IDAHO DEPARTMENT OF CORRECTION
Serious Incident Review (SIR) Report

Date: 05/21/12 Facility/District: ICC Incident Location: F-1

Type of Incident: On 05/05/12, at 1154, the Idaho Correctional Center had an incident in F pod of their close custody unit involving an assault with weapons. Security Threat Group members from the Aryan Knights (AK) and Severely Violent Criminals (SVC) hid in a janitor closet during a recreation movement. When the next quadrant of offenders were released into the dayroom the AK and SVC offenders came out of the closet and attacked members of the Youngsters Fucking Society (YFS) with weapons. There were 13 offenders involved in this incident.

Time and date of incident: 05/05/12 11:54

Offenders Involved:

Name:	[redacted]		
Name:			
Name:			
Name:			
Name:			
Name:			
Name:			
Name:	Redmond, William	IDOC#:	69512
Name:	Mitchell, Steven	IDOC#:	95294
Name:	Cunningham, Blaine	IDOC#:	55891
Name:	McNeil, Randy	IDOC#:	67575
Name:	Price, Christopher	IDOC#:	66757
Name:	Wilson, Michael	IDOC#:	61348

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(Add additional rows if necessary)

Staff Involved:

Name:	Sharp, Jerry	Associate #:	1507
Name:	Carrick, Garth	Associate #:	8836
Name:	Taylor, Joel	Associate #:	8786
Name:	Huntley, Ashley	Associate #:	0581
Name:	Mullen, Annette	Associate #:	0273
Name:	Wittmann, James	Associate #:	0173
Name:	Skogsberg, Dustyn	Associate #:	1142
Name:	Griffith, Travis	Associate #:	0179
Name:	Anderson, Blake	Associate #:	1045
Name:	Soto, Rogelio	Associate #:	6401
Name:	Goldfuss, Amanda	Associate #:	0465
Name:	Gibbens, Nathan	Associate #:	1154
Name:	Moore, Nicole	Associate #:	7583
Name:	McCurdy, Douglas	Associate #:	1335
Name:	Nordio, Keith	Associate #:	1343
Name:	Thompson, Donald	Associate #:	3110
Name:	Trana, Christopher	Associate #:	7592
Name:	Price, Nicholas	Associate #:	8871
Name:	Rodriguez-Villela, Luiz	Associate #:	6437
Name:	Clayton, Michael	Associate #:	1272

Name: Mills, Jacob Associate #: 1264

(Add additional rows if necessary)

Others Involved:

Name: LeMaster, Carrol Registered Nurse
Name: Burmeister, Michelle Licensed Practical Nurse
Name: Segal, Jodi Licensed Practical Nurse

(Add additional rows if necessary)

Was force used? Yes [x] No [ ]

Did all involved staff members completed information reports? Yes [ ] No [x]

If reports were not completed, explain why:

Shift Supervisor only completed a 105 and an ICC Incident Report form. There is no report on his actions. Medical Staff did not complete reports.

Name and job title of the shift commander (correctional facility) or supervisor (community corrections) at the time of the incident:

Brian Johnson – Unit Manager

Describe the shift commander/supervisor's involvement:

The shift commander in this incident was Unit Manager Brian Johnson. In the reports received and during interviews, there was no clear indication during the incident of who was in charge. The shift commander did not seem to recognize the scope of the incident and his duties. The Shift commander who was in charge seemed to be unsure of all of the weapons, injuries, and offenders being moved through the crime scene during the incident. After the initial combatants were removed from the tier he gave orders to go get the rest of the offenders out of their cells for treatment. He was unaware that the offenders were being moved unrestrained and allowed to contaminate items from the crime scene.

The report written by the shift commander stated inmates appeared to have weapons. However, during the panels interview with the shift commander stated he knew weapons were involved.

The Shift commander did not feel this incident rose to the level of activating ICS because by the time he arrived on scene the incident was already over as the offenders were no longer combative. As of 05/21/12 staff seem to be unclear of what emergency procedures they are using. When asked if they are using IMT or ICS the panel was told by the shift commander they are and have been using ICS. When asked how they are trained on ICS he stated "Annually". However, it is clear that they are not using the Incident Command System.

