THE CRUZAN GROUP
PUBLIC SAFETY CONSULTANTS

December 10, 2021

Louis Poitra, Division Chief
BIA Internal Affairs Division
1001 Indian School Road, NW
Albuquerque, NM 87104

Dear Louis,

The Cruzan Group has greatly appreciated the opportunity to work with the BIA and is pleased to provide our final deliverable of task 5, future state recommendations, Study of In-Custody Deaths. This final task has been added to our final version of tasks 1-4 which were previously provided.

Based upon our in-depth analysis in tasks 1-4, we found areas for improvement in policy, training, investigative timeliness, thoroughness and supervision, external coordination, and report standardization and have provided our recommendations for improvement toward a future state. We understand and respect the many difficulties Native American communities face. Our recommendations are realistic and achievable with minimal cost implications and, if implemented will greatly enhance and improve ICD investigations in the future.

Thank you again for this opportunity. The Cruzan Group remains steadfast in our commitment to working with the BIA to identify solutions to issues within Indian Country.

Darren A. Cruzan, President
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THE CRUZAN GROUP
PUBLIC SAFETY CONSULTANTS

Study of
In-Custody Death Investigations

Produced For

BUREAU OF INDIAN AFFAIRS
OFFICE OF JUSTICE SERVICES

Evaluate the thoroughness and effectiveness of the closed In-Custody investigations

Task 1

Case Number: I17002208

(b) (6), (b) (7)(C)

TCG #1

In-Custody Death Administrative Investigation Evaluation

Case Number: KOL120-16-352

Subject/Victim: (b) (6), (b) (7)(C)
Date of Death: (b) (6), (b) (7)(C) 2016
Time in Custody: 9 days
Report Date to BIA: January 3, 2017
Location of Death: Turtle Mountain, North Dakota
Cause of Death: (b) (6), (b) (7)(C)
Manner of Death: (b) (6), (b) (7)(C)
Facility Type: Bureau of Indian Affairs (BIA)

Case Synopsis:

On (b) (6), (b) (7)(C) 2016, (b) (6), (b) (7)(C) was taken to the Turtle Mountain Correctional Facility on a tribal warrant for unlawful ingestion of a controlled substance. During the intake process the correction officer (CO) asked a series of medical and psychological questions as part of the normal booking protocol. During this process (b) (6), (b) (7)(C) stated that [redacted] had some type of (b) (6), (b) (7)(C) injury, which the CO documented. Because of [redacted] injury the staff transported [redacted] to a medical facility to be cleared for incarceration. After a medical evaluation, [redacted] was prescribed (b) (6), (b) (7)(C) On (b) (6), (b) (7)(C) 2016, (b) (6), (b) (7)(C) returned to a medical facility due to complaints of feeling ill. In this visit (b) (6), (b) (7)(C) was prescribed (b) (6), (b) (7)(C)

On (b) (6), (b) (7)(C) 2016, (b) (6), (b) (7)(C) had a scheduled bond hearing. During this court appearance the presiding judge decided that (b) (6), (b) (7)(C) was incapable of being present due to [redacted] medical condition and re-scheduled [redacted] court date. When interviewed during the administrative investigation, a CO stated that usually an inmate would have been taken to the hospital, but because (b) (6), (b) (7)(C) had been medically cleared the day before, [redacted] assumed [redacted] condition was due to (b) (6), (b) (7)(C); therefore, [redacted] did not transport [redacted] back to the medical facility. (b) (6), (b) (7)(C) was found nonresponsive in [redacted] segregated housing cell on the morning of (b) (6), (b) (7)(C), 2016, during the breakfast feeding. The first responding COs took lifesaving measures and emergency medical services were immediately contacted.

The administrative investigation included interviews of staff involved during both the night and day work shifts. All staff were given their administrative rights and provided statements. The administrative investigation found that the night shift COs routinely did not perform the required (b) (7)(E) cell checks, and they admitted to falsifying the cell check log to reflect the checks had been performed. [redacted] of the [redacted] COs working the night shift received some level of discipline based on negligent or careless performance of their assigned duties.

Evaluation Methodology:

All case records provided by the BIA Office of Justice Services (OJS) to The Cruzan Group were reviewed by five experienced case reviewers for investigative timeliness, thoroughness, and reporting. Observations noted by each reviewer were consolidated and used for development of this evaluation report. All review questions included by the BIA were considered, and responses are included in the investigation observations as either a pro or con as directed in the solicitation.

Investigation Observations (Pro):

- The investigation clearly explained when and why the inmate was brought into custody.
- The investigation indexed the agency forms and logs as exhibits and referenced them within the body of the investigative report.
- The investigation referred multiple times to the requirement of (b) (7)(E) [1] and the fact that staff was aware of the policy but could not identify exactly where the requirement was included in the BIA-OJS Corrections Handbook.
- There were staffing rosters attached to the investigation identifying the individuals working on the date of (b) (6), (b) (7)(C) death.
- The administrative investigation included death scene photographs.
- The administrative investigation included a death scene sketch.
- Facility surveillance video was included in the administrative investigation.
- The investigation generalized the responsibilities and duties for the COs working the night shift.
- The investigation revealed that a (b) (7)(E) [2] the night (b) (6), (b) (7)(C) died.
- The investigation revealed negligence and misconduct on the part of several COs.
- The investigation explained how the investigators utilized the facility video surveillance as evidence in this case.

Investigation Observations (Con):

- The criminal investigative interviews occurred on (b) (6), (b) (7)(C) 2016, and the administrative investigation interviews occurred five months later in (b) (6), (b) (7)(C) 2017. This delay in the initiation of the administrative investigation may have caused a deterioration of evidence and negatively impacted the effectiveness of any

[1] BIA-OJS Corrections Handbook, C2-30-02 Cell Checks-Daily Operations, states in part that; (b) (7)(E)

[2] BIA-OJS Corrections Handbook, C4-32-6-C, (Assignment Master Schedule) states in part that; (b) (7)(E)

corrective action taken. While we understand the need for the criminal investigation to take precedence over the administrative investigation, an opportunity for them to run in parallel should be considered in future cases.

- From information made available for this review, the booking officer made the decision at intake to send (b) (6), (b) (7)(C) to the medical facility based on medical history. No information was found regarding the training/qualifications of the booking officer who made that decision.
- The administrative investigation did not determine if the cell check logs had been routinely falsified by corrections officers on other occasions or if this incident was an isolated occurrence. Making this determination may have led to an understanding of whether revisions to policy or procedure(s) may be appropriate.
- Other time log entries by COs who did not admit to falsifying entries seemed suspect. These entries were found to be (b) (7)(E) The BIA-OJS Corrections Handbook requires (b) (7)(E)
- The administrative investigation investigator did not attend (b) (6), (b) (7)(C) autopsy.
- Autopsy photographs were not included in the administrative investigation.
- The investigation did not determine if (b) (6), (b) (7)(C) prescription for (b) (6), (b) (7)(C) was filled or administered to
- Statements by the CO regarding (b) (6), (b) (7)(C) having (b) (6), (b) (7)(C) in court on (b) (6), (b) (7)(C) 2016, were not clarified during interview.
- The treating physician was not interviewed regarding medical facility visit and diagnosis.
- The administrative investigation did not include an interview of the presiding judge who continued (b) (6), (b) (7)(C) case after finding was unable to appear in court. Having the judge's perspective on evaluation of (b) (6), (b) (7)(C) health may have been informative as to whether staff took appropriate action when deciding not to seek additional health services for (b) (6), (b) (7)(C)
- Evidence of (b) (6), (b) (7)(C) was observed by the CO who found (b) (6), (b) (7)(C). This indicates time of death was between two to four hours earlier than when was found nonresponsive and is consistent with video evidence showing stopped all movement in cell at 4:19 a.m. on (b) (6), (b) (7)(C) 2016. The investigation did not consider how this time of death refutes the opinion of COs that (b) (6), (b) (7)(C) time of death was close to the time was discovered nonresponsive in cell nor the implications of how the failure by COs to perform cell checks throughout the night may have been a factor in (b) (6), (b) (7)(C) death.
- The investigation included relevant records and court documents, and medical examiner's autopsy report but we were unable to locate the order to continue (b) (6), (b) (7)(C) bond hearing.

- The investigation did not clearly explain why several COs working the night shift were not certified or why they were not required to familiarize themselves with the corrections handbook.
- The administrative investigation does not include evidence that appropriate rights advisements were provided to staff prior to being questioned regarding the incident[3].

Prosecution Referral:

The Federal Bureau of Investigation (FBI) obtained a declination for prosecution from the U.S. Attorney's Office at the conclusion of their criminal investigation. Documentation was not found reflecting coordination with a prosecutor at the conclusion of the administrative investigation to address (b) (6), (b) (7)(C) Additionally, no prosecutor review or approval was obtained prior to the use of a Kalkines rights advisement (providing immunity from criminal prosecution) for interviews of two COs.

All administrative investigations concluding that employee(s) did not comply with confinement policy or whose behavior amounted to misconduct should be referred to the appropriate United States Attorney's Office for prosecution review. Declinations by that office should be in writing, should outline the reasoning for the declination, and be included in the administrative investigation.

Investigative Effectiveness in Aiding Policy Modifications/Updates:

The investigative report did not provide any recommendations to modify or update BIA policy, despite identifying various problems. The investigation did reveal significant weaknesses in supervision leading to the (b) (6), (b) (7)(C) (b) (6), (b) (7)(C). These conditions provide a foundation for recommendation(s) related to appropriate human resource staffing, training, and potential facility modifications to reduce the potential for reoccurrence. For example, leveraging technology to improve the integrity of cell check logs may be achieved by moving from manual cell check logs to using an electronic log system that requires COs to swipe their ID at each cell they check throughout their shift.

Policy involving the responsibility for prosecution referral and coordination as well as the use of the Kalkines rights advisement should reviewed and changed as needed.

[3] Following appropriate agency policy, a Kalkines or Garrity rights advisement should be provided to any employee being interviewed in an internal agency investigation.

Other Observations:

- Insufficient supervision on the night shift at the confinement facility contributed to a failure to perform proper cell checks, improper documentation of facility logs, and overall ineffective oversight of confinement operations.
- This investigation did not focus on facility related humane treatment. The facility was reported to be extremely hot, and fans were used to provide some improved comfort for inmates.
- The administrative investigation included a memo from (b) (6), (b) (7)(C) dated (b) (6), (b) (7)(C) 2017, to (b) (6), (b) (7)(C) regarding Turtle Mountain Corrections Site Visit. In this memo, stated observed major issues that needed to be addressed in order for Turtle Mountain Corrections to be in compliance with BIA-OJS corrections policy. No additional follow up regarding findings was noted in the case file.

Case Number: I17002403

(b) (6), (b) (7)(C)

TCG #2

In-Custody Death Administrative Investigation Evaluation

Case Number: I17002403

Subject/Victim: [redacted]
Date of Death: [redacted] 2017
Time in Custody: 9.5 hours
Report Date to BIA: July 27, 2017
Location of Death: Eastern Nevada Agency, Duck Valley Reservation, Owyhee, NV
Cause of Death: [redacted]
Manner of Death: [redacted]
Facility Type: Bureau of Indian Affairs (BIA)

Case Synopsis:

On [redacted] 2017, at approximately 8:18 p.m., [redacted] was booked into the Owyhee Detention Center on charges of disorderly conduct and failure to obey a lawful order. At approximately 5:28 a.m. on [redacted] 2017, [redacted] was found nonresponsive in a holding cell. [redacted] was being housed in an overflow cell along with [redacted] During a morning check, the correction officer (CO) recognized [redacted] and requested additional assistance from another CO. When they entered the cell in an attempt to rouse [redacted], they noted that [redacted] and when they rolled [redacted] onto [redacted] back, they observed the presence of [redacted]. [redacted] contacted the on-duty supervisor, who advised them to check for signs of life and begin life saving measures. [redacted] immediately contacted emergency services and returned to the scene. Emergency medical technicians (EMT) responded within seven minutes of the initial dispatch. The EMTs at the scene halted any further lifesaving treatment and contacted the coroner's office.

Both criminal and administrative investigations were conducted of this incident. The criminal investigation was conducted by the Federal Bureau of Investigation (FBI) and was relatively brief in detail. The FBI determined there was no element of criminal activity involved in this incident. The administrative investigation revealed that the COs in this incident followed the appropriate practices in accordance with BIA Office of Justice Services (OJS) standard operating procedures. However, the administrative investigation noted that during the booking process a document referred to as the Suicide Intervention Screening Form was blank because the intake CO failed to complete this form.

Evaluation Methodology:

All case records provided by the BIA Office of Justice Services (OJS) to The Cruzan Group were reviewed by five experienced case reviewers for investigative timeliness, thoroughness, and reporting. Observations noted by each reviewer were consolidated and used for development

of this evaluation report. All review questions included by the BIA were considered, and responses are included in the investigation observations as either a pro or con as directed in the solicitation.

Investigation Observations (Pro):

- The investigation explained when and why [redacted] was brought into custody.
- The administrative investigation revealed and documented that when [redacted] was booked into the facility, the CO failed to complete the Suicide Intervention Screening Form.
- The administrative investigation referred to the confinement policy that outlines [redacted][1] in accordance with the corrections handbook. The investigation also identified where the procedure is found in the handbook.
- The administrative investigative report included the duty roster identifying the on-duty staff the day of [redacted] death.
- The administrative investigation included a cell assignment log that indicated the number of inmates incarcerated and their locations on the night of [redacted] death.
- The FBI death scene photographs were included in the administrative report.
- This administrative investigation focused on CO's working the night shift and identified what role each individual played during the incident.
- All witnesses were interviewed either through the criminal or the administrative investigation.
- The administrative investigation revealed that the staff on-duty the date of the death followed BIA policy in dealing with an in-custody death.
- The administrative investigation explained that video recording was captured of the date and time of [redacted] death. Because the camera was positioned to capture images outside the holding cell, the only view captured was of staff and emergency personnel coming and going from the hallway.

Investigation Observations (Con):

- There is no evidence in neither the administrative nor criminal report that lifesaving efforts were taken by COs once [redacted] was found nonresponsive. The interview with [redacted] revealed that [redacted] made two separate calls to [redacted] supervisor looking for direction and guidance regarding what actions to take.
- The administrative investigation does not provide any information regarding potential overcrowding of the confinement facility at the time of [redacted] death.
- The administrative investigation does not document any effort to review facility surveillance video records to verify the cell check log entries reflecting that [redacted] cell checks had been performed the day of the incident.

[1] BIA-OJS Corrections Handbook, C2-30-02 Cell Checks-Daily Operations, states in part that; [redacted]

- The administrative investigation did not explain what each log was used for and why.
- The administrative investigation did not identify any policy or training deficiencies except that a specific booking form created to identify possible suicidal tendencies was not properly filled out.
- It appears that the FBI only made a cursory report on the death probably based on the facts and autopsy report. While they did conduct some interviews and took some death scene photographs, only a few FBI investigative reports (302s) were included in the administrative investigation report.
- The administrative report did not include autopsy photographs.
- We were unable to determine if either the FBI or the BIA Internal Affairs Division (IAD) investigator attended the medical examiner's autopsy of [redacted] Best practices include the administrative investigation investigator attending the autopsy for all in-custody deaths.
- No death scene sketch was included with the administrative investigation report.
- The administrative investigation failed to determine that the intake CO did not completely fill out the Arrestee Supplemental Booking Form. This form consists of multiple questions involving everything from substance involvement to disability issues. Only the top portion of the report was completed with the inmate's personal identification information. Also, both COs stated that [redacted] never advised them that [redacted] had any medical issues. However, there was no written record verifying that [redacted] was ever asked this question.
- The administrative investigation did not include any documentation or mention of the COs receiving their administrative rights[2] before being questioned in this investigation.
- The administrative investigation was not initiated and completed in a timely manner. The criminal investigation was completed on [redacted] 2017, and the IAD investigator received most of the direct evidence on or around [redacted] 2017. The BIA-IAD did not conduct interviews with the witnesses of this incident until [redacted] 2018 and these interviews were conducted telephonically. The final administrative investigative report was written on [redacted] 2018, approximately eight months after receiving the evidence and a full year after [redacted] death.
- The administrative investigation did not include an interview of [redacted] and instead, relied on the FBI interview from the criminal investigative report.
- The administrative investigation did not include questioning of the arresting officer ([redacted]) nor the COs regarding information [redacted] passed along upon [redacted] arrest. [redacted] claimed [redacted] told [redacted] that [redacted] According to the COs and EMTs [redacted] was found [redacted]. [redacted] was noted in the photographs of [redacted] body, which is consistent with [redacted] being [redacted] at the time of [redacted] death. It is unclear whether the information provided by [redacted] was ever passed along to the COs. [redacted] statement

[2] Following appropriate agency policy, a Kalkines or Garrity rights advisement should be provided to any employee being interviewed in an internal agency investigation.

is documented in [redacted] interview by the FBI and this point should have been resolved during the administrative investigation.

- The administrative investigation did not include any information regarding difficulties CO's at the Eastern Nevada Agency have in getting medical attention for inmates during evenings and weekends.

Investigative Effectiveness in Aiding Policy Modifications/Updates:

Despite identifying various problems, the investigative report did not provide any recommendations to modify or update BIA policy.

Prosecution Referral:

No documentation was found reflecting coordination with a prosecutor at the conclusion of the administrative investigation.

All administrative investigations concluding that employee(s) did not comply with confinement policy or whose behavior amounted to misconduct should be referred to the appropriate United States Attorney's Office for prosecution review. Declinations by that office should be in writing, should outline the reasoning for the declination, and be included in the administrative investigation.

Case Number: I18000104

(b) (6), (b) (7)(C)

TCG #3

In Custody Death Administrative Investigation Evaluation

Case Number: 18000104

Subject/Victim: (b) (6), (b) (7)(C)
Date of Death: [redacted] 2018
Time in Custody: 9.5 Hours
Report Date to BIA: May 6, 2018
Location of Death: Blackfeet Agency, Montana
Cause of Death: (b) (6), (b) (7)(C) [redacted]
Manner of Death: [redacted]
Facility Type: Bureau of Indian Affairs (BIA)

Case Synopsis:

On [redacted] 2018, at approximately 7:28 a.m., (b) (6), (b) (7)(C) was arrested for possession of an open container and brought to the BIA Blackfeet Correctional Facility. Once at the facility, [redacted] voluntarily submitted to a blood alcohol content (BAC) via preliminary breath test (PBT) and registered a [redacted][1]. The intake correction officer (CO) completed all the necessary paperwork to include the forms that document any symptoms of suicidal tendencies, and any medical problems [redacted] may have reported. [redacted] was placed in a holding cell referred to as the "drunk tank" and was housed with three other inmates. At 12:25 p.m. [redacted] informed the (b) (6), (b) (7)(C) that [redacted] was not feeling well and was (b) (6), (b) (7)(C). [redacted] dismissed [redacted] concerns and believed [redacted] only made the complaint because [redacted] wanted to leave the confinement facility.

Video surveillance footage revealed that at approximately 3:40 p.m. [redacted] told [redacted] that [redacted] was having (b) (6), (b) (7)(C). (b) (6), (b) (7)(C) reported the complaint to the control center and notified emergency services. While making these notifications, [redacted] monitored [redacted] on video and witnessed [redacted] (b) (6), (b) (7)(C). (b) (6), (b) (7)(C) [redacted] responded to the drunk tank where both officers checked for vital signs. [redacted] checked [redacted] wrist for a pulse and [redacted] checked [redacted] carotid artery. The result of this effort was that [redacted] believed [redacted] had no pulse while [redacted] concluded that [redacted] did have a pulse. A review of video surveillance footage found that this discrepancy delayed the application of any lifesaving measures for the following seven minutes until emergency medical services arrived on the scene. Once there, the emergency medical technicians (EMT) began cardio-pulmonary resuscitation efforts. [redacted] was transported to the local hospital where [redacted] was pronounced dead at 4:40 p.m.

A log entry reflects that the Federal Bureau of Investigation (FBI) was notified of [redacted] death on [redacted] 2018, and were present at the facility that day. There is no record of the FBI investigative effort into the matter. A BIA special agent responded to the death scene and conducted the investigation. The results of the administrative investigation found supervisory

[1] The Montana legal blood-alcohol limit is .08

(b) (6), (b) (7)(C) to be in violation of BIA policy C4-42-03, negligent or careless performance of assigned duties. The report further found that both (b) (6), (b) (7)(C)

Evaluation Methodology:

All case records provided by the BIA Office of Justice Services (OJS) to The Cruzan Group were reviewed by five experienced case reviewers for investigative timeliness, thoroughness, and reporting. Observations noted by each reviewer were consolidated and used for development of this evaluation report. All review questions included by the BIA were considered, and responses are included in the investigation observations as either a pro or con as directed in the solicitation.

Investigation Observations (Pro):

- The facility surveillance footage depicting (b) (6), (b) (7)(C) death was included in the administrative investigation.
- The BIA Internal Affairs Division (IAD) investigator conducting the administrative investigation identified multiple policy violations by staff, explained each policy and clearly referenced where they were derived from.
- The administrative investigation included relevant training certificates for the COs involved.
- The administrative investigation included the results of voluntary interviews with all staff that were present at the time of (b) (6), (b) (7)(C) death.
- The administrative investigation included compelled interviews with the COs that were working that day. The notice of administrative rights (Kalkines)[2] was provided in writing to each CO and documented in the file (refer to prosecution referral section for additional information).
- The investigation explained how (b) (6), (b) (7)(C) was brought into the facility and why. The file included both the police report and dispatch logs.
- The investigative report provided detail outlining the steps taken in the booking process. It explained what forms were filled out and the purpose each served. The case file included all copies of the forms that were generated during (b) (6), (b) (7)(C) booking process.
- The administrative investigation determined that COs did not (b) (7)(E) as required by BIA policy[3], did not maintain a log indicating (b) (6), (b) (7)(C) had been observed, and did not document any direct physical contact with (b) (6), (b) (7)(C).

[2] Following appropriate agency policy, a Kalkines or Garrity rights advisement should be provided to any employee being interviewed in an internal agency investigation.
[3] BIA-OJS Corrections Handbook, C2-30-02 Cell Checks-Daily Operations, states in part that; (b) (7)(E)

- The administrative investigation found [redacted] was not provided with appropriate medical attention in despite [redacted] telling COs [redacted] was not feeling well, [redacted] and [redacted].
- The administrative investigation provided copies of the logs that were generated the day of [redacted] death.
- The administrative investigation report included death scene photographs.
- The administrative investigation report included a death scene sketch.
- The administrative investigation report included the autopsy report.
- The administrative investigation identified what duties each CO was performing throughout the day of [redacted] death.
- The administrative investigation outlined the policies that were not followed. The investigation explained what those policies were and where they are located in the BIA-OJS Corrections Handbook.
- This administrative investigation includes a complete video recording of the incident.
- The administrative report included copies of the inmate cell assignment log and the duty roster for the day [redacted] died. On [redacted] 2018, the inmate population was 44 with [redacted] COs working.
- The administrative investigation included statements made by staff who were interviewed without receiving an appropriate administrative rights warning.

Investigation Observations (Con):

- The administrative investigation report lacks a header section with the full identification of the deceased. In various parts of the police report and confinement documentation the deceased name is correctly spelled as [redacted] and in other parts of the report incorrectly spelled as [redacted] causing potential confusion about the correct spelling.
- The death scene sketch documented during the administrative investigation is insufficient to provide any detail surrounding the event.
- The administrative report does not include any record of an investigator attending the autopsy of [redacted]
- The administrative investigation did not include any autopsy photographs.
- The administrative investigation did not include interviews of any medical staff including the responding EMTs or treating physician.
- The administrative investigation did not include interviews of [redacted] cellmates present inside cell [redacted] at the time of [redacted] death.
- During the administrative investigation no investigative effort was made to review and include information pertaining to [redacted] incarceration history. [redacted] stated "[redacted] was always trying to get out of jail" in [redacted] interview as a justification for not reporting [redacted] request for medical attention.
- [redacted] medical records pertaining to [redacted] emergency medical services were not included in the administrative investigative report. No information was provided regarding events occurring at the hospital including medical lifesaving steps taken and the identity of those medical staff involved in [redacted] treatment.

- The administrative investigation included (b) (6), (b) (7)(C) made by other COs during their interviews, but no effort was documented to check personnel files for any counseling, or disciplinary measures taken in the past.
- There were no FBI investigative reports (302) attached to the administrative investigation and no record indicating the FBI conducted an investigation into (b) (6), (b) (7)(C) death.

Investigative Effectiveness in Aiding Policy Modifications/Updates:

The administrative investigation identified failures related to the initial response that could have contributing factors to (b) (6), (b) (7)(C) death. The investigation also revealed CO non-compliance with conducting (b) (7)(E) cell checks of inmates.

Prosecutive Referral:

No documentation reflecting coordination with a prosecutor at the conclusion of the administrative investigation was found. (b) (6), (b) (7)(C)
Additionally, no prosecutor review or approval was obtained prior to the use of a Kalkines rights advisement (providing immunity from criminal prosecution) preceding the interviews of the COs.

