UNITED STATES DEPARTMENT OF THE INTERIOR
Office of Inspector General
1849 C Street NW
MS 5341
Washington, DC 20240

November 1, 2005

Memorandum

To: Secretary

From: Earl E. Devaney
Inspector General

Subject: Report on Child's Death at Chemawa Indian Boarding School

I enclose the Office of Inspector General's (OIG) Report of Investigation concerning the tragic death of a 16 year-old girl at the Chemawa Indian Boarding School for your review and consideration for administrative sanctions. I feel very strongly that the inactions and indifference demonstrated by several Bureau of Indian Affairs (BIA) officials should not go unpunished. [Ex. 5].

On December 6, 2003, Cindy Gilbert (aka Cindy SoHappy) died while in the custody of the Bureau of Indian Affairs at the Chemawa Indian Boarding School (CIS) in Salem, Oregon. Gilbert, who was 16 years old at the time of her death, had been placed in the school's detention facility after being found intoxicated on school grounds. The Federal Bureau of Investigations conducted a criminal investigation into the death of Gilbert and presented its findings to the Assistant United States Attorney of the District of Oregon who declined criminal prosecution against the on-duty personnel at the school. The FBI's investigation focused on the events which occurred on the night of her death and the action of on-duty personnel, however, and did not address the conduct of upper-level BIA officials.

The Office of Inspector General opened an investigation after learning that BIA senior management had been previously alerted that the CIS holding facility failed to meet detention standards and that the continued use of the school's detention cells was a serious liability. In addition, BIA Internal Affairs Agents reported to the OIG that the lack of supervision and training on the part of BIA education administrators and CIS staff may have contributed to the student's death.

Our investigation included dozens of interviews with current and former staff, managers and senior officials in both the BIA Office of Law Enforcement Services (OLES) and BIA Office of Indian Education Programs (OIEP), in addition to a review of hundreds of documents regarding the operation of the school and its detention facility. We developed evidence that inaction on the part of senior officials within BIA OIEP and OLES resulted in the failure to maintain a safe environment at the detention facility and, ultimately, became a significant factor

in Gilbert's death. The OIG investigation was provided to the Criminal Section of the Department of Justice Civil Rights Division for review and prosecution. In December 2004, we received notice that the case was declined for prosecution because it did not constitute a prosecutable violation of federal criminal civil rights statutes. Remarkably, the Civil Rights Division does not have jurisdiction over federal detention facilities; their jurisdiction is limited to state and local detention facilities.

[Ex. 5].

In June, 2005, we sought additional review by the Office of Public Integrity at the Department of Justice. Again, we received a declination suggesting that while the consequences were appalling, the conduct of the BIA Officials that contributed to this tragedy is better addressed in another forum.

Therefore, we believe that an additional review for administrative sanctions, with a focus on the historical pattern of inaction and disregard for human health and safety, would implicate senior officials within the Bureau of Indian Affairs – including the directors of the Office of Indian Education Services (OIES) and Office of Law Enforcement and Security (OLES). These officials failed to take action that may have prevented the untimely death of Cindy Gilbert and endangered countless other students.

We found records to indicate that annual inspection reports (1996-2003) from BIA-OLES and Indian Health Services (IHS) routinely identified the urgent need to establish clear policies and procedures and to establish emergency medical screening capabilities with on-site medical professionals at CIS. The reports warn that the school was using the detention cells unlawfully and in violation of BIA and National detention standards, including lack of medical screening, no documentation of charges, and use of cells for social detoxification.

BIA officials had long been alerted to the potential liabilities associated with the detention facility and were provided clear recommendations to correct the deficiencies. The recommendations, however, were never acted upon. An argument between the law enforcement and education programs ensued, concerning who within BIA "owned" the problem. OLES and OIEP became embroiled in what essentially became a turf war.

In addition to the bureaucratic disagreement, we believe the evidence reflects negligence and mismanagement in the oversight of the detention facility. Chemawa school staff reported that they had not received training for monitoring intoxicated or drugged students or any other detention training. Records indicate that up to 240 students a year had been placed into the cells, some with no documented reasons, and at times up to 30 students had been placed in the four cells at once.

A review of the detention videotape surveillance of Gilbert's cellblock the evening of her death indicates that no school personnel entered the cell to check on her for several hours after her incarceration. Approximately one and a half hours elapsed after she stopped moving before someone check on her. Further, the investigation found that the employee monitoring the

cellblock was not trained in detention matters and was unaware of many of the policies in place to provide safe and secure detention.

[Ex. 5]. The report of investigation details employee involvement and is briefly summarized below:

1. OIEP Official

Although he was aware of the liability concerns at CIS as early as February 2003, the OIEP official failed to follow up with the OLES Director Robert Ecoffey to resolve the issues and did not address the concerns brought to his attention by the education line officer, who had direct oversight of the school supervisor and the CIS program, until after the death of Cindy Gilbert.

2. Special Officer (Retired), [Ex. 6 and 7C]

While the special officer was assigned to the Portland area as the area special officer for the BIA, OLES, he supervised the law enforcement personnel at CIS. In 1989-1990, the Detention Facility at the CIS was built with BIA funds allocated for a juvenile detention facility and was operated by BIA law enforcement personnel while the special officer was at the Portland area office. During this time, the special officer knew CIS students were being detained in the CIS detention facility.

In 1996, the special officer conducted an inspection of the CIS law enforcement program and the detention holding facility as part of a BIA, OLES Inspection and Evaluation team. The inspection report outlined the detention facilities deficiencies, specifically identifying health and safety concerns. In 1999 the special officer became BIA, OLES, District V, Deputy Commander, in Portland, OR, with oversight of the CIS law enforcement program. Even with prior knowledge of the CIS law enforcement program and detention facility deficiencies, the special officer took no corrective action to ensure the safety of students who were being placed in the holding cells.

Following a 1998 BIA, OLES inspection of the detention facility, the special officer, then a Supervisory Criminal Investigator, Portland Area, was directed to implement corrective measures for the deficiencies which were outlined in an action plan. The special officer forwarded the action plan and letter to the CIS law enforcement officer and asked that the corrective actions be implemented. The special officer never followed up to ensure the corrective measures were properly implemented.

A pattern of indifference and neglect was continued after the special officer became the Supervisory Special Agent in Charge (SAC). The special officer failed to report the conditions of the holding cells and the way juveniles were being placed in the cell to his supervisors. The special officer also requested annual statistics of the law enforcement activities at the CIS.

In March 2002, several e-mails were sent to the special officer from the BIA Deputy Director of OLES, regarding the BIA police officer at the CIS. In one e-mail the special officer replied, "He is a forgotten step child. Maybe we ought to consider placing him under OLES?" Even after the concerns about the police officer position at the school, the special officer failed to address the matter either directly or with his supervisors.

3. Robert Ecoffey – Former Director, BIA, OLES (presently BIA, Deputy Regional Director for Indian Services, Great Plains Region, Aberdeen, SD.)

As early as March 2002, Ecoffey had been alerted by staff members of the jurisdictional and liability issues related to having a BIA police officer at the CIS. Ecoffey did not address concerns about the police officer position at the school.

In February 2003, Ecoffey received specific notice from the OIEP Deputy Director about the liability concerns. Ecoffey delegated resolution to the Acting OLES Deputy Director and the OLES Deputy Director. No follow up was done by Ecoffey to ensure the issue was addressed.

Ecoffey was briefed in May 2003 by a BIA, OLES Inspections and Evaluations investigator who conducted a review of the CIS law enforcement program. The investigator informed Ecoffey of liability and safety concerns with CIS detention facility. Ecoffey told the investigator he would look into the matter, but he failed to even delegate the problems to staff and he did not follow up.

