After-Action Report

Disturbance
Willacy County Correctional Facility
Raymondville, Texas
February 20 - March 1, 2015

SUBMITTED BY:

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Correctional Programs Division
Reviewer-In-Charge

5-11-2015
Date Submitted

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I. INTRODUCTION/EXECUTIVE SUMMARY

The Federal Bureau of Prisons (Bureau) contracted with Management and Training Corporation (MTC) to manage and operate the Willacy County Correctional Center (WLC) in Raymondville, Texas. WLC is a low security facility with male offenders serving federal terms of imprisonment. The facility's original capacity was 3,174. The day of the disturbance the population was 2,834. All federal inmates placed in WLC were non-U.S. citizens, and only Bureau inmates were incarcerated at the facility.

On Friday, February 20, 2015, at approximately 11:11 a.m. (all times are Central Standard Time) staff were notified (b)(5),(b)(7)(E) (b)(5),(b)(7)(E) At approximately 1:04 p.m., inmates engaged in a disturbance that fully involved the institution. The disturbance lasted until March 1, 2015, and resulted in minor staff and inmate injuries with significant property destruction encompassing the majority of WLC. There were no inmate escapes.

On March 9, 2015, Frank Strada, Assistant Director of the Bureau's Correctional Programs Division (CPD), appointed an after-action review team which visited the facility March 24-26, 2015. The team was assembled to identify the causal factors leading up to the incident and any issues or concerns impacting current and future Bureau contracts to house federal inmates.

The team included:

- Angela P. Dunbar, Senior Deputy Assistant Director, CPD, Reviewer-in-Charge;
- (b)(6),(b)(7)(C),(b)(7)(C) Associate General Counsel, Legislative and Correctional Issues Branch, Office of General Counsel (OGC), Central Office;
- (b)(6),(b)(7)(C),(b)(7)(F) Assistant General Counsel, Commercial Law Branch, OGC, Central Office;
- (b)(6),(b)(7)(C),(b)(7)(F) Chief, Acquisitions Branch; Administration Division (ADM), Central Office,
- (b)(6),(b)(7)(C),(b)(7)(F) Assistant Administrator, Correctional Services Branch, CPD, Central Office;

- (b)(6),(b)(7)(C),(b)(7)(E),(b)(7)(F)

The review team defined its scope to address the following areas of review:

Causation Factors: Identify and describe the chronology of events, the factors that caused the disturbance at WLC, and the responses of the various law enforcement and contract authorities to the disturbance;

Prior Contract Management: Review and analyze the Bureau's contract oversight and monitoring functions at WLC prior to the disturbance, to determine whether appropriate monitoring and accountability for discrepancies occurred;

Prior Utilization of External Resources: Review and analyze whether Bureau resources outside of contract oversight and monitoring functions were utilized, or could have assisted, in avoiding this disturbance (e.g., training, intelligence sharing, resources);

Future Contract Management Improvements: Analyze and determine what future improvements can be made in the areas of contract management, oversight, and monitoring (e.g., staffing, policy, on-site responsibilities) that could assist the Bureau in future management of contract facilities;

Future Contract and Statement of Work Provisions: Analyze and determine what improvements can be made to the contract and statement of work documents to assist the Bureau in future management of contract facilities. Areas of focus include provisions for obtaining emergency assistance, performance award consequences, and corrective action measures for discrepancies;

Analysis and Critique of Disturbance Response: Analyze and critique the actions of WLC, MTC, and the Bureau, in response to the disturbance for the purpose of future emergency preparedness, negotiation, and inmate management, including post- disturbance management of the inmate population.

Legal Issues: Analyze the Bureau's legal authority to intervene in a contract corrections setting during an emergency situation where federal inmates are being housed. This will assist in the development of protocols and future

improvements in the Bureau's responsiveness to crisis situations.

II. CHRONOLOGY OF EVENTS

February 19, 2015

9:20 p.m. A correctional officer working in [redacted] (b)(5),(b)(7)(E) reported he [redacted] (b)(5),(b)(7)(E) for the morning of February 20, 2015.