All administrative investigations concluding that employee(s) did not comply with confinement policy or whose behavior amounted to misconduct should be referred to the appropriate United States Attorney's Office for prosecution review. Declinations by that office should be in writing, should outline the reasoning for the declination, and be included in the administrative investigation.

Case Number: I19000099

(b) (6), (b) (7)(C)

TCG #4

In Custody Death Administrative Investigation Evaluation

Case Number: I19000099

Subject/Victim: (b) (6), (b) (7)(C)
Date of Death: (b) (6), (b) (7)(C) 2019
Time in Custody: 5 Days
Report Date to BIA: April 11, 2019
Location of Death: Coleville Tribal Correctional Facility, Nespelem, WA
Cause of Death: (b) (6), (b) (7)(C)
Manner of Death: (b) (6), (b) (7)(C)
Facility Type: Tribal

Case Synopsis:

On (b) (6), (b) (7)(C) 2019, (b) (6), (b) (7)(C) was arrested and brought to the Colville Tribal Correctional Facility (CTCF) where (b) (6) was charged with public nuisance. From the first encounter with the arresting officer, (b) (6), (b) (7)(C) was described as (b) (6), (b) (7)(C) This type of behavior continued over the next five days until (b) (6), (b) (7)(C) 2019, when (b) (6), (b) (7)(C) was found (b) (6), (b) (7)(C) in (b) (6), (b) (7)(C) assigned cell. (b) (6), (b) (7)(C) . (b) (6), (b) (7)(C) was discovered during feeding and no other inmates were housed in the housing block with (b) (6), (b) (7)(C). The responding correction officers (CO) (b) (6), (b) (7)(C) . It was determined by the COs that (b) (6), (b) (7)(C) was deceased, and no lifesaving measures were initiated. Emergency medical services were contacted, and they also determined that (b) (6), (b) (7)(C) was deceased. The Federal Bureau of Investigation (FBI) office in Spokane, WA was contacted, and it was determined that the Colville Tribal Police Department (CTPD) would handle the in-custody death investigation. The BIA Internal Affairs Division (IAD) conducted the following administrative investigation.

The CTPD detective assigned to the case was also the deputy coroner for the local county. Evidence was collected, pictures were taken, and an autopsy was performed of (b) (6), (b) (7)(C) Video recordings from the facility were collected and included in the case file. The video recordings documented the last time (b) (6), (b) (7)(C) made contact with staff was at 9:46 a.m. and captured (b) (6), (b) (7)(C) outside the cell in the dayroom at 10:10 a.m. Finally, the video recording captured the incident when the CO discovered (b) (6), (b) (7)(C) at 11:01 a.m. The criminal case findings found that no action by the confinement facility staff contributed to the death of (b) (6), (b) (7)(C).

The administrative investigation was performed by BIA-IAD following the criminal investigation. This investigation found that none of the actions of the CTDF staff contributed to the death of (b) (6), (b) (7)(C) but identified various policy violations that should be corrected.

Evaluation Methodology:

All case records provided by the BIA Office of Justice Services (OJS) to The Cruzan Group were reviewed by five experienced case reviewers for investigative timeliness, thoroughness, and reporting. Observations noted by each reviewer were consolidated and used for development of this evaluation report. All review questions included by the BIA were considered, and responses are included in the investigation observations as either a pro or con as directed in the solicitation.

Investigation Observations (Pro):

- The BIA-IAD investigation revealed that of the [redacted] COs who were working the first shift on [redacted] 2019, only [redacted] of the [redacted] employees had a valid first aid/cardiopulmonary resuscitation certification (CPR) as required by BIA policy[1]. IAD's interview with [redacted] revealed it is common practice at the CTCF to have employees working as officers in the confinement facility who do not possess valid CPR and/or first aid certification because training was not made available to them.
- The BIA-IAD investigation into this matter revealed on [redacted] 2019, [redacted], the COs did not conduct a cell check on [redacted] or pod [redacted][2].
- The administrative investigation included interviews of the pertinent witnesses to [redacted] death.
- The administrative investigation revealed that several required booking forms were not completed for [redacted] upon facility intake. Specifically, the suicide and medical assessment forms were not completed, and other forms related to behavior, state of mind and medical condition were not completed until the following day on [redacted] 2019.
- The investigation established cell checks were properly conducted at the start of the shift, but that during a gap of [redacted] no cell checks were performed. During this time [redacted].
- The investigation determined that for five days no official referral to the [redacted] was made even though staff stated [redacted] was [redacted]. Additionally, [redacted] was moved to two different cells and each time began to [redacted]
- The investigation documented that upon the custody transfer both the arresting officer and booking officer believed that [redacted] was due to [redacted].
- The administrative investigation found that proper and timely notification to CO supervisors and the FBI concerning [redacted] death were made.

[1] BIA-OJS Corrections Handbook C2-43-02 (C) requires that the program will develop an annual first Aid and CPR recertification schedule and implement the schedule.
[2] BIA-OJS Correction Handbook, C2-30-02 Cell Checks-Daily Operations, states in part that; [redacted]

- Evidence was collected, death scene photographs were taken, an autopsy was performed, and autopsy photographs were collected.
- Surveillance video recordings were included in the case file. The video recordings documented the last time [redacted] had contact with staff was at 9:46 a.m. and showed [redacted] outside [redacted] cell in the dayroom area at 10:10 a.m. Finally, the video recording captured the CO discovering (b) (6), (b) (7)(C) at 11:01 a.m.
- The administrative report included a sketch/diagram of the facility but not the actual death scene.

Investigation Observations (Con):

- The administrative investigation should have extended its focus on several of the booking forms that were dated the day after [redacted] initial intake. The jail management system timestamped these forms on [redacted] 2019. When asked, the booking officer had no explanation as to why or how this could have happened. The administrative investigation did not determine if this was an error, a potential problem with automated intake system, or an effort by staff to create a document after the fact that should have been completed upon [redacted] intake.
- The toxicology report was not included in the administrative investigation report. The toxicology report may have (b) (6), (b) (7)(C) [redacted]
- There were discussions with COs concerning the need to take [redacted] to (b) (6), (b) (7)(C) [redacted] because of (b) (6), (b) (7)(C), but this never took place because the COs were shorthanded and did not have personnel to take [redacted] for an examination. The administrative investigation did not resolve whether COs should have ensured [redacted] received an evaluation pursuant to BIA policy[3].
- The administrative investigation does not document any interview of court personnel regarding [redacted] appearance date. Interviews of court staff may have provided insight to (b) (6), (b) (7)(C) [redacted] on that date.
- The administrative investigation does not include evidence that appropriate rights advisements were provided to staff prior to being questioned regarding the incident[4].
- [redacted] arrest history was collected however (b) (6), (b) (7)(C) a summarization of its content may have clarified key and relevant points.
- A death scene sketch was not attached to the administrative investigation report.
- An autopsy was performed but there is no record of the administrative investigation representative attending.

[3] C2-20 Inmate Intake and Classification Policy

[4] Following appropriate agency policy, a Kalkines or Garrity rights advisement should be provided to any employee being interviewed in an internal agency investigation.

Investigative Effectiveness in Aiding Policy Modifications/Updates:

The administrative investigative report identified areas of noncompliance with BIA policy and made recommendations that CTCF management work to identify the program deficiencies.

Prosecution Referral:

No documentation was found to reflect coordination with a prosecutor at the conclusion of the administrative investigation to address (b) (6), (b) (7)(C)

All administrative investigations concluding that employee(s) did not comply with confinement policy or whose behavior amounted to misconduct should be referred to the appropriate United States Attorney's Office for prosecution review. Declinations by that office should be in writing, should outline the reasoning for the declination, and be included in the administrative investigation.

Case Number: I19000131

(b) (6), (b) (7)(C)

TCG #5

In-Custody Death Administrative Investigation Evaluation

Case Number: 19000131

Subject/Victim: [redacted]
Date of Death: [redacted] 2019
Time in Custody: 12.5 Hours
Report Date to BIA: May 20, 2019
Location of Death: Rosebud Sioux Tribe Adult Corrections, Mission South Dakota (tribal)
Cause of Death: [redacted]
Manner of Death: [redacted]
Facility Type: Tribal

Case Synopsis:

On [redacted] 2019, at approximately 10:30 p.m., [redacted] drove [redacted] vehicle to the Rosebud Sioux Tribe Adult Corrections Facility (RSTADF) and began beating on the employee entrance door until [redacted] was met by [redacted]. [redacted] explained that [redacted] told [redacted] that [redacted] would feel safer inside the jail and forced [redacted] way into the employee entrance before [redacted] was restrained on the entry hallway floor by COs. The tribal police department was contacted, and [redacted] was arrested for trespassing and possession of [redacted] which was found in [redacted]. [redacted] was booked into the facility and voluntarily provided a urine sample. The rapid urine test tested [redacted] Once the intake process was completed, [redacted] was placed in a general holding cell with other inmates. [redacted] was observed by staff striking another inmate in the face while the inmate was sleeping causing the inmate to [redacted] was immediately removed and asked why [redacted] punched the inmate to which [redacted] was then moved to a single cell where a CO observed [redacted] slamming [redacted] head into the cell door, [redacted]. [redacted] was removed and placed in a restraint chair to stop [redacted] from further harming [redacted] attempted to spit on the COs and a spit hood was placed on [redacted]. Emergency medical services (EMS) was contacted and requested to evaluate [redacted]. The emergency medical technicians (EMT)s concluded that [redacted] was fine, and no further medical treatment was necessary. When the dayshift arrived, [redacted] was removed from the chair and permitted to walk around to get circulation moving in [redacted] extremities before being once again placed in the restraint chair. The [redacted] decided to have [redacted] transported to the hospital for further evaluation and the Special Operations Response Team (SORT) was requested to conduct the transport. As [redacted] was being taken into the sallyport [redacted] attempted to escape but was caught by a police officer and restrained on the ground where [redacted] continued to fight and resist. The [redacted] used [redacted] radio to request the facility staff bring the restraint chair to the sallyport where [redacted] was again placed back into the restraint chair by force. The investigation and reports indicate that [redacted] was struck with knee blitzes, elbow strikes, and body blows to aid in securing [redacted] into the chair. [redacted] was returned to RSTADF and EMS was once again called to treat [redacted]

(b) (6), (b) (7)(C), which was believed to have occurred during the physical altercation. The (b) (6), (b) (7)(C) requested that the medical services unit transport [redacted] to the local hospital while [redacted] remained in the restraint chair. Because the EMS vehicle was too small to accommodate the restraint chair EMS requested a van be brought to the jail. While waiting for the van to arrive, [redacted] became (b) (6), (b) (7)(C) . [redacted] was removed from the chair and cardiopulmonary resuscitation (CPR) was initiated by the on scene EMTs. [redacted] was transported to the hospital and pronounced dead on [redacted] 2019, at 11:18 a.m.

The Federal Bureau of Investigation (FBI) conducted a criminal investigation including interviews, evidence collection, and scene photography. The investigation concluded there was no criminality regarding [redacted] death. Bureau of Indian Affairs (BIA), Internal Affairs Division (IAD) subsequently conducted an administrative investigation.

Evaluation Methodology:

All case records provided by the BIA Office of Justice Services (OJS) to The Cruzan Group were reviewed by five experienced case reviewers for investigative timeliness, thoroughness, and reporting. Observations noted by each reviewer were consolidated and used for development of this evaluation report. All review questions included by the BIA were considered, and responses are included in the investigation observations as either a pro or con as directed in the solicitation.

Investigation Observations (Pro):

- The investigation concluded that based on the preponderance of evidence, no employee of the RSTADF committed any misconduct which contributed to the [redacted] death. However, the investigation did reveal that a restraint chair log was not initiated or maintained when [redacted] was first put in the chair and kept in it until (b) (6), (b) (7)(C) [redacted] It also documented the fact that (b) (7)(E) checks were not performed regularly on the inmate in the restraint chair in accordance with the BIA policy[1].
- The investigation recommended remedial training be conducted on the use of the restraint chair and spit hood policy.
- The IAD investigation revealed checks on [redacted] while [redacted] was fitted with a spit guard were not completed as required by BIA policy[2].
- The administrative investigation included death scene photographs.
- The IAD investigation revealed there was no evidence of employee training in CPR or the Automated External Defibrillator (AED) device in the employee training files. Although

[1] BIA-OJS Corrections Handbook C2-04-07, Observation of Inmates in a Restraint Chair states that (b) (7)(E) [redacted]

[2] BIA-OJS Corrections Handbook C2-04-07, Observation of Inmates in a Restraint Chair. [redacted] was checked on at (b) (7)(E) [redacted]. Policy states that (b) (7)(E) [redacted]

the investigation revealed no RSTACF employee started or conducted CPR on [redacted], it is a skill required by policy[3] when applying first aid to any inmate in the facility.

Investigation Observations (Con):

- The administrative investigation did not include the facility surveillance video footage for review.
- Neither the criminal nor administrative investigations resulted in the collection of the restraint chair as evidence as is common practice following its use resulting in an in-custody death. A best practice would be to retain the chair as evidence until it can be concluded its use did not contribute to the in-custody death. Additionally, no photographs of the chair were collected or appended to the report.
- The investigation revealed that force was used multiple times to gain [redacted] compliance, but [redacted]. BIA policy[4] requires [redacted] was not mentioned or appended to the report as required by the same BIA policy.
- We were unable to locate record of interview with [redacted], the [redacted] for the daywork shift on the date of [redacted] death. [redacted] was involved in the incident in the sallyport, requested SORT, requested EMS transport [redacted] in the restraint chair, and the first to observe [redacted]. The administrative investigative report states [redacted] was interviewed by [redacted] on October 8, 2019; however, the interview summary is not included in the administrative report. An incident report written by [redacted] was appended to the administrative report. This is relevant because [redacted] were interviewed and stated [redacted] heard from four individuals, including one inmate who had been incarcerated during the incident that [redacted] had [redacted] The [redacted] also alleged that [redacted] came to [redacted] home and [redacted] The administrative investigation provides no follow-up regarding the four individuals or the statement that [redacted] allegedly made to [redacted]
- The administrative investigation included statements made by staff who were interviewed without receiving an appropriate administrative rights warning[5] (Garrity/ Kalkines).
- The administrative investigation did not include any autopsy photographs of [redacted] and there is no indication that a BIA-IAD investigator was in attendance.
- The administrative investigation did not include a death scene sketch.

[3] BIA-OJS Corrections Handbook requires in section C2-43-02 (C) that the program will develop an annual first Aid and CPR recertification schedule and implement the schedule.
[4] BIA-OJS Corrections Handbook C-156 (Facility Reports)
[5] Following appropriate agency policy, a Kalkines or Garrity rights advisement should be provided to any employee being interviewed in an internal agency investigation.

- The administrative investigation did not include an interview of (b) (6), (b) (7)(C), the inmate assaulted by [redacted] while incarcerated.
- No interview is documented of any other inmates incarcerated at the time of [redacted] death to verify witness statements collected.

Investigative Effectiveness in Aiding Policy Modifications/Updates:

The investigation recommended remedial training be conducted on the use of the restraint chair and spit hood policy.

Prosecution Referral:

No documentation was found reflecting coordination with a prosecutor at the conclusion of the administrative investigation.

All administrative investigations concluding that employee(s) did not comply with confinement policy or whose behavior amounted to misconduct should be referred to the appropriate United States Attorney's Office for prosecution review. Declinations by that office should be in writing, should outline the reasoning for the declination, and be included in the administrative investigation.

Case Number: I20000085

(b) (6), (b) (7)(C)

TCG #6

In-Custody Death Administrative Investigation Evaluation

Case Number: I20000085

Subject/Victim: [redacted]
Date of Death: [redacted] 2020
Time in Custody: 36 Days
Report Date to BIA: March 26, 2019
Location of Death: Fort Toten, ND
Cause of Death: [redacted]
Manner of Death: [redacted]
Facility Type: Bureau of Indian Affairs (BIA)

Case Synopsis:

On [redacted] 2020, in the Spirit Lake Tribal Community of North Dakota, a call for service regarding a domestic dispute was made to the residence of [redacted] Knowing that the police were called and that [redacted] had two outstanding tribal warrants, [redacted] ran from the residence wearing only a T-shirt, shorts, and a pair of shoes in -10 degrees Fahrenheit. After approximately one hour, [redacted] was arrested by the Turtle Mountain Police Department and brought to the Fort Totten Adult Corrections Facility (FTACF). Emergency medical services (EMS) were contacted, and [redacted] was evaluated for [redacted]. Due to [redacted] caused the emergency medical technicians (EMT) to inform the arresting officer that [redacted] needed further medical attention at the local hospital. [redacted] was taken to the hospital, evaluated, treated, and released before the arresting officer transported [redacted] back to the FTACF.

On [redacted] 2020, at approximately 3:26 p.m., inmates in a dayroom housing block began to bang on the block door and yell for help. The commotion caught the attention of [redacted] who was inside the control room with [redacted] They each observed via video surveillance that [redacted] appeared to be in medical distress. [redacted] responded to the block and tried to provide aid to [redacted] who by then [redacted] asked that [redacted] request EMS for a medical emergency. [redacted] stated in [redacted] report that [redacted] Once EMS was on scene, [redacted], [redacted], and [redacted] from the Fort Totten Police Department initiated cardiopulmonary resuscitation (CPR). The EMS personnel on scene pronounced [redacted] dead at 4:10 p.m. that day.

The criminal investigation was conducted by the BIA-Office of Justice Services (OJS) - Branch of Criminal Investigations[1] (BCI) assisted by the Federal Bureau of Investigation (FBI). Both [redacted] from the FBI and [redacted] from the BCI met at the jail on March 26, 2020,and began the investigation. The criminal investigation included the review of facility video surveillance footage, interviews of COs, interviews of inmates in the housing area, reviewing

[1] The BCI was an element of BIA-OJS for a period of time before it was eliminated in a reorganization

relevant documents, and attending the autopsy of [redacted] The investigation revealed that [redacted] was engaging in calisthenics (burpees) with other inmates in the block which was common practice every day around 4:00 p.m. However, on this day, [redacted] stopped [redacted] exercises, walked around to cool down, and then [redacted].

The administrative investigation included pertinent interviews, police reports, jail documentation, jail logs, EMS reports, and the autopsy report. The BCI investigator obtained a subpoena for [redacted] medical records resulting in the collection of all records for the treatment of [redacted] on [redacted] 2020. The administrative investigation concluded that the actions of the employees at FTACF did not contribute to [redacted] death. The administrative investigation found that upon [redacted] intake, several booking forms were not properly filled out and no medical clearance form was found.

Evaluation Methodology:

All case records provided by the BIA Office of Justice Services (OJS) to The Cruzan Group were reviewed by five experienced case reviewers for investigative timeliness, thoroughness, and reporting. Observations noted by each reviewer were consolidated and used for development of this evaluation report. All review questions included by the BIA were considered, and responses are included in the investigation observations as either a pro or con as directed in the solicitation.

Investigation Observations (Pro):

- The administrative investigation provided some detail into how the incident transpired that resulted in the incarceration of [redacted] Detailed information about the incident that led to [redacted] arrest were made by [redacted] in [redacted] statements to a doctor at the emergency room.
- The administrative investigation explained the initial booking forms pertaining to [redacted]
- The administrative investigation provided the appropriate cell check logs for the day of [redacted] death. Because the checks were timely, and in accordance with policy, there was no investigative emphasis placed on the process of cell checks.
- The administrative investigation included [redacted] medical records obtained by the BCI investigator pursuant to a court ordered subpoena in accordance with the Health Insurance Portability and Accountability Act of 1996[2]. This is a "best practice" and the only investigation we reviewed that included this investigative step. These records showed that during [redacted] medical visit [redacted] had [redacted] which was consistent with the findings of the autopsy.
- The administrative investigation included the autopsy report.
- The administrative investigation included a death scene sketch.

[2] The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

- The administrative investigation explained each officer's activities on the date of [redacted] death and during the incident.
- The administrative investigation included interviews of other inmates present on the date of [redacted] death to clearly establish the events on that day considering all witness accounts.
- The administrative investigation report clearly concluded that "no officer misconduct" contributed to [redacted] death.
- The administrative investigation report outlined the BIA confinement policies that were not followed and explained each policy and where they are found in the corrections handbook.
- The criminal investigation report included documentation of the review of facility surveillance video footage on the day of [redacted] death; however, the surveillance footage was not included in the administrative investigation.

Investigation Observations (Con):

- The administrative investigation [redacted] at the time of [redacted] death as required by BIA policy[3]. The shift report for the 8:00 a.m. to 8:00 p.m. shift on [redacted] 2020, identified [redacted] as being on duty. None of the log entries for the day, incident reports, police reports, or the criminal or administrative investigative reports reviewed make any mention of [redacted]. Records do not reveal any report nor contact with other COs that day by [redacted]. If on duty that day, there is no indication that [redacted] was involved in the incident.
- The administrative investigation included statements made by staff who were interviewed without receiving an appropriate administrative rights advisement[4] (Garrity/ Kalkines).
- The administrative investigation did not include any autopsy photographs. It is unknown if the BCI investigator attended the autopsy.
- The administrative investigation included 20 to 30 pages of medical documents for review and interpretation by a recipient of the report. An evaluation and summary by a medical doctor to translate the findings for non-medically trained readers would be a "best practice" and ensure the proper and intended interpretation of these records.
- The FBI did not establish an agency case number or document any investigative interviews or activity on their standard form 302 pertaining to this investigation. As

[3] C4-32-6-C, (Assignment Master Schedule) states in part that; [redacted]

[4] Following appropriate agency policy, a Kalkines or Garrity rights advisement should be provided to any employee being interviewed in an internal agency investigation.

such, the criminal investigation of this matter was not actually a "joint" investigation with the FBI and instead was the responsibility of the BIA-OJS BCI.

Investigative Effectiveness in Aiding Policy Modifications/Updates:

The report identified the booking policies that were violated and the need for remedial training.

The investigative report did not provide any recommendations to modify or update BIA policy.

Prosecution Referral:

No documentation was found reflecting coordination with, or a prosecution referral being made to the appropriate United States Attorney's Office during the criminal or administrative investigations.

All administrative investigations concluding that employee(s) did not comply with confinement policy or whose behavior amounted to misconduct should be referred to the appropriate United States Attorney's Office for prosecution review. Declinations by that office should be in writing, should outline the reasoning for the declination, and be included in the administrative investigation.

Case Number: I20000112

(b) (6), (b) (7)(C)

TCG #7

In-Custody Death Administrative Investigation Evaluation

Case Number: I20000112

Subject/Victim: (b) (6), (b) (7)(C)
Date of Death: [redacted] 2020
Time in Custody: < 5 hours
Report Date to BIA: May 1, 2020
Location of Death: Cherokee Tribal Detention Center, Cherokee, NC
Cause of Death: (b) (6), (b) (7)(C)
Manner of Death: [redacted]
Facility Type: Tribal

Case Synopsis:

On [redacted] 2020, (b) (6), (b) (7)(C) approached Cherokee Tribal Police (CTP) [redacted] at a traffic check point and informed [redacted] that (b) (6), (b) (7)(C) had [redacted] in the [redacted] parking lot. [redacted] responded to the scene, administered [redacted] to the [redacted] individual (b) (6), (b) (7)(C) and requested assistance. [redacted] arrived and took charge of the scene and conducted a search of (b) (6), (b) (7)(C) which revealed [redacted]. [redacted], who had been in (b) (6), (b) (7)(C) was arrested and taken to the Cherokee Tribal Detention Center (CTDC) at 4:10 p.m. [redacted] was X-ray scanned and strip searched by (b) (6), (b) (7)(C) [redacted] was placed in a safe room instead of a cell, not because [redacted] was a threat to [redacted] but because [redacted] prisoners were being housed in the other two holding cells. The investigation report explained that the safe cell is approximately ten feet away from the booking desk. During the rest of the day, multiple COs spoke to and observed [redacted], due to [redacted] proximity to the booking desk. It was reported that during this time [redacted] was heard crying and repeatedly yelling out that [redacted] wanted to use the phone. A shift change occurred at 6:00 p.m. and [redacted] was the last employee to speak with [redacted] at approximately 7:00 p.m. Additionally, [redacted] reported that [redacted] physically observed [redacted] at the cell window at 7:57 p.m. At 8:28 p.m. [redacted] entered [redacted] cell to serve warrants on [redacted] and observed [redacted] in medical distress. An emergency call was made, [redacted] responded and administered (b) (6), (b) (7)(C) to [redacted]. [redacted] also initiated chest compressions. During this medical response, [redacted] was found in the cell next to [redacted] head and it was seized as evidence. The Cherokee tribal emergency medical services (EMS) arrived at 8:31 p.m. and assumed emergency lifesaving procedures however, [redacted] died. Once [redacted] was removed from the cell by EMS, the Cherokee Tribal Police responded and began collecting evidence and

[1] (b) (6), (b) (7)(C) [redacted]

taking photographs. During the evidence collection (b) (6), (b) (7)(C) were found in (b) (6), (b) (7)(C) located in the cell. (b) (6), (b) (7)(C)

The case file provided police reports and interviews that were conducted. When (b) (6), (b) (7)(C) was interviewed, (b) (6) stated that (b) (6) and (b) (6), (b) (7)(C) purchased (b) (6), (b) (7)(C) on the (b) (6), (b) (7)(C). (b) (6), (b) (7)(C) explained that (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) told the officers that (b) (6), (b) (7)(C)

The criminal investigation was conducted by the Cherokee Tribal Police Department and the administrative investigation was conducted by Bureau of Indian Affairs (BIA), Internal Affairs Division (IAD). The administrative investigation includes multiple police reports, emergency medical technician (EMT) reports, dispatch logs, reports of interviews, documents obtained, and the autopsy report. All recorded interviews were transcribed, and photographs of both the arrest and cell location were taken. The administrative investigative report indicates there was facility surveillance video footage from the area outside of the cell, but no monitoring equipment was installed in the actual cell. No facility surveillance video footage was included in the administrative investigation case file. The administrative investigation determined that no action(s) of the employees of the Cherokee Tribal Detention Center contributed to (b) (6), (b) (7)(C) death. The administrative investigation proposed two recommendations, the first recommendation was to provide staff with additional training on the use of the X-ray scanner and the second recommendation was to create a form to document cell checks in the holding cells.