4. CIS Residential Living Specialist

The residential living specialist was the direct supervisor of the staff who monitored the holding cells the night Cindy Gilbert died. The specialist knew about the Indian Health Service Safety Inspections but failed to implement the corrections, especially regarding the training of staff. The specialist continued to direct his staff to place the students in the holding cells after being directly warned of the liabilities and safety concerns.

5. CIS Supervisor

The CIS supervisor was the direct supervisor of the CIS staff and was responsible for the welfare and safety of the students. The CIS supervisor did not ensure the CIS staff was properly trained, especially when it came to incarcerating the students in the holding cells.

The CIS supervisor knew about the Indian Health Service Safety Inspections but failed to implement the corrections. The CIS supervisor continued to direct his staff to place the students in the holding cells even after being directly warned of the liabilities and safety concerns.

The CIS supervisor failed to address concerns of the staff about placing students in the holding facility with high Blood Alcohol Concentrations; he also failed to have medical assessments conducted on incarcerated students.

6. OIEP Area Line Officer

The OIEP area line officer had direct oversight of the school supervisor and the CIS program. The area line officer did nothing to ensure that the CIS supervisor had the resources to properly train the CIS staff, especially when it came to incarcerating the students in the holding cells.

The area line officer received the OLES and IHS inspections but failed to take action to ensure that the deficiencies were corrected. The area line officer knew the CIS staff continued to place students in the holding cells, even after he had been warned of the liabilities and safety concerns.

The area line officer only forwarded one of the IHS inspection reports to his supervisor. He did not send the other inspection reports because he believed nothing would be done to address the problems.

7. Acting CIS Supervisor

The acting CIS supervisor was the direct supervisor of the CIS staff and was responsible for the student's welfare and safety. The acting CIS supervisor did not ensure the CIS staff was properly trained, especially when it came to incarcerating the students in the holding cells.

The acting CIS supervisor knew about the Indian Health Service (IHS) Safety Inspections and did not implement the corrections. Although the acting CIS supervisor sent a memorandum in March 2002 to his staff directing them to take immediate action to address the deficiencies outlined in the October 2001 inspection report, he continued to direct his staff to place the students in the holding cells without ensuring that corrective measures were implemented.

The acting CIS supervisor was assigned to the OIEP Portland Area Office with the knowledge the same practices and conditions existed while he served as the CIS supervisor. The acting CIS supervisor did not address the concerns with his supervisor.

8. BIA OLES Detention Program Specialist

The BIA OLES Detention Program specialist is responsible for oversight of the BIA Detention Program and knew the CIS had holding cells but did not think the cells were under OLES because they were not in a law enforcement facility. The Detention Program specialist said he placed the CIS detention facility on the list with other BIA and Tribal jails because he did not know the status of the facility. The Detention Program specialist did not actually check on the CIS detention facility status until after Cindy Gilbert's death.

I sincerely appreciate your review of this matter for corrective administrative action. As is our practice, I respectfully request that you provide a written response, citing any action taken as a result of your review. Since I have been asked to provide a copy of our final report to the Chairmen of the

Senate Committee on Indian Affairs and the Senate Finance Committee, as well as Senator Gordon H. Smith of Oregon, I would appreciate receiving your response as soon as practicable, so I might include it with my transmission of the Report of Investigation to the Senators.

If I can answer any questions you might have, I will be glad to do so. If you have questions that I cannot answer, I will be happy to make the investigating agents available to you. I can be reached at (202) 208-5745.

Investigative Report

On the Chemawa Indian School Detention Facility

This report contained information that has been redacted pursuant to 5 U.S.C. §§ 552(b)(6) and (b)(7)(C) of the Freedom of Information Act and the Privacy Act, 5 U.S.C. § 552a. References indicating gender are written in the masculine form to protect the identities of individuals and to facilitate the reading of the report.

Results in Brief

On December 9, 2003, the Office of Inspector General (OIG) was notified of the December 6, 2003 death of 16-year-old Cindy Gilbert, a female student at the Chemawa Indian School (CIS) in Salem, Oregon. Gilbert, had been placed in the school's detention facility after being found intoxicated on school grounds. Initially, BIA Internal Affairs Division (IAD) was assigned to conduct an administrative review of the incident while the FBI conducted the death investigation.

However, on December 15, 2003, the OIG assumed responsibility of the investigation after learning that BIA senior management had been previously briefed that the CIS holding facility failed to meet detention standards and that the continued use of the school's detention cells would be a liability. In addition, IAD reported to us that the lack of supervision and training on the part of BIA education administrators and CIS staff may have contributed to the student's death.

Our investigation included dozens of interviews with current and former staff, managers, and senior officials in both the BIA Office of Law Enforcement Services (OLES) and BIA Office of Indian Education Programs (OIEP), in addition to a review of hundreds of documents regarding the operation of the school. Evidence developed indicates that inaction on the part of senior officials within BIA OIEP and OLES resulted in the failure to maintain a safe environment at the detention facility and, ultimately, became a factor in Gilbert's death.

Background

On December 6, 2003, Cindy Gilbert was found dead in a cinderblock cell in the detention facility on the CIS campus after being detained for consuming alcohol. Gilbert, a.k.a. Cindy Lou Bright Star Gilbert Sohappy, from Warm Springs, OR, had attended CIS since August 26, 2003. She was in her first year at the school.

At approximately 8:15 p.m., a home living assistant (HLA) saw from the dormitory three students helping another female student trying to walk. The female student appeared intoxicated and fell down, after which the students helped her back up. The HLA left the dormitory and approached the students, who tried to hide the intoxicated female. The HLA informed the intoxicated student, later identified as Gilbert, that he would escort her to the Student Services Center, where staff members would process her for an alcohol consumption infraction. Since the student had trouble walking, the HLA supported her to keep her from falling. The HLA asked another CIS staff member to assist him in walking the student to the Student Services Center.

After arriving at the Student Services Center, the HLA and another CIS staff member led the student to a couch, after which the staff member left the area. The HLA described the student as "falling over" while sitting on the couch. She also tried to get up from the couch, but she cooperated when told to sit down again. In addition to the HLA, staff members in the Student Services Center that evening included a CIS clerk and the dormitory managers.

The CIS clerk administered a breath alcohol test to Gilbert using a portable hand-held breath alcohol testing instrument (Intoximeters Inc., Alco-Sensor IV), designed to measure Blood Alcohol Concentration (BAC).[1] On the first attempt, Gilbert's laughing caused the mouth piece to fall out of the instrument without registering a reading. During a second effort, Gilbert only blew halfway into the instrument. The BAC registered at .192 – more than twice the adult legal intoxication limit of .08 for Oregon. When interviewed, the CIS clerk described Gilbert's intoxicated state as falling over and having difficulty speaking. The CIS clerk conveyed his concern for Gilbert to a dormitory manager, saying, "[Gilbert's] really drunk." The CIS clerk informed the dormitory managers of Gilbert's BAC reading.

According to the HLA and the CIS clerk, Gilbert appeared considerably intoxicated. However, she answered questions even though she had trouble sitting up. One of the shift supervisors described Gilbert as, "looking up, smiling, talking with staff," and did not appear any different than other intoxicated students brought to the Center. Another dormitory manager questioned Gilbert as to the type of alcoholic beverage she had consumed. Gilbert disclosed that she had been drinking "Cuervo" (a brand name of tequila). Information regarding the amount and where Gilbert obtained the alcohol was not ascertained.[2]

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[1] When an intoxicated student comes to the Student Services Center, the student normally is given a BAC test, administered by any staff member present in the administration office. The CIS clerk, like the rest of the CIS staff members, never received training on how to use the alcohol testing instrument.