If applicable, the name and title (if available) of any medical personnel involved:

Dr. Agler
LeMaster, Carrol Registered Nurse
Burmeister, Michelle Licensed Practical Nurse
Segal, Jodi Licensed Practical Nurse

Describe in general, any medical care given:

The panel did not receive reports from medical staff in regards to this incident. There was limited information given in reports as to the medical care given. With the information provided it appears that medical staff noted injuries and stitched up the wounds that warranted it.

What department policies, SOPs, FMs, post orders, living guides, etc. govern the incident?

SOP-507.02.01.001 Emergency Preparedness

What department policies, SOPs, FMs, post orders, living guides, etc. govern the incident?

SOP 504.02.01.002 Security Threat Group Management
SOP 317.02.01.001 Searches: Cell/Living Unit, and Offender
SOP 307.02.01.001 Use Of Force
SOP 116.02.01.002 Custody of Evidence
SOP 105.02.01.001 General Reporting and Investigations of Major Incidents
Idaho Correctional Center Post Orders – General ICC Post Orders ICC PO-00
Idaho Correctional Center Post Orders – Close Custody D-E-F ICC PO-100
Memo from Chief Jepson 3/15/10 (OC)
ICC Inmate Handbook
Contract CPO 012167 Amendment 5 Contract subsection 2.6 Security and Control section (d)

Were policies, SOPs, FMs, post orders, living guides, etc. followed?

SOP 507.02.01.001 Emergency Preparedness was not followed. The shift commander stated that Incident Command System was not followed as he did not think the incident rose to that level because the incident was contained by the time he arrived at the unit several minutes after the initial "Code Blue" was called. It appears that staff do not understand when to implement ICS. By not using ICS the resources were dispatched to the wrong area and other resources were not used efficiently. Staff on the tier did not have a clear understanding of who was in charge during the incident. The shift commander stated that he had control in the foyer of the pod but could not say who the group leader or on scene supervisor was on the tier.

SOP 504.02.01.002 Security Threat Group Management was not followed. Offenders documented in the IDOC offender system, ICS, as part of a Security Threat Group, were housed together in quadrants of the tier. One quadrant of offenders was just moved onto the tier. These offenders were suspected members of the Security Threat Group YFS (Youngsters Fucking Society). Staff stated they knew that members of the YFS group had safety concerns being housed around members of the Aryan Knights (AK) and the Severely Violent Criminals (SVC). However, the unit manager, knowing this information, decided to move a group of YFS onto the tier, on the same level, as the AK and SVC. The Unit Manager and some of the other unit supervisors were consulting suspected leaders of STG groups, in essence getting their approval before making moves.

SOP 317.02.01.001 Searches: Cell/Living Unit, and Offender was not followed. Clothed body searches were not conducted on offenders who were leaving their cells. These should be conducted frequently to make sure offenders on the tiers are not carrying contraband such as homemade weapons. Although cell searches were shown as being completed, a review of several months of logs showed no major contraband found. Based on staff interviews a good cell search is completed in 15 minutes. This is a very short period of time for a two person cell.

Idaho Correctional Center Post Orders – General ICC Post Orders ICC PO-00 was not followed. The officer did not check ID's or have the offenders identify themselves as they were leaving to recreation. The officer on the tier did not conduct an informal count of the offenders left on the tier after a recreation movement. This would have alerted him to the fact that six offenders were unaccounted for. The officer admits that he thought they were all out so there was no need to look in the windows. Furthermore, the windows are frequently blocked out by the offenders making seeing into the cell for accountability impossible unless stopping and putting your face up to the window while cupping your hands to block out light from the tier. This makes it impossible for staff to observe and count living breathing flesh in that cell. The frequency of windows being covered can be noted in weekly reports from the contract monitors as well as when this panel went on the tier there were many windows covered to which offenders were refusing to remove the objects blocking the light. Offenders have affected an escape in the past in IDOC facilities by covering a window to which staff did not check. By not checking or having the offender remove the items blocking his window they could not see that he was altering the window in preparation for an escape.

Were policies, SOPs, FMs, post orders, living guides, etc. followed?

