BOARD OF INQUIRY REPORT

June 20, 2008, Homicide of Correctional Officer Jose Rivera United States Penitentiary Atwater, California

SUBMITTED BY:

G. Maldonado, Jr.
South Central Regional Office
Chairperson

4-17-09
Date

INTRODUCTION

Upon the order of the Director of the Bureau of Prisons, a Board of Inquiry (hereafter Board) was appointed to review the facts and circumstances surrounding the serious incident at the United States Penitentiary, Atwater (hereafter USP Atwater) on Friday June 20, 2008, when Correctional Officer Jose V. Rivera was assaulted and murdered by two inmates.

The Board was comprised of the following members:

G. Maldonado Jr., Regional Director, South Central Regional Office (SCRO) (Chair);

Helen J. Marberry, Complex Warden, Federal Correctional Complex Terre Haute;

Linda R. Thomas, Correctional Services Administrator, Correctional Programs Division;

Andre Matevousian, Correctional Services Administrator, Western Regional Office;

Douglas W. Curless, Senior Attorney, Federal Correctional Institution (FCI) Phoenix;

Ben Wheat, Regional Psychology Services Administrator, SCRO, and;

Vernon Ledesma, Supervisory Special Agent, Office of Internal Affairs.

The purpose for the Board was to review the facts and circumstances surrounding the homicide at USP Atwater on Friday, June 20, 2008, when Correctional Officer Jose Rivera was assaulted and murdered by two inmates (SABLAN, Jose Cabrera, Reg. No. 90470-011 and GUERRERO, James Ninete Leon, Reg. No. 03744-045).

Due to the pending criminal homicide investigation into this matter, the Board was instructed to coordinate their review with the Federal Bureau of Investigation (FBI) and the Office of the United States (U. S.) Attorney for the Eastern District of California and to focus on matters related to institution security. The scope of this Board includes a review of the overall institution security policies and procedures in relation to this incident.

The Board traveled on Monday, July 21, 2008, and held an initial meeting, that evening, at the hotel to introduce themselves and discuss a plan for conducting the next day's inquiry and to set an agenda for the week.

When the Board arrived at USP Atwater on Tuesday, July 22, 2008, the penitentiary was in lockdown status, so the Board was not able to observe normal operations of the USP. Staff were conducting mass shakedowns of all living units and common areas of the institution and had accomplished this in eight of the 12 living units of the USP.

On Tuesday morning, the Board met with the FBI Special Agent investigating the case. The Board was given a 90-minute overview of the case and investigation, including the review of the security videotapes. The Board then toured USP Atwater, including Units 5A and 5B, the Special Housing Unit (SHU) and the SHU annex, Inmate Systems Management (ISM), Receiving and Discharge (R&D), and a general tour of the compound. The Board interviewed all, but one staff member (who was on annual leave and not reachable), who responded to the emergency and who had relevant information regarding the incident. The Board also interviewed several staff who were not present, but who wanted to be heard by the Board. The Board also interviewed all inmates in Unit 5A. All members of the USP's Executive Staff and Special Investigation Agent (SIA) were interviewed. The Board Chair met with the President of the Local Union.

All members of the Board reviewed the videotape of the incident in Unit 5A multiple times. The Board also reviewed the videotape of Unit 5A operations on the day prior to the event. Additionally, the Board reviewed videotapes of other housing units and operations throughout the USP, to gain perspective on operations at the penitentiary. The Board also reviewed numerous documents regarding staffing, inmate discipline, other inmate assaults on staff, and security logs.

The Board concluded its on-site investigation and review on Friday, July 25, 2008. The Board conducted a televideo conference on Wednesday, August 13, 2008, to discuss proposed findings and recommendations.

INSTITUTION OVERVIEW

USP Atwater opened in 2000 and began receiving inmates in 2001. USP Atwater is a hard-to-fill duty station. The penitentiary has been designated as a bonus post. At the time of the Board, USP Atwater had a staff complement of 332 of an authorized

complement of 389. Custody has 189 filled positions of an authorized 219. Approximately 30% of the staff have less than three years experience with the Bureau of Prisons (hereafter BOP). Approximately 80% of the staff have less than 10 years of BOP experience. On June 19, 2008, the date of inmate Guerrero's arrival, SENTRY indicated there were 1,123 inmates housed at USP Atwater and 113 inmates housed at the Satellite Camp.