Evaluation Methodology:

All case records provided by the BIA Office of Justice Services (OJS) to The Cruzan Group were reviewed by five experienced case reviewers for investigative timeliness, thoroughness, and reporting. Observations noted by each reviewer were consolidated and used for development of this evaluation report. All review questions included by the BIA were considered, and responses are included in the investigation observations as either a pro or con as directed in the solicitation.

Investigation Observations (Pro):

- The administrative investigation explained in sufficient detail how and why (b) (6), (b) (7)(C) was brought to the detention center. The initial police reports were present in the administrative investigation report.
- The administrative investigation noted a failure by CO's to report shift activities (cell checks). Multiple COs stated they had communicated with and checked on the welfare of (b) (6), (b) (7)(C) during (b) (6), (b) (7)(C) detention. However, these cell checks were not documented because COs said they did not have a specific form to document the checks.

- The administrative investigation explained in detail what each log or document was used for and the information it contained.
- The administrative investigation addressed cell check documentation because during this incident the facility did not have a form to document cell checks for holding cells.
- The investigation provided the duty roster and cell assignments of all staff and inmates on the date of [redacted] death. The investigation reported that there were [redacted] staff members on duty and 49 inmates in custody on the night of [redacted] death.
- The administrative investigation included the detention logs.
- The administrative investigation included court documents, EMS reports, and the autopsy report.
- The administrative investigation included death scene photographs.
- The administrative investigation explained what each officer was doing and what duties they were performing at the time of [redacted] death. The report explained who responded, what actions they took and the times these actions took place.
- Between the administrative and criminal investigations, all pertinent witnesses were interviewed.
- This investigation found that no actions taken by the CTDC staff contributed to the death of [redacted]. The investigation did make two recommendations for additional training and the creation of a needed cell check form.
- The administrative investigation did not include any facility video footage but documented the review of the video by investigators during the criminal investigation.
- The administrative investigation included a timeline prepared by investigators that was very effective in putting together all the CO statements. The timeline is an example of a "best practice."
- The administrative investigation included a background check on [redacted] that revealed [redacted] had been arrested multiple times [redacted] and other offenses dating back to [redacted]. However, as a "best practice" these arrests should be explained in a written report to ensure proper interpretation of the events.

Investigation Observations (Con):

- The investigation report noted that [redacted] was searched prior to being placed into the cell and no items of evidence were discovered. Added effort should have been made to determine how [redacted] were introduced into the confinement facility. Consideration could have been made to send the evidence to a criminal laboratory [redacted]
- The administrative investigation did not include an interview of [redacted] who was present in the booking area as mentioned in the statement of [redacted]. This witness interview may have provided additional insight to the events of that day.
- The administrative investigation did not include laboratory analysis of the [redacted] collected at the death scene. No documentation of [redacted]

- The investigation was not conducted by the Federal Bureau of Investigation (FBI) and no mention of FBI involvement or notification was made in the reports in violation of BIA policy[2].
- The administrative investigation does not include any autopsy photographs.
- The administrative investigation does not include a death scene sketch.
- The administrative investigation does not indicate that a BIA-IAD investigator attended the autopsy of [redacted]
- The administrative investigation included statements made by staff who were interviewed without receiving an appropriate administrative rights advisement[3] (Garrity/ Kalkines).
- The administrative investigation did not indicate that any medical personnel who responded to the scene or provided [redacted] treatment were interviewed.
- The investigation did not include the interview of [redacted] who reported [redacted].
- No record of next of kin contact or interview was included in the investigative report. Such an effort may have provided insight to [redacted] and provide an opportunity to answer questions family members may have.

<u>Investigative Effectiveness in Aiding Policy Modifications/Updates:</u>

The administrative investigation did propose two recommendations. The first recommendation was to provide staff additional training on the use of the X-ray scanner and the second was for creating a form to address documenting cell checks in the holding cells.

<u>Prosecutive Referral:</u>

No documentation was found reflecting coordination with, or a prosecution referral being made to the appropriate United States Attorney's Office.

All administrative investigations concluding that employee(s) did not comply with confinement policy or whose behavior amounted to misconduct should be referred to the appropriate United States Attorney's Office for prosecution review. Declinations by that office should be in writing, should outline the reasoning for the declination, and be included in the administrative investigation.

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[2] BIA-OJS Law Enforcement Handbook, 3rd Edition 2-42 Investigation of BIA OJS/Tribal Officer Involved Shootings and In-Custody Death incidents.

[3] Following appropriate agency policy, a Kalkines or Garrity rights advisement should be provided to any employee being interviewed in an internal agency investigation.

Case Number: I20000120

(b) (6), (b) (7)(C)

TCG #8

In-Custody Death Administrative Investigation Evaluation
Case Number: I20000120

Subject/Victim: (b) (6), (b) (7)(C)
Date of Death: (b) (6), (b) (7)(C) 2020
Time in Custody: < 1 Day
Report Date to BIA: May 11, 2020
Location of Death: Blackfeet Adult Correctional Facility, Browning, Montana
Cause of Death: (b) (6), (b) (7)(C)
Manner of Death: (b) (6), (b) (7)(C)
Facility Type: Bureau of Indian Affairs (BIA)

Case Synopsis:

On the morning of (b) (6), (b) (7)(C) 2020, Blackfeet Law Enforcement Services (BLES) received a call of a (b) (6), (b) (7)(C) Upon arriving on the scene, (b) (6), (b) (7)(C) spoke with the complainant who is identified as (b) (6), (b) (7)(C) . (b) (6), (b) informed (b) (6), (b) (7)(C) that (b) (6), (b) (7)(C) was intoxicated and had been involved in a fight with multiple subjects. (b) (6), (b) (7)(C) arrested (b) (6), (b) (7)(C) for disorderly conduct and transported (b) (6), (b) to the Indian Health Services (IHS) Center for treatment of (b) (6), (b) (7)(C) . The responding officers requested that (b) (6), (b) (7)(C) guard (b) (6), (b) (7)(C) at the hospital so they could return to service. (b) (6), (b) (7)(C) went to the hospital to guard (b) (6), (b) (7)(C) and (b) (6), (b) (7)(C) was subsequently cleared for incarceration by (b) (6), (b) (7)(C) . (b) (6), (b) (7)(C) transported (b) (6), (b) (7)(C) to the Blackfeet Adult Correctional Facility (BACF) arriving at 6:30 a.m. (b) (6), (b) (7)(C) was uncooperative during the booking process and was changed into jail issue clothing by (b) (6), (b) (7)(C) . (b) (6), (b) (7)(C) was placed in a "management" cell with inmate (b) (6), (b) (7)(C) at 6:37 a.m., where (b) (6) remained for the next 13 hours until (b) (6) was found nonresponsive. (b) (6), (b) (7)(C) was moved out of the management cell long before (b) (6), (b) (7)(C) was found nonresponsive. At approximately 7:20 p.m. (b) (6), (b) (7)(C) opened the management cell door and discovered that (b) (6), (b) (7)(C) had died. (b) (6), (b) (7)(C) requested assistance, and emergency medical services were contacted. No lifesaving procedures were attempted because no personal protection equipment was available for use and they determined (b) (6), (b) (7)(C) had (b) (6), (b) (7)(C) . The emergency medical service (EMS) personnel arrived within four minutes of being notified and (b) (6), (b) (7)(C) was pronounced dead at the scene by (b) (6), (b) (7)(C) Glacier County Sheriff's Office who is also the assistant coroner for Glacier County, MT. (b) (6), (b) (7)(C) took death scene photographs and collected evidence at the death scene. An autopsy was later conducted on (b) (6), (b) (7)(C) which found (b) (6), (b) cause of death to be (b) (6), (b) (7)(C) and the manner of death determined to be (b) (6), (b) (7)(C)

The criminal investigation was initiated by the Federal Bureau of Investigation (FBI) and the Glacier County Sheriff's Office. The only investigative documentation in the criminal investigation report is from (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) conducted interviews

and followed leads that indicate (b) (6), (b) (7)(C) , prior to being arrested and brought to the BACF.

The administrative investigation focused on any potential wrongdoing by staff as it related to this in-custody death. The administrative investigation revealed that proper protocol was not followed by staff as it related to the BIA policy governing (b) (7)(E) cell checks[1]. The investigation included a detailed video review that identified [redacted] COs who falsified cell check logs that day indicating they had performed cell checks as required when they actually had not. The investigator included the results of interviews, staff written statements, EMS reports, BLES reports, and dispatch logs among other relevant documents to the administrative investigative report.

Evaluation Methodology:

All case records provided by the BIA Office of Justice Services (OJS) to The Cruzan Group were reviewed by five experienced case reviewers for investigative timeliness, thoroughness, and reporting. Observations noted by each reviewer were consolidated and used for development of this evaluation report. All review questions included by the BIA were considered, and responses are included in the investigation observations as either a pro or con as directed in the solicitation.

Investigation Observations (Pro):

- The administrative investigation report included the arresting officers report, body worn camera video footage of the incident, and the police report following the determination by the coroner's office that the manner of death was [redacted].
- The administrative investigation included all the booking forms to include the medical release from the hospital but did not go into detail about what each form was used for and why.
- The administrative investigation includes death scene photographs.
- This administrative investigation focused on the (b) (7)(E) cell checks. The investigator pointed out the procedure and where it could be found in BIA policy along with the determination that [redacted] correctional officers were in violation of this policy.
- The administrative investigation included the (b) (6), (b) (7)(C) to show and explain the discrepancy between what was logged by the COs and what the actual surveillance video footage revealed. Therefore, the logs were vital in determining if cell checks had been properly conducted.
- The administrative investigation provided relevant documentation pertaining to [redacted] including court records, previous medical records, and the autopsy report.

[1] BIA-OJS Corrections Handbook, C2-30-02 Cell Checks-Daily Operations, states in part that; (b) (7)(E) [redacted]

- The investigation explained who, what, when, where and how as it related to the response to this in-custody death.
- The investigation contained hours of video footage covering the time [redacted] was booked into the jail until the time of [redacted] death.
- The administrative investigation included both the staff duty roster and inmate cell assignment sheet for the date of [redacted] death reflecting there were 25 inmates and [redacted] sworn correctional officers working on the night of [redacted] death.

Investigation Observations (Con):

- The administrative investigation report did not include an interview of [redacted] regarding [redacted] observations of [redacted] health or any conversations they may have had.
- The administrative investigation report did not include any interview of the attending physician who medically cleared [redacted] for incarceration.
- The administrative investigation did not include a death scene sketch.
- The administrative investigation did not include autopsy photographs.
- The administrative investigation did not indicate if a BIA Internal Affairs Division (IAD) investigator attended the autopsy.
- The administrative investigation did not identify inadequate confinement facility staffing as a potential concern and a non-compliance issue with BIA policy[2].
- No FBI form 302's were included in the administrative investigation report.
- There was only limited follow up on the reported incident where [redacted] (prior to [redacted] arrest). Even if this was handled by FBI or the local coroner, this should have been part of this report to clearly establish whether [redacted] were caused prior to [redacted] arrest and not while in custody. There is mention of a verbal coordination with the coroner about this information but no written report.
- An error was made in the reporting of the event timeline in the administrative investigation report. In the report of the surveillance video review, it was noted [redacted] appeared to be [redacted] at 4:48 p.m., experiencing [redacted] at 4:50 p.m., and last seen [redacted] at 5:00 p.m. In the summary section of the report, it states [redacted] was seen [redacted] at 4:58 p.m., experiencing [redacted] at 5:00 p.m., and last seen [redacted] at 5:10 p.m., each event ten minutes later than the investigator review record stated. The CO log indicates cell checks were performed at 5:00 p.m. This discrepancy causes confusion to the reader as to the time of death or when [redacted] should have been observed by the COs as being in distress.
- The autopsy report of [redacted] indicated death was due to [redacted]. This may be inconsistent with the rest of the report that

[2] BIA-OJS Corrections Handbook C4-32-6-C, (Assignment Master Schedule) states in part that; [redacted]

documents (b) (6), (b) (7)(C) [redacted]. The administrative investigation should have attempted to resolve this discrepancy.

- The administrative investigation indicates that some interviews were conducted without an appropriate rights advisement to staff prior to being questioned regarding the incident[3].

Investigative Effectiveness in Aiding Policy Modifications/Updates:

The investigative report recommended changes to modify or update BIA policy. The investigation revealed significant weaknesses in supervision leading to the failure of corrections officers to perform required inmate checks and the falsification of cell check logs. The report also recommended basic lifesaving and first aid training be provided to staff.

Prosecution Referral:

No documentation was found reflecting coordination with a prosecutor at the conclusion of the administrative investigation to address (b) (6), (b) (7)(C) [redacted] Additionally, no prosecutor review or approval was obtained prior to the use of a Kalkines warning (providing immunity from criminal prosecution) for interviews the of COs.

All administrative investigations concluding that employee(s) did not comply with confinement policy or whose behavior amounted to misconduct should be referred to the appropriate United States Attorney's Office for prosecution review. Declinations by that office should be in writing, should outline the reasoning for the declination, and be included in the administrative investigation.

[3] Following appropriate agency policy, a Kalkines or Garrity rights advisement should be provided to any employee being interviewed in an internal agency investigation.

Case Number: I20000220

(b) (6), (b) (7)(C)

TCG #9

In-Custody Death Administrative Investigation Evaluation

Case Number: I20000220

Subject/Victim: (b) (6), (b) (7)(C)
Date of Death: (b) (6), (b) (7)(C), 2020
Time in Custody: 132 Days
Report Date to BIA: September 13, 2020
Location of Death: Owyhee Detention Center, Eastern Nevada Agency
Cause of Death: (b) (6), (b) (7)(C)
Manner of Death: (b) (6), (b) (7)(C)
Facility Type: Bureau of Indian Affairs (BIA)

Case Synopsis:

We found a conflict between the case number provided by BIA OJS for review (I20000220) and the case number affixed to the investigative records within the file (I120000220). Also, we noted a third case number on one accountability form pertaining to Phoenix (I200000220).

On (b) (6), (b) (7)(C) 2020, (b) (6), (b) (7)(C) was arrested on an outstanding failure to appear warrant by the BIA Office of Justice Services (OJS) Eastern Nevada Police Agency (ENA). The warrant was regarding a probation violation. (b) (6), (b) was brought to the Owyhee Detention Center (ODC) and processed without incident. The investigation later revealed that the booking paperwork was complete, except for question 10 on the Suicide Screening Form asking if (b) (6), (b) (7) had ever attempted suicide in the past. (b) (6), (b) (7)(C) was the officer who processed (b) (6), (b) that night and was asked why the question was skipped to which (b) (6), (b) replied that it was an oversight on (b) (6), (b) part. (b) (6), (b) (7)(C) For example, on the day of (b) (6), (b) (7)(C) death (b) (7)(F) CO was left on duty while (b) (7)(F) CO was transporting an inmate (b) (7)(F) miles away for medical services.

On (b) (6), (b) (7)(C) 2020, (b) (6), (b) was sentenced to (b) (6), (b) days in jail and received (b) (6), (b) (7) remaining suspended sentence from a prior conviction. It appears that (b) (6), (b) adapted to the confinement system and did not cause any issues over the next four months leading to (b) (6), (b) (7)(C). (b) (6), (b) (7)(C)

(b) (6), (b) (7)(C)

[1] (b) (6), (b) (7)(C)

(b) (6), (b) (7)(C)

On (b) (6), (b) (7)(C) 2020, (b) (6), (b) was being transported to a doctor's appointment (b) (6), (b) (7)(C) Following this incident, the facility attempted to charge (b) (6), (b) criminally for (b) (6), (b) (7)(C), however it appears that no further actions were taken. (b) (6), (b) (7) was later charged with institutional violations and received an additional (b) (6) days of disciplinary segregation and placed in cell (b) (6), (b) (7)(C)

On (b) (6), (b) (7)(C) 2020, at approximately 8:36 p.m., (b) (6), (b) was found by (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) and immediately began performing cardiopulmonary resuscitation (CPR). Help arrived, including emergency medical services, and CPR was performed for the next 26 minutes until (b) (6), (b) was pronounced dead.

The criminal investigation was conducted by the Federal Bureau of Investigation (FBI) and the reports are contained in the administrative investigation report. The FBI responded and interviewed all the COs that were involved. They reviewed the detention facility video footage and took pictures of the death scene. The FBI investigation found no probable cause to believe a criminal act had occurred regarding (b) (6), (b) (7)(death.

Evaluation Methodology:

All case records provided by the BIA Office of Justice Services (OJS) to The Cruzan Group were reviewed by five experienced case reviewers for investigative timeliness, thoroughness, and reporting. Observations noted by each reviewer were consolidated and used for development of this evaluation report. All review questions included by the BIA were considered, and responses are included in the investigation observations as either a pro or con as directed in the solicitation.

Investigation Observations (Pro):

- The administrative investigation described the events that led up to (b) (6), (b) (7)(incarceration. The case file included all the law enforcement officers reports and photographs that were taken at the time of (b) (6), (b) (7)(C) arrest.
- The administrative investigation included and explained the specific forms relative to the incident, (i.e., medical screening form and suicide screening form).
- The administrative investigation included the autopsy report.
- The administrative investigation included death scene photographs; however, these photographs only depict the scene after (b) (6), (b) (7)(C) .

- The administrative investigation included relevant court documents, transcripts of interviews, agency forms, reports, and logs. It included officer training records, [redacted] medical records, criminal history, and all relevant police reports. The assigned BIA Internal Affairs Division (IAD) investigator should be commended for reporting in [redacted] investigation attempts made to locate and interview two witnesses regarding this incident. One was (b) (6), (b) (7)(C) who was present during (b) (6), (b) (7)(C), had access to the (b) (6), (b) (7)(C) [redacted], and whose cell was adjoining [redacted] cell. The other individual was a citizen who filed a complaint regarding that night. Neither individual was located or responded to [redacted] request for an interview.
- This investigation explained the personal property items found in [redacted] cell.
- The administrative investigation described what each CO did and what actions they took during and after the incident.
- The administrative investigation found that the actions taken by staff did not contribute to [redacted] death.
- The administrative investigation included the collection of court documents relating to (b) (6), (b) (7)(C) [redacted]
- The administrative investigation included next of kin interviews which is considered a best practice.
- The administrative investigation included (b) (6), (b) (7)(C) [redacted]
- The administrative investigation report was well written. There was an effort to provide information about the events that occurred with [redacted] prior to [redacted] death such as, previous contacts with the facility, [redacted] various requests for (b) (6), (b) (7)(C), medical, and even trips to the jail library were all captured with supporting documentation. The report laid out (b) (6), (b) (7)(C) [redacted]
- The administrative investigation revealed that during the night shift on the date of [redacted] death (b) (7)(F) certified and [redacted] uncertified CO were scheduled on duty.
- The administrative investigation revealed that during the day shift on the day of [redacted] death (b) (7)(F) CO was on duty while (b) (7)(F) CO was required to transport an injured inmate for medical services [redacted] miles away from the confinement facility.
- The administrative investigation included a review of cell check daily logs and facility surveillance video and determined that five (b) (7)(E) cell checks were not performed

by staff on (b) (6), (b) (7)(C) 2020, in violation of BIA policy[2]. A cell check was performed of [redacted] at (b) (7)(E) [redacted] on (b) (6), (b) (7)(C) 2020, when [redacted] was found deceased (b) (6), (b) (7)(C) [redacted].

- The administrative investigation found (b) (7)(E) [redacted] the night of [redacted] death in violation of BIA policy[3]. (b) (6), (b) (7)(C) [redacted]. Because this change would mean the night shift would have (b) (7)(F) [redacted] officer working, (b) (6), (b) (7)(C) requested (b) (6), (b) (7)(C) [redacted] work that evening.

Investigation Observations (Con):

- The administrative investigation did not include the detention facility surveillance video footage.
- The administrative investigation did not include the death scene photographs that were collected after (b) (6), (b) (7)(C) [redacted].
- At no point during the initial death scene processing were photographs of [redacted] in [redacted] cell taken, despite (b) (6), (b) (7)(C) [redacted]
- The administrative investigation did not include a death scene sketch and it is unknown if one was prepared.
- The administrative investigation does not include copies of the rights advisements[4] reported as having been provided to staff before they were interviewed.
- The administrative investigation indicates some staff were interviewed without being provided an appropriate rights advisement.
- Additional effort should have been made to interview the other prisoners who had been incarcerated on the night of [redacted] death, including (b) (6), (b) (7)(C) who was present when [redacted] body was discovered. Their statements as witnesses are valuable to determining the facts of the evening and may preclude them from providing a different account of the event in the future.
- The administrative investigation did not resolve (b) (6), (b) (7)(C) [redacted]

[2] BIA-OJS Corrections Handbook, C2-30-02 Cell Checks-Daily Operations, states in part that; (b) (7)(E) [redacted]

[3] C4-32-6-C, (Assignment Master Schedule) states in part that; (b) (7)(E) [redacted]

[4] Following appropriate agency policy, a Kalkines or Garrity rights advisement should be provided to any employee being interviewed in an internal agency investigation.

(b) (6), (b) (7)(C) It is recommended that the BIA undertake this review (b) (6), (b) (7)(C)

- (b) (6), (b) (7)(C)
- (b) (6), (b) (7)(C)
- The agency dispatch log from the date of [redacted] death attached to the administrative investigation (attachment 12) is heavily redacted making it impossible to review. No reference to the reason for this redaction was found in the investigative report.

Investigative Effectiveness in Aiding Policy Modifications/Updates:

The investigative report did identify policy violations including noncompliance with the requirement to perform cell checks, absence of conducting an after-action report, training deficiencies, and no proper management plan to address inmate overcrowding and adequate employee staffing. No recommendations to modify or update BIA policy were made in the administrative report.

Prosecution Referral:

No documentation was found reflecting coordination with a prosecutor at the conclusion of the administrative investigation. Additionally, no prosecutor review or approval was obtained prior to the use of a Kalkines warning (providing immunity from criminal prosecution) for the interviews of the COs.

All administrative investigations concluding that employee(s) did not comply with confinement policy or whose behavior amounted to misconduct should be referred to the appropriate United States Attorney's Office for prosecution review. Declinations by that office should be in writing, should outline the reasoning for the declination, and be included in the administrative investigation.

Case Number: I17002363

(b) (6), (b) (7)(C)

TCG #10

In Custody Death Administrative Investigation Evaluation
Case Number: I17002363

Subject/Victim: (b) (6), (b) (7)(C)
Date of Death: (b) (6), (b) (7)(C) 2017
Time in Custody: 4 Days
Report Date to BIA: June 14, 2017
Location of Death: Northern Cheyenne Agency, Lame Deer, MT
Cause of Death: (b) (6), (b) (7)(C)
Manner of Death: (b) (6), (b) (7)(C)
Facility Type: Bureau of Indian Affairs (BIA)

Case Synopsis:

On (b) (6), (b) (7)(C) 2017, (b) (6), (b) (7)(C) was arrested by the BIA Crow Agency Police for firing a shot in the air from a .223 rifle. The incident occurred at a four way stop in the downtown area of the Crow Reservation. At the scene, (b) (6), (b) (7)(C) submitted to a portable breath test (PBT) and received a (b) (6), (b) (7)(C) blood alcohol content. Once at the Lame Deer BIA Jail, (b) (6) again submitted to a PBT test which resulted in a (b) (6), (b) (7) blood alcohol content during intake. (b) (6), (b) (7)(C) was charged with driving under the influence (DUI), disorderly conduct, and public nuisance and booked into the Lame Deer BIA Jail facility and placed in a general population block, where (b) (6) stayed until (b) (6), (b) (7)(C) 2017.