SOP 307.02.01.001 Use Of Force was not followed. By not using the equipment and tools available the responding officers put themselves in harm's way. Staff failed to recognize the seriousness of the situation therefore they did not use the tools available for protection such as shields, stab vests, pepperball gun, and restraints that were in [redacted]. Responding staff also did not obtain effective use of force equipment or protective equipment on their way to the quell incident. Not only did this slow the process of containment but put staff safety in serious jeopardy. It is apparent in the response by the staff on the tier and ERT response that they did not take into account the behaviors and risk factors associated with close custody offenders, therefore they did not escalate their level of response to the level of the incident by considering other lethal or less lethal options as back up.

The safety equipment that could have been used for this incident is located in [redacted], however, staff did not take with them nor were they directed to take with them control equipment or protective gear to the incident. Had ICS been implemented this gear could have been distributed to staff as they arrived on scene. Based on interviews, staff seemed hesitant to use the use of force equipment available in [redacted]

SOP 116.02.01.002 Custody of Evidence was not followed. Once combative offenders were restrained, staff returned to get other offenders out of their cells for medical treatment. While this was taking place other offenders were picking up objects in the crime scene and carrying them around. Furthermore, the cells in which offenders were fighting were left unsecured once those offenders were removed. The shift commander did declare a crime scene and a log was started however the log is incomplete and does not include important/complete information. Clothing items that were collected were placed all in one bag and they were all wet therefore unusable by the crime scene detectives.

Staff did do well in that they took pictures off all offenders involved and included their names, IDOC number, date, time, and who photographed the offenders. This helps staff correctly identify those who were involved in the incident and can be instrumental in the investigative and prosecutorial process. This leaves no doubt who was involved as they were photographed immediately after they were removed from the incident.

SOP 105.02.01.001 General Reporting and Investigations of Major Incidents. While a 105 was completed by the shift commander and notification was made, the verbiage in the 105 was inaccurate. The shift commander wrote "The attacking inmates appeared to have weapons..." even though he had been to the incident scene and witnessed the weapons himself.

Memo from Chief Jepson 3/15/10 (OC): The memo that Chief Jepson wrote on 03/15/10, that staff who are certified to use OC will carry it. His failure to deploy OC in response to this incident delayed containment of the offenders involved.

Based on the professional opinions of the SIR board, did the staff respond properly?

In our opinion the staff member on the tier initially acted appropriately by using the radio to call in the incident and deploying OC. He then advanced into the group of fighting offenders to deploy more OC. While doing so he assessed the situation and believed that an offender's life was in jeopardy since he was being stabbed by another offender. He pulled the offender doing the stabbing off of the victim. While we would not normally recommend that staff place themselves into the middle of a group of combative offenders, we commend him for his courage during this incident.

The initial responding staff member had appropriate containment equipment but chose not to use it. Had he used the OC and used it in conjunction with the verbal direction he was giving we believe he could have

Based on the professional opinions of the SIR board, did the staff respond properly?

contained the offenders and/or had a faster resolution to the incident. Because responding staff chose not to use the OC he increased the risk to the other staff member and himself on the tier.

The ERT team responded quickly to the scene. However, they did not use safety/containment equipment that was available to them. The other pods were not celled up which could have led to a more serious incident. More staff were needed in this incident to effectively control the situation. The pod control officer was left alone to do the log book, open doors, answer the radio and phone. This led to an incomplete log of events that transpired during the incident. Again, had ICS been implemented more resources would have been available to accomplish these tasks.

Prior to the incident the Unit Manager was allowing the unit to be operated outside of the guidelines of the post orders. There was minimal accountability for staff or offenders who were not following established rules or procedures. According to staff interviews the unit has been operating for more than a year outside of the established post orders. Contract staff provided a pass down log as evidence, along with the interviews that the panel conducted with staff, that supports the fact the Unit Manager had directed staff to deviate from post orders in regards to dayroom operations as far back as November. When interviewing the Unit Manager she did admit that staff should have been opening the cell doors one at a time.