THE VICTIM

Correctional Officer Jose V. Rivera was 22 years old at the time of his death. He was a four-year veteran of the Navy, and completed two tours of military duty in Iraq. He began his career with the BOP as a Correctional Officer on August 5, 2007, and was in his probationary year. He was working as the Unit Officer in Unit 5A on the day he was murdered. He was in the process of locking down the unit, to conduct the 3:30 p.m. official count, when he was attacked and killed by two inmates.

THE ASSAILANTS

Based upon a review of the security tape and interviews with staff and inmates, the assailant who stabbed the victim with an ice pick type weapon was inmate Sablan. SENTRY indicates inmate Sablan is a boarder from the Territory of Guam. He was convicted and sentenced for Murder, Attempted Murder, and Felony Escape in Guam on August 15, 1990. Inmate Sablan received a Life Sentence for Murder, a consecutive 20-year sentence for Attempted Murder, and a consecutive five year sentence for Felony Escape. He currently has a U.S. Marshals Service detainer for Felon in Possession of a Firearm with a 33-month consecutive sentence. Inmate Sablan had a significant disciplinary history, including five 100-level incident reports, four 200-level incident reports, and four 300-level incident reports. Major incident reports included Assaulting With Serious Injury, Fighting, Possessing a Dangerous Weapon, Possessing Drugs and Intoxicants. In 1992, at USP Lompoc, he physically assaulted a female correctional officer. He had three years of clear disciplinary conduct prior to the homicide. He was the unit orderly at the time of the Assault.

Upon review of the security tape and interviews with staff and inmates, the assailant who chased down the victim, tackled and held him to the ground, was inmate Guerrero. SENTRY indicates inmate Guerrero was convicted and sentenced in the U. S. District Court for the Territory of Guam for Conspiracy to Commit Armed Bank Robbery. He received a life sentence on July 9, 1998. He

had been previously convicted in the U. S. District Court for the Territory of Guam of Deprivation of Rights Under the Color of Law, 18 U.S.C. § 242. He received a 10-year sentence on May 7, 1992. Inmate Guerrero had a history of assaulting staff, including several incidents of serious assault and fighting with inmates.

On August 14, 2008, inmates Sablan and Guerrero were indicted by a federal grand jury in the Eastern District of California. The grand jury returned a true bill charging inmates Sablan and Guerrero with three death penalty eligible charges. Each defendant was charged with a violation of 18 U.S.C. § 1111(a), First Degree Murder, 18 U.S.C. §1114(a), First Degree Murder of a United States Correctional Officer, and 18 U.S.C. § 1118, Murder by a Federal Prisoner Serving a Life Sentence. The Honorable Oliver W. Wanger, U.S. District Court for the Eastern District of California (Fresno), was randomly selected as the trial court Judge.

FACTUAL BACKGROUND

On June 19, 2008, inmate Guerrero arrived at USP Atwater from USP Coleman as a 309 disciplinary transfer. He was originally assigned a cell in Unit 2B by the Unit Manager. During intake screening inmate Guerrero was interviewed by Special Investigation Specialist (SIS) technician Ziragosa. Inmate Guerrero indicated he would not cell with any other inmates on Unit 2. SIS technician Ziragosa convinced inmate Guerrero to cell with another Guamainian, inmate Sablan in Unit 5A. On the evening of June 19, 2008, inmate Guerrero convinced the Operations Lieutenant he could not be celled with inmate Sablan because they were both “Alpha” personality types. The Operations Lieutenant told inmate Guerrero to “find a cell” and inmate Guerrero found cell #222. His cell assignment was changed for the third time in less than 24 hours. However, SENTRY still reflected inmate Guerrero was celled in #213. The rest of the evening was uneventful.

After reviewing the tapes and interviewing staff and inmates, the Board found, the morning of June 20, 2008, things in Unit 5A appeared to be uneventful. At an undetermined time, in the afternoon, the Asian/Pacific Islanders in Unit 5A began consuming intoxicants. They continued to drink for an undetermined period of time prior to the call for the 3:30 p.m. count.

Correctional Officer Rivera had been assigned as the Unit Officer to housing unit 5A for June 20, 2008. At approximately 3:18 p.m., Officer Rivera called count and began to secure the unit in

anticipation of the 3:30 p.m. count.

At approximately 3:20 p.m. Officer Rivera approached a group of Asian/Pacific Islanders near cell 116. Officer Rivera engaged the group in a brief conversation. Inmates Sablan and Guerrero appear to be intoxicated. The group began to breakup.