On (b) (6), (b) (7)(C) 2017, (b) (6), (b) (7)(C) complained to correction officers (CO) about having (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) was subsequently transported to the Cheyenne Indian Health Services where (b) (6) was seen by a doctor and cleared to return to the corrections facility. On (b) (6), (b) (7)(C) 2017, (b) (6), (b) (7)(C) was transferred to a holding cell because (b) (6), (b) (7)(C) By early morning on the following day, (b) (6), (b) (7)(C) was moved again, but this time to a special management cell. The reason given was to better monitor (b) (6), (b) (and so that (b) (6) could have a place to use the bathroom. (b) (6), (b) (7)(C) had previously been held in a holding cell without a toilet and (b) (6) urinated on the floor. COs also noted that (b) (6), (b) (7)(C) On (b) (6), (b) (7)(C) 2017, at approximately 12:00 p.m., (b) (6), (b) (7)(C) observed (b) (6), (b) (7)(C) in the management cell. Because (b) (6), (b) (7)(C) , (b) (6), (b) (7)(C) asked for assistance to check on (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) entered the cell thinking (b) (6), (b) (7)(C) was sleeping but upon further observation realized that (b) (6), (b) (7)(C) Immediately, (b) (6), (b) (7)(C) began providing cardiopulmonary resuscitation (CPR) to (b) (6), (b) (7)(C) while (b) (6), (b) (7)(C) retrieved the automated external defibrillator (AED) and contacted emergency medical services (EMS). Once the emergency medical technicians (EMT)'s arrived on the scene they did not continue further cycles of CPR. The time of death was declared as 12:28 p.m.

The criminal investigation was conducted by the Federal Bureau of Investigation (FBI) who interviewed (b) (7)(F), (b) (6), (b) (7) COs and collected evidence. There were no crime scene photos taken however, the jail facility surveillance video footage gives a perspective of the cell, the response,

and where [redacted] body was positioned. There are statements that were made to suggest that [redacted] was [redacted] when [redacted] rolled [redacted] over, and that is evident in the facility surveillance video footage. The criminal investigation determined that there was no probable cause to believe a crime had been committed.

Evaluation Methodology:

All case records provided by the BIA Office of Justice Services (OJS) to The Cruzan Group were reviewed by five experienced case reviewers for investigative timeliness, thoroughness, and reporting. Observations noted by each reviewer were consolidated and used for development of this evaluation report. All review questions included by the BIA were considered, and responses are included in the investigation observations as either a pro or con as directed in the solicitation.

Investigation Observations (Pro):

- The administrative investigation included surveillance video footage, court documents, agency logs, autopsy report, criminal investigation, and witness transcripts.
- The administrative investigation included the police report that explained in detail the events that led up to [redacted] arrest and incarceration.
- The administrative investigation determined there was a lack of documentation in the shift log regarding cell checks and monitoring equipment to check on the inmate's well-being. In addition, the shift log did not differentiate between the BIA policy requirement[1] for [redacted] cell checks [redacted]
- The administrative investigation explained what each officer did when they responded to the in-custody death. The statements written by the officers explained what they were doing and duties they performed prior to discovering [redacted] nonresponsive.
- The IAD prepared a detailed chronological event report initiated from [redacted] booking to being discovered nonresponsive in [redacted] cell. This is a best practice and makes the report much easier to read and understand.
- The administrative investigation revealed that the detention facility was holding [redacted] the number of inmates it was designed to house in violation of BIA policy[2] when this death occurred. No explanation for this policy violation was provided.

[1] BIA-OJS Corrections Handbook, C2-30-02 Cell Checks-Daily Operations, states in part that; [redacted]

[2] BIA-OJS Corrections Handbook, C2-19 Population Management Control, states in part that the facility supervisor will make every effort to prevent overcrowding.

Investigation Observations (Con):

- The administrative investigation documents [redacted] but the investigation did not determine the veracity of any of these [redacted]. These allegations may have been resolved during the investigation through interviews of several inmates that were being housed in general population with [redacted]
- The administrative investigation did not reveal [redacted] during this incident in violation of BIA policy[3].
- The administrative investigation did not explain or review any forms or screenings documentation. The logs and forms are present in the case file, but no explanations on their use or purpose is provided.
- The administrative report did not include any medical records generated by the EMT's that responded or the paperwork from the hospital when [redacted] was medically released on [redacted] 2017.
- The administrative investigation did not include any crime scene photographs despite there being a reference to the FBI having collected some photos.
- The administrative investigation did not include autopsy photographs despite there being a reference to the FBI having collected some photos.
- There is no evidence in the administrative investigation that the BIA Internal Affairs Division (IAD) investigator attended the autopsy of [redacted].
- The administrative investigation included the autopsy report, but the toxicology report was missing and should be included as part of the investigative report.
- The administrative investigation did not include a death scene sketch.
- The administrative investigation report did not include any medical records to determine the extent of [redacted] or the cause of [redacted].
- The administrative investigation did not note an unresolved question rising from the autopsy report: [redacted] This point should have been addressed with the medical examiner or other medical expert for resolution.
- The administrative investigation was not initiated or completed in a timely manner. Records show that the BIA-IAD was notified about this in-custody death through email chains and other reports on June 14, 2017. The FBI responded and began the criminal investigation which they concluded around September 15, 2017. The BIA-IAD

[3] BIA-OJS Corrections Handbook, C4-32-6-C, (Assignment Master Schedule) states in part that; [redacted]

Investigation began with interviews of the confinement facility staff on November 8, 2017, two months after the conclusion of the FBI criminal investigation. The final administrative investigative report is dated June 2, 2020, with no explanation as to why it took almost two and a half years to complete the report.

- The administrative investigation did not include an interview of (b) (6), (b) (7)(C). (b) (6), (b) (7)(C) was the officer that found (b) (6), (b) (7)(C) nonresponsive and performed CPR on (b) (6), (b) (7)(C)
- The administrative investigation report did not recommend changes to bring the facility into compliance for maximum inmate housing.

Investigative Effectiveness in Aiding Policy Modifications/Updates:

The administrative investigation recommended additional staff training for staff on inmates (b) (6), (b) (7)(C) and preparation of a proper management plan to prevent overcrowding should be followed at all times. The report did not provide any recommendations to modify or update BIA policy.

Prosecutive Referral:

No documentation was found reflecting coordination with a prosecutor at the conclusion of the administrative investigation to address the findings of the investigation. Additionally, no prosecutor review or approval was obtained prior to the use of a Kalkines[4] warning (providing immunity from criminal prosecution) for the interviews of two COs.

All administrative investigations concluding that employee(s) did not comply with confinement policy or whose behavior amounted to misconduct should be referred to the appropriate United States Attorney's Office for prosecution review. Declinations by that office should be in writing, should outline the reasoning for the declination, and be included in the administrative investigation.

[4] Kalkines v. United States 473 F.2d 1391 (Ct. Cl. 1973): A Kalkines warning advises the employee that they are *required* to participate in the IG / OPR investigation and failure to participate may result in administrative disciplinary action. The Kalkines warning should also inform the employee that the employee's answers during the investigation *cannot be used against them* in a criminal proceeding unless the employee commits perjury.

Case Number: I18000079

(b) (6), (b) (7)(C)

TCG #11

In Custody Death Administrative Investigation Evaluation
Case Number: I18000079

Subject/Victim: (b) (6), (b) (7)(C)
Date of Death: [redacted] 2018
Time in Custody: 2 Days
Report Date to BIA: July 5, 2018
Location of Death: Wind River Correctional Facility, Wyoming
Cause of Death: (b) (6), (b) (7)(C) [redacted]
Manner of Death: [redacted]
Facility Type: Tribal

Case Synopsis:

On [redacted] 2018, the Wind River Police Department responded to a call regarding an intoxicated [redacted] wishing to go to jail. [redacted] was subsequently arrested and charged with public intoxication and brought to the Wind River Correctional Facility (WRCF) at 1:38 p.m. When [redacted] arrived, [redacted] submitted to a portable breath test (PBT) that resulted in a reading of [redacted] blood alcohol content (BAC). During the booking process, [redacted] was documented as having suffered from several medical conditions, (b) (6), (b) (7)(C) [redacted]. After the booking process was complete, correction officers (CO) placed [redacted] in a drunk tank for 24 hours. During that period, [redacted] submitted to three more PBT's. The first test was at 8:05 p.m. and [redacted] registered a [redacted] BAC. [redacted] was again tested at 4:26 a.m. on [redacted] 2018, and registered a [redacted] BAC. Finally, at 8:41 a.m. on [redacted] 2018, [redacted] was tested again and registered a [redacted] BAC. On [redacted] 2018, at 9:07 a.m. [redacted] was moved to a general housing block with eight other inmates. According to (b) (6), (b) (7)(C) written statement the day shift reported to the night shift that [redacted] was going through (b) (6), (b) (7)(C) and was asking for medical attention and [redacted] medication. It was also documented in the log that [redacted] medication could not be administered until prescribed by a doctor. At approximately 9:00 p.m. [redacted] asked (b) (6), (b) (7)(C) [redacted] to check (b) (6), (b) (7)(C) [redacted] Subsequently, [redacted] was given (b) (6), (b) (7)(C) [redacted]

The criminal investigation reported that facility surveillance video footage was reviewed and showed [redacted] last movement was at 5:05 a.m. on the morning of [redacted] 2018. The CO reports showed that [redacted] was found nonresponsive during the morning breakfast feeding at 7:55 a.m. that day. [redacted] was found after inmate (b) (6), (b) (7)(C) informed [redacted] that [redacted] was [redacted] (b) (6), (b) (7)(C) entered the cell and checked on [redacted] who [redacted] described as (b) (6), (b) (7)(C) [redacted]. (b) (6), (b) (7)(C) immediately informed [redacted] who responded to the scene. The reports state that emergency medical services (EMS) was contacted, but there is no evidence that they ever responded. Also, it appears that because of the condition of the body no lifesaving attempts were made after [redacted] was found nonresponsive.

The criminal investigation was conducted by the Federal Bureau of Investigation (FBI) who responded and reviewed the facility surveillance video footage. They also collected several

pieces of evidence, took photographs of the crime scene, and conducted two interviews of inmates who had been housed with [redacted]. One interview was with [redacted] who had been incarcerated with [redacted] at the time of [redacted] death. The other interview was with [redacted] the inmate who notified staff about [redacted] condition. There are no interviews in the case file with the COs involved in this incident. There was no surveillance video footage or crime scene photographs made available for review by The Cruzan Group. The criminal investigation was not thorough or complete. The administrative investigation did not result in the compilation of a report and the records pertaining to this matter that were made available for review were completely disorganized.

Evaluation Methodology:

All case records provided by the BIA Office of Justice Services (OJS) to The Cruzan Group were reviewed by five experienced case reviewers for investigative timeliness, thoroughness, and reporting. Observations noted by each reviewer were consolidated and used for development of this evaluation report. All review questions included by the BIA were considered, and responses are included in the investigation observations as either a pro or con as directed in the solicitation.

Investigation Observations (Pro):

- The investigation documentation included the initial police report that explained how and why [redacted] was brought to the correctional facility.
- The investigation documentation included the agency forms and documents pertaining to [redacted] intake as part of the file.
- The staffing roster was present among the documents reviewed.

Investigation Observations (Con):

- The administrative investigation included the agency forms and documents among records provided. However, no explanation of what the records were and what they are used for was provided.
- The investigation did not explain the intake process, inmate monitoring, or cell checks. It did not determine if cell checks had been conducted as required by BIA policy[1]. The criminal investigative report indicated that the FBI agents reviewed facility video surveillance footage, but the video was not included in the administrative investigation.
- The staffing roster was present among the records provided. The shift log reflects that on [redacted] 2018, the beginning inmate count was 47 (36 males and 11 females) and the

[1] BIA-OJS Corrections Handbook, C2-30-02 Cell Checks-Daily Operations, states in part that; [redacted]

end of day count was 54 (41 males and 13 females). There were (b) (7)(F) COs working on the day (b) (6), (b) (7)(C) died.

- Records indicate that (b) (7)(E) at the time of (b) (6), (b) (7)(C) death in violation of BIA policy[2]. According to the shift log, (b) (6), (b) (7)(C) was called at 7:58 a.m. and then responded to the facility.
- Several court related documents were included for review without any explanation as to their relevance to the investigation.
- The administrative investigation did not include autopsy photographs.
- The administrative investigation did not include death scene photographs.
- The administrative investigation did not include a death scene sketch.
- The records provided do not indicate that an BIA Internal Affairs Division (IAD) investigator attended (b) (6), (b) (7)(C) autopsy.
- The administrative investigation did not indicate that a review of cell checks was performed for the date of (b) (6), (b) (7)(C) death.
- The administrative investigation did not include any witness interviews or any CO interviews. Therefore, the only evidence of what occurred was taken from the written statements provided by witnesses during the investigation conducted by the FBI.
- The evidence in both the police report and booking documents show that when (b) (6), (b) (7)(C) was initially brought to the WRCF, (b) (6), registered a (b) (6), (b) (7)(C) BAC. In accordance with BIA policy[3] (b) (6), (b) (7)(C) should have been medically cleared for incarceration before being accepted by the facility. (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) was never taken to a medical facility to be evaluated and cleared for incarceration. This point was not addressed in the administrative investigation.
- During the criminal investigation the FBI conducted inmate interviews documenting that (b) (6), (b) (7)(C) asked for medical attention but never received it. Further, during intake, (b) (6), (b) (7)(C) informed COs that (b) (6), (b) (7)(C). At no point, even after asking for (b) (6), (b) (7)(C), is there any record of (b) (6), (b) (7)(C) being taken for a medical evaluation in violation of BIA policy[4]. Further, (b) (6), (b) (7)(C) statement that (b) (6), (b) (7)(C) comments to the COs about (b) (6), medical complaints/needs were not explored. The administrative investigation did not consider these serious violations of policy during the investigation. The administrative investigation documentation is 164

[2] BIA-OJS Corrections Handbook, C4-32-6-C, (Assignment Master Schedule) states in part that; (b) (7)(E)

[3] Corrections Handbook, C2-42-02 it states in part that; any inmate who is considered "extremely intoxicated" must be cleared for incarceration before that individual can be accepted.

[4] BIA-OJS Corrections Handbook, Health Care Decisions, C-2-40-03,04, states in part that; Inmates may request urgent and emergency medical care verbally to staff. Detention staff will immediately notify the on-duty supervisor and emergency services will be contacted. Whether the inmate request is verbal or written, the detention officer will document this on the daily activity log.

pages in length but is disorganized and contains an estimated 40 pages of duplicate information.

- The administrative investigation did not seek to resolve information raised in FBI form 302s documenting witness interviews of other inmates/cellmates. [redacted] stated that [redacted] was asking the COs for help, but the COs did not do anything. In this instance, no effort was made to determine if [redacted] allegations were truthful. [redacted] also stated it seemed [redacted] was [redacted] sometime around 5:00 a.m. so [redacted] tried to wake [redacted] up but discovered [redacted] was nonresponsive. This was not considered in the documentation of the video review by investigators.
- Statements by former inmates described facility conditions at WRCF as being overcrowded and having air conditioners that did not work. Former inmates also complained about not getting enough food while incarcerated. None of these claims were reviewed during the administrative investigation. One final claim made by an inmate was that someone who allegedly asked for medical assistance was told by COs "too bad you should not have been drinking" and then the inmate died a few days later. The above statements were not investigated or addressed in the administrative investigation.
- The administrative investigation did not consider why [redacted] remained in custody after [redacted] was determined to be [redacted] at 8:41 a.m. on [redacted] 2018. In most parts of the United States, public intoxication results in a fine. If this is the case then when [redacted] was no longer intoxicated and was not a threat to [redacted] or others, [redacted] could have been released on a personal recognizance order that states [redacted] either appear in court or pays [redacted] fine.

Investigative Effectiveness in Aiding Policy Modifications/Updates:

The investigative report did not provide any recommendations to modify or update BIA policy.

Prosecution Referral:

An FBI 302 appended to the file reflects a written declination for criminal prosecution was obtained from the United States Attorney's Office by the FBI. No documentation was found to reflect coordination with a prosecutor at the conclusion of the administrative investigation.

All administrative investigations concluding that employee(s) did not comply with confinement policy or whose behavior amounted to misconduct should be referred to the appropriate United States Attorney's Office for prosecution review. Declinations by that office should be in writing, should outline the reasoning for the declination, and be included in the administrative investigation.

Case Number: I20000058

(b) (6), (b) (7)(C)

TCG #12

In Custody Death Administrative Investigation Evaluation

Case Number: I20000058

Subject/Victim: (b) (6), (b) (7)(C)

Date of Death: (b) (6), (b) (7)(C) 2020

Time in Custody: 4.5 hours

Report Date to BIA: March 1, 2020

Location of Death: Shiprock Corrections, Navajo Nation New Mexico

Cause of Death: (b) (6), (b) (7)(C)

Manner of Death: (b) (6), (b) (7)(C)

Facility Type: Tribal

Case Synopsis:

On (b) (6), (b) (7)(C) 2020, the Navajo Nation Shiprock Police District received multiple calls from (b) (6), (b) (7)(C) requesting police assistance because (b) (6), (b) (7)(C) was out of control, and (b) (6), (b) believed that (b) (6) had consumed some type of drug. (b) (6), (b) (7)(C) was later found at the Navajo Nation Medical Center banging on the doors and windows of the building. (b) (6), (b) (7)(C) reported that (b) (6), (b) (7)(C) said (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) was arrested for disorderly conduct and taken to the Shiprock Detention Center at approximately 8:30 p.m. (b) (6), was accepted into the facility and processed. Due to (b) (6), (b) (7)(C) was placed in a solitary housing unit. On (b) (6), (b) (7)(C) 2020, at 12:05 a.m., (b) (6), (b) (7)(C) was conducting a head count prior to shift change and saw (b) (6), (b) (7)(C) sitting up against the wall but nonresponsive to (b) (6), (b) commands. (b) (6), (b) (7)(C) left the area and requested assistance from (b) (6), (b) (7)(C) who was in the parking lot preparing to leave for the night. Together, they both returned to the solitary cell and found that (b) (6), (b) (7)(C) was not breathing and was nonresponsive. They immediately initiated CPR and contacted EMS. The report stated that EMT's arrived on scene at 12:20 a.m. along with many other Shiprock police officers to assist. (b) (6), (b) (7)(C) was transported to the hospital and pronounced dead at 12:42 a.m. by the attending physician.

It is unclear if a criminal investigation was conducted for this in-custody death. It appears initially a detective with the Navajo Nation Shiprock Police detectives began conducting interviews of the (b) (6), (b) (7)(C), but after that, no further information was made available. No documentation exists to show that the Federal Bureau of Investigation (FBI) was ever notified regarding (b) (6), (b) (7)(C) in-custody death in violation of Bureau of Indian Affairs (BIA) policy[1].

[1] BIA-OJS Law Enforcement Handbook 2-42 Investigation of BIA OJS / Tribal Officer Involved Shootings and In-Custody Death Investigations

Evaluation Methodology:

All case records provided by the BIA Office of Justice Services (OJS) to The Cruzan Group were reviewed by five experienced case reviewers for investigative timeliness, thoroughness, and reporting. Observations noted by each reviewer were consolidated and used for development of this evaluation report. All review questions included by the BIA were considered, and responses are included in the investigation observations as either a pro or con as directed in the solicitation.

Investigation Observations (Pro):

- The administrative investigation records included the initial police report that explained how and why the inmate was brought to the correctional facility.
- The shift schedule was provided along with the booking in and out sheet. On the night [redacted] died there were 12 inmates in custody and [redacted] working - a violation of BIA policy[2].
- The administrative investigation documentation included court papers, medical services documentation, and the autopsy report.

Investigation Observations (Con):

- The documents provided for review include a BIA Internal Affairs Division (IAD) checklist indicating investigative actions were completed but an administrative investigation report regarding [redacted] death was not provided.
- The records provided included a document with notes showing that on March 4, 2020, arrangements were made to conduct interviews with staff from the Shiprock Detention Center. Despite this, no administrative investigation interview reports were provided for review.
- Investigative activity [redacted] at the detention facility during the shift when [redacted] died.
- Records indicate that the facility surveillance video footage was collected but it was not provided for this review.
- The investigative information provided was extremely disjointed and hard to follow during the investigative review.
- There is no indication that the FBI was ever notified of [redacted] death in violation of BIA policy[3].
- The records provided include several agency forms, logs and documents, however, no explanation about what they were and what they are used for was provided.

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[2] BIA-OJS Corrections Handbook, C4-32-6-C, (assignment master schedule) states in part that; [redacted]

[3] BIA-OJS Law Enforcement Handbook, 2-42-01

- The investigation did not explain the intake process, inmate monitoring, or cell checks.
- There are several documents that indicate that there was surveillance video footage available. However, surveillance video footage was not provided for review.
- There were no interview reports or reference to interviews of the emergency medical technicians (EMT) or medical personnel.
- The documents provided contained some unexplained discrepancies. It is noted the police report indicates [redacted] was arrested on [redacted] 2020, and booked into Shiprock Corrections. The victim's last name was officially [redacted] but [redacted] was booked under the name [redacted] and referred to as [redacted] in the police reports. In another document it was stated that [redacted] reported [redacted] changed [redacted] name sometime in the past but might not have followed the legal name change process. Also, in some documents such as previous arrests, [redacted] last name was [redacted] which leads to confusion for the reader. A best practice may be to include a note in the report of known aliases for the subject.
- The toxicology report showed [redacted] This would be a best practice.
- There are two arresting/transporting questionnaires. In one the arresting officer checked the block "YES" indicating [redacted], and in the other document the block is checked "NO." There is no explanation provided regarding this discrepancy.
- The records provided reflected [redacted] had previous contacts with the facility and a criminal history but no explanation of this was documented in an investigative report.
- A photograph of [redacted] was found among the documents provided but there was no explanation for them and why it was included.
- The documents provided did not include any death scene photographs.
- The documents provided did not include any autopsy photographs.
- The documents provided did not include a death scene sketch.
- The documents provided did not indicate that a BIA-IAD investigator attended the autopsy.
- There is no indication that any of the COs were ever interviewed by BIA-IAD.
- No question was raised as to why [redacted] was not referred for a [redacted] in accordance with BIA policy[4]. The report basically consists of police reports, some statements provided by a few COs but no detailed statements. The statements provide the basic information, but their statements clearly indicate [redacted] even one CO indicated [redacted]. This information should have been clarified in the investigation.

[4] BIA-OJS Corrections Handbook C2-20 Inmate Intake and Classification Policy

- Detention facility logs with notations of the various checks performed and other details of the day were not provided.
- It appears that the investigation was conducted by Navaho Nation Shiprock Police personnel, however this is unclear in the report.
- No record of other inmates being interviewed was found.

Investigative Effectiveness in Aiding Policy Modifications/Updates:

The investigative report did not provide any recommendations to modify or update BIA policy.

Prosecutive Referral:

No documentation was found reflecting coordination with, or a prosecution referral being made to the appropriate United States Attorney's office at the conclusion of the administrative investigation.

All administrative investigations concluding that employee(s) did not comply with confinement policy or whose behavior amounted to misconduct should be referred to the appropriate United States Attorney's Office for prosecution review. Declinations by that office should be in writing, should outline the reasoning for the declination, and be included in the administrative investigation.

Case Number: KOL120-16-009

(b) (6), (b) (7)(C)

TCG #13

In Custody Death Administrative Investigation Evaluation
Case Number: KOL120-16-009

Subject/Victim: (b) (6), (b) (7)(C)
Date of Death: (b) (6), (b) (7)(C) 2016
Time in Custody: < 12 hours
Report Date to BIA: January 11, 2016
Location of Death: Pine Ridge Detention Center, South Dakota
Cause of Death: (b) (6), (b) (7)(C)
Manner of Death: (b) (6), (b) (7)(C)
Facility Type: Bureau of Indian Affairs (BIA)

Case Synopsis:

On (b) (6), (b) (7)(C) 2016, the Oglela Sioux Tribal Department of Public Safety (OSTDTS), was contacted several times regarding an intoxicated (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) arrived on the scene and subsequently arrested (b) (6), (b) (7)(C) for public intoxication. (b) (6), (b) (7)(C) transported (b) (6), (b) (7)(C) to the Pine Ridge Detention Center at 8:47 p.m. where (b) (6), (b) (7)(C) was processed into custody. The correction officer (CO) report indicated that upon arrival (b) (6), (b) (7)(C) was (b) (6), (b) (7)(C) causing them to think (b) (6) may be suffering from (b) (6), (b) (7)(C). Because of this, the COs decided to house (b) (6), (b) (7)(C) in a medical segregation cell. This was done so that (b) (6), (b) (7)(C) could be provided with a (b) (6), (b) (7)(C) Further, according to the CO's written statements, (b) (6), (b) (7)(C) was given several opportunities to provide a blood alcohol content (BAC) utilizing a portable breath test (PBT), however, (b) (6), (b) (7)(C)

A review of the facility surveillance video footage revealed that a cell check was conducted at 12:17 a.m. by (b) (6), (b) (7)(C) in which (b) (6), (b) (7)(C) physically contacted (b) (6), (b) (7)(C) The next time (b) (6), (b) (7)(C) was checked was during the daywork shift change/head count which was around 8:31 a.m. It was at this time that (b) (6), (b) (7)(C) found (b) (6), (b) (7)(C) nonresponsive and requested assistance. It should be noted that the failure of staff to have performed cell checks was in violation of BIA policy[1]. According to the CO written statements, cardiopulmonary resuscitation (CPR) was initiated by correction staff and emergency medical services (EMS) was contacted. It is unclear as to what happened after that because it appears (b) (6), (b) (7)(C) was never taken to the hospital

[1] BIA-OJS Corrections Handbook, Cell Checks-Daily Operations, C2-30-02, states in part that; (b) (7)(E)

and the coroner was contacted. (b) (6), (b) (7)(C) time of death was recorded as 8:40 a.m. on (b) (6), (b) (7)(C) 2016.