[2] Intoxicated students are normally asked a series of questions, which are not standardized or documented. The questions relate to the student's physical condition, the amount of alcohol consumed, when they last consumed alcohol, and how they obtained it. The questions vary with each staff member. No formal medical or suicide assessments have been used at the school for several years.

After Gilbert's BAC test, the supervising staff sent her to the holding facility. Such action is usually taken at the discretion of the staff (primarily the dormitory managers), who decide whether an intoxicated student should go to their dormitory room, the holding facility, or to the emergency room for medical treatment.[3]

One of the dormitory managers interviewed indicated that, as the shift supervisor, the other dormitory manager handled the situation with Gilbert and sent her to the holding facility. However, information from the CIS clerk, one of the dormitory managers, and the HLA refuted the other dormitory manager's account. Their collective recollection of what occurred indicated that the other dormitory manager took charge of the incident and ordered Gilbert to be transported to the holding facility (Dormitory No. 11). The CIS clerk stated that he overheard the other dormitory manager making arrangements with security to have Gilbert placed in the holding facility.

A security guard responded to the radio request to transport Gilbert to the holding facility. When interviewed, the security guard stated that he believed one of the dormitory managers had directed him to transport Gilbert. After the security guard arrived at the Student Services Center, one of the dormitory managers and the HLA escorted Gilbert to security guard's vehicle. They had difficulty placing Gilbert into the vehicle due to her intoxicated condition. Once inside, Gilbert wanted the HLA to stay with her, so the HLA accompanied the security guard while Gilbert was transported to the detention facility. According to the fact-finding review of Gilbert's death, conducted by the dormitory managers, Gilbert was transported to the holding facility at 8:20 p.m.

The holding facility is located in the CIS facilities management building next to the BIA law enforcement office, approximately 400 yards from the Student Services Center. The security guard contacted the BIA police officer by radio and asked him to help with Gilbert when they arrived at the holding facility. Upon arrival, Gilbert was removed from the vehicle and escorted into the facility by the HLA and the BIA police officer. In his incident report, the police officer noted, "Ms. Gilbert appeared to be highly intoxicated, and had a strong odor of alcoholic beverages upon her breath and person, was very unsteady on her feet (could not walk without assistance), had slurred speech, and blood-shot eyes." During separate interviews, the police officer gave the same account of Gilbert's condition as he had written in his incident report but added that she was able to respond to his questions and she, "Didn't seem to be any more intoxicated than anyone else that evening."

Gilbert was placed by herself on a mattress in holding cell No. 4, lying on her side, due to her highly intoxicated condition.[4] A copy of the videotape from the holding facility camera monitoring system indicated Gilbert entered the cell at 8:27 p.m.

That evening, a residential living assistant (RLA) was assigned by a dormitory manager to monitor the students placed in the facility. Four intoxicated students already had been placed in the facility for monitoring when Gilbert arrived. During an interview with the RLA, he recalled that when

[3] The alcohol breath test serves as a tool to help staff determine the best way to help intoxicated students. Unfortunately, no thresholds or guidelines were established as to which actions should be taken for specific BAC readings.

[4] The four holding cells measure approximately 10 by 7 feet each and are constructed of concrete walls and floors. A drain is located in the middle of the floor. A tamper-proof camera located in the upper corner of each cell allows staff members to monitor detained students at a control station adjacent to the cells. Each metal holding cell door contains a small glass window and a remote locking mechanism that can be accessed at a panel at the control station.

Gilbert was brought into the holding cell, "they were almost carrying her." Once Gilbert had been placed in the cell, the BIA police officer, the security guard, and the HLA left the holding facility, leaving the RLA alone to monitor all the cells via the camera video system.

The BIA police officer did not inquire about Gilbert's BAC level when she was placed in the holding cell. The officer stated that had he known Gilbert's BAC level, he would have told the RLA to keep a closer eye on her.[5]

The RLA watched Gilbert on the camera monitor and heard her from the cell. The RLA noted, "All I saw Cindy doing was laying there moaning, kind of babbling like, and rolling around. I don't know, like she was really miserable." Gilbert eventually moved to a position in the middle of the cell where the RLA thought she finally went to sleep. On previous occasions, the RLA had observed intoxicated students displaying the same kind of behavior as Gilbert. The RLA documented Gilbert's activities on a preprinted form, titled, "BUREAU OF INDIAN AFFAIRS, LAW ENFORCEMENT SERVICES, CHEMAWA INDIAN SCHOOL DETENTION FORM FOR HOLDING." [6]

The BIA police officer stated that he checked on Gilbert's condition at 8:35 p.m. The monitoring system video showed the police officer observing the cell monitor with the RLA at 8:40 p.m. The police officers' opinion was that Gilbert appeared to be doing well but had moved off the mattress near the drain in the center of the floor. The video tape recording also indicated that Gilbert stopped moving at 9:26 p.m.

At 11:11 p.m., the video tape showed the RLA entering Gilbert's cell for the first time since the student came to the facility. The RLA stated that he went into the cell at that particular moment because he (the RLA) felt "weird" and wanted to push the hair back off of Gilbert's face. When the RLA entered the cell, he noticed Gilbert was not breathing. The RLA immediately called the Student Services Center by telephone for assistance. The RLA also called the police officer on the radio to notify him of Gilbert's situation. The security guard overheard the radio transmission to the BIA police officer and arrived at the holding facility approximately 20 to 25 seconds prior to the police officer. The police officer stated that the security guard and the RLA were trying to get a response from Gilbert when he entered the cell. The police officer tried to revive Gilbert by shaking her, using an ammonia stick, and performing a sternum rub. After the unsuccessful attempts to stimulate a response, the police officer and the security guard proceeded to perform Cardio-Pulmonary Resuscitation (CPR). The security guard directed the police officer to call 911 and additional CIS staff for assistance.

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[5] The BIA police officer related that he usually could tell the intoxication level of students by their behavior, attitude, slurred speech, red eyes, and ability to answer questions. He acknowledged it is not uncommon for a student to have a .25 BAC reading and be able to carry on a conversation. He referred to those students as "accomplished drinkers."

[6] During the RLA's 6 years of employment, he has monitored students on more than 15 occasions without receiving any training on how to monitor or handle intoxicated students. The RLA stated that when he first monitored students, he was told to write down the student's name, what s/he was held for, and how they behaved every 15 minutes. He contended he was never told to physically go into the cells to check on the students. The only written guidance provided to him for monitoring detained students were the instructions on the "Detention Form for Holding" that was developed to provide a written record of each student detained in the detention facility. Staff members monitoring intoxicated students write down the student's behavior in 15-minute increments.

A Salem Fire Department Emergency Medical Services (EMS) unit was dispatched to the CIS at 11:22 p.m. After arriving at about 11:29 p.m., EMS personnel assumed resuscitation efforts. At approximately 11:45 p.m., EMS personnel informed the BIA police officer that Gilbert was dead and nothing further could be done for her. The Oregon State Police and the county medical examiner subsequently responded to the situation, followed by a BIA special agent and special agents from the FBI, who had been notified by the BIA police officer.

Gilbert's body was transported to the Oregon State Police, Medical Examiner Division, in Portland, OR, where the state medical examiner performed an autopsy on December 8, 2003. The state medical examiner determined that Gilbert's death resulted from complications of acute ethanolism. The medical examiner's report indicated that Gilbert's blood alcohol level was .37, and her urine alcohol level was .43, as determined from samples sent for toxicology examination.

One of the dormitory managers notified Gilbert's aunt, Corrina SoHappy, the student's guardian, of her death. The dormitory manager also contacted his supervisor, the RLS, who instructed him to conduct a fact-finding summary of the incident.