The video revealed inmate Guerrero grabbed a plastic chair and raised it in the air and dropped it to the floor. Inmates Guerrero and Sablan then left the first floor of the unit and went up the stairs to the second tier of Unit 5A. Officer Rivera began to secure the bottom tier of Unit 5A.

Inmate Guerrero began to walk toward the stairwell near the front door. Inmates DOWAI, Kenneth, Reg. No. 00339-005, and TO, Conghau, Reg. No. 18722-018, approached inmate Guerrero and appeared to be talking to him near cell 119. Inmate Sablan is standing outside cell 115.

Inmate Sablan walked over to inmate Guerrero in front of cell 119. Inmates Guerrero and Sablan began to walk toward the stairwell and up to cell 223. When they reached cell 223, inmate Sablan opened cell 223. Inmates Sablan and Guerrero continued to stand outside the cell with the door open. Inmate Sablan entered cell 223, followed by inmate Guerrero who entered cell 223 with a chair in his hand.

At approximately 3:22 p.m., Officer Rivera finished securing the bottom tier of Unit 5A and began to approach the stairwell to the second tier. He began securing the top tier beginning with cell 232.

At approximately 3:23 p.m., Officer Rivera reached cell 223 and began to close the door as inmates Sablan and Guerrero were standing outside the cell. Inmate Guerrero stepped inside cell 223 as Officer Rivera began to close the door. Inmate Sablan remained standing outside cell 223.

Inmate Sablan appeared to pull something from his pocket, and in a stabbing motion struck Officer Rivera in the torso. Inmate Guerrero rushed from the cell as Officer Rivera runs from inmates Sablan and Guerrero. Officer Rivera reached the stairwell first and began to descend to the first floor of the unit.

Inmate Sablan struck Officer Rivera in the shoulder as they ran down the stairwell. Officer Rivera turned while on the stairwell and head butted inmate Guerrero in an attempt to defend himself. Inmate Sablan swung his arm with the weapon in hand attempting to

strike Officer Rivera.

Officer Rivera reached the bottom of the stairwell and ran in the direction of cell 108. It appeared Officer Rivera activated his body alarm at this point of the incident. He was being pursued by inmates Sablan and Guerrero as they ran into a plastic trash can.

Officer Rivera was tackled around the legs by inmate Guerrero near cell 105. He was held to the ground by inmate Guerrero. Inmate Sablan got on top of Officer Rivera and began to strike Officer Rivera with the ice pick type weapon.

Inmate Sablan struck Officer Rivera approximately eight times in the torso until the arrival of the first staff on the scene.

Unit Secretary Drayton entered the unit through the Unit Team Door. She approached the scene of the struggle. She appeared to be shouting commands at the inmates.

She was followed into the unit several seconds later by Unit Manager Bowles. She entered the unit through the Unit Team Door. As Unit Manager Bowles moved toward the assault, she positioned herself near a chair. Several staff reported Unit Manager Bowles was on the radio requesting assistance. She also appeared to be shouting commands to the inmates. She did not intervene or render assistance during the assault.

Unit Secretary Drayton closed the gap between herself and the inmates and Officer Rivera, who continued to struggle. It appeared she was yelling commands at the assailants. She did not attempt to physically intervene at that time. A few seconds later, Unit Secretary Drayton then moved closer to the assault and attempted to control inmate Sablan’s arm.

At approximately 3:25 p.m., responding staff entered through the Unit 5A door. Responding staff began removing inmates Sablan and Guerrero from Officer Rivera. Both inmates were resisting, were combative, as they continued to assault Officer Rivera.

Inmate Sablan was the first to be removed from Officer Rivera by responding staff. Inmate Guerrero was next removed from Officer Rivera’s lower body by the responding staff. Staff began administering life saving efforts to Officer Rivera. Officer Rivera was placed on a gurney and rushed to Health Services.

Once in Health Services, BOP staff continued to perform life saving techniques and an outside ambulance was summoned. Officer

Rivera was taken to an outside hospital and was pronounced dead at the hospital. Officer Rivera's remains were taken into custody by the Merced County Sheriffs-Coroner's Office at that time. The family was notified of the death by the Coroner's Office. A postmortem autopsy was scheduled for June 24, 2008.