A criminal investigation was conducted by the Federal Bureau of Investigation (FBI) who arrived at the facility at 10:15 a.m. on (b) (6), (b) (7)(C) 2016. Their criminal investigation was included in the administrative investigation case file as were the self-written statements by the COs involved, autopsy report, arresting officers report, surveillance video footage, and some agency documentation. A notation in the BIA Indian Affairs Division (IAD) summary case log indicated that the FBI notified the BIA-IAD investigator that the assistant united states attorney (AUSA) declined to file any criminal charges.

Evaluation Methodology:

All case records provided by the BIA Office of Justice Services (OJS) to The Cruzan Group were reviewed by five experienced case reviewers for investigative timeliness, thoroughness, and reporting. Observations noted by each reviewer were consolidated and used for development of this evaluation report. All review questions included by the BIA were considered, and responses are included in the investigation observations as either a pro or con as directed in the solicitation.

Investigation Observations (Pro):

- The criminal investigation explained in the summary how the inmate arrived at the detention facility. Also, the arresting officer's report was present in the casefile.
- The administrative investigation included the autopsy report with photographs taken during the autopsy.
- The administrative investigation contained written statements by the COs involved. These written statements detailed what each CO did and when they did it.
- The information provided included the 17 pages of booking records pertaining to [redacted] dating from [redacted] which was useful to document the frequency and reasons [redacted] was arrested or had contact with law enforcement. [redacted] record indicated [redacted] arrests were (b) (6), (b) (7)(C) [redacted]. While the collection of this record was considered a quality investigative step, a summary report could have been prepared to ensure a report reader understood the records and their pertinence to the investigation.

Investigation Observations (Con):

Documentation in the case file shows that an administrative investigation was assigned to the BIA-IAD, however, there was not an administrative investigative report provided to The Cruzan Group for review. There was no documentation to show that interviews were conducted by the BIA-IAD or that any investigation was completed to determine if staff negligence or policies were violated that could have contributed to this in-custody death. This is an incomplete file and very difficult to evaluate without the administrative investigation.

- The information provided did not explain the staffing roster or the inmate population at the time of (b) (6), (b) (7)(C) death. It appears that (b) (7)(F) officers were assigned to work dayshift and (b) (7)(F) officers were assigned to work the night shift on that day. It is unclear what the inmate population was on the day of (b) (6), (b) (7)(C) death.
- There was no explanation of purpose and content of any agency logs that were included in the information provided.
- The information provided did not include any evidence that a BIA-IAD investigator attended the autopsy of (b) (6), (b) (7)(C).
- No death scene sketch was included for review.
- No death scene photographs were included for review.
- The administrative investigation did not develop clear evidence of CO misconduct regarding the failure to perform cell checks. A best practice would be to include a timeline of when checks were performed throughout the time preceding (b) (6), (b) (7)(C) death.
- The administrative investigation does not include witness interviews that were conducted during the criminal investigation. In addition, it does not appear that BIA-IAD conducted any interviews during the administrative investigation and simply accepted the handwritten or typed statements of the COs.
- There is no documentation present that identifies any agency policy violations that may have occurred. No recommendations were included for changes to agency policy.
- There was significant facility surveillance video footage collected that showed six different camera views. However, no camera view from inside the medical segregation cell was provided.
- The investigation included random pages of the agency standard operating procedure, but no explanation as to why, or if anyone was in violation of any of the policies found referenced in the file.
- The last contact with (b) (6), (b) (7)(C) allegedly occurred at 6:47 a.m. but when (b) (6) was checked on at approximately 8:30 a.m. (b) (6), (b) was described as being (b) (6), (b) (7)(C) by (b) (6), (b) (7)(C). There is no further description of (b) (6), (b) (7)(C) Based on the information provided, no determination can be made if the (b) (6), (b) (7)(C) This point should have been clarified through a reinterview of the CO who found (b) (6), (b) (7)(C) nonresponsive.

Investigative Effectiveness in Aiding Policy Modifications/Updates:

The investigative report did not provide any recommendations to modify or update BIA policy. The investigation did reveal the failure of COs to perform required inmate checks, however it appears that no recommendation for disciplinary action was made in the investigation.

Prosecution Referral:

The BIA-IAD summary case log indicated that the FBI notified the BIA-IAD Investigator that an AUSA declined to pursue any criminal charges but said they believed there were policy issues to be resolved. It is unknown if the AUSA had been informed about (b) (6), (b) (7)(C) [redacted] No documentation was found reflecting coordination with, or a prosecution referral being made to the proper United States Attorney's Office during the administrative investigation.

All administrative investigations concluding that employee(s) did not comply with confinement policy or whose behavior amounted to misconduct should be referred to the appropriate United States Attorney's Office for prosecution review. Declinations by that office should be in writing, should outline the reasoning for the declination, and be included in the administrative investigation.

Case Number: KOL120-16-084

(b) (6), (b) (7)(C)

TCG #14

In Custody Death Administrative Investigation Evaluation
Case Number: KOL120-16-084

Subject/Victim: (b) (6), (b) (7)(C)
Date of Death: (b) (6), (b) (7)(C) 2016
Time in Custody: 1 day
Report Date to BIA: March 25, 2016
Location of Death: Blackfeet Adult Correctional Facility / Browning Montana
Cause of Death: (b) (6), (b) (7)(C)
Manner of Death: (b) (6), (b) (7)(C)
Facility Type: Bureau of Indian Affairs (BIA)

Case Synopsis:

On (b) (6), (b) (7)(C) 2016, (b) (6), (b) (7)(C) was arrested by (b) (6), (b) (7)(C) for theft under $500 dollars. (b) (6), (b) (7)(C) was accused of stealing two bottles of liquor which were found on (b) (6), (b) person at the time of (b) (6), (b) arrest. (b) (6), (b) was taken to the Blackfeet Adult Correctional Facility and placed in their custody at approximately 8:50 p.m.

On (b) (6), (b) (7)(C) 2016, at 6:00 p.m, (b) (6), (b) (7)(C) assumed their night shift posts. A review of the video contained in the report revealed that (b) (6), (b) (7)(C) was housed in a cell that consisted of two bunkbeds and what appears to be an institutional toilet/sink combination. The cell could accommodate up to four inmates, but during this time only (b) (6), (b) (7)(C) and inmate (b) (6), (b) (7)(C) were present. Through facility surveillance video footage review, (b) (6), (b) (7)(C) was observed physically moving (b) (6), (b) legs at 6:10 p.m. and then was not observed moving again. (b) (6), (b) (7)(C) checked on (b) (6), (b) (7)(C) at 7:34 p.m. and over the next 11 minutes, (b) (6), (b) (7)(C) was observed making multiple trips to the cell door and banging on it in an attempt get someone's attention. At one point, (b) (6), (b) (7)(C) was observed looking up into the camera and pleading for help. At 7:43 p.m., (b) (6), (b) (7)(C) was observed (b) (6), (b) (7)(C) At 7:44 p.m., (b) (6), (b) (7)(C) was observed entering the cell and checking on (b) (6), (b) (7)(C). (b) (6), (b) immediately left and did not return for three minutes. When (b) (6), (b) (7)(C) returned, both (b) (6), (b) (7)(C) entered the cell. (b) (6), (b) (7)(C) removed (b) (6), (b) (7)(C) and did not return for the entire incident, leaving (b) (6), (b) (7)(C) alone with the nonresponsive (b) (6), (b) (7)(C). At no point were attempts to begin life-saving measures initiated. At 7:50 p.m., (b) (6), (b) (7)(C) arrived and (b) (6), (b) (7)(C), with the assistance of (b) (6), (b) (7)(C), and initiated cardiopulmonary resuscitation (CPR) which continued until emergency medical services (EMS) arrived and took over. The emergency medical technicians (EMT) removed (b) (6), (b) (7)(C) from the cell at 7:58 p.m.

The criminal investigation into this matter was not included in the administrative investigation case file even though there is evidence the Federal Bureau of Investigation (FBI) was notified and that they had seized some evidence from the scene.

The administrative investigation was initiated by the BIA Internal Affairs Division (IAD) in June 2016, after the being notified of (b) (6), (b) (7)(C) death by the Department of the Interior (DOI),

Office of Inspector General (OIG) on May 16, 2016. The administrative investigation did not address why BIA-IAD had not received notification at the time of [redacted] death and why it took so long for them to initiate an administrative investigation into [redacted] in-custody death after being notified by the DOI OIG.

Evaluation Methodology:

All case records provided by the BIA Office of Justice Services (OJS) to The Cruzan Group were reviewed by five experienced case reviewers for investigative timeliness, thoroughness, and reporting. Observations noted by each reviewer were consolidated and used for development of this evaluation report. All review questions included by the BIA were considered, and responses are included in the investigation observations as either a pro or con as directed in the solicitation.

Investigation Observations (Pro):

- The administrative investigation included [redacted] police report and a summary of [redacted] interview.
- The administrative investigation found COs had not performed required [redacted] cell checks on the day of [redacted] death in violation of BIA policy[1].
- The administrative investigation included relevant documentation such as booking forms, medical and suicide screening forms, court records, earlier medical records, and the autopsy report.
- The investigation contained video footage of the time [redacted] last moved, and up to the time the EMT's removed [redacted] from the cell.
- The administrative investigation identified the failure of staff to provide timely lifesaving treatment to [redacted]
- The administrative investigation included medical records from the prior week which listed [redacted] medical issues and hospitalization.

Investigation Observations (Con):

- The administrative investigation was not conducted in a timely manner. Investigative activity began approximately two and half months after [redacted] death and the report was void of any explanation as to why this was the case.
- The FBI was notified and responded to the scene on the following day. The administrative investigation does not include any FBI investigative reports.
- The administrative investigation references that the FBI collected evidence at the scene but no record of any examination of those item(s) was provided.
- The administrative investigation did not include an explanation as to the use of each detention log.

[1] BIA-OJS Corrections Handbook, C2-30-02 Cell Checks-Daily Operations, states in part that; [redacted]

- Interviews of CO staff were conducted using appropriate rights advisement during the administrative investigation[2].
- The administrative investigation did not address facility staffing numbers. The investigation did provide both the staff duty roster and inmate cell assignment sheets for the day of (b) (6), (b) (7)(C) death. There were 52 inmates and (b) (7)(F) sworn COs on duty (b) (7)(E), a violation of BIA policy[3]. The investigative report stated that (b) (6), (b) (7)(C) attempted to contact (b) (6), (b) (7)(C) different supervisors to no avail to gather direction or guidance.
- The administrative investigation did not indicate any death scene processing was conducted. The report did not include any death scene photographs, description of (b) (6), (b) (7)(C) cell, (b) (6), (b) bedding or what (b) (6), (b) (7)(C) was wearing when (b) (6), (b) was found.
- The administrative investigation did not include any autopsy photographs or any reference that they had been collected.
- No death scene sketch was included for review and there was no indication one had been prepared.
- The administrative investigation did not indicate that the BIA-IAD investigator attended the autopsy of (b) (6), (b) (7)(C).
- The administrative investigation did not address the (b) (6), (b) (7)(C) which was noted in the autopsy report. (b) (6), (b) (7)(C)
  During the administrative investigation no investigative effort was made to investigate this point.
- The administrative investigation did not include an interview of the responding EMTs.

Investigative Effectiveness in Aiding Policy Modifications/Updates:

The investigative report did not provide any recommendations to modify or update BIA policy.

Prosecution Referral:

No documentation was found reflecting coordination with a prosecutor at the conclusion of the administrative investigation to address (b) (6), (b) (7)(C)

[2] Following appropriate agency policy, a Kalkines or Garrity rights advisement should be provided to any employee being interviewed in an internal agency investigation.
[3] BIA Corrections Handbook, C4-32-6-C, (Assignment Master Schedule) states in part that; (b) (7)(E)

All administrative investigations concluding that employee(s) did not comply with confinement policy or whose behavior amounted to misconduct should be referred to the appropriate United States Attorney's Office for prosecution review. Declinations by that office should be in writing, should outline the reasoning for the declination, and be included in the administrative investigation.

Case Number: KOL120-16-294

(b) (6), (b) (7)(C)

TCG #15

In Custody Death Administrative Investigation Evaluation

Case Number: KOL120-16-294

Subject/Victim: (b) (6), (b) (7)(C)
Date of Death: (b) (6), (b) (7)(C) 2016
Time in Custody: <4 hours
Report Date to BIA: November 1, 2016
Location of Death: Havasupai Indian Reservation, Arizona
Cause of Death: (b) (6), (b) (7)(C)
Manner of Death: (b) (6), (b) (7)(C)
Facility Type: Bureau of Indian Affairs (BIA)

Case Synopsis:

On (b) (6), (b) (7)(C) 2016, at 5:43 p.m., (b) (6), (b) (7)(C) and (b) (6), (b) (7)(C) responded to the residence of (b) (6), (b) (7)(C) who had called the police requesting that (b) (6), (b) be removed from the residence because (b) (6), had been drinking. When the officers arrived, (b) (6), (b) (7)(C) was observed sitting on a folding chair and (b) (6), (b) (7)(C) was sitting on the steps outside of (b) (6), (b) (7) home. When (b) (6), (b) (7)(C) saw the police, (b) (6), immediately knelt to the ground with (b) (6), (b) hands on (b) (6), head. (b) (6), (b) (7)(C) advised (b) (6), (b) (7)(C) that (b) (6), was under arrest for disorderly conduct. At this moment, (b) (6), (b) (7)(C) stood up and attempted to run away. (b) (6), (b) (7)(C) pursued (b) (6), (b) (7)(C) around the corner of the house and utilized an electronic control device (ECD) to subdue (b) (6), (b) (7)(C) A struggle ensued until (b) (6), (b) (7)(C) arrived and assisted in taking (b) (6), (b) (7)(C) into custody. The report described (b) (6), (b) (7)(C) as (b) (6), (b) (7)(C) and (b) (6), (b) (7)(C) needed to use (b) (6), (b) (7)(C) to restrain (b) (6), (b). Because an ECD was utilized, the arresting officer made the decision to have (b) (6), (b) (7)(C) medically cleared at the local clinic. When (b) (6), (b) (7)(C) arrived at the medical facility, (b) (6), complained about (b) (6), (b) (7)(C) . The attending physician was concerned that (b) (6), (b) (7)(C) may have suffered some type of (b) (6), (b) (7)(C) injury and consulted with a doctor at Kingman Regional Medical Center (KRMC), which is a larger, better equipped facility possessing an x-ray machine. A decision was made to medevac (b) (6), (b) (7)(C) to KRMC for a more extensive evaluation. From the time of the arrest to the Medevac, (b) (6), (b) (7)(C) was described by all involved as (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) continued to (b) (6), (b) (7)(C) throughout the evening. Because of (b) (6), (b) (7)(C), the attending physician at the clinic administered (b) (6), (b) (7) to (b) (6), (b) (7)(C) for the flight. In addition, (b) (6), (b) (7)(C) was strapped to a backboard to prevent any further injury to (b) (6), (b) (7)(C) and for the protection of the flight crew. The flight departed at 8:21 p.m. on (b) (6), (b) (7)(C) 2016, en route to KRMC. During the flight (and according to the FBI criminal investigation) the flight crew (b) (6), (b) (7)(C) that they were concerned for their own safety. Based on these concerns the crew administered (b) (6), (b) (7)(C) to (b) (6), (b) (7)(C). While in flight at 8:36 p.m., (b) (6), (b) (7)(C) and the crew administered (b) (6), (b) (7)(C) . Cardiopulmonary resuscitation (CPR) was initiated during

the flight and continued at the KRMC for approximately an hour. The attending physician at the KRMC pronounced (b) (6), (b) (7)(C) dead at 9:38 p.m.

The Federal Bureau of Investigation (FBI) conducted the criminal investigation. The special agents interviewed the police officers involved, as well as the (b) (6), (b) (7)(C). They also interviewed (b) (6), (b) (7)(C), both attending physicians, and a nurse working at the clinic the night (b) (6), (b) (7)(C) was brought in. The FBI collected the ECD used that evening which was equipped with video technology. The report stated that the video was reviewed and corroborated the statements made by (b) (6), (b) (7)(C). However, the video footage was not included in the administrative investigative file.

Evaluation Methodology:

All case records provided by the BIA Office of Justice Services (OJS) to The Cruzan Group were reviewed by five experienced case reviewers for investigative timeliness, thoroughness, and reporting. Observations noted by each reviewer were consolidated and used for development of this evaluation report. All review questions included by the BIA were considered, and responses are included in the investigation observations as either a pro or con as directed in the solicitation.

Investigation Observations (Pro):

- The administrative investigation included the criminal investigation, police reports, autopsy report, internal affairs summary report, and standard operating procedures associated with the use of an ECD.

Investigation Observations (Con):

- The administrative investigation did not include identifying and interviewing witnesses who were in the back yard of the residence when (b) (6), (b) (7)(C) was arrested.
- The administrative investigative report was limited to the statements and written reports of the tribal police officers.
- No autopsy photographs were included in the investigative file.
- The administrative investigation does not indicate that a BIA internal Affairs Division (IAD) investigator attended the autopsy of (b) (6), (b) (7)(C).
- No death scene photographs were included in the report and may not have been collected.
- No death scene sketch was included in the report and may not have been collected.
- The administrative investigation did not include conducting interviews of emergency medical technicians and medical doctors/staff who treated (b) (6), (b) (7)(C).
- The administrative investigation did not include a review of body worn camera video footage related to the arrest of (b) (6), (b) (7)(C). The police officers stated that their body cameras were activated when the ECD was used however, there is no indication this footage was ever viewed or considered.

- The administrative investigation did not follow up on the autopsy report finding that (b) (6), (b) (7)(C) A toxicology report was not included in the investigative file and should have been collected and reviewed with the medical examiner. (b) (6), (b) (7)(C)
- Once the manner of death was declared (b) (6), (b) (7)(C), the FBI closed their investigation, and it appears the administrative investigation was also concluded.
- The administrative investigation did not include a criminal history check of (b) (6), (b) (7)(C) to determine if there was a history of (b) (6), (b) (7)(C). There were indications that law enforcement had prior contact with (b) (6), (b), but this was never verified or documented.
- The administrative investigation did not include any ECD training records demonstrating the officer had been properly trained and used the ECD within agency policy.
- The administrative investigation did not question why no use of force investigation was conducted by the agency to determine if the force used in the arrest of (b) (6), (b) (7)(C) was appropriate given the circumstances.
- The report is simple and easy to follow and consistent with the officer's statements, but the death could be called into question because of significant missing information.

Investigative Effectiveness in Aiding Policy Modifications/Updates:

The investigative report did not provide any recommendations to modify or update BIA policy.

Prosecution Referral:

The administrative investigation includes a record of the FBI having referred their investigation to the appropriate United States Attorney's Office. No documentation was found reflecting coordination with a prosecutor at the conclusion of the administrative investigation.

All administrative investigations concluding that employee(s) did not comply with confinement policy or whose behavior amounted to misconduct should be referred to the appropriate United States Attorney's Office for prosecution review. Declinations by that office should be in writing, should outline the reasoning for the declination, and be included in the administrative investigation.

Case Number: KOL120-17-138

(b) (6), (b) (7)(C)

TCG #16

In Custody Death Administrative Investigation Evaluation
Case Number: KOL-120-17-138

Subject/Victim: (b) (6), (b) (7)(C)
Date of Death: (b) (6), (b) (7)(C) 2017
Time in Custody: 3 hours
Report Date to BIA: May 29, 2017
Location of Death: Pine Ridge Adult Offenders Facility, Pine Ridge SD
Cause of Death: (b) (6), (b) (7)(C)
Manner of Death: (b) (6), (b) (7)(C)
Facility Type: Bureau of Indian Affairs (BIA)

Case Synopsis:

On (b) (6), (b) (7)(C) 2017, officers from the Oglala Sioux Tribal Police Department conducted a traffic stop on the Pine Ridge Indian Reservation after receiving information that a (b) (6), (b) (7)(C), who had just checked out of the (b) (6), (b) (7)(C) was believed to be selling drugs. The (b) (6), (b) (7)(C) driver was searched, found to be in possession of illegal substances, and detained for arrest by the local sheriff's office. The (b) (6), (b) (7)(C), including (b) (6), (b) (7)(C), were arrested for possession of (b) (6), (b) (7)(C) by the tribal police and transported to the Pine Ridge Detention Center (PRDC). The investigation revealed that prior to their arrival to the facility at 9:58 a.m., (b) (6), (b) (7)(C) informed the transporting officer that (b) (6), (b) had (b) (6), (b) (7)(C). Once at the PRDC, the transporting officer relayed that information to the booking officer and asked if (b) (6), (b) (7)(C) should be taken to the medical center. The booking officer notified (b) (6), (b) (7)(C) who decided to accept (b) (6), (b) (7)(C) into the detention facility in violation of BIA policy[1]

The investigation explained that the transporting officer requested an analyst to respond to the facility and administer a urinalysis exam to (b) (6), (b) (7)(C). When (b) (6), (b) (7)(C) took (b) (6), (b) (7)(C) to the restroom to get a sample, (b) (6), (b) (7)(C) and stated that (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) also informed (b) (6), (b) (7)(C) that (b) (6), (b) had (b) (6), (b) (7)(C) during the transport. (b) (6), (b) (7)(C) along with (b) (6), (b) (7)(C) were placed in separate single occupancy cells at the request of the police. The investigation found that (b) (6), (b) (7)(C) physically checked on (b) (6), (b) (7)(C) at 11:00 a.m. At 11:10 a.m. inmate (b) (6), (b) (7)(C) was out of (b) (6), cell for (b) one-hour recreation period. Upon returning to (b) (6), cell, (b) (6), (b) (7)(C) heard (b) (6), (b) (7)(C) making unusual sounds and approached (b) (6), cell to check on (b) (6), (b). (b) (6), (b) (7)(C) stated that (b) found (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) reported this information to the booking desk and causing COs to respond to (b) (6), (b) (7)(C) cell and contact emergency medical services. The emergency medical technicians (EMT)s arrived at 11:25 a.m. and transported (b) (6), (b) (7)(C) to the

[1] BIA Corrections Handbook, C2-20 Inmate Intake and Classification Policy

Indian Health Service hospital at 11:30 a.m. [redacted] subsequently [redacted] and was pronounced dead at the hospital.

The criminal investigation was conducted by the Federal Bureau of Investigation (FBI). The criminal investigation contained all relevant interviews of both correctional staff and police officers. The FBI also interviewed inmate [redacted] and [redacted] who had been arrested with [redacted]. The facility surveillance video footage was collected, and the autopsy report was included with the investigative report. During the criminal investigation, it was discovered through an interview with [redacted] that during the car ride to the facility, [redacted] stated that the [redacted] had with [redacted] was [redacted] from the [redacted] driver.

Records indicate an administrative investigation was conducted by BIA Internal Affairs Division (IAD) but no administrative investigative report was provided for our review.

Evaluation Methodology:

All case records provided by the BIA Office of Justice Services (OJS) to The Cruzan Group were reviewed by five experienced case reviewers for investigative timeliness, thoroughness, and reporting. Observations noted by each reviewer were consolidated and used for development of this evaluation report. All review questions included by the BIA were considered, and responses are included in the investigation observations as either a pro or con as directed in the solicitation.

Investigation Observations (Pro):

- The FBI was notified and upon arrival conducted interviews. Their investigative effort was documented on FBI 302s and were included as part of the records provided.
- The administrative investigation was conducted by the BIA-IAD. The investigator reinterviewed all involved. The records provided included the criminal investigation along with CO training records and some administrative investigation warnings[2].
- The majority of the records provided relate to the day that led up to [redacted] arrest. The multiple police reports provided explain how [redacted] was brought into custody.
- The administrative investigation file included the autopsy report.
- The administrative investigation explained who each officer was and what role they played at the time of [redacted] death.
- The administrative investigation file included facility surveillance video footage depicting several different camera angles.