Details of Investigation

Background History on the Chemawa Indian School Detention Facility

BIA OIEP oversees 184 schools throughout the United States, with 68 classified as boarding schools and peripheral dormitories. The boarding schools are divided into two categories: Reservation Boarding Schools (RBS) and Off Reservation Boarding Schools (ORBS). According to a 1999 OIEP report, "An overwhelming majority (80 percent) of enrolling students are considered highly 'at-risk'." These high-risk students attending ORBS require more intensive and specialized services than students attending other schools. Students are considered high risk because of their past behavior, as well as exposure to physical abuse, neglect, substance abuse, and unsafe sexual behavior. [7]

Founded in 1880, the BIA-operated Chemawa Indian School (CIS) is one of seven ORBS. It remains the oldest continuously operated Indian boarding school, primarily servicing tribes from the Northwest and Alaska. Located 6 miles from Salem, OR, CIS is a designated federal enclave with exclusive federal jurisdiction. Through the years, security and law enforcement matters have been handled in conjunction with the U.S. Marshals Service, FBI, and the General Services Administration (GSA), according to which agency possessed jurisdictional authority.

Due to increasing alcohol and drug use, student assaults on staff members, and destruction/theft of government property, school administrators became concerned about creating a safer learning and living environment.[8] In the late1970s, school administrators began requesting a permanent law enforcement presence on the CIS campus. Several options emerged with which to handle jurisdictional issues and provide the school's needed security. Despite numerous agencies and government officials providing law enforcement services to CIS, the situation remained unresolved until 1980.

On July 22, 1980, GSA Administrator R. G. Freeman III delegated authority to Secretary of the Interior Cecil Andrus to appoint special uniformed police to protect persons and property at CIS. The delegation allowed the Secretary to re-delegate the authority to appropriate Department of the Interior (DOI) officers or employees. The resulting authority received by the Secretary enabled hiring law enforcement officers to patrol the campus, enforcing misdemeanors through the Central Violations Bureau (CVB) and felonies outlined in Title 18 United States Code (USC). In 1986, the BIA hired a police officer and a criminal investigator and assigned them to CIS.

With a permanent law enforcement presence, the school found itself in a dilemma in that it did not have a place to hold arrested students or those involved in serious incidents. Intoxicated students or those displaying uncontrollable behavior were either returned to their dormitory rooms or were transported to "holding rooms" operated by the Indian Health Service's (IHS) Chemawa Alcoholism Education Center (CAEC) Program at the IHS clinic on the campus.

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[7] ORBS administrators report that they deal with students who are on probation from juvenile court systems or come from dysfunctional homes where drug and alcohol abuse is common. The 1999 OIEP Boarding School report cites studies that confirm this information, stating 80 percent of enrolled students have a history of current alcohol or substance abuse and 80 percent have one or both parents with drinking problems.

[8] CIS reported weekly alcohol or substance abuse by many of their students.

In June 1987, IHS closed the CAEC holding rooms after allegations involving non-compliance with building, fire, and safety codes. There were also concerns over repairs for damaged rooms, student civil rights, and the absence of holding room policies. Following this closure, the school lacked resources to handle students who committed crimes or alcohol-related infractions, as well as those who demonstrated uncontrollable behaviors. As a result, school staff restrained students, placing them "on gym mats on the floor of the home living counselors' waiting room." School administrators tried to locate juvenile detention facilities from the state, county, and city law enforcement agencies that could house CIS students, but overcrowding and jurisdictional concerns made those resources unavailable. The nearest BIA or tribal detention facility was approximately 160 miles away and thus an unrealistic solution to detention problems.

Establishment of Detention Holding Cells

In 1988, OIEP and BIA OLES applied for a new campus detention facility using a Program of New Institutions (PONI) grant to fund the construction.[9] The PONI grant proposal submitted by the CIS outlined reasons for the new institution, specifically stating that "No facilities are available to put juveniles in detention when out of control or on drugs and alcohol." The CIS School Board endorsed the proposed "juvenile detention facility" on July 13, 1987, an action required for the grant.

The PONI grant proposal contained several attachments, including memorandums justifying the need for the facility and addressing the law enforcement jurisdiction at CIS. In a March 23, 1988, letter attached with the proposal, an attorney in the solicitor's office concurred with the need for "a federal on-site custodial facility." This attorney specifically cautioned the OIEP administration: "In undertaking to provide custodial services for students who are out of control and disfunctional [sic] due to their misuse of alcohol or a controlled substance (drugs) the persons considering your funding request should keep in mind that the Federal Tort Claims Act (28 U.S.C. 2671 et seq.) provides a legal basis upon which the government may be held liable for the personal injuries resulting from the negligent acts or omissions of its employees in carrying out a federal program." The attorney went on to admonish, "Thus, the BIA's needs for adequate staffing to properly implement the program of providing custodial care for this type of person should also be considered. We understand that the school has a working agreement with the Indian Health Service to provide medical evaluation and assistance to students in custodial care."

The holding facility was completed in the later part of 1989. As the proposal outlined, the school initially established the facility to detain juveniles. Supervisory responsibility over the holding facility within the BIA was never specifically defined. Both OIEP and OLES supervised the law enforcement program at various times.

CIS Holding Facility Policies and Procedures

In 1989, a working group from various agencies developed the holding facility policy and procedures, which were completed and used in the first years of the facility's operation. This document included a "Holding Facility Policy" statement, procedures for dealing with intoxicated students or students displaying out-of-control behavior, guidelines for medical assessments, procedures for the holding facility, and counseling/social services policies and procedures. We interviewed the

[9] The PONI grant provided renovation and/or construction of detention facilities, using congressionally appropriated funds resulting from Public Law 99-570, Anti-Drug Act of 1986.

former school principal and supervisor; he indicated that he had developed the policy and procedures for the new holding facility. The BIA criminal investigator stated that he also assisted in writing the initial holding cell procedures and implementing their use.

The CIS developed an "Emergency Medical Assessment" form that became part of the procedures. The initial holding facility procedures instructed staff members that "the Supervisor contacts the Indian Health Service (IHS) staff person on duty for a medical assessment." The IHS staff member would then conduct the medical assessment and make a determination that the medical problem either required admission to the hospital or that the student could be safely placed in the holding facility.

It is unclear when the school discontinued the procedures for medical assessments as noted in the initial policy and procedures manual.[10] A number of subsequent inspections conducted by BIA OLES and IHS throughout the years identified numerous holding facility deficiencies, including specific deficiencies regarding medical assessments and in the way students were placed in holding cells without proper procedures for staff to follow.

In order to address these deficiencies, the OIEP area line officer directed the acting CIS supervisor to develop policies and procedures for CIS law enforcement and security personnel. The acting CIS supervisor enlisted the BIA police officer's assistance. The police officer first drafted a Law Enforcement and Security Program Plan for 1996 and 1997, which included detention facility procedures. The security plan, titled, "Chemawa Law Enforcement and Security Action Plan," outlined procedures for campus security, patrol activities, and scheduling. Additional policies and procedures for handling and monitoring intoxicated and uncontrollable students were subsequently added at a later date. The BIA police officer updated this document annually, which was reviewed by the acting CIS supervisor or an equivalent supervisor, and forwarded it to the OIEP area line officer.

The police officer used reference material from the BIA, the Cheyenne River Indian Tribe Detention Program, and the Department of Justice to develop detention facility procedures. Procedures specifically described how to monitor students placed in the holding cells. This document states: "Continuous monitoring of the student will be provided and a personal, visual, check will be performed every 15 minutes, and more often if the student is intoxicated, combative or restrained." When interviewed, he explained that looking in the cell window served as a check on the student. If the student did not move, the individual monitoring the student was supposed to open the door and confirm the student's condition. The procedures also stated, "A physical check of every student brought into the detention area will be performed." The police officer defined "physical check" as a thorough search of the student to locate contraband. The police officer or the security staff under his supervision normally conducted such a check.