The Coroner's Report and Autopsy stated Officer Rivera suffered 28 sharp force injuries. Twenty-one of the injuries were puncture wounds and the others were superficial slice wounds. Seven of these injuries were to the head and neck area.

The cause of death was determined to be two puncture wounds to the left chest which penetrated the heart muscle resulting in Officer Rivera bleeding to death ("Cause of Death: Puncture wounds to left chest with resultant cardiac tamponade, left hemothorax, and left lung atelectasis."). At the conclusion of the autopsy the Coroner ruled the manner of death to be homicide.

FINDINGS

Cell Assignments - Inmate Guerrero was transferred to USP Atwater as a 309 disciplinary transfer. His Disciplinary Segregation (AD) time is assumed to have expired on June 17, 2008, while in transit, two days prior to arrival at USP Atwater. SENTRY records reflect he was never on disciplinary status at his prior designation. SENTRY only showed him on AD status while in SHU at his previously designated facility.

Inmate Guerrero was assigned to two different general housing units within the first 24 hours of arrival at the USP. Cell assignment was initially made by the Unit Team, then changed by the Operations Lieutenant. The SENTRY entry for inmate Guerrero's cell assignment did not correspond to the cell he was occupying.

Staff and inmate interviews indicate inmates entering a housing unit, awaiting a cell assignment, are told to find a cell by count time, if not, they would be assigned a cell in the SHU.

It should be noted, eight months prior to the homicide, there was a staff hostage situation in Unit 5A. The inmate hostage takers claimed cell assignments were being controlled by gangs, not staff. They took the Unit 5A Officer hostage using homemade metal ice pick type weapons. After negotiation with the Hostage Negotiation Team (HNT), the officer was released and the hostage takers surrendered. The officer received a contusion to the upper lip and no other major injuries. An After Action Report was conducted by the Regional Office (After Action Report, Staff

Hostage, United States Penitentiary Atwater, California, Date of incident October 31, 2007, (hereafter AAR). The hostage takers indicated the reason for the hostage taking was a "tax" on cells imposed by inmate gangs. The issue had been raised with institution staff and no action had been taken by staff. This was perceived by inmates as an accepted practice. The AAR team found the taxing of cells was a contributing factor for the number of assaults and protective custody cases at USP Atwater.

Count Issues - It appears from a review of the videotape, Officer Rivera called count and began counting while inmates were out of their cells and continuously moving about the floor. One inmate ran past Officer Rivera and just entered his cell prior to Officer Rivera locking the cell door.

Some testimonial evidence from staff and inmates suggests inmates are not necessarily in their assigned cells during count. They are counted in a cell, but not necessarily their designated cell. Inmate Sablan was not in his assigned cell at the time of the incident.

Intoxicants - After a review of the videotapes, it appears the assailants were intoxicated at the time of the homicide. This was also confirmed by the inmates interviewed, on Unit 5A, who were interviewed after the incident. Inmate Sablan admitted to the FBI, he was drunk at the time of the incident and stated he did not remember what had happened. The two assailants were not administered Breathalyzer, Blood, or Urinalysis tests after the incident. However, videotapes were made of inmates Sablan and Guerrero after they were secured in the visiting room cells, and the evidence is very clear they were intoxicated.

The medical assessments conducted on the inmates after the homicide failed to note any slurring of speech or any other signs of intoxication which were noted in the video reviews of the inmates.

After interviews with staff and inmates, review of the videotapes of the incident, review of Unit Logs, and other records, the Board found intoxicants were extremely easy for inmates to make and obtain, despite efforts to eliminate the available ingredients from the Commissary. Intelligence derived from inmate mail and interviews indicated inmates are "cooking" the sugar out of soda (possibly by use of stingers) to provide ingredients for intoxicants.

Intoxicants are easily obtained by the inmate population at USP Atwater. This is indicated by the large quantities of

intoxicants discovered by staff and recorded in the Unit Logbooks. The intoxicants were mainly sold and transported in empty plastic soda bottles which were sold in the commissary.

After interviews with staff and inmates, review of the videotapes of the incident, review of Unit Logs, and other records, the Board found many times intoxicants would be discovered, logged in the confiscation log and disposed without an incident report being written.

After interviews with staff and inmates, review of the videotapes of the incident, review of Unit Logs, and other records, the Board found on several occasions intoxicated inmates were locked in their cells to "sleep it off," were not taken to the Lieutenants' office, and were not written incident reports. Intoxicants are a 200-level incident report and cannot be informally resolved by policy.