The Unit Manager has also been using STG leadership counsel in regards to moves of STG offenders. During our interview with the Unit Manager she admitted that she talked to a leader of the YFS in regards to making moves. This process was confirmed by the other staff members that we interviewed. She continues to group offenders in her pods by STG affiliation and encourages offenders to group together in "communities". The STG influence on staff is so pronounced that while interviewing staff, staff refer to offenders crimes as "solid" or "lame". While interviewing the Unit Manager as well as unit staff we learned that the Unit Manager has also allowed offenders to influence the way rule violations are corrected. The Unit Manager stated when STG offenders tell her that enforcing the rules will make it more difficult for her staff she chooses not to enforce holding the offenders accountable. Her decision to include STG leadership in unit management decisions contributes to STG groups gaining more control and authority in the unit.

In our professional opinion the shift commander's response could have been handled more appropriately such as the shift commander did not seem to recognize the scope of the incident and his duties. The Shift commander who was in charge seemed to be unsure of all of the weapons, injuries, and offenders being moved through the crime scene during the incident. The report written by the shift commander stated inmates appeared to have weapons. However, during the panels interview with the shift commander stated he knew weapons were involved.

What, if anything, can be done to reduce the risk of a similar incident in the future?

Offender Accountability-
Frequent informal counts completed after each movement or tier rotation. This will allow staff to account for all the offenders as well as be alerted to any offenders in the wrong area.

Recreation and Dayroom-
Movements should be completed in a very controlled manner. Offenders should be given firm guidelines and instructions from staff during the movement process. Offenders should be made to line up to go to recreation and not allowed to wander the tier. During this process of outside movement the offenders will be accounted for by identification card and numerical counting process.

Janitor closets should be secured at all times unless directly supervised by an officer. The officer could

What, if anything, can be done to reduce the risk of a similar incident in the future?

open the door for the offender to get the supplies out and then immediately secure the door and reverses this process to return the supplies.

Currently offenders are allowed 5 to 10 minutes with their doors open to gather property to use during dayroom and leave the cell. This should be changed to an auditory announcement letting the offenders know they have 5 minutes to prepare for dayroom. Cell doors could then be immediately secured as offenders leave their cells, one cell at a time. Establishing this process would decrease the amount of time needed to transfer offenders from their cells to recreation and dayroom. This would also prevent them from going into areas that are restricted and increase staffs ability to account for the offenders.

Tier Checks-
Staff are not accounting for living breathing flesh. Proper tier checks and addressing potential security hazards such as covering windows should be part of the tier check process.

Searches-
Frequent pat searches during movements and dayroom time will allow staff to uncover contraband such as weapons used during this incident. Quality cell searches versus quantity. Staff need to spend significant time in a cell to uncover serious contraband. Two offenders with close custody property cannot be searched properly in 15 minutes. The requirement to do pat searches should be added to their unit post orders.

Rule Enforcement-
Enforcing all rules including those that may seem insignificant to staff and offenders ensures a safe and clean environment and also allows staff to gauge the attitude of the inmates on the tier. Offenders on the tier displayed verbal resistance to complying with rule enforcement. Supporting staff in rule enforcement and rewarding staff for diligence in this area will encourage staff to take ownership of the unit.

Equipment-
Equipment should be readily available and used by staff assigned to the pod. For example, using a flashlight to see into the cells. Staff should be required by post order to carry and use the necessary equipment.

Location of less lethal munitions and the comfort level of supervisory staff to authorize the use of such weapons needs to be evaluated to increase their usage and effectiveness.

STG Management-
The STG population needs to be diversified. Housing offenders from the same security threat group all in the same "walk" allows them to increase their power base. Furthermore, allowing offenders of a STG to request a "walk" of their own, and then housing them and their affiliates together, is allowing the offenders to control the unit and contradicts procedure outlined in SOP 504.02.01.002 Security Threat Group Management.

Post Orders-
Post orders need to be followed and should be reviewed frequently to ensure they are effective and reflect desired practices. Staff should be held accountable for signing that they have read the post orders and are following them.

Results, findings, and recommendations on the following:

Commendation or disciplinary action:

Corrective action should be considered with the unit manager Norma Rodriguez as many of her decisions

Commendation or disciplinary action:

and her lack of managing the employees and her unit resulted in an atmosphere that allowed this incident to occur.

