CORRECTIONS BRANCH
Critical Incident Review

Subject: Inmate Escape

Date of Incident: s.15 2014 from medium custody, Alouette Correctional Centre for Women

Review Team:
Don Tosh, Chair
Warden, Fraser Regional Correctional District

Herjinder Grewal, Member
Assistant Deputy Warden, Alouette Correctional Centre for Women

Breanna Altenried, Member
Community Advisory Board, Alouette Correctional Centre for Women

Shane Muldrew, Participant/Observer
Inspector, Investigation and Standards Office

Review Dates: s.15 to s.15 2014 at Alouette Correctional Centre for Women

Mandate and Scope of Review:

On s.15 , 2014, the assistant deputy minister, Corrections Branch requested that a critical incident review be conducted to investigate the circumstances surrounding the escape of inmate s.22 at Alouette Correctional Centre for Women (ACCW) and to specifically address the following:

- Compliance with Adult Custody policies and procedures
- The provision of emergency procedures; and
- Any other factors that may be relevant to this incident.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the *Public Service Act.* While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action. Consequently, unionized employees were provided with the opportunity to have union representation during the interviews.

Consistent with Corrections Branch policy, all evidentiary material, including any original records, tapes, and transcripts, has been maintained at ACCW.

An independent review by the Investigation and Standards Office of the Ministry of Justice was conducted concurrently with this investigation. A separate report may be submitted by that office.

Background:

On s.22 2014, inmate s.22 ("the subject"), s.22 , was admitted to ACCW. She was s.22 s.22

The subject has a s.22 s.22

The subject's institutional assessment classified her as secure and for placement on s.15,s.22 Unit, a secure general population unit. The subject's assessment indicated no previous history of escape or attempted escape.

On s.22 2014, a review was conducted by a classification officer, and the subject's classification was subsequently changed to medium custody. The CORNET Client Log indicates the subject was moved to s.15,s.22 Unit. The subject met classification criteria with the intent of increasing her access to programs.

The CORNET Client Log of s.22 2014, indicates the correctional supervisor of programs requested a review of the subject for clearance to work in s.22 The classification officer conducted the review and the subject was cleared to start work in s.22

The CORNET Client Log of s.22 , 2014, indicates the correctional supervisor of programs hired the subject to start work in s.15,s.22 s.22

A CORNET Client Log entry of s.22 2014, made by the officer supervising the s.22 work area, indicated the subject showed up to work in the morning and did not show up in the afternoon, but remained on ACCW premises.

On s.22 , 2014, a formal count had been conducted and cleared at approximately s.15 hours. Medium custody inmates had access to unit and yard areas.

s.15 hours, a correctional officer (CO) was alerted s.22 s.22 . The CO immediately called and reported the information to the correctional supervisor (CS)

office. Details were provided and the CO requested that the CS check s.15
s.15

The CS exited the office s.15 . He met with the CO who reported the information and he scanned the s.15 area. The CS confirmed that s.15 ; however, it was s.15

s.15 . The CS immediately called a code red, alerting the centre that an escape was in progress, and identified the location and direction of the subject running s.15
s.15

At the time of the escape s.15
s.15

s.15

At approximately s.15 hours, all identified responders and available staff were in or on route to s.15 area. The assistant deputy warden of regulations requested that the facility be locked down and a formal count conducted.

s.15

Other correctional staff responders arrived and assisted s.15 to gain control of the subject s.15,s.22 and applying restraints. s.15 and staff report that the subject s.15

s.15

Once the subject was restrained she was escorted s.15 , and secured s.15 by corrections staff. The subject was questioned briefly and asked to identify herself. At this time the subject should have been read her rights on arrest, but this was not done. The subject identified herself, provided little additional

information, and then stated that she was s.22
This alleged s.22 was later investigated and found to be unsubstantiated.

A CO made contact with the Ridge Meadows Royal Canadian Mounted Police (RCMP) detachment requesting the attendance of a member. s.16
s.16
s.16 An RCMP file # 14-s.16 was provided and the escape package and Report to Crown Counsel was turned over to the RCMP.