10:20 p.m. The shift lieutenant relayed information that inmates [redacted] (b)(5),(b)(7)(E) The [redacted] (b)(5),(b)(7)(E)

11:30 p.m. The Associate Warden (AW) was notified. [redacted] (b)(5),(b)(7)(E) [redacted] (b)(5),(b)(7)(E) [redacted] (b)(5),(b)(7)(E) After further investigation into this intelligence [redacted] (b)(5),(b)(7)(E) [redacted] (b)(5),(b)(7)(E)

February 20, 2015

2:50 a.m. [redacted] (b)(5),(b)(7)(E) [redacted] (b)(5),(b)(7)(E).

3:00 a.m. Inmates assigned to work in the food service department [redacted] (b)(5),(b)(7)(E) were utilized to prepare the breakfast meal.

[redacted] (b)(5),(b)(7)(E)

At approximately 4:33 a.m. the shift lieutenant reported to the Bureau oversight staff that on February 19, 2015, at 10:20 p.m. [redacted] (b)(5),(b)(7)(E) shift. In addition, at 3:30 a.m., on February 20, 2015, [redacted] (b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

4:52 a.m. The administration notified the oversight staff that (b)(5),(b)(7)(E) (b)(5),(b)(7)(E) (b)(5),(b)(7)(E) (b)(5),(b)(7)(E)

5:42 a.m. Some inmates participated in pill line. (b)(5),(b)(7)(E) (b)(5),(b)(7)(E)

6:00 a.m. (b)(5),(b)(7)(E) (b)(5),(b)(7)(E) after 9:27 p.m. on February 19, 2015. The (b)(5),(b)(7)(E)

9:40 a.m. (b)(5),(b)(7)(E) (b)(5),(b)(7)(E)

10:27 a.m. The warden called the county sheriff's office and requested assistance (b)(5),(b)(7)(E)

11:51 a.m. Inmates assigned to (b)(5),(b)(7)(Unit (b)(5),(b)(7)(E) (b)(5),(b)(7)(E)

11:53 a.m. Inmates assigned to (b)(5),(b)(7)(E) Unit (b)(5),(b)(7)(E) (b)(5),(b)(7)(E)

1:04 p.m. (b)(5),(b)(7)(E) (b)(5),(b)(7)(E)

Inmates initiated the disturbance at WLC that involved the entire compound and several hundred inmates.

1:31 p.m. (b)(5),(b)(7)(E) Housing Units. The Warden (b)(5),(b)(7)(E) for accountability and regrouping.

1:47 p.m. (b)(5),(b)(7)(E) (b)(5),(b)(7)(E)

3:00 p.m. (b)(5),(b)(7)(E)
(b)(5),(b)(7)(E)

5:00 p.m. Additional (b)(5),(b)(7)(E) agencies arrived to assist with the disturbance.

6:00 p.m. (b)(5),(b)(7)(E) arrived to plan operations.
(b)(5),(b)(7)(E)

9:00 p.m. (b)(5),(b)(7)(E)
(b)(5),(b)(7)(E) The inmates' aggressive behavior decreased. (b)(5),(b)(7)(E)
(b)(5),(b)(7)(E)

February 21, 2015

12:34 a.m. (b)(5),(b)(7)(E) arrived at WLC.

12:45 a.m. (b)(5),(b)(7)(E)
(b)(5),(b)(7)(E)

1:45 a.m. (b)(5),(b)(7)(E)

2:00 a.m. (b)(5),(b)(7)(E)
(b)(5),(b)(7)(E)

7:40 a.m. Other MTC managed facilities, (b)(5),(b)(7)(E)
(b)(5),(b)(7)(E)

11:03 a.m. (b)(5),(b)(7)(E)
(b)(5),(b) arrived on scene. (b)(5),(b)(7)(E)

11:30 a.m. (b)(5),(b)(7)(E)
(b)(5),(b)(7)(E)

5:02 p.m. The first 75 inmates are moved out of WLC (b)(5),(b)(7)(E)
(b)(5),(b)(7)(E)

9:38 p.m. (b)(5),(b)(7)(E) arrives at WLC facility.

10:00 p.m. JPATS flight canceled due to bad weather in the Colorado Springs, CO, area

10:15 p.m. (b)(5),(b)(7)(E) arrive at WLC facility.

10:49 p.m. Additional (b)(5),(b)(7)(E) arrives at WLC facility.

February 22, 2015

1:30 a.m. (b)(5),(b)(7)(E) are on-site at WLC facility.

