TESTIMONY OF THE HONORABLE EARL E. DEVANEY
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BEFORE THE COMMITTEE ON INDIAN AFFAIRS
UNITES STATES SENATE
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Mr. Chairman and members of the Committee, I want to thank you for the opportunity to address the Committee this morning concerning the state of detention facilities in Indian Country.

In September of 2003, my office began an assessment of Indian Country detention facilities. I initiated this assessment following a conversation with the Chair of the Attorney General's Advisory Committee on Indian Country, United States Attorney for the District of Minnesota, Thomas Heffelfinger, who had expressed his general concerns to me about the overcrowding and poor conditions of Indian Country jails. I then discovered that these same concerns had been articulated for years by the Department of Justice in numerous reports. My office had also been receiving unofficial reports of appalling conditions at the detention facilities in Indian Country. With all this information, I felt compelled to address these concerns immediately.

We selected a team of seasoned investigators and auditors to visit a predetermined number of facilities and collect information about their management and operation. Our focus was on whether the funds designated for Indian Country detention facilities were being properly expended and whether these facilities were safe and secure.

I would like to point out that we began our assessment well before the confirmation of the present Assistant Secretary for Indian Affairs, and prior to any of the recent media disclosures of allegations made by a former BIA law enforcement official.

While we have completed all our planned site visits, we have not finished our analysis of the funding issues or BIA's management of the Detention Program. However, given the Committee's interest in this issue, I will gladly summarize our findings, thus far, and share with the Committee the same concerns I shared with Secretary Norton in April of this year when I gave her an interim report on the deplorable conditions we were finding at some of these facilities. Thus, my report to her then and to you today, focuses primarily on deaths, attempted suicides, escapes of inmates and officer safety issues. While we have visited only 27 of the 74 detention facilities in Indian Country, we assume that similar incidents have occurred at other detention facilities. Therefore, we believe it is imperative that BIA takes immediate action to alleviate these potentially life-threatening situations at all Indian detention facilities.

Under the Indian Law Enforcement Reform Act of 1990, BIA is required to provide law enforcement services on reservations. In addition, under the Indian Self-Determination Act, BIA provides funding to tribes for detention services. Of the 74 detention facilities in Indian Country, 20 are operated by BIA's Office of Law Enforcement Services (OLES), 46 receive BIA funding for detention services under Public Law 96-638, and 8 are operated by tribes. Of the 74 facilities, 28 house adult inmates, 11 house juveniles, and 35 house a combination of both adults and juveniles.

For many years the BIA detention program has been characterized as drastically understaffed, underfunded, and poorly managed. BIA's Director of Law Enforcement has oversight authority for BIA-operated and 638-contract detention facilities. Until very recently the Director oversaw these facilities through six district commanders and with a three person detention staff at OLES Headquarters.

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

Based on our visits, we discovered that serious incidents are not always communicated up the chain of command. Our review of the Serious Incident Log maintained by the OLES detention program and a similar log kept by the OLES internal affairs unit revealed that many of the incidents we identified occurring within the last three years were not contained in these logs. In fact, during this three year time frame we found close to 500 serious incidents – including deaths, suicide attempts and escapes – that were either undocumented or not reported to the BIA/OLES.

The following are some examples of the serious situations we have identified so far in our assessment.

Deaths and Suicides

We learned of ten deaths from the facilities we visited. Five of these deaths were suicides and five were non-suicides. Inexplicably, only 5 of these deaths had been reported to OLES. Among those deaths reported to OLES is the recent death of a 16-year old student who died while in a detention cell at the Chemawa Indian School in

Oregon. BIA operates the Boarding School which has a detention facility. This case is under active investigation by my office in conjunction with the U.S. Attorney in Portland, Oregon.

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

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

Attempted Suicides

Based on our findings, suicide attempts appear to be a regular occurrence at many of these facilities. At the BIA-run Northern Cheyenne Detention Facility in Montana there have been an alarming 41 suicide attempts within the last three years. Only 2 of those incidents were actually reported to the OLES.

At many of the facilities, we found multiple suicide attempts made by the same inmate. For example, during 2001, an individual detained at the Shiprock facility in New Mexico attempted to hang himself seven times using articles of clothing or towels left in the cell. The correction officer's response was quite elementary—if the inmate tried to hang himself with his socks, they took his socks away; if he tried to hang himself with

his towel, they took the towel away—until finally the inmate was left in his cell without any clothing.