At approximately s.15 hours, SSP confirmed the centre's identification count was cleared.

s.15 moved the subject to ACCW records department and placed her in a holding cell and later escorted her to segregation. Arrangements were made for a health care assessment on the subject s.22
s.22

Contact was made with the acting deputy warden, warden and an email was sent to the provincial director, informing them of the situation and circumstances.

A thorough perimeter check and search of the areas used to execute the escape was conducted as per Adult Custody Policy. No other persons were located.

On s.15 2014, interviews were conducted with several inmates allegedly identified as having knowledge of the subject's intent to escape. All inmates interviewed stated that they had no prior knowledge of her escape plans.

The area used to gain access s.15 by the subject was assessed. An urgent request was submitted to the designated property maintenance company, Workplace Services Incorporated (WSI), requesting s.15
s.15 be secured. These areas were secured promptly.

The Digital Video Monitoring System (DVMS) was reviewed post-incident. The review of video footage confirmed the presence of the subject in several locations. Recordings showed the subject s.15 assessing the area around s.15 The subject appeared to be assessing s.15
s.15
s.15 The subject was in this area moments prior to making her way over to the
s.15

Recordings showed the subject s.15
s.15

s.15,s.22

s.15,s.22 confirmed with the subject that he would be on the road between 8:00 and 8:30 p.m.

Based on the circumstances of this escape, the resources in place, and the quick response by all staff involved, it must be noted that the elapsed time from the initial code being called to the apprehension and securing of the subject was only minutes.

Findings:

- The initial classification and risk assessment, both upon intake and subsequent classification reviews, were as per Adult Custody Policy (ACP) and ACCW's standard operating procedures (SOP).
- Classification officers had signed designation letters as per ACP.
- s.15
-
-
-

- s.15

- A code red was called on a portable radio, but not announced over the intercom system to expedite the movement of inmates to cells and units.
- Staff response to the code was appropriate and very quick. Some clarity is required regarding the pursuit of escapees; specifically, when to pursue and whether pursuit should be conducted in pairs.
- Upon detention of the subject, staff did not advise the subject of her rights upon arrest, as required under ACP 2.11.
- Otherwise, staff response to the escape was in compliance with ACP and ACCW SOP.
- s.15,s.22

- Management followed up after the incident with staff to assess the need for a Critical Incident Review Team (CIRT) debriefing. An operational debrief was not conducted with staff.

Recommendations:

1. ACCW management to ensure that s.15 is secured to mitigate any future access. s.15 s.15 s.15 s.15 s.15
2. ACCW management to ensure the s.15 area is incorporated into daily security checks s.15 check) to identify s.15 s.15
3. ACCW management to ensure that code red response training is scheduled and conducted on a monthly basis. Training is to include review of contingency plans, policy, and best practices, with consideration for tabletop exercises.
4. ACCW management to ensure that at the conclusion of critical incidents they conduct an operational debrief for all staff involved.
5. ACCW management to consult with WSI and review the quality and level of s.15 s.15

s.15

6. ACCW management to conduct a building assessment utilizing a diverse cross-section of staff from the centre. The intent of the building assessment is to review structures, fences, perimeter and gates to identify any areas that pose a risk, vulnerability and security concern to the operation of the centre. A report of the assessment is to be provided to the warden for consideration and action.

ADULT CUSTODY DIVISION
Operational Review

Subject:

Walk-away of inmate from November House at Fraser Regional Correctional Centre

Date of Incident:

s.15 2014

Investigator:

Harry Draaisma, Deputy Warden, Fraser Regional Correctional Centre

Review Dates:

s.15 2014 to s.15 2014

Mandate and Scope of Review:

The provincial director, Adult Custody Division, requested that an operational review be undertaken in response to an inmate walk-away that occurred at Fraser Regional Correctional Centre (FRCC) on s.15 2014. The review considered specifically the following:

- Compliance with Adult Custody policies and procedures
- Compliance with FRCC standard operating procedures;
- The provision of emergency notifications and procedures;
- Initiatives required to prevent a walk-away under similar circumstances; and
- Any other factors that may be relevant to this incident.

One of the potential consequences of any investigation is that the findings may disclose just cause for discipline pursuant to the *Public Service Act*. While the discipline of staff is not the mandate of this investigation, the facts contained in this review are available to managers empowered to take such action.