February 23, 2015

10:00 p.m. Evening meal delivered and pill line completed with no issues. (b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

11:50 p.m. (b)(5),(b)(7)(E) by WLC staff.

February 24, 2015 - March 1, 2015

All inmates assigned to the WLC facility were transported to other Bureau and contract facilities.

(b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

III. ANALYSIS OF EVENTS

The after-action review team identified and analyzed the following contributing factors:

A. Pre-Disturbance Decisions

It was common practice for several months prior to the disturbance for inmate representatives from each housing unit to meet with members of the local executive staff. During these meetings the executive staff informed the inmates of upcoming events and issues that may affect the population. In turn inmate representatives were responsible for passing this information to the rest of the inmate population, (b)(5),(b)(7)(E)
(b)(5),(b)(7)(E)
This also appeared to be a platform for the inmate representatives to negotiate issues, such as commissary, food, and health care. (b)(5),(b)(7)(E)
(b)(5),(b)(7)(E)

- February 19, 2015, (b)(5),(b)(7)(E)
(b)(5),(b)(6),(b)(7)(C),(b)(7)(E),(b)(7)(F)

- February 20, 2015, (b)(5),(b)(6),(b)(7)(E)
(b)(5),(b)(6),(b)(7)(C),(b)(7)(E),(b)(7)(F)

- February 20, 2015, at approximately 1:04 p.m., (b)(5),(b)(6),(b)(7)(E)
(b)(5),(b)(7)(E)

1. Communication

The review team identified significant areas of concern regarding (b)(5),(b)(7)(E) These findings were corroborated from numerous information sources.

a) Executive Staff

MTC executive staff (warden, AW equivalent) routinely met and communicated (b)(5),(b)(7)(E)
(b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

b) Inmate Perception of Staff Credibility

(b)(5),(b)(7)(E)

B. Health Services

Inmate perceptions of inadequate medical care over an extended period of time contributed to the MTC fragile atmosphere.

1. Staffing

While Health Services staffing levels are not a direct causation factor for this disturbance, (b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

The team found that staffing levels for the year preceding the disturbance were adequate. There was a shortage of one nurse and a doctor prior to the disturbance. The team also found through staff and inmate interviews there were long wait times for inmates to see the doctor. Once the inmate was referred to the doctor, as much as six weeks could pass before they were seen. The inmates were charged a copayment, but felt as

though they didn't receive any treatment. Oftentimes the inmates would have worked thru their ailment before they were seen by medical personnel.

C. (b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

3. Training

The Bureau had provided all training to the contractor in accordance with contractual requirements. The contractor had not requested additional training to enhance performance and/or meet basic contractual obligations. The after-action review team identified that MTC had not provided (b)(5),(b)(7)(E) sufficient training on how to effectively (b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

(b)(5),(b)(7)(E) When interviewed, it appeared staff were unable to

identify trends or respond accordingly due to the lack of basic training.

4. Institution Staff Response

Information gathered by the team indicated there was ample time to prepare for a potential disturbance based on when intelligence was received. (b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

(b)(5),(b)(7)(E) The response was slow, disorganized and chaotic. (b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

5. Outside Emergency Assistance

MTC management received assistance from other agencies, including (b)(5),(b)(7)(E) (b)(5),(b)(7)(E) (b)(5),(b)(7)(E) and there was no evidence of serious or coordinated attempts to escape.

(b)(5),(b)(7)(E)

IV. OTHER FACTORS

The team identified the following additional areas as relevant, although not directly related to causing the disturbance.

A. Prior Contract Management

The team reviewed all of the oversight files to determine if proper oversight was conducted by the on-site staff and if any trends were identified that should have been addressed prior to the February 20, 2015, disturbance.

Definitions:

- A Notice of Concern (NOC) is issued when the contractor is performing below a satisfactory level and the issue(s) are more than a minor or repetitive deviation.

- A Letter of Inquiry (LOI) is used to seek information from the contractor in order to determine if policies and procedures are being followed. An LOI is issued when information the Government has does not provide a complete picture to determine if the contractor is meeting the terms of the contract.

- Self-reporting is done by the contractor to identify issues the contractor identifies in their own performance

- A deduction may be taken by the administrative contracting officer and allows the Bureau to reduce a contractor's invoice by the value of any service not performed as required by the contract.