Corrective action should be considered with Sgt. Carrick for failing to use Use of Force equipment (OC) to control the incident. His actions delayed the containment and resolution of this incident.

Unit staff should be held accountable for signing post orders and for following them.

In spite of the fact that Officer Skogsberg's actions may have contributed to this incident the panel members commend him for his courage in taking action to stop the offenders' assault.

The panel would also like to commend Sgt. Sharp for his actions to take control of the incident and directing staff.

Staffing:

Although the unit appeared to have appropriate staffing several of those staff were performing other duties which distracted them from the duties assigned to the post they were filling.
Supervisory staff who are filling in officer posts need to insure that they focus on that post and do not leave the area.

Staffing of the unit needs to be consistent. In reviewing the schedule it appeared that staff were double posted.

Policy and SOP:

The facility should consider utilizing a command structure that models the Incident Command System. Staff are unsure of what emergency system they are using and when it is appropriate to activate it, and seem to feel that ICS is appropriate only for large scale emergencies. The panel recommend that all staff receive more training in the Incident Command System and perform routine simulations to become proficient in the ICS system.

Post orders need to be revised to reflect a safe operational system allowing staff time to complete the required tasks. In reviewing the post orders the panel found that if staff followed what was written they would gain accountability as the staff would be controlling the movement instead of the offenders.

Operational Issues:

The STG population is grouped into quadrants in D-E-F which increases the STG power base. This population should be diversified among quadrants and pods.

Staff should be enforcing the living guide and unit rules for cell conditions.

Staff should be accountable for following the Post Orders and facility memorandums. This incident may have been avoided had staff been following the D-E-F and General Post Orders.

Pat searches and unclothed body searches could be completed with more regularity. Pat searches should be completed of offenders exiting their cells and leaving the unit or going on to the recreation yard. Property brought out of cells should be searched by staff. Offenders returning to the unit or from the recreation yard should be pat searched and accompanying property searched as well. D-E-F and General Post orders could be more specific and use stronger language about the importance of maintaining a safe facility through proper searches.

Multiple cell searches by multiple staff are listed on a single search summary form. Each individual cell

Operational Issues:

search should be reported singularly for clarity on contraband found and issues with the cell.

CCA's IMT system seems to create confusion among staff as to who is in charge of the incident and who is managing the immediate resolution by directing the ERT members who respond to the incident. This confusion extends farther when determining whether or not to use ICS. CCA indicates that IMT is similar and compatible with ICS. However, ICS provides clear understanding and direction as to how to announce the Incident Commander and command structure for the incident. By eliminating the use of a dual system (IMT and ICS), CCA would eliminate the confusion among staff when responding to an incident.

D-E-F Post Orders provide the offenders a 5-minute window to exit their cells for dayroom and recreation time. This 5-minute period is to allow offenders to gather any property that they might need during day room hours. Facility operations could be improved by eliminating this 5-minute grace period and instead, announce the movement to the dayroom/recreation 5 minutes before the movement. D-E-F staff indicated that they must keep to their schedule and thus fail to follow post order requirements for direct offender supervision at each cell before the cell door is opened and the offender is allowed to exit the cell and begin the 5-minute egress period. If staff follows the post orders as written, it would take 40 minutes to transition to and from the dayroom for each dayroom period.

Staff should complete informal counts of offenders leaving the unit to maintain offender accountability. In this case if the floor officer had counted the offenders left on the tier, he would have realized that 6 offenders were unaccounted for.

During and after the incident, not all of the offenders were restrained because staff felt that they were not a threat. These offenders were moved and allowed back out of their cells without restraints. All offenders should be restrained in an incident to ensure safety to staff and other offenders.

Either the janitor's closet was left un-secured or unit staff missed a lock that had been tampered with on the janitor's closet during security device inspections. Staff must complete security device inspections carefully and follow the post orders which require the janitor's closets to remain secured. Staff visibility could be improved by adding a window to the janitor closet door or an expanded metal gate instead of the solid door.

Offenders should be required to keep windows clear in order to verify that the window has not been tampered with. Cell windows could be covered to conceal D-E-F deficiencies and lead to the ability for offenders to escape from the facility.