A further documented example of intoxicated inmates being allowed to "sleep it off" was discovered. A staff member found an intoxicated inmate on the unit. The inmate was sent to the Lieutenants' Office and was later returned to the unit to "sleep it off." The inmate then assaulted the reporting staff member on the unit. The staff member suffered a broken jaw as a result of the assault.

In summary, inmates making intoxicants, and intoxicated inmates are not being held fully accountable under the institution disciplinary process.

Weapons - An ice pick type weapon was recovered at the scene of the murder. Weapons appeared to be plentiful at the penitentiary. At the time the Board left the penitentiary, 175 weapons had been recovered during the mass shakedowns conducted in eight of the 12 housing units.

Preliminary information indicates the origin of the material used to make the weapon used to kill Officer Rivera is suspected to be from the Food Service Department's dishwasher.

Interviews with staff and inmates indicated if a weapon was discovered in an inmate's quarters, there would be no disciplinary action taken. If an inmate was discovered with a weapon on his person, he was written an incident report and taken to SHU.

It should be noted the AAR found the metal in the dishwasher had been utilized by inmates to fashion weapons for use in the staff

hostage taking incident. The AAR, recommended the source of the material used to create these weapons be identified and removed. **Staff Response** - At the time of the attack a GS-8 Senior Officer was acting as the Operations Lieutenant, there was an acting Captain, and an Associate Warden who had recently arrived at USP Atwater. They acted in an appropriate manner during the emergency until the Captain and other members of the Executive Staff returned to the penitentiary.

As a result of interviews with staff and inmates, review of the videotapes of the incident, review of Unit Logs, and review of other records, it was determined there was only one person in the unit with the key to the front door of Unit 5A at the time of the attack. That person was the Unit Officer, who was attacked and killed. Neither of the two staff in the unit had a key to the unit's front door. The Compound Officer had to open the unit to responding staff.

There was a delay entering the Unit 5A front door until the Compound Officer arrived with a key to the Unit 5A front door.

It appears the body alarm was activated at approximately 3:24 p.m. The Unit Secretary arrives first coming from the unit offices, seconds after the body alarm is sounded. She has no key to the front door of the unit. She approaches the inmates, but does not initially intervene in the assault. The Unit Manager is the second person to arrive on the scene, coming from the unit offices. She arrives several seconds after the Unit Secretary. She too, does not have a key to the front door. She positions herself next to a chair, but away from the assault. She does not intervene in the assault. Outside responding staff arrive at the unit, but cannot get in. The Compound Officer arrives and uses his key to open the front door, which allows staff to enter the unit. This delay to get responding staff into the unit could have been reduced, had any of the other unit staff had a key to the front door. It appears from reviewing the tape, Officer Rivera is stabbed at least 10 times before the first staff member arrives on the scene. There appear to be at least another seven stabbings before the mass staff respond to the emergency.

The assailants were secured in good order and video cameras were obtained and utilized in a timely manner. The assailants were removed from the scene and placed in the non-contact visiting cells in the visiting room.

No Breathalyzer or other types of sobriety tests were administered at the time of the incident. The medical assessment of the inmates did not contain references to the inmate's

intoxication or intoxicated behavior.

No designated staff were available to deploy less than lethal munitions since no written plan has been developed.

Lockdown of the penitentiary after the incident was accomplished in an orderly fashion.

FCI Dublin responded to the USP to transport the assailants and arrived at approximately 9:25 p.m. They were escorted by the California Highway Patrol. They removed the assailants from USP Atwater at approximately 10:00 p.m., on the evening of the homicide.

Additional Crisis Support Team (hereafter CST) responded from the Regional Office and FCI Dublin, on the night of the homicide, to assist the Atwater CST in what had occurred that evening. Thirty-two staff from Victorville and FCI Dublin came to the USP in order to relieve those staff who wanted to attend the memorial service for Officer Rivera.

Medical Response - The Board found staff responded quickly and admirably in rendering life saving aid, transporting Officer Rivera to Health Services, and giving heroic emergency assistance. The outside ambulance response was excellent and the response at the outside hospital was also excellent.

Outside Law Enforcement Response - The Board found excellent cooperation and assistance were provided by the FBI, U. S. Attorneys Office for the Eastern District of California, the California Highway Patrol, the outside medical ambulance company, the community hospital, the Merced County Sheriff's Office, and the Office of the Coroner.