The CIS Law Enforcement and Campus Security Program Plan (1998-1999), which included holding facility policies and procedures for dealing with intoxicated students, was written as a handbook and forwarded to dormitory managers and shift supervisors. When interviewed, the RLS could not say whether staff had received or were familiar with the holding cell procedures, since no

[10] According to former education line officer, the medical assessment form was implemented and used from 1990 through 1995 while he had oversight of the school. The BIA police officer did not recall using the form and stated that no medical assessment was performed prior to a student's placement in a holding cell. Although forms for these critical assessments appear to have been developed, it remains unclear when they were discontinued, or if they, in fact, ever were used.

follow-up or formal training had been conducted. The acting CIS supervisor confirmed the RLS' admission concerning the lack of CIS holding facility training on how to deal with intoxicated students.

Handling of Intoxicated Students

A student found intoxicated on campus initially goes to the Student Services Center for "in-processing." Students intoxicated during school hours become the responsibility of academic staff. After school hours or on weekends, the residential living staff deals with intoxicated students.

During the initial intake, a BAC test is administered. After the BAC reading, supervisory staff members decide whether a student should go to his/her dormitory room, the holding facility, or the emergency room for medical treatment. Through the years, several staff members expressed concern about the lack of clear guidelines regarding BAC levels that would determine where intoxicated students should be placed. The lack of adequate standards forced staff to make subjective determinations concerning whether or not to place intoxicated students in the holding facility. According to the RLS, he requested guidance from the CIS supervisor in determining what BAC level would cause a student to be sent for medical treatment. The RLS stated that the CIS supervisor responded, "That's for you to figure out."

Once the intoxicated students arrive for evaluation, the staff asks a series of questions related to students' physical condition, the amount of alcohol consumed, when they last consumed it, and how they obtained it. As previously noted, the questions vary with each staff member since they are neither standardized nor documented. [11]

The RLA assigned to each dormitory complex must monitor intoxicated students if they are returned to their dormitory rooms. When the RLA was interviewed, he reported having to monitor two dormitories at one time. These could hold up to 35 students each. The RLA explained that during those instances, he had to "go from one dorm to another, checking rooms back and forth."

Law enforcement or security personnel provide transportation for students placed in the holding cells. Students are searched and placed in one of four cells, then monitored primarily by the residential living staff. The students may be observed through windows in each of the cell doors; however, occupants cannot be seen unless they are standing directly in front of the windows. The staff can also observe students using the camera in each cell at the monitor at a consol adjacent to the cells.

As noted above, staff members monitoring the students are suppose to write down the student's behavior in 15-minute increments on the "Detention Form for Holding." This form also provides opportunity to list the students' personal data, BAC readings if the students are intoxicated, the reasons for detention, the students' behavior, any injuries/medical problems, and a list of personal belongings and physical observations. For the majority of the staff interviewed, the written instructions on the form proved to be the only guidance provided for monitoring students in the cells.

According to the BIA police officer, some of the staff received verbal coaching on how to monitor students in the holding facility; however, this guidance was never documented. In addition,

[11] See footnote 3.

the majority of the staff who monitored students never received formal training or saw written holding facility policies and procedures, including specific guidance on handling intoxicated students.

The students detained in the cells remained there until released on a supervisor's orders. Detention varied from 1 to 72 hours, depending on the infraction, student's behavior, or the discretion of the staff. Students released from the holding facility returned to their dormitory rooms, many still in an intoxicated condition that required additional monitoring by residential living personnel. If a student required medical attention, the student would be taken to the IHS clinic located on the CIS campus prior to the clinic closing at 5:00 p.m. After hours, students requiring medical assistance would be transported to the Salem Hospital emergency room.

Student Detention Records

Most of the documentation for students placed in the holding facility appeared to be incomplete. The forms we retrieved indicated that during the period from September 2002 through October 2003, a total of 822 students were detained. Of those documented student detentions, 30 were undated. In addition, 240 detained students who were identified as being under the influence showed no recorded BAC level. Of those with recorded BAC levels, 15 intoxicated students who were placed in the holding facility had more than twice the adult Oregon State legal intoxication limit of .08. The BAC levels for some students had been documented at .249, or three times the legal limit; at .455 or five times the legal limit; and, in one instance, at .49, which is six times the legal limit. Additionally, 88 of the detained students had no documented reasons for being held.

Data compiled by the CIS law enforcement program for the 2000 through 2001 school year identified 573 students detained in the facility, primarily for alcohol or drug abuse**.** The information also indicates that 96 students were 18 years old or older. The design of the holding facility does not provide for sight and sound separation between adults and juveniles while incarcerated in a lock-down facility, as required by law.

Detention Facility Inspections

In June 1995, Holleyman Associates Architects, PLLC, located in Oklahoma City, OK, conducted a facility needs assessment on the CIS holding facility. The assessment report outlined structural deficiencies in the facility and touched on safety concerns for staff and inmates. Assessors indicated that the facility was non-compliant with 24 out 59 standards listed in the report.

The Holleyman report recommended renovating the booking/control area and installing an interior and exterior camera monitoring system to provide proper security. Cell doors were equipped with manual turn-key locking mechanisms that were not detention grade and needed to be replaced. Other major areas of non-compliance included improper sight and sound separation between males and females, juveniles and adults, and violent and non-violent inmates; problems with emergency lighting, air quality, and perimeter security; lack of emergency equipment; use of foamed mattresses; problems with a secure evacuation area; and no fire hose stations. The Holleyman report estimated the renovation and repair cost would total $119,163, which included expanding the facility by four additional cells and adding a secure safe area for the inmates during evacuations. Following the report, the school replaced the cell doors and installed an interior camera monitoring system.

The BIA OLES inspection of the holding facility and the law enforcement program in April and May 1996 delineated numerous deficiencies. The report noted that the facility did not function as a law enforcement entity by national and BIA standards and that students placed in the facility were not charged with any crime. Instead, the facility appeared to be used as a "social detoxification unit," detaining individuals until sober enough to be released. The report advised that "technically both medical and social detoxification are medically supervised." BIA OLES recommended that the facility be removed from the oversight and responsibility of law enforcement if it continued to be used in this manner.

The BIA OLES inspection also raised concerns regarding the lack of a formal program for the facility and the haphazard condition of available records. During the inspection, law enforcement personnel were able to produce a manual for the inspectors, but it was not readily available. The manual lacked comprehensive policies and procedures to operate the facility, and the report pointed out that the manual was not used by the staff detaining students. BIA OLES inspectors noted, "Staff use their common sense in supervising a student lock-down to sober up, because there is no law enforcement personnel to supervise or therapeutic personnel to evaluate the student."

The inspection report concluded that CIS needed the holding facility but that it required reprogramming to better serve school needs. Additionally the report admonished, "It is amazing that the program has not been sued, because its window of liability is wide open. It has no detention personnel, no support staff, no operational descriptions, no funding, and no clear authority to be used as a correctional institution."

Another CIS supervisor brought the 1996 BIA OLES inspection report to OIEP area line officer's attention. In a July 14, 1996 memorandum to the OIEP area line officer, the CIS supervisor wrote: "We should be able to meet several of these recommendations fairly quickly. We may still need some funding support from somewhere to completely get the program in line, especially in the area of specialized training of personnel." He was referring to the deficiencies outlined in the report.