[2] Following appropriate agency policy, a Kalkines or Garrity rights advisement should be provided to any employee being interviewed in an internal agency investigation.

Investigation Observations (Con):

- No final BIA-IAD administrative investigative report was prepared pertaining to their investigation. This review was performed only of the documents found in the investigative file.
- The administrative investigation did not include booking forms, cell check logs, or other relevant jail documentation about (b) (6), (b) (7)(C) intake and incarceration.
- The administrative investigation file did not include any explanation as to why [redacted] was not referred for medical clearance afte (b) (6), (b) (7)(C) [redacted]
- The administrative investigation file referred to one cell check that was conducted by (b) (6), (b) (7)(C) during the (b) (7)(E) of (b) (6), (b) (7)(C) incarceration in violation of BIA policy[3]. The administrative investigation did not explore this area or the potential of employee misconduct in the failure to properly check cells during their duty shift.
- The administrative investigation file did not include any indication the BIA-IAD investigator attended the autopsy.
- The administrative investigation file did not include any medical records pertaining to (b) (6), (b) (7)(C) emergency services.
- The administrative investigation file did not include any crime scene photographs.
- The administrative investigation file did not include any autopsy photographs.
- The administrative investigation file did not include interviews of the medical personnel.
- The administrative investigation file did not conclude whether the actions taken during the incident were proper and compliant with BIA policy.
- The administrative investigation file did not document the BIA policy violation of co-housing male and female inmates in the same block.
- In the administrative investigation interview of (b) (6), (b) (7)(C) stated that when [redacted] asked (b) (6), (b) (7)(C) about (b) (6), (b) (7)(C), [redacted] stated "[redacted] is back in a cell now - [redacted] is your problem." (b) (6), (b) (7)(C) said the comment upset [redacted] and caused [redacted] to contact [redacted] sergeant to report it. The administrative investigation file never explained why [redacted] made the decision to accept custody of (b) (6), (b) (7)(C) without medical clearance, given the information [redacted] received about (b) (6), (b) (7)(C) [redacted], or why [redacted] became angry at (b) (6), (b) (7)(C) remark.
- No report of the review of the toxicology report was made during the administrative investigation.

[3] BIA-OJS Corrections Handbook C2-30-02 Cell Checks Daily Operations: (b) (7)(E) [redacted]

- The administrative investigation did not include a laboratory report to prove if the [redacted]
- The administrative investigation file did not resolve a conflict as to whether [redacted] The other [redacted] arrested with [redacted] could have been reinterviewed to clarify the events. This information is important because it could help determine [redacted]
- Once the death was ruled [redacted] due to [redacted], no further criminal or administrative investigation activity was conducted. The administrative investigation should have continued until all logical leads had been pursued and all facility and medical records had been reviewed and considered.
- The administrative investigation effort did not include an interview of the [redacted] arrested by the county police.
- The administrative investigation effort did not include a criminal history check on any of the [redacted].
- The information reviewed contained very limited critical documentation needed to be considered a thorough investigation.
- The administrative investigation did not include evidence that appropriate rights advisements were provided to some staff prior to being questioned regarding the incident.
- The administrative investigation file had multiple interview memorandums with captions related to person(s) unrelated to the investigation into [redacted] death. This is the result of the investigator "cutting and pasting" information from other interview documents and not reviewing it well enough to find the error. This also showed a lack of supervisory review in the investigation process.

Investigative Effectiveness in Aiding Policy Modifications/Updates:

The documents provided did not provide any recommendations to modify or update BIA policy.

Prosecution Referral:

No documentation was found reflecting coordination with a prosecutor at the conclusion of the administrative investigation. Additionally, no prosecutor review or approval was obtained prior to the use of a Kalkines warning (providing immunity from criminal prosecution) for the interviews of the COs.

All administrative investigations concluding that employee(s) did not comply with confinement policy or whose behavior amounted to misconduct should be referred to the appropriate United States Attorney's Office for prosecution review. Declinations by that office should be in writing, should outline the reasoning for the declination, and be included in the administrative investigation.

In Custody Death Evaluation: Evaluate the Effectiveness of IAD's Current ICD Investigation Report to Modern Day Standards

Task 2

In Custody Death Evaluation: Evaluate the Effectiveness of IAD's Current ICD Investigation Report to Modern Day Standards

Task 2

Summary:

In this task The Cruzan Group evaluated the effectiveness of the current in-custody death (ICD) investigation report to modern day standards. In reviewing the 16 ICDs we were provided it was often difficult to locate important documents such as medical treatment reports, autopsy and toxicology reports, and staff logs because they were located in different places in each investigative case file. In many cases, important documents were not included in the file at all. There did not appear to be any standardization or consistency throughout the organization in the way the Bureau of Indian Affairs (BIA) ICD investigative case files were organized.

4.6.2 Deliverables:

a. Analysis of policy deficiencies related to ICD's and the administrative investigation. This should provide explanation of the policy deficiency and examples of recommended updates to the specific policy which contributed or could have positively or negatively affected the outcome.

Modern Day Report Standard Review:

Administrative investigations are conducted for the purposes of examining what happened that led to the inmate death and to determine if any action, or inaction of staff contributed to that death. For this reason, each final administrative investigative report should contain all the facts necessary to clearly communicate to the reader what happened that led to the ICD occurring. The report information should be logical, comprehensive, and organized in a way that makes the report easy to understand. Documents collected during the investigation that help clarify points or support investigative findings should be summarized in the report narrative and referenced as an easily found attachment. If the investigation finds that staff were negligent in some manner the basis for that negligence (policy violation) should be clearly established and supported by evidence outlined in the report. If circumstances surrounding the death reveal policy or procedure weaknesses, the administrative report should clearly articulate these findings to management for corrective action. Clearly stated findings provide the foundation for recommendation(s) related to appropriate human resource staffing, training, and potential facility modifications to reduce the potential for reoccurrence.

An example or a simple but clear finding and recommendation is provided:

> *Leveraging technology to improve the integrity of cell check logs may be achieved by moving from manual cell check logs to using an electronic log system that requires the CO to swipe their ID at each cell they check throughout their shift. With this system, opportunities for false entries in the cell check log are eliminated, and accountability for COs conducting the checks as required are vastly improved.*

The Cruzan Group carefully reviewed the BIA, Office of Justice Services (OJS) draft ICD report format provided by the BIA internal affairs division (IAD). We compared this format to report formats obtained from external agencies and applied our subject matter knowledge of report writing to the evaluation. Our effort resulted in us adding to the existing content of the draft format in order to build a more robust report. We also reorganized the location of report paragraphs to better align the sequence of reporting with the manner in which an actual administrative investigation would proceed. Additional paragraphs and subheadings were input to reflect modern day industry standards for conducting death investigations. For example, we moved the time, date, and location of the ICD to the beginning of the report along with an investigative synopsis that presents the investigation results. This employs the "bottom-line up front" approach and aids the reader in understanding what the investigation concluded. All the information contained in the body of the report should support the synopsis finding.

We changed the location of the identification information of the deceased in the report format. In cases we reviewed we noted that sometimes the first mention of the deceased was several pages into the report. Moving this information to the front of the report makes it clear to the reader who the report is about and, although subtle, reflects respect for the deceased.

Administrative observations are placed at the end of the report after the aspects of the death investigation have been presented and a legal determination regarding potential criminality made. Potential administrative or policy violations should be addressed in this section and examined thoroughly with recommendations for any appropriate corrective action.

Each allegation should be listed separately and include a conclusion as to whether it is a founded or unfounded allegation. Evidence to support either conclusion should be included.

This report like other reports will form the basis of the agency's historical record of the ICD and often can be one of the first documents requested by interested parties through the Freedom of Information Act (FOIA).

Attached to this report (Task 2) we have attached a copy of our recommended revisions to the draft BIA-IAD report format.

Policy Review

In reviewing the BIA OJS Law Enforcement Handbook sections addressing the roles and responsibilities for the investigation of ICDs we found four areas related to our search:

- In the policy section of 2-42 of the BIA Law Enforcement Handbook there are two relevant paragraphs that state:

> *By mutual agreement, the Federal Bureau of Investigation will exercise primary criminal investigative responsibility for federal criminal matters involving BIA-OJS and Tribal law enforcement officer (LEO) shootings and in-custody death incidents.*
>
> *The FBI will take a primary role in **most** BIA/Tribal law enforcement shootings or in-custody death incidents. BIA-OJS will conduct internal administrative investigations of all BIA-OJS/Tribal law enforcement officer-involved shootings or in-custody death incidents.*

- In section 2-42-03 of the BIA OJS Law Enforcement Handbook the policy states:

> *Per the mutual agreement between OJS and the FBI, whenever a prisoner dies while in the custody of any BIA-OJS/Tribal LEO Program or whenever a prisoner dies inside any BIA OJS law enforcement or correctional facility, the FBI shall exercise primary investigative responsibility for conducting a criminal investigation. This includes both BIA-OJS direct service and BIA-OJS contract facilities.*

- In section 5-01-03, BIA OJS Law Enforcement Handbook (Internal Affairs Areas of - Responsibility) it states:

> *Internal Affairs Division is responsible for investigating officer involved shootings and in-custody deaths.*

In reviewing these areas of the BIA OJS Law Enforcement Handbook, three of them direct that the FBI has primary investigative responsibility for the investigation of ICD incidents. In the fourth section we found the Internal Affairs Division is responsible for investigating ICD incidents. We believe policy revision may be needed to clarify these sections. In its current form, the BIA OJS Law Enforcement Handbook may lead to confusion and assumptions by BIA-IAD staff that could affect the timeliness and thoroughness of investigations. In several of the cases we reviewed, even routine investigative tasks such as death scene processing, identification and collection of physical evidence, photography, witness interviews and employee compelled interviews were either not noted in the investigators report, or simply not completed at all. Some of this could be attributed to a misunderstanding of roles and responsibilities.

While the BIA OJS Law Enforcement Handbook makes several references to an agreement between the BIA and FBI, we found that no such agreement exists. The lack of a formalized memorandum of agreement (MOA) or memorandum of understanding (MOU) which clearly defines the roles and responsibilities of each agency when responding to and investigating in-custody deaths would improve the overall response to future ICD incidents.

The completion of a formalized MOU/MOA between the FBI and BIA as well as an agreed upon investigative process should be considered.

Points to be considered for inclusion within the MOU/MOA include:

- Timeliness of FBI response to the death scene
- Timeliness of BIA-IAD administrative investigation
- Information sharing and communication strategy between agencies
- Role of tribal law enforcement agencies
- Coordination with U.S. Attorney regarding the criminal investigation and the administrative investigation
- Investigative tasks to be accomplished and responsibilities include:
    - Obtaining of search warrants related to the incident
    - Obtaining of Health Insurance Portability and Accountability Act (HIPPA) subpoenas, if applicable
    - Witness interviews
    - Death scene documentation
        - Scene photography
        - Scene sketching
        - Evidence identification and collection (including surveillance video)
- Autopsy attendance and photography
    - Crime lab coordination
    - Medical record review and interpretation

In Custody Death Evaluation of Whether Investigations Meet Common Industry Standards for Proper Evaluation of In-Custody Death Incidents Pursuant to Law, Policy, and Training

Task 3

In Custody Death Evaluation of Whether Investigations Meet Common Industry Standards for Proper Evaluation of In-Custody Death Incidents Pursuant to Law, Policy, and Training
Task 3

Summary:

In this task The Cruzan Group evaluated whether the investigations meet common industry standards for proper evaluation of Bureau of Indian Affairs (BIA) in-custody death (ICD) incidents pursuant to law, policy and training.

Methodology and Approach:

After an extensive review of the 16 ICD Investigations, The Cruzan Group made the determination to consider all investigations provided for our review from 2016, 2017, and 2018 rather than only choosing one for comparison purposes. This approach exceeds the performance standard in the solicitation and supplies more robust information for consideration. We used the same rationale when we compared 2019 ICD investigations to 2020 ICD investigations and included all investigations provided in this contract effort for comparison and to provide a clearer picture of the actual current state. The only exception to this methodology for determining regression or progression pertains to the investigation of the ICD of (b) (6), (b) (7)(C) (KOL120-16-294). The circumstances of this ICD were very different than the other 15 cases we reviewed because (b) (6), (b) (7)(C) died while being medevac'd for medical services and was never actually held in a confinement facility.

Also, we found that three of the case files provided did not contain an administrative report of investigation making it impossible to thoroughly evaluate each report. These three cases occurred in 2016, 2018, and 2020. In these cases, we reviewed all documentation provided and did our best to evaluate them by the criteria set forth in this study.

4.7.2 Deliverables:

I. Written evaluation should compare of OJS/Tribal investigative practices to industry standards related to ICDs:

We reviewed all 16 ICD administrative investigations to determine how the cases were initiated, assigned, investigated, supervised and concluded. We looked at investigative timeliness and thoroughness as well as investigation reporting and coordination with external stakeholders. We also examined the training of existing internal affairs investigators and identified training believed necessary for effective ICD investigations. The sum of these findings were used in considering Office of Justice Services (OJS)/tribal investigative practices compared to those of two outside agencies.

We consulted with representatives from two separate police agencies with confinement operation responsibilities. One agency representative was the chief investigator within a state prison system where ICD investigations are often conducted. The second agency representative

was from a large metropolitan sheriff's office who led jailing operations and performed multiple ICD investigations. With both representatives we discussed their standard approach to an ICD investigation including tools and methods employed and their best practices. We reviewed redacted versions of actual ICD investigative reports from one agency to review format, content, and organization and glean ideas for comparison with BIA Internal Affairs Division (IAD) investigations.

Overall, our findings regarding the BIA-ICD investigative practices are captured in the individual case summaries we have delivered (task 1) and included in each of our other task deliverables. At a policy level, we have identified areas of weakness in BIA-OJS policy that promote misunderstanding of roles and responsibilities that may impact response and processing of death scenes. We also found that no interagency agreement actually exists between BIA-OJS and the FBI to ensure investigators understand how ICD investigations should be undertaken to ensure evidence is not missed and that conclusions include all relevant information.

Response by BIA-IAD to ICD incidents was found to be inconsistent. Our review could not verify that in each case a BIA-IAD investigator responded to the scene and participated in the conduct of the investigation. In some cases, the FBI led the investigation but failed to properly document the death scene in accordance with ordinarily accepted investigative practices. Death scene photographs, death scene sketches, and autopsy photographs were found missing from case files and may never have even been collected. Among the 16 ICD investigations we reviewed we did not find one instance of a BIA-IAD investigator attending the autopsy and collecting evidence and photographs. Although focused on the administrative investigation and not the criminal investigation, attending the autopsy provides an in-depth understanding of the cause and manner of death that both investigators need an understanding of to perform timely and thorough investigations. Each of the representatives from the agencies we coordinated with confirmed that their ICD investigations include performing these detailed investigative steps.

Administrative investigative interviews should proceed after coordination with the FBI has determined the criminal investigation has resulted in necessary evidence collection and the prosecutor has opined on the case. A best practice is to initiate the administrative investigation upon notification of the death and in parallel to the ongoing criminal investigation so that evidence of employee misconduct can be examined quickly, and any disciplinary or corrective action taken. In some cases, we found the administrative investigation was commenced long after the criminal investigation was closed.

In several of the administrative ICD investigations we found that the case focus was not on employee misconduct. We understand that the administrative ICD investigation is undertaken to gain understanding of the circumstances leading to the inmate's death. Information indicating employee misconduct uncovered in this effort should be carefully investigated in consultation with the appropriate United States Attorney's Office. The most egregious

examples of misconduct we observed was the failure of correction officers to perform required cell checks and to respond to requests by inmates for medical services.

The timeliness of the completion of all but one of the 16 administrative ICD investigations we reviewed exceeded the BIA-OJS policy standard of 90 days. While the policy allows for supervisor approval of a time extension, no documentation was found to reflect that such an approval was requested or granted in any case reviewed. In fact, no record of supervisor review(s) during the investigations we examined was found in any case file.

In summary, with adjustments to policies, training of BIA-IAD staff on the expectations for quality investigations of ICD incidents, and supervisor engagement during on-going investigations, the BIA-IAD would easily align themselves with the best practices of external agencies performing similar investigations.

II. Written evaluation of 16 ICD Investigations Showing any Shortcomings in the Investigative Process and Written account of the investigation:

A thorough case review with observations of investigation pros and cons are detailed in deliverable 1 of this evaluation study (Evaluate the thoroughness and effectiveness of the closed in-custody investigations). This delivery includes a written case summary for each individual investigation. The shortcomings found in investigative practices are identified in each individual case review report and are not repeated here in this delivery. Instead, we have isolated some trending observations of investigative shortcomings for consideration in this part of our report:

1. Investigative Response:
    a. Delayed response to in-custody death scenes
    b. Inconsistent notification and collaboration with the FBI
    c. Limited death scene documentation
        i. Death scene photography
        ii. Death scene sketching
2. Autopsy
    a. Limited instances of BIA-Internal Affairs Division (IAD) attendance at autopsies
    b. Inconsistent collection of autopsy photography
    c. Absent coordination with medical examiner/coroner regarding autopsy findings
3. Case file documentation
    a. Multiple instances of no administrative investigation report prepared
    b. No centralized investigation review and approval process within BIA
    c. No record of supervisory case review or guidance
    d. Inconsistent reporting of in-custody deaths in Indian Country
    e. No standardized case file organization, format or content

4. Investigative Training (covered in detail in Task 4)

The Cruzan Group used information obtained from thorough reviews of 15 ICD Investigations from 2016 to 2020 (not including KOL120-16-294 – (b) (6), (b) (7)(C)). We examined the investigations and evaluated the investigative timeliness and investigative thoroughness for each. We also examined and opined on case file organization from the standpoint of clarity of reading, organization, and consistency of format throughout the organization.

III. Analysis of any Regression or Progression in OJS Procedures/Practices of ICD cases from 2020 versus past ICD cases:

Investigative Timeliness:

In evaluating the timeliness of the investigations, we considered the time it took to initiate ICD cases after notification, the time to perform certain investigative steps and the overall time an investigation remained open from the date BIA-IAD was made aware of the inmate death to the date the administrative report of investigation was completed.

In accordance with the BIA-OJS Law Enforcement Handbook investigations of complaints will be completed by the BIA-IAD within 90 days of being opened. Investigations continuing past 90 days must be approved by a BIA-IAD supervisor.

Our review did not reveal any supervisor reviews of ICD investigations and all cases except one exceeded the 90-day opened case policy. It is a quality practice to keep a case log with each investigation in which investigators can document their investigative activity as the case proceeds and supervisory case reviews can be recorded.

Of the 15 case files we reviewed we found:

- In 2016 there were two ICD administrative investigations initiated, however due to the lack of a completed administrative report of investigation, we were unable to determine a timeline for one of the cases. The one completed investigation in 2016 took two months and 12 days to complete.
- In 2017 there were four ICD administrative investigations that took an average of one year, six months, and 17 days to complete.
- In 2018 there were two ICD administrative investigations that took an average of one year, five months, and 12 days to complete.
- In 2019 there were two ICD administrative investigations that took an average of nine months and six days.
- In 2020 there were five ICD administrative investigations that took an average of three months and 16 days.

In comparing timeliness of the administrative investigations completed in 2016, 2017, and 2018 against the timeliness of administrative investigation completion in 2019, we found that there has been **progression** regarding this issue. In addition, when comparing 2019 with 2020 there appears to be a continued **progression** regarding timeliness.

Investigative Thoroughness:

Investigative thoroughness relates to an evaluation of whether the investigative activity in the case was comprehensive and resulted in the resolution of all logical questions surrounding the ICD. This is a highly subjective area, but some standard investigative steps are an accepted practice in the specialized field of death investigations. To make a comparison between cases from each of the five years we examined we chose 11 different areas to review that we find essential to consider in all ICD investigations. We examined each investigative report to determine if these steps were included in the investigative activity. We then looked at the cases collectively in each year of this study to conclude if the agency regressed or progressed in each area among the years compared.

The 11 investigative thoroughness areas we applied to each investigation include:

1. Attachment of criminal investigation report to administrative investigation
2. Inclusion of an investigative timeline
3. Serious Incident report inclusion
4. Police report attachment
5. Booking documents attached
6. Autopsy report attached
7. Court documents attached
8. Rights advisements
9. Witness interviews
10. Recommendations for policy or procedure improvement
11. Coordination with prosecutor

1. **Attachment of Criminal Investigation Report to Administrative Investigation Reports:** We reviewed the 15 administrative ICD investigations to identify those that included the criminal investigative report in the final administrative investigation report. We recognize that in limited circumstances the FBI may not provide copies of all criminal investigation records. In those instances, we believe a case entry explaining the absence of the records would be appropriate. In comparing administrative ICD investigations that were initiated in 2016, 2017, and 2018 against those administrative ICD investigations initiated in 2019 we observed a **regression**. In comparing administrative ICD investigations initiated in 2019 against those administrative ICD investigations

initiated in 2020 we observed a **progression**. Overall, the inclusion of the criminal investigation reports is an area for potential improvement.

- two cases in 2016 two had criminal reports attached (100%)
- four cases in 2017 three had criminal reports attached (75%)
- two cases in 2018 one had criminal reports attached (50%)
- two cases in 2019 one had criminal reports attached (50%)
- five cases in 2020 three had criminal reports attached (60%)

2. **Inclusion of an Investigative Event Timeline:** We reviewed the 15 administrative ICD investigations to identify those that included an investigative event timeline in the final administrative investigation report. We consider the construction of a timeline a quality investigative practice that we observed in select BIA-IAD ICD investigations. In comparing administrative ICD investigations that were initiated in 2016, 2017, and 2018 against those administrative ICD investigations initiated in 2019 we observed a **regression**. In comparing administrative ICD investigations initiated in 2019 against those administrative ICD investigations initiated in 2020 we observed a **progression**. Overall, the inclusion of investigative event timelines is an area for potential improvement.

- two cases in 2016 zero timelines (0%)
- four cases in 2017 three timelines (75%)
- two cases in 2018 zero timelines (0%)
- two cases in 2019 zero timelines (0%)
- five cases in 2020 two timelines (40%)

3. **Serious Incident Report Inclusion:** We reviewed the 15 administrative ICD investigations to identify those that included a serious incident report (SIR) in the final administrative investigation report. In comparing administrative ICD investigations that were initiated in 2016, 2017, and 2018 against those administrative ICD investigations initiated in 2019 we observed a **progression**. In comparing administrative ICD investigations initiated in 2019 against those administrative ICD investigations initiated in 2020 we observed **no change**. Overall, the inclusion of the SIR's report has been a standard and continuous practice by the agency.

- two cases in 2016 two included SIR (100%)
- four cases in 2017 four included SIR (100%)
- two cases in 2018 one included SIR (50%)
- two cases in 2019 two included SIR (100%)
- five cases in 2020 five included SIR (100%)

4. **Police Report Attached:** We reviewed the 15 administrative ICD investigations to identify those that included a police report in the final administrative investigation

report. In comparing administrative ICD investigations that were initiated in 2016, 2017, and 2018 against those administrative ICD investigations initiated in 2019, as well as comparing administrative ICD investigations initiated in 2019 against those administrative ICD investigations initiated in 2020, we observed **no change**. Overall, the inclusion of the police reports has been a standard and continuous practice by the agency.

- two cases in 2016 — two Police Reports (100%)
- four cases in 2017 — four Police Reports (100%)
- two cases in 2018 — two Police Reports (100%)
- two cases in 2019 — two Police Reports (100%)
- five cases in 2020 — five Police Reports (100%)

5. **Booking Documents Attached:** We reviewed the 15 administrative ICD investigations to identify those that included a booking document in the final administrative investigation report. In comparing administrative ICD investigations that were initiated in 2016, 2017, and 2018 against those administrative ICD investigations initiated in 2019 we observed a **progression**. In comparing administrative ICD investigations initiated in 2019 against those administrative ICD investigations initiated in 2020 we observed **no change**. Overall, the inclusion of the booking documents has been a standard and continuous practice by the agency.

- two cases in 2016 — two booking info (100%)
- four cases in 2017 — three booking info (75%)
- two cases in 2018 — two booking info (100%)
- two cases in 2019 — two booking info (100%)
- five cases in 2020 — five booking info (100%)

6. **Autopsy Report Attached:** We reviewed the 15 administrative ICD investigations to identify those that included an autopsy report in the final administrative investigation report. In comparing administrative ICD investigations that were initiated in 2016, 2017, and 2018 against those administrative ICD investigations initiated in 2019 we observed a **progression**. In comparing administrative ICD investigations initiated in 2019 against those administrative ICD investigations initiated in 2020 we observed **no change**. Overall, the inclusion of the autopsy reports has been a standard and continuous practice by the agency.