Window checks to verify that each cell window is secured and in good condition should be completed and documented at regular and frequent intervals to ensure that they are in good condition and provide security as intended.

Incident commanders and shift supervisors should follow evidence handling and crime scene protection standard procedures to ensure that evidence is appropriately collected and can be used to prosecute offenders who commit crimes.

Staffing in D-E-F was not maintained at an appropriate level and was inadequate at the time of the incident. Each position identified should be filled and staffed to ensure safety in the unit and adequate emergency response.

The ERT responded quickly to the incident and began resolution efforts immediately. There was confusion in the response that could have been avoided if staff and taken a few seconds to organize their actions when entering the tier, including ensuring that the crime scene and evidence was preserved. Staff was in a

Operational Issues:

hurry to resolve the incident and overlooked evidence collection and crime scene preservation.

Staff is reluctant to use force options available to them and at the adequate level to safely resolve the incident. For instance, this incident involved immediate imminent life-safety concerns, yet no physical force was used, and only OC was used to quell the attack when other less lethal options were available (pepper ball launcher, munitions.) Some responding staff responded to the incident with OC but chose not use it even though it would have been appropriate to do so and would have helped in containment and isolation of the incident. Less-lethal shotguns are stored [redacted: 2 - IC 9-340(b)(4)(a)(i): specific security information].

Staff failed to complete adequate and proper tier checks by looking in each cell and visually verifying the safety and well-being of the occupants by seeing living, breathing humans. This error directly contributed to the incident.

Training:

Staff failed to adequately protect and collect evidence and the crime scene and allowed offenders to tamper with the evidence and crime scene. The crime scene log was also inadequate. Staff should be trained to have a better understanding in this area.

Staff is not consistently conducting pat searches, which is allowing contraband and weapons to be passed from offender to offender. Cell search logs do not indicate that staff are finding any significant contraband. These factors contribute to a lack of safety and security in D-E-F.

Staff should to be trained to complete adequate tier checks by checking on offenders and the conditions of the offenders' cells.

When completing escorts of the combative offenders from the pod, staff failed to maintain adequate spatial relationships between each escort.

Staff failed to use leg restraints on the close custody offenders involved which could have allowed them to continue combative behavior.

Supervisors and staff are confused about ICS and when and how it is to be used. Further in depth training of ICS is needed.

Equipment Issues:

Staff responded to this incident without equipment that was available to them but could have been used to gain offender compliance while decreasing the risk to staff safety such as: shields, protective vests, leg restraints, respirators/gas masks, a pepper ball launcher [redacted: 2 - IC 9-340(b)(4)(a)(i): specific security information], and less lethal munitions.

Less lethal munitions and weapons to deploy those munitions are located in [redacted: 2 - IC 9-340(b)(4)(a)(i): specific secu...]. This location [redacted: 2 - IC 9-340(b)(4)(a)(i): specific security information]. The panel recommends that an area [redacted: 2 - IC 9-340(b)(4)(a)(i): specific sec...] be identified to store these weapons. Also, to avoid confusion, the weapons can be fashioned with orange stocks identifying them as less lethal deployment systems.

Staff is reporting for duty without checking out the proper equipment needed to complete their duties such as flashlights, or checking out the equipment and not using it.

The brand and make of OC used by staff did not seem as effective as other brands and makes such as

Equipment Issues:

Sabre Red. The panel suggests that ICC management further research this issue.

Other:

This same type of incident, with offenders hiding in the janitor's closet, happened less than one year ago. While the panel was told changes were made so this type of incident could not happen again, it appears that staff had reverted back to the same practices that allowed both incidents to occur. Furthermore, the unit manager and unit staff stated the shortcuts were in an effort to keep their schedules on time as not to disrupt the offender population. These changes were either approved by the unit manager, who was the same unit manager for both incidents, or she had knowledge that the unit was being operated in this manner and she took no steps to correct the issues. The panel recommends that facility managers address the issue of management of the unit.

Signatures of review panel

D.W. Crosby	1462	6-7-12
Chairperson	Associate #	Date
Nicole Tabor	4182	6/7/12
Panel member	Associate #	Date
H. Tan Duty	7520	6/7/12
Panel member	Associate #	Date

(Add additional rows if necessary)