Crisis Support Team Response - Atwater CST did an outstanding job responding to this tragic incident. The team was activated within minutes of the event. Those team members who were not present at the institution were immediately recalled and returned to the institution. The Executive Assistant also provided exemplary assistance, as he initially followed Officer Rivera to the hospital, notified the family of his death, and provided comfort and support to the family in conjunction with the CST.

Shortly after arriving at the penitentiary, on the evening of Officer Rivera's death, the CST Team Leader (Chief Psychologist) quickly relinquished her leadership responsibilities to the Warden's Secretary Michelle Salm. The Chief Psychologist had

previously made it clear to the Executive Staff at the penitentiary she did not want to be the Team Leader. It should be noted, Michelle, who is not the team leader, took charge of the penitentiary's CST response. Once the immediate crisis was over, she continued to direct the activities of the CST to include assisting Officer Rivera's family, providing emotional support to numerous staff, and assisting in the coordination of the memorial service.

Regional assistance from Chaplain Gabrian (Regional CST Coordinator) and Dr. Richard Ellis (Regional Psychology Services Administrator) arrived at the penitentiary within two hours of the death of Officer Rivera. Chaplain Gabrian recommended the activation of the CST from FCI Dublin to assist the Atwater CST. On June 23, 2008, Chaplain Gabrian and the penitentiary Executive Staff determined they had enough CST resources on-site. Ten days after the incident CST members from Victorville and Terminal Island were activated by the Western Region for a brief period of time.

The seven members of the Atwater CST remained active for 18 days after the incident. They carried the largest workload for the CST response. Nine CST members from Dublin, two from Victorville, and two from Terminal Island assisted in performing CST activities at various times. On July 8, 2008, the Atwater CST was debriefed by Chaplain Joe Pryor of the Central Office.

The Warden did not meet with the family until the Monday following the incident, three days later.

Security Threat Group (STG) Issues - Posted Picture File - The Posted Picture File Program Statement (P. S.) 5510.11, requires the Bureau to identify inmates and/or detainees who, because of prior record, current offense, institutional adjustment, pose a significant threat to staff or inmate safety.

It was determined inmate Guerrero had previously been in the inmate Posted Picture File at USP Coleman from 9/00 until 12/07 for his involvement in a hostage situation and an assault on staff in 1998.

A review of Cardfiles data indicated inmate Guerrero had numerous reports of assaulting staff and inmates while in the custody of the Guam Department of Corrections and the BOP.

Based upon inmate Guerrero's previous history of violence against staff, he should have been placed in the institutions Posted Picture File prior to his arrival at USP Atwater.

A review of Posted Picture Files data indicated inmate Sablan had five assaults, one with a weapon, on inmates. He previously assaulted a female staff member in 1992.

It appeared Officer Rivera had not reviewed the Posted Picture File for six of the ten months he worked at USP Atwater. Documentation reviewed reflects the signatures of officers in the Posted Picture File were signed by a single person on several occasions prior to the homicide.

STG File Maintenance - An audit of USP Atwater files disclosed inmate Sablan had a "Ghost" file prepared upon his arrival to USP Atwater. The file remained in the SIS Office without any action for the entire time he was housed at USP Atwater. A further inquiry of the entire STG files revealed hundreds of files were never completed, or if completed, were not loaded in SENTRY. (A ghost file is a temporary file on an inmate compiled of all and any information available at the time of admission. The ghost file is discarded when the original file from the sending institution is received or it serves as a reminder to develop a file on the inmate. The number of ghost files indicates no files were sent from the sending facility nor was a proper file developed by Atwater staff.)

Searches - As a result of interviews with staff and inmates, review of the videotapes of the incident, review of Unit Logs, and review of other records, the Board found routine pat searches were not being conducted, by staff including unit officers, when inmates entered or exited their unit. Pat searches appeared to occur only in front of the dining room and other limited areas on the day watch.

Although mass searches were conducted, they were not thorough and only targeted specific items, such as ingredients for making intoxicants.

As previously indicated in the **Weapons** section of the report, several repairs were made to the dishwasher in Food Service to replace stainless steel rods from the conveyor belt. However, this area was never identified as a source of weapons material with appropriate controls to restrict inmates from removing parts for the purpose of making weapons. This was noted in the AAR. In the AAR, the Unit Officer in Unit 5A was taken hostage by two inmates armed with homemade weapons.