This CIS supervisor summarized the deficiencies for the OIEP area line officer, saying, "BIA Law Enforcement has decided that the school's holding facility cannot be utilized, as it has been for several years." He continued, "In the verbal exit interview [the BIA Detention Specialist conducting the inspection] stated that we would be open for a law suit if we used the facility for many of the purposes that we have used it for in the past. He specifically listed the alcohol and/or drug involved students and further included violent, angry students, and the potentially criminally involved students." He further added, "Without the means to de-escalate angry, sometimes violent students or to detoxify alcohol and/or drug involved students, we will experience an overwhelming number of crises and emergency situations each day." In an interview, the OIEP area line officer acknowledged receiving the CIS supervisor's memorandum but did not address any of the holding cell issues until 1998, except for replacing the cell doors.

The BIA criminal investigator authored another BIA OLES inspection report of the CIS holding facility in June 1998**.** This consisted of a single page of program review and a corrective action plan. During the course of our investigation, we contacted BIA OLES in an attempt to obtain any additional information or field notes regarding this inspection. BIA OLES could not produce the requested documentation. We found that this report lacked the detail of earlier inspection reports. The report indicated that the school had recently installed a camera monitoring system in each of the cells and listed detention stats for the 1997 through 1998 school years.

The corrective action plan attached with the BIA criminal investigator's report listed eight deficient areas with a completion target date for each, as well as the individual responsible for implementing the corrective measures. Neither the corrective action plan nor the overview report gave any explanation or background as to how the deficiencies were identified. In fact, the report actually contradicted itself, with the corrective action plan deficiencies portion stating, "Although this program is understaffed, it appears to be managed effectively." The listed deficiencies referenced serious safety and liability issues, including first aid and CPR training for the staff, basic detention officer training, and development of suicide and medical screenings at the time of booking.

A subsequent copy of the corrective action plan obtained during our investigation documented the deficiencies as being corrected. During the BIA police officer's interview, he admitted being aware of the inspection and the corrective action plan, which stated that the deficiencies were completed or addressed. The police officer forwarded the completed corrective action plan to the BIA criminal investigator.

Regarding the medical screenings that were listed as being completed, the police officer understood this to mean he only had to document the student's injuries and not a medical assessment. He stated that he had discussed this matter with the BIA criminal investigator, who indicated there was no need for a detailed screening. The police officer further asserted that medical assessments had never been performed prior to placing students in the holding cells and that no medically qualified personnel had evaluated the students prior to detainment, except for suicide attempts addressed by the IHS clinic on the campus.

The BIA police officer also discussed the report with the acting CIS supervisor but could not recall if they had talked about medical screening. However, the police officer did recall discussing with the acting CIS supervisor the issue of having medical personnel accessible during the evening hours on another occasion. The supervisor told the police officer that no funding was available. The 1998 inspection report went from supervisor to area line officer on July 17, 1998, with an attached

memorandum requesting that the OIEP area line officer review and comment. The report was also forwarded to the special officer by the BIA OLES acting director on June 25, 1998, with an attached memorandum instructing the special officer to "Please review the attached reports and ensure the programs under your purview comply with the action plan." After interviewing the OIEP area line officer, the police officer, and the acting CIS supervisor, we determined that the medical and suicide screenings were never implemented following the 1998 BIA OLES recommendation.

Most of the CIS staff received first aid and CPR training. However, the BIA police officer said he discussed detention training with someone in BIA OLES, possibly with the special officer, who supervised the Portland area. The police officer was told that since school personnel monitored the students, they did not need detention training. No other training options were pursued. The BIA police officer was unsure of any training made available for dormitory staff. After we interviewed the RLS and several residential staff members, we determined that they had not received any detention training, although they still had primary responsibility for daily monitoring of detained students in the holding facility.

On September 29, 2000, October 16, 2001, and December 5, 2002, IHS conducted environmental health and safety surveys at CIS. The first survey addressed issues concerning holding facility occupancy standards previously discussed in this report. In addition, the September 29 report referenced information received from the staff that more than 30 students had been detained in the four cells at one time. Other information indicated that the cells were used to hold students not only for safety concerns, but also as a punishment.

The September 29 report also mentioned the school's use of the BAC test results as an indicator of a student's need for medical attention as well as the fact that the BAC test would not detect drug abuse. The survey report specifically raised medical concerns and pointed out that: "The security staff are reportedly trained as First Responders but are not necessarily prepared for medical emergencies such as life-threatening complications from drug and alcohol interaction. A more appropriate solution would be to have a medical evaluation conducted and if necessary to send intoxicated students to a local contract detoxification facility providing medical interventions. This has been checked in the past but no local facility has been identified who will admit minors. Another alternative would be to hire or contract with medically qualified professionals who would be available after hours for evaluations."

The September 29 report further stated: "Lock-down facilities create the issue of liability in a school setting." It suggested the school seek alternative solutions to their needs, either through contracting local facilities or hiring additional staff. Again the report reiterated, "An on-call nurse would be helpful for after-hours injuries and medical evaluations." The 2001 and 2002 IHS surveys reported, "The holding cell facility is unchanged since the last survey." Both surveys addressed the same concerns outlined in the first survey but with additional emphasis noted in the 2001 survey: "Intoxicated students should have a medical evaluation conducted before being placed in the facility…" The survey continued: "There should be adequately trained staff in the detention facility at all times that students are present."

IHS forwarded the surveys to CIS administrators, including the OIEP area line officer, the acting CIS supervisor, the CIS supervisor, and the RLS. After the acting CIS supervisor received the October 2001 survey, which was released to the school on March 22, 2002, he sent the survey to his department heads, managers, and supervisors. In a memorandum dated March 28, 2002, which he

attached to the survey, he wrote: "You're directed to take immediate action(s) to address these identified deficiencies and/or develop an interim abatement plan for each identified deficiency." The acting CIS supervisor did not recall any efforts to resolve issues concerning the medical screenings. However during numerous meetings with IHS, he asked for additional medical resources, which IHS stated were unavailable.

The OIEP area line officer confirmed that he was aware of the IHS surveys and had reviewed the reports. He related being involved in numerous negotiations with IHS to make medical staff available after hours and on weekends. However, an agreement was never reached between OIEP and IHS. He regarded the discussions with IHS as "just not fruitful" and stated that the problem was never resolved. IHS provides services to the students during the day, which the OIEP area line officer stated was impractical for the needs of the school in that the major need for medical services occurred after hours. He went on to say OIEP could have contracted after-hours medical services but it "just never got done." He forwarded the 2000 IHS report to his supervisor, the OIEP deputy director, but never sent him any subsequent follow-up reports. When interviewed, the deputy director could not recall seeing the report and said he was preparing to retire, which created a supervisory turn-over in his office.

In May 2003, the BIA Inspection and Evaluation Division inspected the CIS law enforcement program and raised concerns about the status of the BIA police officer and the holding cells. Two BIA special agents (one was the inspecting agent) briefed Robert Ecoffey, BIA OLES director, on the inspecting agent's findings in May 2003.

In a December 16, 2003, memorandum to the Assistant Chief of BIA OLES Internal Affairs, outlined the inspection briefing discussions with Ecoffey. The BIA inspecting agent addressed concerns that the BIA Police officer was in a one-man duty station and needed to report to someone in law enforcement. The inspecting agent also addressed the holding cells, writing that he "explained to Mr. Ecoffey that there are holding cells at the Chemawa Indian School." He informed Ecoffey this was against BIA policy and asked him how it should be handled. Ecoffey told him that the BIA Education Department pays for the CIS detention facility and that it was not the responsibility of BIA OLES. The inspecting agent reiterated his concerns in the memorandum, writing that he "again explained if the BIA Police officer were locking students in this facility, responsibility would fall under the Office of Law Enforcement Services. Mr. Ecoffey explained he would look into the matter."