- two cases in 2016 — two autopsy reports (100%)
- four cases in 2017 — four autopsy reports (100%)
- two cases in 2018 — one autopsy report (50%)
- two cases in 2019 — two autopsy reports (100%)
- five cases in 2020 — five autopsy reports (100%)

Although the practice of obtaining and attaching the autopsy report to the final administrative ICD report has been a standard and continuous practice our review did not reveal a careful review or consideration of the autopsy report in the investigation. A quality investigative practice includes attendance at the autopsy and a careful review of each autopsy report coupled with coordination with the medical examiner in instances where toxicology or other autopsy details require clarification for understanding.

7. **Court Documents Attached:** We reviewed the 15 administrative ICD investigations to identify those that included court documents in the final administrative investigation report. In comparing administrative ICD investigations that were initiated in 2016, 2017, and 2018 against those administrative ICD investigations initiated in 2019 we observed a **slight progression**. In comparing administrative ICD investigations initiated in 2019 against those administrative ICD investigations initiated in 2020 we observed another **slight progression**. Overall, the inclusion of investigative event timelines is an area for potential improvement.

    - two cases in 2016 — zero court documents (0%)
    - four cases in 2017 — two court documents (50%)
    - two cases in 2018 — one court document (50%)
    - two cases in 2019 — one court document (50%)
    - five cases in 2020 — three court documents (60%)

8. **Rights Advisements:** We reviewed the 15 administrative ICD investigations to identify those that included the use of rights advisement notices in the final administrative investigation report. In comparing administrative ICD investigations that were initiated in 2016, 2017, and 2018 against those administrative ICD investigations initiated in 2019 we observed a **regression**. In comparing administrative ICD investigations initiated in 2019 against those administrative ICD investigations initiated in 2020 we observed a **progression**. Overall, the use of rights advisement is an area for potential improvement.

    - two cases in 2016 — two warnings of administrative rights (100%)
    - four cases in 2017 — two warnings of administrative rights (50%)
    - two cases in 2018 — one warning of administrative rights (50%)
    - two cases in 2019 — zero warnings of administrative rights (0%)
    - five cases in 2020 — one warning of administrative rights (20%)

Our case reviews found a systemic weakness in the use of rights advisements during investigations. The use of voluntary notices (Garrity) should be used when interviewing employees about their involvement in any ICD investigation. The use of compelled warnings (Kalkines) should be used only after review and consent of an appropriate prosecutor. Additionally, training on the proper use of warnings for investigative staff is recommended.

9. **Witness Interviews:** We reviewed the 15 administrative ICD investigations to identify those cases in which additional witness interviews should have been conducted before case closure. This is a subjective area, but a quality investigative practice includes the interview of all identified witnesses. When comparing ICD investigations from 2016, 2017, and 2018 with administrative ICD investigations conducted in 2019 as well as cases conducted in 2019 against those conducted in 2020, we observed a **slight progression** in conducting all relevant interviews. Overall, the use of rights advisement is an area for potential improvement.

    - two cases in 2016 — two cases relevant interviews remaining (100%)
    - four cases in 2017 — two cases relevant interviews remaining (50%)
    - two cases in 2018 — two cases relevant interviews remaining (100%)
    - two cases in 2019 — one case relevant interviews remaining (50%)
    - five cases in 2020 — two cases relevant interviews remaining (40%)

10. **Recommendations for Policy or Process Improvements:** We reviewed the 15 administrative ICD investigations to identify those that included recommendations for improvement to policy or procedures in the final administrative ICD investigation report. Careful consideration of how an ICD occurred and what may be changed in policy or procedure to prevent a reoccurrence is a best practice following all administrative investigations. A comparison of administrative ICD investigations that were initiated in 2016, 2017, and 2018 against those administrative ICD investigations initiated in 2019 we observed a **progression**. In comparing administrative ICD investigations initiated in 2019 against those administrative ICD investigations initiated in 2020 we observed a **slight regression**. Overall, recommendations for policy or process improvements at the conclusion of administrative ICD investigations is an area for potential improvement.

    - two cases in 2016 — zero with recommendations (0%)
    - four cases in 2017 — one with recommendation (25%)
    - two cases in 2018 — one with recommendation (50%)
    - two cases in 2019 — two with recommendations (100%)
    - five cases in 2020 — four with recommendations (80%)

11. **Coordination with Prosecutor:** We reviewed the 15 administrative ICD investigations to identify those cases in which coordination with, or referral to an appropriate prosecutor was accomplished before the investigation was closed. A quality investigative practice includes coordinating with the prosecutor prior to the use of Kalkines warnings and prior to closing the investigation. The coordination should include a careful analysis of all information collected, including all evidence of employee misconduct. Once informed of all facts, a prosecutor may accept the investigation for prosecution of decline prosecution. Declinations should be written and include the reasoning as to why no prosecution was warranted in the case.

There were no instances observed of prosecutor coordination in the 16 administrative ICD investigations we reviewed. Overall, the coordination with prosecutors is an area for improvement.

Investigative Case File Organization

We made numerous observations regarding investigative case file organization and management. In our review of the 16 administrative ICD investigations, we observed inconsistency among the cases with respect to organization, content, and report format. These observations resulted in the following areas for the agency to consider policy revision:

Case File Organization: Our review found case files that contained records that pertained to a different investigation, documents included in a random order that made it difficult to understand, and cases missing key records that should be collected in any ICD investigation. A quality practice among investigative agencies is to set up an agency wide standard case file template directing how all records collected during the investigation are maintained. The benefits of a standardized organization template include helping any newly assigned investigator or supervisor know exactly where certain records may be found in the investigative file. As an example, we found 12 different investigators were involved in the 16 cases we reviewed, and each had a different way of approaching case file organization. Organizing all records such as investigative reports, witness/subject/victim statements with rights advisements, legal documents including subpoenas or search warrants, evidence documents, records and other documents gathered during the investigation should appear in the same case file location regardless of who the investigator may be. It is highly recommended that an index be used to aid in the immediate understanding of where documents sought may be found. In our review we found that 11 of the 16 case files used attachment or exhibit sleeves to improve organization. This is noted as a quality practice, however, these cases did not include an explanation or guide as to what was included in the numbered attachments or exhibits. Overall, case file organization of administrative ICD investigations is an area for improvement.

Case File Content: Our review of all 16 administrative ICD investigations found that most cases had key documents expected to be collected in any ICD incident. A quality investigative practice is to include a summary section in the case file where investigators can make notes about investigative activity conducted, document an investigative plan, and provide space for supervisor review comments. We did not find any such record in the cases we examined and believe adding this practice may improve the consistency of case organization, supervision and improve overall timeliness of case completion. Overall, case file content of administrative ICD investigations is an area for improvement.

Case Report Format: A quality practice is for agencies to identify a standardized case file format that is directed for use by all investigators in the organization. A standardized report writing format will identify sections of the report where documentation of investigative activity is included. In our review, we found cases that did not include an administrative investigative report and others that used a report format that was very easy to read and understand. Whether or not a report was written, the comprehensiveness of a report, and the report format was varied based on the investigator involved and/or the location of the incident. We recommend the agency adopt a standard report format that will include all the necessary sections for ICD and other IAD investigations throughout the organization. Overall, case report format of administrative ICD investigations is an area for potential improvement.

Our review also found the case numbering convention used by the agency confusing. In looking at some case numbers it appears they may be locally generated numbers rather than being created centrally. A quality investigative practice is to have case numbers issued from the agency and include alphanumeric characters identifying the office assigned to perform the investigation. We recommend the agency review their case numbering process for potential improvement.

Evaluation of Practical Application of the BIA In-Custody Death Investigation to include if Investigators have Proper Training and Skills to Effectively Investigate ICD Incidents

Task 4

Evaluation of Practical Application of the BIA In-Custody Death Investigations to Include if Investigators have Proper Training and Skills to Effectively Investigate ICD Incidents
Task 4

Summary:

In this task, The Cruzan Group evaluated the practical application of the BIA in-custody death (ICD) investigations to include if investigators have proper training and skills to effectively investigate ICD incidents.

Methodology:

The Cruzan Group assessed sixteen (16) closed in-custody death (ICD) administrative investigations which occurred between 2016 and 2020 and evaluated the practical application of the investigations to include if investigators had the proper training and skills to effectively investigate the incidents.

We reviewed the United States Department of the Interior's (DOI) Departmental Manual (DM) Part 446 which sets forth policy for the establishment of Internal Affairs (IA) units, as well as training standards for law enforcement officers, the Bureau of Indian Affairs (BIA) – Office of Justice Services (OJS) Law Enforcement Handbook, and the BIA OJS Corrections Handbook.

We requested and reviewed training records of the BIA special agents assigned to the Internal Affairs Division (IAD).

We also reviewed the training syllabus for several of the Federal Law Enforcement Training Centers (FLETC) applicable training programs, as well as American Correctional Association, Federal Bureau of Investigation (FBI) Law Enforcement Executive Development Association, and commercially available training, such as Daigle Law Group for Internal Affairs Training. Additionally, we reviewed numerous published periodicals and reports.

To provide an accurate assessment of training needed/required of BIA-IAD investigators, we studied the roles and responsibilities BIA had for the response to ICD investigations. In our work we looked for regulation(s), law(s) or agreement(s) that formally delineated roles and responsibilities between BIA, the FBI and Tribal Law Enforcement programs in responding to ICD investigations. We found that chapter 26 of the United States DOI's DM Part 446 sets forth policy for the establishment of Internal Affairs (IA) units to investigate specific categories of alleged criminal acts or misconduct among specified DOI personnel.

As part of our review of the BIA OJS Law Enforcement Handbook we did not find any training requirements for BIA-IAD Investigators identified.

A review of DOI DM 446 found that section 26.6 set forth a requirement that within one year of being assigned to an IA unit, all full-time IA investigators will successfully complete:

- The Federal Law Enforcement Training Center - Criminal Investigator Training Program (CITP) or an equivalent training program approved by the Director - Office of Law Enforcement and Security (OLES); and,
- A specialized IA investigations training course approved by the Director - OLES.

Our research indicates that the Director OLES has approved both the Basic and Advanced Internal Affairs Training Program offered through the Daigle Law Group for IA investigators throughout DOI Internal Affairs.

As a part of our study BIA-OJS provided training records for eleven of the twelve BIA-IAD special agents who served as the lead agent of one of the sixteen (16) cases we reviewed. We examined these records to provide an understanding of the current state of training of BIA-IAD staff. Our examination of these records found:

Investigator Training

- Criminal Investigator Training – Eleven of the twelve BIA-IAD Investigators have received this training. One investigator attended in 2000, one in 2002, one in 2006, two in 2009, two in 2010, one in 2015, and three attended in 2016.

- Internal Affairs Investigation Training - Five of the twelve BIA-IAD Investigators have received this training. One investigator attended in 2015, two in 2018, and two attended in 2019.

- Interview and Interrogation Techniques: Three of the twelve BIA-IAD Investigators have received this training. One investigator attended in 1997 and again in 2016, and two attended in 2016.

4.8.2 Deliverables:

A report that provides multiple well-defined recommendations and detailed plans for how to close the gap between current state and future state by:

a. Recommendations on the Appropriate Training and Certifications Needed to Conduct In-Custody Death Administrative Investigations:

I. Identify specific training programs to increase the investigative skill set of investigators, in comparison to any deficiencies identified.

As previously identified, DOI DM 446, section 26.6 sets forth a requirement that within one year of being assigned to an IA unit, all full-time IA investigators will successfully complete:

- The Federal Law Enforcement Training Center - Criminal Investigator Training Program (CITP) or an equivalent training program approved by the Director - Office of Law Enforcement and Security (OLES); and,
- A specialized IA investigations training course approved by the Director - OLES.

When combined, these investigative courses provide a basic understanding of the roles of IAD investigators, they fall short of providing the IAD investigator with adequate training to specifically address ICD's. Based upon our in-depth reviews of the ICD files and identified deficiencies documented in other sections of this study as well as our review of the training records of IAD investigators, we believe that the following four training courses should be mandatory for all IAD investigators conducting administrative investigations of ICDs to better equip them for success.

Criminal Investigator Training Program (CITP)

The Federal law Enforcement Training Center (FLETC) Criminal Investigator Training Program (CITP) provides a program of instruction that fulfills basic criminal investigative training requirements. However, rather than being agency-specific, the program addresses common knowledge, skills, and abilities that are expected of all investigators.

While CITP provides training on skills such as Interviewing for Criminal Investigators, Case Management, Report Writing, basic Law Enforcement Photography and Video, and Federal Criminal Law, there is a lack of in-depth training dedicated to crime scene processing (only five hours of classroom and four hours of lab), and nothing related to in-custody death investigations.

To address this shortcoming, we believe that in addition to CITP or other approved criminal investigative training program, the Indian Country Criminal Investigator Training Program (ICCITP) should be considered as a mandatory add-on requirement for all investigators assigned to the Internal Affairs Division.

BIA - Indian Country Criminal Investigator Training Program (ICCITP)

In this (77 hour long) class, the investigators receive not only classroom lecture, but also hands on experience investigating and processing mock crime scenes.

Additionally, the students receive:

- 16 hours of lecture on adult death investigations
- 4 hours of lecture on major crime investigations in Indian Country
- 8 hours of instruction on photography
- 4 hours of instruction on crime scene sketches
- 16 hours of training on crime scene techniques

- 7 hours of crime scene lab

Internal Affairs Investigations Training Program (IAITP)

The FLETC Internal Affairs Investigations Training Program (IAITP) is designed to orient experienced law enforcement officers and related personnel to the unique investigative and legal aspects of conducting internal affairs investigations, both administrative and criminal. The program provides instruction on the techniques and procedures used in these investigations, the statutory and constitutional legal issues that arise when dealing with governmental employees as witnesses and subjects, advanced interviewing techniques useful in integrity investigations, and investigative techniques helpful in obtaining information on the internet. That instruction is reinforced and expanded through the presentation of case studies/discussion by guest lecturers that typically include a highly experienced internal affairs investigator and two highly respected attorneys specializing in the government and the defense perspective in conducting internal affairs investigations.

The Advanced Interviewing for Law Enforcement Investigators Training Program (AILEITP)

The FLETC Advanced Interviewing for Law Enforcement Investigators Training Programis designed to enhance the skills of law enforcement criminal investigators as they conduct interviews of victims, witnesses and suspects. During their initial law enforcement training, students are taught the basic steps of a law enforcement interview. While these steps are important to learn, understand and apply, this initial training laid only the basic foundation needed for the beginning criminal investigator. The AILEITP will provide the students with an arsenal of methods and skills to use during the course of various interview and interrogation situations they will face on a daily basis. The AILEITP instruction will teach students how to obtain information effectively through various interview and interrogation methods, techniques and theory.

Throughout the AILEITP, students will take part in lectures, hands-on exercises with immediate instructor feedback, and an end of program interviewing laboratory. The AILEITP will have various break-out sessions where students will have more one-on-one time with an instructor, thus enhancing the entire training experience.

Based upon our review and analysis, consideration should be given to providing investigators training opportunities at one or more of the following FLETC investigative training programs to assist them in the investigation of ICDs occurring in Indian Country.

FLETC - Advanced Forensic Techniques in Crime Scene Investigations I (AFTCSI I)

The Advanced Forensic Techniques in Crime Scene Investigations I (AFTCSI-I) program is designed for qualified law enforcement officers, criminal investigators, crime scene technicians, and civilians who have a background in crime scene processing and investigations. The program

offers the student many laboratory and crime scene exercises to become proficient in the location, documentation, collection, and preservation of physical evidence commonly encountered at a crime scene. The class culminates in an eight-hour practical exercise where the students will investigate and document a crime scene utilizing the new skills and techniques acquired during the program.

FLETC - Recovery of Evidence from CCTV Video Recording (RECVR)

The Recovery of Evidence from CCTV Video Recording (RECVR) is designed to provide the responding officer and/or the investigator with the best practices for recognizing, collecting, and properly transporting sensitive digital video evidence from crime scenes in such a manner that preserves the evidentiary integrity of the video. Emphasis is placed on collection of evidence, preserving the evidentiary integrity of the video and utilization of correct software to accurately play and review the collected video. Students will demonstrate their comprehension of the material and techniques taught in this course through extensive laboratory and practical exercises using various proprietary and non-proprietary recorders. The RECVR training program tuition includes state-of-the-art hardware and software which will be issued to each student and will be demonstrated and used during class.

II. Identify specific certifications OJS should secure to improve its service and capabilities, in comparison to any deficiencies identified.

While the Cruzan Group identified several organizations claiming to provide certifications for Internal Affairs Investigators, The Cruzan Group does not endorse any organization over another. We do believe however, that the training programs identified below provided by FBI-LEEDA and The Institute for the Prevention of In-Custody Death would be beneficial for IAD investigators.

FBI-LEEDA's Managing and Conducting Internal Affairs Investigation

This certification course focuses on individual skill development, procedures and contemporary best-practices for conducting and managing not just internal investigations, but all phases of administrative procedure by law enforcement and other governmental disciplines. The course of instruction addresses internal control processes, administrative procedure and agency accountability measures. The course content has value for all managerial and supervisory levels in law enforcement and other governmental disciplines (including, but not limited to corrections, correctional probation, fire service, human resources, and OIG entities).

This seminar is interactive, and attendees participate in capstone scenarios designed as an application of learning. FBI-LEEDA's Managing and Conducting Internal Affairs Investigations certification course has been recognized by the majority of state POSTs for mandatory retraining credit. (https://fbileeda.org/page/POSTCertByDate)

Institute for the Prevention of In Custody Deaths (ipicd.com)

Beginning in 2006, the IPICD hosted and produced the *first* international conference about excited delirium, arrest-related, and sudden in-custody deaths. IPICD conference presenters are world-class researchers, scientists, attorneys, physicians, and criminal justice practitioners who share the latest scientific, legal, medical, and best practices with attendees who come from across the globe. the IPICD concentrates on providing train-the-trainer and forensic instruction through its seminal scientifically- and legally based excited delirium, arrest-related death, sudden in-custody death, forensics, suicide, amendment-based use-of-force, and other risk management programs. Specifically, IPICD has a training course identified as Arrest Related and In-Custody Death Investigative Specialist.

The Professional Internal Affairs Certification for Public Safety
(https://ia.patc.com/certification)

A professional training, education and certification program offered by Public Agency Training Council (Indianapolis, IN) and endorsed by the National Internal Affairs Investigator Association. Successful completion of certification requirements will designate the attendee as a certified Internal Affairs Investigator/Supervisor through Public Agency Training Council.

National Internal Affairs Investigators Association
(niaa.org)

The National Internal Affairs Investigators Association (niaa.org), may prove to be beneficial to IAD investigators. The NIAIA is the only national organization dedicated to educating, developing, and assisting internal affairs units and their investigators. The NIAIA hosts an annual training conference that showcases issues of concern and interest to IA investigators and provides extensive opportunities for networking with other IA professionals.

b. Provide recommendation of any equipment deficiencies.

I. Identify specialized equipment which may aid in IAD investigations.

Our review of the ICD investigations provided did not reveal any specialized equipment deficiencies. However, it is a best practice for investigators be familiar with and access to an investigative crime scene kit. Our coordination with the Director, United States Indian Police Academy resulted in identifying a training program on investigative equipment already in existence. Attendees at this course are provided a fully equipped crime scene kit and taught how to use the included tools through a series of mock crime scenes based on actual crimes that occurred in Indian Country. Here is some additional information regarding this program:

The Indian Country Criminal Investigator Training Program (ICCITP) provides participating BIA, Tribal, and FBI special agents with training in crime scene investigation to include report writing, crime scene processing, physical evidence documentation and packaging, trace and

biological evidence, photography, latent print development, death investigation (pattern injuries, asphyxia, fire & electricity, gunshot wounds, pediatric death investigation), medical considerations or child abuse and homicide, digital evidence, interviewing, human trafficking, IC jurisdiction, domestic, elder, and child abuse, wound analysis, forensic pathology, case management, missing persons, and working with federal prosecutors.

Throughout the program, agents are trained utilizing their individually assigned crime scene kits. Agents respond to multiple crime scenes in locations (open/closed areas) they will experience in Indian Country. Each scenario is based on an actual case from Indian Country which requires a full crime scene investigation utilizing the issued kit. Upon successful completion of the program, agents are issued their crime scene kits as a resource to support their investigative efforts in Indian Country.

Define Plans to Reach Future State
Task 5

Define Plans to Reach Future State

Task 5

Summary: The Cruzan Group reviewed the Bureau of Indian Affairs (BIA), Office of Justice Services (OJS) detention policy associated with in-custody deaths (ICD) and the conduct of administrative investigations. We found multiple areas for improvement in policy and operations which if addressed would more appropriately resolve potential employee misconduct and more consistently identify areas for potential policy or procedure improvement.

Methodology:

Achieving an improved future state involves careful consideration of the current state with the objective of incorporating known best practices, modern capabilities, leveraging technology, improving training, and ensuring consistent, clear policy for staff understanding.

After an extensive review of the 16 ICD Investigations, The Cruzan Group considered all findings (pro and con) as well as the analysis performed in tasks 2-4 to establish a clear picture of the current state of BIA response to ICD incidents. With this understanding, our team was able to identify specific areas for potential improvement that the BIA may consider in planning policy and procedure changes for the future.

Suboptimal or Missing Strategies, Infrastructure, Capabilities, Processes, Practices, Technologies, or Skills:

Our team identified a variety of areas for improvement in the BIA-OJS response to ICD incidents, performance of investigations, and investigative reporting. We have separated these observations into the broader categories of investigative policy, investigative training, investigative response, investigative thoroughness, investigative supervision, external coordination, and investigative reporting for more detailed discussion:

1. Investigative Policy

Policies and procedures are an essential part of any organization and provide an understanding to staff of how day-today operations are performed. Policies should be current and in compliance with laws, regulations, and department/agency policies to support decision-making while aiding efficiency of internal process expectations of an agency in the performance of all investigative activity.

a. We understand that the BIA-OJS corrections and law enforcement policies and procedures are documented in two separate handbooks. Each handbook serves as both the agency policy on corrections/law enforcement operations and the procedure manual for staff to follow in performing those operations. A best practice would be to separate the two so that policy can serve to address high level issues and show

compliance with relevant laws and regulations while a procedure manual can provide detailed guidance to staff on how they are expected to perform the full range of duties required by the agency. Policy is a dynamic area of operations that requires continuous engagement with ever changing laws, regulations, and best practices for updating policies and procedures.

b. A review of each handbook identified a variety of directives that require clarification or updating to keep them in line with modern day practice. This is not as much a deficiency in policy as evidence that these policies are not regarded as continually changing guidance required for consistent agency operations. A policy team should be continuously scanning the legal and regulatory environment for changes as well as remaining connected to law enforcement associations to glean new innovative ideas regarded as best practices that can be included in BIA-OJS policy and procedures.

c. As detailed in task 2, the BIA-OJS Law Enforcement Handbook contains four sections that address roles and responsibilities for the investigation of ICDs. Two of them direct that the FBI has primary investigative responsibility for the investigation of ICD incidents. One states the FBI will take a primary role in "**most"** BIA/tribal law enforcement shootings or in-custody death incidents, and one states that the BIA-IAD is responsible for investigating ICD incidents. We believe policy revision is needed to clarify roles and responsibilities. In its current form, the BIA-OJS Law Enforcement Handbook could lead to confusion and assumptions that could affect the timeliness and thoroughness of in-custody death investigations.

d. The BIA-OJS Law Enforcement Handbook makes several references to an agreement between the BIA and FBI. We found that no such formalized memorandum of agreement (MOA) or memorandum of understanding (MOU) exists. A formalized MOU/MOA between the FBI and BIA-OJS as well as an agreed upon investigative process that includes timeliness of BIA-IAD and FBI response to the death scene, information sharing and communication strategy between agencies, the role of tribal law enforcement agencies, and coordination with the U.S. Attorney should be established. We recommend BIA-OJS reconsider the position that all ICD incidents will be investigated by the FBI. We believe a best practice is for the BIA-IAD to work jointly in any ICD investigation from the initial notification of death through the presentation of any findings to the appropriate prosecutor at conclusion of the case.

RECOMMENDATION: The BIA-OJS should consider separating policy matters from the existing Corrections and Law Enforcement Handbooks so that each handbook could be enhanced into a procedure manual for the agency. A policy team should be established to continuously monitor for changes requiring updates to both policies and procedures to maintain a modern stance on corrections and law enforcement issues. The BIA-OJS leadership should review the current stance on BIA-IAD response to ICD incidents and determine if promoting a joint investigation procedure is best for agency operations. The BIA-OJS leadership team should work with FBI

leadership to establish a mutual agreement regarding the response to, and investigation of ICD incidents. This policy should consider the recommendations our team made in Task 2 for inclusion in the mutual agreement. Any agreement made should be maintained annually and updated as necessary.

