPA to develop training standards and modules for BIA and tribal detention officers that would, at a minimum, eliminate the need for separate adult and juvenile detention courses.**	**48**
22.	**DOI-OLES should conduct routine scheduled and unscheduled inspections to determine compliance with the juvenile sight and sound restriction wherever adult and juvenile offenders are co-located.**	**52**
23.	**DOI-OLES should assist BIA-LES with the development and implementation of appropriate standards for Indian Country detention facilities. Consideration for size, capacity, and type of facility should be taken into account. Standards should, at a minimum, identify core health and safety requirements that would be applicable to all jails regardless of size and capacity.**	**53**
24.	**DOI-OLES and BIA-LES should consult with the tribes and continue to explore using regional detention facilities to accommodate longer-term inmates and to reduce overcrowding at smaller facilities.**	**53**
25.	**BIA-LES should facilitate regular regional meetings for all BIA and tribal detention administrators to encourage collaborative efforts and discussions on detention best practices.**	**56**