Consequently, unionized employees were provided with the opportunity to have union representation during interviews.

Consistent with branch policy, all evidentiary material, including any original records, tapes and transcripts, has been maintained at FRCC.

Background:

On s.15 2014 at approximatelv s.15 hours an inmate was identified by control as s.15 s.15

November House is an open custody classified living unit located just behind and east of the FRCC main building in the secure fenced envelope of the main building. It is a Sprung structure and resembles a big white tent-type building. It can only be accessed via the control centre through a man and vehicle gate from the outside. It can hold 48 inmates but on this date it had a count of 31 and there were two correctional officers (CO) and one correctional supervisor (CS) in the unit at the time.

The inmate was a general population sentenced inmate and was classified as open custody. s.22 s.22

Findings:

The inmate is seen on the Digital Video Monitoring System (DVMS) on the s.22

s.22 The emergency response code red (escape) is called by the CO in control and staff are seen converging behind the inmate in pursuit s.22

The classification was correct as per classification training and Adult Custody Policy (ACP). s.15,s.16 s.15,s.16

s.15

the inmate leaving the unit would not fall outside recreational guidelines and his movement out of the unit be considered out of the ordinary.

Classification and November House staff and supervisors stated the inmate was s.15 November House living unit staff told s.15,s.22
s.15,s.22

Officers said the inmate was aware of this and for whatever reason decided to try and escape s.15

An officer said she and the other officers were surprised by the emergency response code and responded by s.15
s.15 . She said she and another officer then went to s.15 as per policy.

According to the DVMS, staff were following policy for s.15
s.15 at the time of the escape.

In talking to Justice Institute of BC staff training officers, they are confident new recruits are informed to s.15
s.15
s.15 There is no check list item for this training.

The training officers also stipulate that all officers involved in an incident complete incident reports as soon as possible. One officer did not. The incident happened at s.15 hours s.15 hours.

The last check was at s.15 hours as per the log book and DVMS, so the visual checks were conducted as per policy.

s.15

s.15

As November House has the CS office in the unit, the supervisors do not sign into the unit book every time they arrive at their office. There are no signatures in the book of any supervisors for that day or the previous few days.

Code red policy was followed as there were staff on staff break who assisted and pursuit was justifiec s.15

s.15

s.15 as per policy s.15 .

s.15,s.22

A supervisor said they heard the call for the code red and responded s.15,s.22

s.15,s.22 He then said s.15

s.15 were successful in finding and returning the inmate to custody.

A supervisor said he asked the inmate why he went and the inmate indicated s.22

s.22 The inmate also did not elaborate on whether he was having any personal issues that compelled him to run away.

The mental health coordinator interviewed the inmate s.22

s.22

s.22

An officer said he checked with others s.15 and no one remembers being told they were tos.15

s.15

s.15

The officer said he did this until he was directed tos.15

s.15

A control officer said he saw the inmate runs.15 and called the code red while informing staff of what was happening. He said s.15

s.15 and continued monitoring

s.15

The control officer said thats.15

s.15

s.15 The control officer said he feels ts.15

s.15

Recommendations:

1. FRCC management is to ensure that supervisors do not let staff leave their shift until they have completed their incident reports.

2. FRCC management is to ensure that a training piece is added to staff and recruit training to let staff know tos.15

s.15 A section addressing this requirement is to be added to the FRCCs.15 standard operating procedure (SOP).

3. FRCC management is to ensure that the FRCC escape SOP, and staff and recruit training, require that visual pursuit by officers is to be conducted in pairs.

4. FRCC management is to ensure that written email direction is provided by the deputy warden of operations to all assistant deputy wardens, supervisors and others who run the centre requiring them to make a visit at least once per shift to the houses, as they must for other living units, and to ensure recording of logs is adhered to as per policy.

5. FRCC management is to ensure that the local SOP for supervisor responsibilities for the houses is amended so that a supervisor must sign into a log book only when visiting those houses where the supervisor does not have an office.

6. FRCC management is to ensure that a supervisor signs the log book each time they review the log book for accuracy as per policy, regardless of where their office is.

7. FRCC management is to ensure that s.15
s.15