2. Investigative Training

Conducting effective ICD investigations requires a strong foundation of training in skill areas including crime scene investigations, evidence identification, collection, and preservation, interviewing, and a basic understanding of manner and cause of death. Without training in these areas, a responding special agent cannot be expected to perform a comprehensive examination of the scene or collection of appropriate physical and testimonial evidence. Further, for the purposes of conducting an administrative investigation, special agents need training in conducting internal investigations, a clear understanding on the use of mandatory rights advisements, and an investigative focus on determining if any misconduct contributed to the circumstances surrounding the ICD.

a. Our examination of the training provided to current BIA-IAD staff found that while most assigned special agents have attended the basic investigator training, one special agent had not. This training is only initial training designed to expose attendees to basic investigative skills and is not a specialized or advanced training in any investigative area. We found that less than half (5/12) of the assigned special agents have attended internal affairs training resulting in most of the special agents not possessing the necessary skills to perform effective internal affairs investigations. Lastly, only three of the assigned special agents (3/12) have attended advanced interviewing training. This training is essential for all internal affairs special agents to attend. Advanced training in conducting interviews ensures internal affairs special agents are prepared to elicit and collect critical testimonial evidence needed to assess all case facts.

RECOMMENDATION: We recommend BIA-OJS develop a structured training management program to identify, track, and schedule mandatory and optional training programs for each special agent to attend. Investigative policy should identify the training each special agent must receive to perform IAD investigations. Efforts should be made to ensure all assigned BIA-IAD special agents will attend mandatory courses within a determined timeline following assignment to the unit. Additionally, the training management effort should continuously identify additional training to enhance team capabilities and schedule attendance at this training routinely. A best practice includes each BIA-IAD special agent attending a minimum of 20 hours of annual training (initial or refresher) to ensure individual competency. Additional training recommendations for consideration are identified in Task 4.

3. Investigative Response

a. BIA-OJS policy sets forth a requirement for BIA-IAD special agents to conduct an administrative investigation into ICD incidents. In the cases we reviewed, we found the BIA-OJS response to death scenes was inconsistent, either because of confusion in agency policy, geographic distance from the incident, or due to a lack of training on death scene investigations. A best practice would include an immediate response to the death scene by the closest BIA-IAD special agent, or, if the BIA-IAD response will be delayed, having a local BIA criminal investigator initially respond to secure the scene pending arrival of the BIA-IAD and FBI. Once BIA-IAD and FBI special agents arrive, actions to secure the scene, identify, collect, and secure evidence, and identify all potential witnesses should be made. In the event of simultaneous FBI response to the scene, the agencies, pursuant to a mutual agreement, should work jointly to ensure all immediate investigative efforts are made to protect vital evidence. Once this is accomplished, the criminal investigation can be led by the FBI, or BIA-IAD (as determined by policy) to determine if any criminal culpability is present. A parallel administrative investigation may be initiated with witness interviews following the collection of testimonial evidence required for the criminal investigation. The BIA-IAD administrative investigation should include a thorough review of evidence collected in the criminal investigation and the BIA-IAD special agent should attend the autopsy of the deceased.

RECOMMENDATION: We recommend that BIA-OJS review existing policy regarding ICD response to determine if changes may be required to ensure the investigative response to these incidents is appropriate. Any changes to policy should be communicated to all staff to ensure understanding and agency expectations in these incidents. The need for additional travel for BIA-IAD special agents for travel costs associated with immediate response to death scenes as well as continued travel for the administrative investigation should be considered.

4. Investigative Thoroughness

a. In all cases we reviewed we found inconsistency in investigative thoroughness. Many criminal and administrative cases were concluded without having taken investigative steps considered fundamental in any death investigation. These activities included collecting relevant documentary and physical evidence, identifying all witnesses, conducting witness interviews, and following logical leads related to potential employee misconduct.

b. An Investigative plan was developed by BIA-OJS and the steps incorporated into the investigative report format. Our team reviewed the proposed steps in the plan and have provided our recommendations for additional efforts to consider. Ensuring that a template investigative plan is followed in all ICD investigations will greatly improve the consistency of thoroughness in these investigations. One caution we offer is to ensure

that the plan is not considered a "checklist" of items to perform before closing a case but instead a starting point that leads to developing other logical leads that are included in the final investigation.

RECOMMENDATION: We recommend implementing the use of a standard investigative plan to be used as a starting point for all future ICD investigations. In implementing this change, deliberate discussion with all BIA-IAD special agents and their supervisors should occur so that the relevance and importance of each investigative step is understood. Further, BIA-IAD staff should be trained to identify instances of potential employee misconduct and how to develop the evidence required to develop or refute such allegations.

5. **Investigative Supervision**

Investigative supervision is an essential part of any agency's effort to ensure compliance with policy and procedures to conduct timely and thorough investigations into events.

a. Our case reviews did not reveal any evidence of investigative supervision being provided to special agents at any point during the ICD investigations we reviewed which contributed to many of the cons we identified in the case summaries. This lack of supervision may have contributed to an initial untimely response by agents to ICD incidents, investigations not initiated in a timely manner, investigative leads not being followed, witness interviews not being conducted, poor death scene and autopsy documentation, improper use of rights advisements, lack of appropriate coordination with the prosecutors, and inadequate investigative reporting.

RECOMMENDATON: We recommend implementing the use of documented supervisory reviews at specified intervals for all future ICD investigations. In implementing this change, the timeliness of investigation, thoroughness of investigation, and the timeliness of reporting can more readily be assured. Further, we recommend that given the serious and sensitive nature of ICD investigations each case be monitored from the date of initiation through case conclusion by BIA-OJS headquarters and that final report approval be made by that office.

6. **External Coordination**

Indian Health Service – MOA (national and local level MOA's to include handling of persons incapacitated by alcohol)

a. It is understood the Indian Health Service (IHS), an operating division within the U.S. Department of Health and Human Services (HHS) is responsible for providing direct medical and public health services, including mental health services to members of federally recognized Native American Tribes and Alaska Native people. The IHS mission statement asserts that they are "the principal federal health care provider and health advocate for Indian people." Despite this overlapping interest between BIA and IHS for

the care of detainees, no national level MOU is in place between the agencies to address how medical needs will be addressed and the roles and responsibilities of each agency.

RECOMMENDATION: The Department of the Interior and HHS develop a national level MOU that directs all regional/local staff (IHS/BIA) to work collectively to tailor a local MOA that fully responds to the needs of each Indian Country detention facility and of its detainees to ensure complete and effective implementation. A key component of this MOU should establish a basic set of guidelines intended to assist in identifying situations where for the safety and well-being of the detainee, alternatives to incarceration strategies should be deployed. In several of the ICD investigations we reviewed, we noted the blood alcohol content of the deceased during booking to be several times higher than the legal limit. It should be clearly articulated both in BIA-OJS policy and within the IHS/BIA MOU that a person who appears to be **"incapacitated by alcohol or drugs"** shall be taken to an approved treatment facility for emergency treatment, or if no treatment facility is available, be taken to an IHS medical facility for observation.

For clarity purposes, we define **"incapacitated by alcohol or drugs"** to mean "a person, as a result of the use of alcohol or drugs, is unconscious, has his or her judgment otherwise so impaired that he or she is incapable of realizing and making a rational decision with respect to his or her need for treatment, is unable to take care of his or her basic personal needs or safety, or lacks sufficient understanding or capacity to make or communicate rational decisions about himself or herself." The decision to classify a detainee as **"Incapacitated by alcohol or drugs"** should be determined by the booking officer upon intake at the detention facility. This decision should be based on a pre-established standard using the BAC level of the detainee, and with input from medical services.

The intent of this recommendation is to first ensure every individual who comes into an Indian Country detention facility be assessed for risk, need, and responsiveness, and that when a detainee is incapable of realizing and making a rational decision with respect to his or her need for medical treatment, they are placed in the care of medical professionals who are trained and equipped to monitor and provide appropriate medical services.

Tribal and US Attorney Coordination

In any ICD investigation where multiple agencies are, or could reasonably be involved (i.e., FBI, BIA, tribal police, US Attorney), it is critical for each agency to have clearly defined roles and responsibilities. These roles and responsibilities should be spelled out and agreed upon well before an incident occurs.

a. We found that in most ICD investigations the FBI obtained a declination for prosecution from the U.S. Attorney's Office at the conclusion of their criminal investigation. However, we did not find that the BIA-ICD special agents coordinated with the U.S. Attorney's office during the conduct, or conclusion of the administrative investigation

regarding any potential employee misconduct. Additionally, no prosecutor review or approval was obtained prior to the use of a Kalkines warning (providing immunity from criminal prosecution) for interviews in which the advisement was used.

b. Many tribes elect to contract programs operated by the federal government for the benefit of the tribe, and to exercise self-determination. With these tribes, the BIA is limited to not more than one performance monitoring visit per year unless the tribe agrees to additional monitoring visits, or if there is reasonable cause to believe that grounds for reassumption exist such as serious performance deficiency.

RECOMMENDATION: All administrative investigations resulting in the conclusion that employee(s) did not comply with confinement policy or whose behavior amounted to misconduct should be referred to the appropriate United States Attorney's Office for prosecution review. Declinations by that office should be in writing, outline the reasoning for the declination, and included in the administrative investigation file.

We recommend that BIA-OJS review existing policy regarding periodic assessments/audits of law enforcement agencies to ensure compliance with all applicable rules and procedures found in the OJS Law Enforcement Handbook and DOI 446 DM 3 (Policy Compliance Evaluation). In addition, we recommend BIA-OJS consider developing a process to ensure there is an open and constant line of communication between district level managers and the tribes they serve. BIA-OJS should also consider developing and providing training to those tribes who have contracted the detention function that specifically addresses policies and protocols to be followed during ICD incidents. Lastly, the BIA-OJS should ensure that copies of all BIA manuals, federal laws, and regulations, as well as any updates, used as standards within that particular contract are provided to the tribe by BIA-OJS.

7. Investigative Reporting

a. The BIA-IAD did not use a consistent case reporting format for ICD reporting of investigations. In the few cases where a format was used, the information flowed easily, and the investigative process/information could readily be understood by the reader. This was not the case in most ICD reports reviewed. Several ICD cases had no final report attached, and as a result, no explanation was provided regarding documents, photographs, statements, or other information contained in the file.

b. The BIA-IAD administrative investigations did not consistently identify areas of existing policy and procedures which, if corrected, may improve BIA-OJS operations.

c. In several ICD administrative investigations involving alleged employee misconduct the criminal investigation report was provided to the supervisor who was charged with taking corrective/punitive action against the employee. The criminal investigative reports in some instances contained death scene photographs, autopsy photographs

and FBI 302's which should not have been provided outside of the law enforcement community. The criminal investigative report information was not relevant to the alleged misconduct and therefore not needed by the supervisor for proposing administrative action.

RECOMMENDATION: We recommend that the investigative reporting format developed be implemented for all ICD investigations. This format should include any findings of alleged employee misconduct and all evidence supporting the allegation. Administrative investigations should include a section to discuss findings of recommendation for policy or procedure improvement. We recommend that for all future ICD investigations, findings/documents from the criminal investigation be separated from the administrative investigation.

Investigative Report Format

(SUPPLIMENTAL TO TASK 4)

U.S. Department of Interior – Bureau of Indian Affairs
Office of Justice Services – Internal Affairs Division

REPORT OF INVESTIGATION

Case Number:	**In Custody Death Investigation**
Investigating Official:	**Date of Report:** (Date special agent submits their ROI)

CLASSIFICATION OF INVESTIGATION:

Administrative Investigation: (This is what the subject employee will be notified of. These allegations should be addressed individually in the summary analysis and findings)

In Custody Death: A death occurred to a person/s in the custody of a law enforcement/correction program.

INVESTIGATION SYNOPSIS: (This alerts the reader what to expect- this is not a complete explanation of facts or evidence rather a brief description of the events)

DATE/TIME OF INCIDENT(S):

- Date @ Time:

LOCATION OF INCIDENT(S):

- Facility address:
- Cell number, holding area or location of the Incident:

DECEDENT(S):

- Name:
- Date of death:
- Address:

NOTIFICATION SUMMARY:

- On DATE, the Bureau of Indian Affairs (BIA), Office of Justice Services (OJS)-Internal Affairs Division (IAD), received notification of an in-custody death that occurred at _____.
- Detail the notification of the FBI and/or other external agencies.

INVESTIGATION SUMMARY:

Summarize investigative actions taken throughout IAD Investigation with written reports or other documents collected during the investigation. The summary should include:

1. **Review Reasons why the deceased was brought into custody:**
    - Obtain and review of police report of arrest:
    - Obtain and review of use of force report(s) related to the arrest:
    - Obtain and review of dispatch log records surrounding the arrest:
    - Obtain and review of audio recordings (including 911 call, dash camera, and/or body worn camera footage related to the arrest:

- Document in a narrative report the contents of any video or audio exhibits

2. Review of Detention Reports and Records:

Documents should be reviewed and explained in separate investigative report(s) to explain any findings to the reader - especially if any discrepancies or irregularities are found.

- Obtain and review intake/booking forms:
- Obtain and review medical clearance (if applicable):
- Obtain and review Inmate Suicide Screening Form:
- Obtain and review Detention Cell Check Logs:
- Obtain and review inmate's property sheet:
- Obtain and review inmate's booking history records:
- Obtain and review inmate's criminal history records:
- Obtain and review inmate housing logs:
- Obtain and review inmate medication logs:
- Obtain and review visitor log for recent visits with deceased
- Obtain and review phone records of deceased
- Obtain and review inmate notes (items found in their cell):
- Obtain and review on-duty staff roster at time surrounding death (schedule before, during, and after death):
- Obtain an inmate roster at time of death
- Obtain and review audio recordings, surveillance footage, and/or body worn camera footage:
    - Prepare a narrative report explaining the surveillance video and comparing the video with other reports and statements of COs
    - Prepare a chronological timeline of all events from the arrest to the death of inmate.
- Obtain and review on-duty correction officer training records:
- Obtain and review arresting police officer training records (if applicable):
- Obtain and review criminal and incarceration history of the deceased
    - Document record and relevance in investigative report

3. Examination of the Deceased Inmate's Cell

- Photograph the location of the death (360-degree photographs of death scene):
- Did the cell/location have lights:
- Did the cell/location have heat/air conditioner:
- Did the cell/location have a two-way monitor/intercom:
- Did the cell/location have windows:
- Did the cell/location have a bed (mat, blankets, sheets, etc.):
- Did the cell/location have running water (sink, shower, drinking fountain, etc.):
- Did the cell/location have a working toilet:
- Did the cell/location have electricity:
- Did the cell/location have a desk, chair, etc.):
- Did the cell/location have properly working security door:

4. Documenting the Key Facility Areas

- Include the location of the death
- Include the location of the control room or other important areas
- Include locations of all COs and other prisoners at time of death.

5. **Obtain and Review Criminal Investigation:**
    - Tribal agency
    - Local agency(ies)
    - State agency
    - Obtain copies of FBI documents and reports:
        - Death scene photographs
        - Death scene sketch
        - Autopsy photographs
        - 302's of FBI investigative activity
        - Evidence and/or laboratory reports of examinations
        - AUSA criminal case review and acceptance/declination for criminal prosecution
    - Other federal agency records

6. **Review Cell Check Procedures:**
    - Review cell check log for date of death
    - Review facility surveillance video to determine if checks were actually performed at times and frequency documented in the report

7. **Conduct Administrative Witness Interview(s) (document each in detailed investigative report):**
    - Police officer(s) involved in arrest
    - Detention staff (all who were on duty at the time of death – others if appropriate)
        - Question regarding cell checks and information collected from step 6
    - Inmates (those who interacted with deceased – include those who are uncooperative or claim to have no knowledge)
    - Medical staff who provided emergency services
    - Next of kin
    - Significant Witness(es) (identified as having direct knowledge of the incident) – include the following information in the investigative report of interview:
        - Name
        - Address:
        - Agency
        - Phone:
        - Email:

      If applicable, include for significant employee witnesses:
        - Career date of hire:
        - Start date of current position:
        - Basic training graduation date and type of training (IPA, CITP, etc...)
        - Supervisor training – has employee applied to be a supervisor?
        - Have they attended Response to Illness, Injury or Death training?
        - CPR / First Aid training – date of most recent attendance?
        - IMARS training?

8. **Conduct Subject Interviews if Misconduct was Identified:**
    - Coordinate with appropriate AUSA prior to using a Kalkines warning

MEDICAL EXAMINATION: Document as a separate paragraph within the report and include a short description of the emergency medical treatment the deceased received and all associated documents and reports and should include as a minimum:

9. **Collect and Review:**
    - EMT reports
    - Treatment facility reports
    - Previous medical history (have reviewed by medical professional and document results in investigative report)
    - Autopsy report
    - Autopsy photographs
    - Toxicology reports
    - Death certificate

FORENSIC ANALYSIS:

10. **Document any Forensic Analysis Performed:**
    - Controlled substances found during search of the deceased and their cell (i.e. powder, syringes, pills)
    - Other evidence submitted for laboratory analysis

OTHER RELEVANT INFORMATION:
Provide any important information regarding the investigation that helped you with the analysis and conclusion.

APPLICABLE POLICY/AUTHORITIES:

BIA, OJS-Directorate of Operations Corrections Handbook 1st Edition

1. C2-43-02 (C): Health Appraisals and Examinations
2. C2-30-02: Cell Checks-Daily Operations
3. C2-18-03: Suicide Identification
4. 4-48 (E): Corrections Codes of Ethics and Conduct

BIA, OJS Corrections employees have the following responsibilities by policy and training to care for inmates:

5. 12-01: Facility Policy and Procedures
6. C1-55: Serious Incident Reporting
7. C2-16: Response to Illness, Injury, or Death
8. C2-20: Inmate Intake and Classification
9. C2-21: Inmate Handbook/Request Forms
10. C2-10: Emergency Management Plans (Employee); Standard Operating Procedures/Facility
11. C2-53: Medication/ Procedures and Form
12. C2-30: Inmate Supervision/Cell Checks
13. C2-43: Health Appraisals and Examinations
14. C4-40: Orientation and On the Job Training
15. C2-08: Control Center and Door Controls
16. C2-26: Housing Assignment/Forms
17. C2-27: Inmate Programs and Services/Forms

18. C2-20-E: Acknowledgement of Inmate Form
19. C2-04: Restraint of Inmates/Forms
20. L2-01: Use of Force
21. C2-03: Inmate Searches/Forms

If Applicable:

22. C2-24: Inmate Transports/Forms
23. C2-19: Population Management Control
24. C1-33-08: Routine and Emergency Repairs
25. C1-34: Food and Meal Services/Forms

DISCOVERY OF ADDITIONAL POLICY/RULE/S VIOLATION(S):
Document all policy violations uncovered during the investigation. Address these allegations individually in the summary analysis and include the specific policy that was violated as well as the impact of that violation.

ADMINISTRATIVE EVIDENCE ANALYSIS AND/OR INVESTIGATIVE ACTIONS:
Analyze all evidence separately and highlight any key evidence identified

Administrative investigation of this matter was conducted by IAD Special Agent (SA) _____. Throughout the course of IAD's investigation numerous items of material and evidentiary value were reviewed and evaluated by IAD related to this in-custody death. The following investigative actions were taken by IAD:

Individualize interviews with the below interview notice:

Interview of Correction Officer John Doe: On January 28, 2020, IAD SA Jane Doe conducted an interview with CO John Doe. The interview was audio recorded and transcribed. For detailed information of the interview please refer to the interview transcription attached to this investigative report (attachment 15 and 16) and/or the audio recording.

SUMMARY OF FACTS:

Develop a Timeline of Events

- Summarize how law enforcement became involved with the deceased prior to their death. Call for service up to the booking (include medical clearance if applicable).
- Summarize the booking process up to the point the inmate was placed in their cell. (Include medical clearance if applicable).
- Summarize their overall incarceration.
- Summarize the last 24 hours the deceased was alive up to their death (food service, cell checks, medical, showers, visits, medication service, judicial process, etc.).
- Summarize the correction officer's response to the medical emergency/death and their actions.

AUSA COORDINATION:

Coordination of findings from the administrative investigation

- Identification of policy infractions and the impact
- Potential criminal violations for prosecution consideration

- Acceptance/declination decision – declination should be in writing and explain the basis for declination

FINDINGS:

The BIA-OJS, IAD, investigation determined an in-custody death occurred within the FACILITY NAME on month, day, year involving inmate NAME. Inmate NAME was pronounced dead while within the custody of the FACILITY NAME. An autopsy was performed which resulted in an opinion by presiding physician NAME that inmate NAME death is attributed to MEDICAL FINDING. The circumstances and manner surrounding inmate NAME death have been classified as MEDICAL FINDING (suicide, homicide, accidental, natural, etc.) by the presiding physician as well as within the final investigative report completed by the INVESTIGATING AGENCY NAME (tribal, local, state, federal, etc.)

The administrative investigation **did / did not** determine based upon a preponderance of evidence that any specific actions of the employee(s) of the FACILITY NAME had a direct impact on, or resulted in, the death of inmate NAME.

Or

The BIA-OJS, IAD, investigation determined an in-custody death occurred within the FACILITY NAME on month, day, year involving Inmate NAME. inmate NAME was pronounced dead while within the custody of the FACILITY NAME. An autopsy was performed which resulted in an opinion by presiding physician NAME that inmate NAME death is attributed to MEDICAL FINDING. The circumstances and manner surrounding inmate NAME death have been classified as MEDICAL FINDING (suicide, homicide, accidental, natural, etc.) by the presiding physician as well as within the final investigative report completed by the INVESTIGATING AGENCY NAME (tribal, local, state, federal, etc.)

IAD's investigation into this matter did determine the following deficiencies and policy violations. The FACILITY NAME management should work to correct the identified program deficiencies and policy violations regarding the following:

Policy violations will be identified. (If no employee misconduct was identified, this section can be removed.)

SUBJECT # 1: John Doe (Title)

Allegation #1: Criminal Misconduct –Use of Force (Excessive)

Provide your analysis (allegation in comparison to policy), and your conclusions. Did the employee violate the rule(s) cited? If so, how? If not, how did your reach this conclusion? What conclusions do you draw from your investigation?

Tribal investigations only: by his/her actions, PO Doe did or did not act within the scope of the BIA, OJS-Law Enforcement Handbook 3rd edition; egregious safety violation. This section states in part, "Employees shall…"

Allegation #2: Administrative Misconduct - Discourteous or disrespectful conduct toward members of the public, co-workers or supervisors.

Provide your analysis (allegation in comparison to policy), and your conclusions. Did the employee violate the rule(s) cited? If so, how? If not, how did your reach this conclusion? What conclusions do you draw from your investigation?

Tribal investigations only: By his/her actions, PO Doe did or did not act within the scope of the BIA, OJS-Law Enforcement Handbook 3rd Edition; egregious safety violation. This section states in part, "employees shall…"(If multiple employees are involved identify each by name and separate their allegations)

ADDITIONAL INVESTIGATIVE FINDING(S):

If facility deficiencies were identified as contributing factors: include the supervisor and or Chief of Police name and the action they took to get the deficiency reported and repaired use the following:

IAD's investigation into this matter did determine the following deficiencies and policy violations. The FACILITY NAME management should work to correct the identified program deficiencies and policy violations regarding the following:

Training deficiencies: Include the name of the employee found deficient and explain in detail the findings

Policy deficiencies: Explain each policy with reference to the policy origin and what noncompliance was observed

RECOMMENDED FINDING(S): (Tribal investigations only-if no misconduct is found, this section can be removed.)

1. Class I – Criminal Misconduct: Use of Force (excessive)

- **UNFOUNDED:** The allegation was false or not factual

2. Class IV – Administrative Misconduct: Discourteous or disrespectful conduct toward members of the public, co-workers or supervisors.

- **EXONERATED:** The investigation revealed the acts occurred, but the employee's actions were justified, lawful or proper (if multiple employees are involved identify each by name and separate their allegations)

FOR BIA/OJS CASES:

This investigative report was forwarded to the BIA/OJS/FOD District XX for an investigative determination (specify the BIA/OJS Division and Office)

If no misconduct was identified, use the following:

The BIA, OJS-IAD investigation into the in-custody death of INMATE NAME was the result of a MEDICAL FINDING. IAD's investigation did not reveal by a preponderance of evidence that the actions of a FACILITY NAME employee were not a contributing factor nor was there any employee misconduct identified.

ATTACHMENTS: This should list all attachments to the report – for example (these examples are not all inclusive):

1. Timeline of events
2. Death scene photographs
3. Death scene sketch
4. Facility surveillance video
5. Autopsy report
6. Autopsy photographs
7. Cell check logs
8. Facility staffing logs / shift log

9. Inmate roster
10. Dispatch log
11. Radio logs pages 4-7, dated 08/09/2017
12. Criminal history report pertaining to the deceased
13. Memorandum of Interview-Police Officer Jane Doe
14. Transcript of interview-Police Officer John Doe
15. Report of Interview of CO John Doe with associated voluntary/compelled rights advisement (Garrity/Kalkines)
16. Report of Interview of medical personnel (EMTs, physician(s), nurse(s))
17. Report of Interview(s) of next of kin
18. Report of Interviews of other inmate(s)
19. AUSA coordination and acceptance/declination of administrative investigation