When interviewed, Ecoffey recalled an inspection of the law enforcement program at CIS and the subsequent conversation with the inspecting agent and the BIA criminal investigator. Ecoffey stated that, at the time of the briefing, he believed the holding cells were just rooms used for detoxification and not actually jail cells. Ecoffey did not view the facility as a detention center and said, "I didn't associate it with jails in a dormitory." Ecoffey admitted that he now agreed the facility is law enforcement's responsibility and that he probably should have involved his detention specialist after he received information about the holding cells. Ecoffey said the matter was forgotten and he did not follow up prior to Gilbert's death. With regard to the briefing, Ecoffey stated that if he had understood what the inspecting agent and the special agent had been trying to convey, the incident could have been avoided.

Oversight of Detention Facility and Law Enforcement Program

Supervisory authority over the holding facility and the law enforcement program has been in question for several years. Since the holding facility was built with BIA detention funds and is co-located with the law enforcement offices, many CIS staff and administrators consider the facility under the authority of law enforcement. However, holding facility operations, the police officer position, and security guards are funded through BIA education dollars, which led BIA OLES administrators to believe OIEP had oversight responsibility. BIA clearly divides activities between OLES and OIEP. From the inception of the CIS law enforcement program, no clear sustained structure or organization has been adopted. Although these concerns have been raised over the years, the situation remains unresolved.

BIA OLES funded and supervised the BIA criminal investigator position assigned to the school. When the BIA criminal investigator was hired, his duties also included supervising the BIA police officer. Numerous documents demonstrate that the BIA police officer and other BIA police assigned to CIS had BIA OLES supervision at one time.

One of the issues we investigated was the BIA police officer's status as a law enforcement officer. According to documentation we obtained, he was, in fact, a certified BIA police officer. Secondly, BIA OLES sent him on several details to assist other BIA law enforcement programs, including a detail as a training officer at the BIA Indian Police Academy.

The BIA criminal investigator's supervision of the BIA police officers assigned to CIS is documented in a certification of performance for one of the police officers, signed and dated by the criminal investigator as his supervisor on January 24, 1991. After the BIA criminal investigator left in 1991, supervisory duties continued through the BIA OLES Portland Area special officer. This supervision transfer is indicated in a letter dated April 12, 1993, from the former school principal and supervisor to the BIA area director, in which the former school principal referenced a meeting with the special officer that requested specific services from BIA law enforcement officers assigned to CIS. According to the former school principal and supervisor, during the meeting, the special officer provided verbal approval for the additional services but also needed a written request. He wrote the letter to the BIA area director, asking him to see that the services were provided.

On May 23, 1994, the education line officer wrote a memorandum to the field representative, Plummer Field Office, and the criminal investigator who questioned the law enforcement supervision.[12] He stated that supervision of the CIS law enforcement program had been delegated to the BIA Portland Area Education Office and expressed concerns about supervising the program from his office due to the need for "close day-to-day supervision." He questioned whether the program should be delegated to the school superintendent. A memorandum from the Portland area education administrator to the CIS principal, dated December 30, 1994, delegated supervisory authority to the principal beginning January 1, 1995.

BIA OLES went through an organizational restructure in 1999, placing police and detention services under the line and budgetary authority of OLES. These services, which were traditionally managed by the area director and agency superintendent, were reorganized, in part, as the result of a

[12] The education line officer could not recall the name of the person who occupied that position at the time the memorandum was sent. The memorandum was addressed as noted in the report.

Presidential Initiative on Indian Country Law Enforcement and Congressional mandates. These changes should have transferred the CIS holding facility and law enforcement program supervisory responsibilities to BIA OLES. However, OLES never assumed supervision of the BIA police officer, the only remaining BIA police officer on the CIS campus. An interview with the special officer characterized the BIA police officer as "forgotten" by the OLES administration, since funding for his position came through OIEP.

In early 2002, OLES personnel again raised concerns about the CIS law enforcement program. E-mails sent within the organization addressed the situation, which prompted OLES to define the BIA police officer's position and come up with a solution.[13] The BIA OLES deputy director primarily handled the matter until he was reassigned to a DOI law enforcement position in Washington, D.C.

During the course of this investigation, we received an original letter from a BIA Internal Affairs special agent, which was inadvertently discovered in a box with unrelated miscellaneous documents in the BIA OLES IAD Office. The original letter and a faxed copy, dated February 21, 2003, was sent by the OIEP deputy director to Ecoffey, along with an attached memorandum from OIEP area line officer, requesting the BIA police officer position at the CIS be placed under the supervision of OLES. It should also be noted that the agent located the letters while going through stacks of boxes containing miscellaneous documents, determining what items should be destroyed. The agent was familiar with CIS investigation and forwarded the letters to OIG investigators.

The OIEP deputy director was aware of the law enforcement concerns and the holding cells at the CIS. However, he thought the use of the cells had been discontinued in 2002. He could not recall ever having any discussions with the OIEP area line officer concerning the CIS holding facility or problems in dealing with intoxicated students at the school.

The letter to Ecoffey outlined the OIEP deputy director's request to discuss the matter with Ecoffey and address his concerns: "As you can see, the school realizes that they may have some liability issues." Both letters had original hand-written notes from Ecoffey to the acting deputy director of operations and deputy director of administration. The note on the faxed copy sent the day the letter was authored read, "get with Ed and resolve this issue. RE 2/24/03, Please respond to the OIEP Deputy Director." On the original letter received by OLES on February 26, 2003, Ecoffey wrote, "Please address ASAP, RE." During the interview with Ecoffey, he acknowledged receiving the OIEP deputy director's letter and the attached memorandum with the notes directing his staff to address the issues. Ecoffey did not recall signing a response to the letter and he did not know if his staff had ever contacted the OIEP deputy director. In separate interviews with the acting deputy director of operations and the deputy director of administration, they recalled receiving the letters with the notes. The acting deputy director of operations did not recall meeting with the deputy director of administration or the OIEP deputy director on the matter but claimed he probably forwarded the letters to the deputy director of administration. The acting deputy director of operations stated that if the letters were in a folder with both his and the deputy director of administration's name on them, he would have looked at them and forwarded the folder to the other person. The deputy director of administration remembers seeing the letters and did meet with BIA personnel officials regarding the transfer of the BIA police officer position to OLES. The deputy director of administration stated that

[13] In an e-mail to the BIA OLES deputy director, dated March 5, 2002, the special officer briefly outlined the history of the CIS police officer position. Specifically, regarding the BIA police officer, the special officer stated, "He is a forgotten step child. Maybe we ought to consider placing him under OLES."

BIA personnel indicated that there was no funding available for another police officer position, after which he provided the information to Ecoffey. According to the deputy director of administration, he took no further action.

When Ecoffey was interviewed by this office on March 18, 2004, the situation had not yet been resolved, even after questions arose about the CIS law enforcement program and the holding facility following Gilbert's death. Regarding the absence of resolution to the issue, Ecoffey acknowledged that there was no excuse for the lack of a decision of the supervision issue. Ecoffey stated that the deputy director for administration was responsible for having the BIA police officer's position changed. In the deputy director for administration's defense, Ecoffey also stated that the BIA Southwest Regional Personnel Office, which handles BIA OLES personnel matters, only takes action if someone personally goes to its office.

According to Ecoffey, he never forwarded any information regarding the CIS holding facility or law enforcement program to his supervisor. This was confirmed when we interviewed a former acting director of BIA and Principle Deputy Assistant Secretary of Indian Affairs, Aurene Martin. Neither the former acting director of BIA nor Martin was aware of the existence of holding cells at the CIS.

Over the years, the supervisory authority of the holding facility has been an even greater area of contention. Depending on the school supervisor, varying views existed of who actually had responsibility. In a memorandum dated October 6, 1989, from the former school principal and supervisor to the residential living specialist, the RLS expressively concluded that law enforcement had no jurisdiction or authority over the holding facility and its operation. The former school principal outlined in the memorandum that the RLS would be supervising the facility. He tasked him with developing comprehensive written operating policies and procedures.