- Contract Facility Monitorings (CFM) are conducted annually to determine contractor compliance with the contract requirements.

B. Overview

- The Contract was awarded on June 6, 2011, for a four-year base period and six, one year option periods.

- The Notice to Proceed was issued on September 1, 2011.

- The last CFM was conducted in March 2014.

- The contractor was scheduled for a CFM in March 2015.

- A total of seven deductions were issued during the life of the contract.

- The number of NOCs issued: 20 in 2012; 25 in 2103 and 5 in 2014.

- Modification 25 was bi-laterally signed on July 5, 2013, that added emergency preparedness requirements to the contract.

- Modification 31 was executed on January 16, 2014, and changed the sub-contractor for health care services. No evidence could be found that medical issues increased when the contractor changed health care subcontractors.

C. Oversight Issues

Evidence was found that some NOCs were issued without corresponding deductions when it may have been appropriate to do so:

- NOC WLC-14-004 was issued on September 29, 2014, for CFM findings including three deficiencies in Health Services, one of which was a repeat deficiency. No evidence was found of a corresponding deduction.

- NOC WLC-13-001 was issued on January 17, 2013, for 18 of 29 J&C files not properly maintained. This was the third NOC. The first two occurrences were in the March 2012 and September 2012 CFMs. Deductions were taken for the 2012 CFMs but not for this NOC.

- NOC WLC-13-013 was issued for not conducting 30-minute SHU checks. This was also noted in the March 2012 and September 2012 CFMs. Two deductions were taken for the CFMs. No evidence was found of a corresponding deduction.

- NOC WLC-13-018 was issued for not conducting SHU rounds. This was the fourth occurrence. No evidence was found of a corresponding deduction.

- NOC WLC-13-019 was issued for internal discipline cases not referred to Office of Internal Affairs. The same issue occurred in NOC 13-005. No evidence was found of a corresponding deduction.

- NOC 13-0024 was issued for not conducting SHU rounds. No evidence was found of a corresponding deduction.

D. Letters of Inquiry

During the review, it appeared that several LOIs may have been issued when it may have been more appropriate to issue a NOC. It could not be determined if there was adequate follow up to the issues noted in the LOIs.

- LOI WLC 13-001 Health Services staffing levels.

- LOI WLC 13-002 Class A tool missing

- LOI WLC 13-004 Key Control

- LOI WLC 13-005 Perimeter Zone Fence Alarm (7 instances)

E. Self-Reporting

- No self-reporting could be found prior to 2013.

- March 26, 2014 – The contractor self-reported releasing an inmate to the wrong detaining authority. This was a repeat to the NOC WLC-13-005. No evidence was found of a corresponding NOC or deduction.

As noted above, there were some areas in which deductions may have been warranted. However, overall, the oversight was conducted in accordance with the contract requirements.

F. Additional Contract Requirements Potentially Relevant to the Disturbance

- (b)(5),(b)(7)(E)

- (b)(5),(b)(7)(E)

- (b)(5),(b)(7)(E)

- (b)(5),(b)(7)(E)

- (b)(5),(b)(7)(E)

G. Legal Issues

The Bureau requires that the contractor have appropriate arrest authority in order to maintain the security of the correctional institution. *PWS at 34*. Concerning the use of force, the Bureau requires the contractor to act consistent with all applicable policies of the Government. *Id*. All use of lethal force by the contractor or any other authority shall be in compliance with Program Statement 5500.12, Correctional Services Procedures Manual, dated October 10, 2003, Chapter 7, Section 702, Use of Firearms. The WLC solicitation did not require the contractor to submit supporting documentation (e.g., memoranda

of understanding with state and local authorities) concerning its use of force and arrest authority.

V. CONCLUSIONS

For the purpose of this review, the conclusion section is divided into two broad parts. The first part provides concluding comments regarding the disturbance's causation. The second section provides concluding comments regarding the Bureau's contractual responsibilities and response.

A. Disturbance

After a review of all documentation pertaining to this incident, interviews with staff and inmates, and a review of applicable policies and procedures, the review team concluded the specific disturbance can be directly attributed to the perception of the inmate population regarding the delay of medical treatment, (b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

The team found wide-spread belief among the inmate population that there were extended waiting times to receive appropriate medical treatment, and that they were being charged for medical services not rendered. This belief was also acknowledged by institution health services staff during interviews. Additionally, the review team believes systemic problems existed in the area (b)(5),(b)(7)(E)

(b)(5),(b)(7)(E) These factors directly contributed to breakdowns.