SHU - USP Atwater has a SHU which holds approximately 140 inmates. They have also created an "annex" for protective

custody cases and special situations. The annex was populated at approximately 50% of capacity. Both SHU and the annex were toured by the Board. During the Board's tour of the SHU, it was noted a large drawing of a nude female was displayed in the SHU laundry area.

Discussions with staff indicated the SHU was always full, and as a result, many inmates who received disciplinary sanctions of DS, either were released from DS status early or never spent time in DS. According to SENTRY records, incident reports are not processed expeditiously, which impacts the crowding levels in the SHU.

A review of the SHU visiting logs from March 2008 through June 2008 indicated Department Heads, Unit Team, and Health Services staff failed to conduct rounds 27.3% of the time. The Executive Staff failed to conduct rounds 29.1% of the time. During the three-month cycle reviewed, the Warden only made rounds five times.

DHO - The DHO was interviewed and indicated a higher than normal number of incident reports for assault were being expunged as a result of staff not meeting the time frames of the DHO process and misplaced DHO packets. The DHO felt the lack of enforcement of the disciplinary process has led inmates to believe they will not be held accountable for their actions. This leads to a dangerous environment for staff and inmates.

A statistical review of SHU hearings from February 2008 through August 2008 indicate there were 81 incident reports for Code 104 (Possession of a weapon). During the time period reviewed, nine of these incident reports were expunged for various errors. More than 10% of these reports were expunged.

Post Orders - Post Orders were reviewed by the Board and were outdated and had not been reviewed and signed off by staff. The Post Orders were worded in a vague manner. They were not comprehensive regarding actions to be taken by first responders. They were not specific to actions to be taken during emergencies, shakedowns, or incident reports.

RECOMMENDATIONS

The Board recommends the following:

Cell Assignment - The procedure for inmate cell assignments should be reviewed. The Case Management Coordinator and Unit

Team need to review pipeline screening procedures and make general housing unit cell assignments.

The Special Investigative Agent (SIA) should have input but should not be assigning cells. The SIA should focus primarily on which inmates need to go directly to SHU before receiving an assigned cell in general population.

A previous hostage AAR, indicated inmates were “selling” cells. The report suggested creating five Admission and Orientation (A&O) cells per unit to avoid placing an inappropriate inmate into general population without proper screening.

Ensure SENTRY records of cell assignments match with Bed Book assignments.

Count Issues - Procedurally, when an officer announces count, the floor should be cleared of inmates before the officer commences to lock cell doors and conduct the official count. If inmates do not clear the floor and report to their cell, the Lieutenant’s Office should be notified.

Other available staff from the Unit Team should be visible in the living area when inmates are secured for count.

Inmates should be counted in their assigned cells per their SENTRY assignment.

Intoxicants - Further reduce intoxicant ingredients in the Commissary. Evaluate whether jellies, jams, dates, and soda in plastic bottles should be eliminated at USPs. Remove milk bladders from Food Service and replace with carton or small pouch milk containers.

Increase frequency of pat searches at Food Service, especially during the evening meal.

Staff should strictly enforce discipline regarding intoxicants and intoxicated inmates. Incident reports should be written for each incident involving intoxicants or intoxication.

Medical assessments of inmates should include signs of intoxication, i.e., slurring of speech, stumbling, inability to maintain the head.

Weapons - Conduct more research into the type of weapons being

manufactured, determine how they are being manufactured, determine what types of materials are being utilized and the origins of the materials (dishwasher rods evading metal detectors). Eliminate, remove, or replace such materials. When specially ordered, dishwasher manufactures should provide all plastic conveyors for their machine thus eliminating the availability of metal rods for the manufacture of weapons.

Conduct more pat searches. Random removal of shoes should be conducted at the metal detectors, as inmates enter the units. We suggest establishing a minimum number of random pat searches at all search locations.

Conduct more area searches with an equal emphasis of recovery of soft contraband, as well as hard contraband.

Staff Response - Unit Team members should be given a key to the unit front doors. There was a delay for responders coming from outside the unit due to the only key to the unit front door being in the possession of the Unit Officer, who was under attack.

Breathalyzer, and urinalysis tests should be conducted on all inmates involved in assault cases where intoxication is suspected.

Consult with the FBI, and if applicable, the U. S. Attorneys Office to determine if blood, or other tests should be administered.

Indications of inmate intoxication should be noted in the medical assessment and work up.