With changes in the CIS school supervisors and residential administrators, the holding facility and the law enforcement program essentially combined to become one program, according to the school staff members we interviewed. However, a review of documents found no clear acceptance of responsibilities for law enforcement officers and detention facilities, except for the overall supervision by BIA. To further confuse the issue, BIA OLES inspected the facility and requested holding facility statistics from law enforcement personnel. Also, the holding facility is adjacent to the law enforcement offices, which further perpetuates the appearance of a relationship with BIA OLES. Finally, law enforcement and security personnel usually placed the students in the cells. During an interview, the acting CIS supervisor admitted to being uncomfortable supervising a law enforcement officer and did not provide close supervision, keeping the BIA police officer "at arms length." For several years, BIA OLES has kept an "Inventory of Indian Country Detention Facilities" that records both BIA and tribal detention programs. The BIA OLES Detention Program specialist established the inventory list of all the detention facilities in Indian Country when he previously served in BIA OLES headquarters from 1993 through 1996. The 2003 inventory list described the CIS holding facility as a 15-year-old juvenile facility with 4 beds that was owned and operated by BIA. Current status was identified as "under review."

At the time the BIA OLES Detention Program specialist prepared the list, he was unsure of what program within BIA was authorized to operate the facility. The facility did not have detention staff and therefore he did not consider it a detention program since it was an unmanned facility on a school campus. He acknowledged that the CIS holding facility remained on the inventory list for

tracking purposes and that the facility came under review in 1999 because of its unclear status. The specialist stated that, in his opinion, identifying responsibility for resolving the CIS issue was difficult because the status of the facility was undetermined.[14]

Office of Indian Education Programs (OIEP)

BIA OIEP manages all BIA educational functions, including developing policies and procedures, supervising OIEP program activities, and approving the expenditure of funds appropriated for BIA education operations.[15] The BIA has a unique responsibility regarding the ORBS in that students must live at the educational institution on a 24-hour basis. This requires management of both the education and residential aspects of the student's life. A safe and healthy living environment for the students must be established and maintained, which depends on resources from the BIA as well as other federal entities. OIEP delegated these responsibilities through the OIEP deputy director and the education line officer to the CIS administration.

Since CIS has full-time custody of the students during the school year, the temporary guardianship of those students is bestowed on staff members through "Loco Parentis." The CIS Parent and Student Handbook (Volume II, July 2003) defines "Loco Parentis" as the "legal obligation applied to the school or its agents to act in place of the parent in a manner, which would provide an appropriate environment conductive to education."

The handbook identifies the school's "Philosophy of Discipline" as helping the students to develop "the responsibility, self-discipline and self-respect necessary to function successfully in school and society. Discipline is also applied when necessary to protect other students and staff and the educational process from dangerous and disruptive acts." Responses to disciplinary problems are outlined in the handbook. Regarding safeguards for disciplined students, it states, "When disciplinary action is taken, the rights and safety of the individual students and the school community, as a whole shall be protected."

Further outlined in the handbook is the school's relationship with law enforcement, which briefly describes the procedures for dealing with students who commit criminal acts. Although the handbook states that "taking children into custody at school and/or conducting an investigation at school is discouraged…," school officials placed several hundred students in the holding facility each school year.

The handbook also states that, if it becomes necessary under the provision of legal statues to place a student in temporary custody, several procedures need to be followed. These include notifying the parents prior to taking a student into custody or interviewing and interrogating a student at the school. Placing a student into custody prior to parent notification requires a court order. Extreme circumstances preventing officers from following the outlined procedures should be reported to school authorities as soon as possible. After interviewing several staff members, we determined that parents

[14] In an April 22, 1998 letter addressed to tribal leaders , Assistant Secretary of Indian Affairs Kevin Gover reviewed the status of future BIA detention facility construction and renovations. The letter listed 34 detention projects pending renovations and repairs that included CIS. The BIA OLES Program Detention specialist indicated that the Assistant Secretary received the information from the Facilities Management Construction Center and not BIA OLES.
[16] See 25 CFR Ch. 1, Section 32.3 (4-1-01 Edition), pages 131 and 132, referencing the mission of OIEP.

were not being notified, and citations were not issued each time a student reported to the holding facility.

When we interviewed Corinna Sohappy, the legal guardian of Gilbert, Sohappy stated that in November 2003, the CIS staff notified her that Gilbert was found intoxicated on campus and would have her privileges restricted. Sohappy added that the CIS staff never told her that Gilbert was placed in a holding cell. Sohappy was not even aware of the existence of the CIS holding cells.

Indian Health Service (IHS)

In 1955, IHS began operating an outpatient school health center on the CIS campus, providing outpatient, contract health, and infirmary services to the students. The facility operated through 1975 and primarily treated the CIS students, although, during this time, eligible individuals from the surrounding community received some health care.

From 1975 to 1980, the CIS campus, including the IHS health center, was rebuilt, using congressional appropriated funds. IHS moved into the new clinic in the fall of 1979, with 17 additional staff positions allocated. Established in 1971, the Chemawa Alcoholism Education Center (CAEC), located on the CIS campus, used the old physician's residence prior to the construction of the new campus. After the new IHS clinic was built, the CAEC moved to the facility and was equipped with two "holding cells." As previously outlined in this report, the cells were closed after a few years of use.

IHS staffing fluctuated several times in the early 1980s due to budget increases or shortages. According to IHS, the CIS Health Center was officially re-designated as a Public Health Services Health Center and was renamed the Western Oregon Service Unit.

A Memorandum of Agreement (MOA) dated August 2, 1995, between the Secretary of the Interior and the Secretary of Health and Human Services, references the original MOA that was created in 1987 pursuant to Public Law (PL) 99-570 and PL 100-690, establishing the coordinated efforts of the BIA and IHS in assisting tribes with development and implementation of their alcohol and substance abuse program resources. The original authorizing statute required the interagency agreement be reviewed and updated yearly.

The MOA identified each agency's responsibilities based on available funding, including the coordination efforts necessary for juvenile detention centers. The MOA established the following: "Responsibility of the IHS: The IHS will provide alcoholism and other drug abuse resources for social detoxification programs at BIA juvenile detention centers and provide emergency medical assessments. Responsibility of the BIA: The BIA will continue to provide funding for program operation and maintenance of detention facilities. At the local agency level, the BIA will include the IHS in all planning of the BIA detention facilities and program operations."

A 1994 decision authorized local tribes to contract heath services to their own tribal communities. This decision transferred the Western Oregon Service Unit funding directly to the tribes. As a result, the CIS clinic lost 20 positions, and infirmary services, including the loss of expanded clinic service hours. CIS administration claimed that contracting medical services directly to the tribes impacted the medical needs of the school, especially the availability of after-hours medical services. IHS contends it provided the CIS every opportunity to participate in any negotiations or meetings

regarding the Western Oregon Service Unit funding. In a 1998 document outlining the history of the CIS Health Center, the Western Oregon Service Unit Director stated that the CIS school board and administration were invited to participate in the tribal contracting negotiations but did not attend.

Subjects

Bureau of Indian Affairs, Office of Law Enforcement Services

Former Director
Former Deputy Director of Operations **(Retired)**
Deputy Director of Administration
Acting Deputy Director of Operations
Detention Specialist
Former Special Agent in Charge, District V **(Retired)**
Police officer

Bureau of Indian Affairs, Office of Indian Education Programs

Director
Education Line Officer, Portland Area
Former CIS School Supervisor
CIS School Supervisor
CIS Residential Living Specialist
CIS Dormitory Manager
CIS Dormitory Manager
Residential Living Assistant

Disposition

Case was submitted for criminal review by the Department of Justice.