Throughout the week of the after action review, it was determined through staff interviews, (b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

(b)(5),(b)(7)(E)

B. Contract Monitoring

After a thorough review of all documentation pertaining to oversight and contractual responsibility, interviews with staff, and a review of applicable policies and procedures, the review team concluded that oversight staff could have utilized available deductions more liberally.

(b)(5),(b)(7)(E)

VI. RECOMMENDATIONS

Through the course of the review, several areas of concern were identified. Many of the following recommendations may involve revising existing and future contracts.

A. (b)(5),(b)(7)(E)

B. (b)(5),(b)(7)(E)

C.

D.

E.

F.

G.

H.

I.

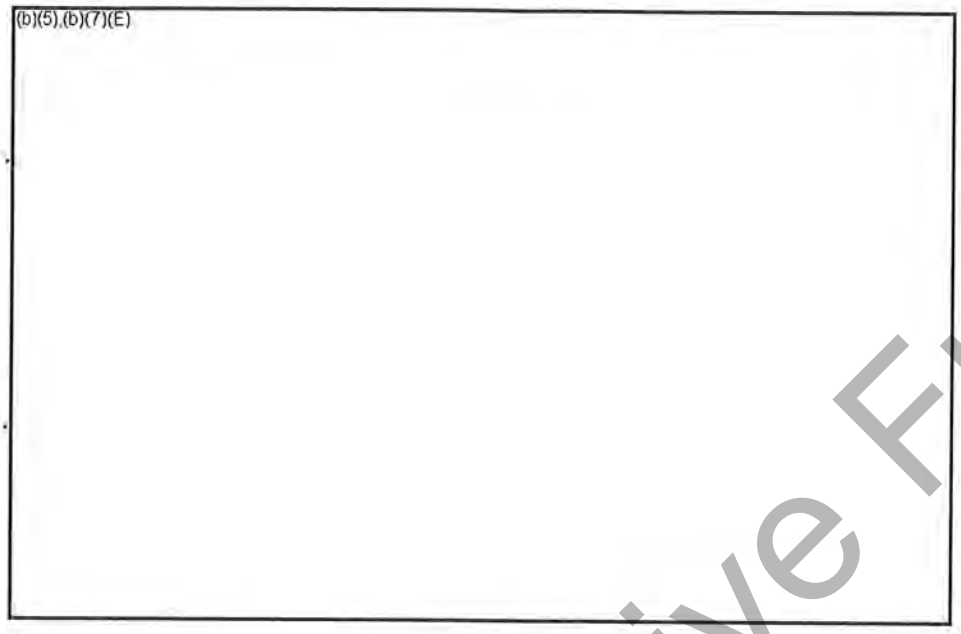
J.

K.

L.

M.

(b)(5),(b)(7)(E)



VII. COST/IMPACT STATEMENT

Instructions: The following impact statement is to be completed as a required element of all After-Action Reports. All amounts must be clearly labeled as estimates or actual final figures. When major portions of the impact statement are based on estimates, an amended impact statement must be filed once more accurate cost/impact information is available.

Reporting Institution - WLC (MTC Business Manager)

Incident Site - WLC

Incident - Disturbance

Incident Dates - Friday, February 20, 2015 through
Sunday, March 1, 2015

BOP Costs to Date -
Overtime for BOP staff - **$1,200,000**
Supplies/Food - $111,500
TDY/After Action Team Travel - **$71,000**
Contract State/Local/Private Costs
For Housing Displaced Inmates - **$220,000**
Total Obligations (thru April 30, 2015, NOT FINAL) - $1,602,500

Notes - Overtime for BOP Staff includes staff working onsite during the disturbance and bus officers during the inmate movements out of Willacy, as well as at BOP facilities taking the inmates. Supplies include clothing, food, etc. Additionally it includes bus transportation and functions related to the transfer and intake/processing of inmates from WLC into BOP facilities

There are potential additional costs related to the housing of some inmates in two private contract facilities (thus far the cost is approximately $80,000 to $100,000 per month.