Develop more guidance for First Responders to emergencies. Perhaps add the following phrase “Do anything possible to stop aggressive or assaultive behavior.” The emergency response plans and Post Orders should identify the expectations for first responders.

The Quick Response Team needs written direction and procedures for response.

Medical Response - Medical assessments of inmates involved in assaultive incidents should reflect whether or not the inmate appears intoxicated due to alcohol or drugs.

CST- The Western Region does not have a formal Regional CST. P. S. 5500.11, *Correctional Services Manual* § 603 states each

region should have a Regional CST. It is recommended the Western Region formalize the selection of the Regional CST

with members selected by the Regional Director. Once constituted, the Regional CST should establish regional response plans and then be announced to the Wardens in the Region.

The current Atwater CST consists of seven members. Four of the members have not attended national CST training. The four untrained members of the Atwater CST should receive national CST training, as soon as possible.

A new CST Team Leader should be selected. Given the shortage of Psychologists at USP Atwater, consideration should be given to either the Family Support Center Manager or the Chaplain.

Expand the size of the Atwater CST from seven members to eight or ten members. This provides enough team members, so two CST team members can be on each shift for at least the first 24 hours of a crisis.

Establish a formal protocol for assisting staff who have been seriously assaulted by an inmate. The Northeast and South Central Regions currently have such programs in place and could share training materials, forms, and procedures with other Regions.

Activate the Atwater CST when the penitentiary comes off lockdown. This would help the staff at the institution as they return to normal operations.

Establish a national protocol for responding to the homicide of a staff member who died at the hands of an inmate. This is a very rare and emotionally charged event. It is critically important for the staff and the Executive Staff at the institution to know what will be done to support staff in the aftermath of such a tragic event. The local CST and Executive Staff, by the nature of the event is directly and personally impacted. To rely solely on the local CST and Executive Staff to carry the burden of assisting staff beyond the first 24 hours is detrimental and harmful. It is important to include an outline of activation and use of Regional CST to augment the local CST. This allows the local CST to receive appropriate support for their own emotional needs. The Warden or Acting Warden should meet with the family immediately after the death of a staff member.

STG Issues - Posted Picture File - Ensure all staff review and sign the Posted Picture File.

Make the Posted Picture File available during Annual Refresher Training, staff recalls, and other mass gatherings of staff.

Unit Officers must be made familiar with inmates in their unit who are on the Posted Picture File.

Posted Picture File P. S. 5510.11 does not require the application of an STG assignment of POSTPIC into SENTRY on inmates assigned to the Posted Picture File. The STG assignment of POSTPIC, as well as the development of specific category identifiers, such as Staff Assault, Escape, etc., should be developed. Policy must also identify who is responsible for entering these assignments into SENTRY. Furthermore, once an inmate is assigned to the Posted Picture File, that assignment should not be removed whenever an inmate is transferred to another facility.

An electronic posted picture system should be developed which indexes inmates by specific category. Instead of viewing inmates in alphabetical order, any staff member should be able to view a specific assignment category, such as housing unit, work detail, education assignment, to see what inmates in that assignment are on the Posted Picture File.

File maintenance - Ensure all STG files are completed and loaded in SENTRY in a timely manner. Do not maintain “Ghost” files. “Ghost” files suggest SIS files are not always received from the sending institution. Current policy provides no specific way to ensure information (SIS packets) are sent from the sending institution.

SHU - Process incident reports in a timely manner to assist with the crowding levels in the SHU. Utilize the annex to its maximum capacity. A position or individual must be designated to make SENTRY changes in an inmate’s SHU status of either AD or DS.

DHO - Ensure the disciplinary process is applied effectively and consistently to the inmate population by ensuring staff follow the disciplinary process and meet the deadlines imposed on timeliness by policy. This can be done by an emphasis in training of staff on incident report writing and the disciplinary process.

Post Orders - Post Orders should be updated and clearly state staff responsibilities in conducting a proper count, conducting searches, and responding to emergencies.

Training - The Board recommends further institutional training in confrontation avoidance techniques, Posted Picture File,

pat searches and area searches, count procedures, escort procedures, and inmate communication.

Additional training should be provided on the discipline system to all Lieutenants and supervisors on policy criteria for placing inmates in the SHU. The failure of not placing inmates in SHU for such infractions, as possession of weapons in their cell, possession of intoxicants, use of intoxicants and severe incidents of insolence must be remedied.

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