Prisoner Escapes

For the most part, the correctional officers at these facilities convey stories of prisoner escapes with an air of casual inevitability. In fact, our impression is one of collective acceptance. In our interviews, correctional officers who discussed escapes also told us that it is simply not possible to prevent inmates from escaping. Since the majority of these facilities often function with only a single officer on duty, officers explained that they simply cannot "keep an eye" on everyone. In addition, we found that some facilities do not notify local law enforcement of prisoner escapes. This is not only disconcerting, it is irresponsible to allow escaped prisoners to travel freely in a community and surrounding areas while the local law enforcement authorities have no information about their escapes.

Physically rundown and deplorably maintained, many of the facilities provide ample opportunity for escape. At one facility, the chain-link fence surrounding the outdoor recreation yard was held together and locked by a set of handcuffs because the inmates had learned the combination to the cipher lock on the gate. While many of the recreation yards at these facilities are fenced-in and crowned with barbed wire, there seems to be a universal acceptance among the correctional officers that if inmates want to climb over the fence and escape, they will.

From weakened and deteriorating locks on cell doors to broken windows in inmate dormitories, the interior of many of these facilities is in extremely poor condition

and therefore does nothing to deter prisoners who set out to escape. For example, the wire-meshed windows in many of the cells at the White Buffalo Youth Detention Center 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 Director at the detention center, these "removable windows" have, in the past, provided a vehicle of escape for a number of detained youths.

Perhaps even more disturbing than the actual circumstances and frequency of inmate escapes at these facilities are the lack of response and importance placed on these incidents by those working at the facilities, both correctional officers and facility directors, alike. At the Shiprock Adult detention facility in New Mexico, one officer chuckled in response to our question about escapes, and said, "Oh yeah, they happen." She then said that a prisoner had escaped from her in June 2003, on foot and in ankle-shackles while she was ushering a line of prisoners from the facility to the courthouse across the courtyard. Since she was the only officer on duty at the time, she said that she could not pursue the fleeing inmate and leave the other prisoners unattended. The officer told us that to the best of her knowledge that prisoner had not yet been apprehended.

Officer Safety

One of the most common problems we found while visiting these facilities is lack of staffing. In many cases, having only one correctional officer on duty per shift is not unusual; it is common practice.

At Mescalero in New Mexico, a female correctional officer was working alone when she was confronted at knife-point by a former inmate who entered the facility

through an unlocked door. Tragedy was averted when the officer locked herself into a detention cell. An inmate at the jail convinced the intruder to leave the officer alone, while a second inmate summoned the police.

The San Carlos facility in Arizona has only four correctional officers on staff to operate what they feel is an overcrowded facility. To address this situation, the facility has placed a 24-hour, 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. At San Carlos, a detention officer on duty has no one for back up if a medical emergency or conduct problem arises. When an officer is working alone, he or she must either wait for assistance or act independently, both of which risk placing themselves or inmates in a potentially life-threatening situation.

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

Aside from a lack of officers on staff, the current officers at these facilities are, for the most part, poorly trained. This lack of training not only hinders the officers'

ability to properly document incidents and follow standard procedures, but also leaves the officers unprepared to prevent physical harm that may be targeted against them or against inmates. In fact, one district commander stated, "We've never received any training on how to operate a detention facility." When asked if his facility followed BIA standards, the commander quipped, "Most BIA standards can't be met, so why even try?"

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

During my discussion with the Secretary in April, I made a number of recommendations to her including instituting new reporting protocols and the prompt investigation by BIA of any serious incident such as those I have cited today. I was pleased by her immediate response to my briefing. Following our meeting, she tasked Associate Deputy Secretary James Cason along with Assistant Secretary David Anderson to begin addressing the concerns I raised. To assist them in this effort, she also made a request to DOJ for an experienced corrections professional from the Bureau of Prisons to be detailed to BIA. That person is now on board and I detect a new sense of urgency about these concerns at BIA.

Our final report, which we hope to have finished at the end of the summer, will provide the Department with additional findings and recommendations regarding

funding, detention standards and policies, detention facility maintenance, health care and social services at the detention facilities, and training and hiring practices of detention personnel.

The responsibility for the conditions and failings we have found at Indian detention facilities can not 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 a Herculean effort to turn these conditions around would be morally acceptable.