EXECUTIVE SUMMARY

On March 1, 2018, at approximately 1820 hours the Incident Command System (ICS) was activated by Correctional Officer (hereafter referred to as COII) Eduardo Aguilar because inmate [redacted] became unruly and was refusing to follow directives while being escorted to count movement.

COII's Alfredo Quintana, Leudar Huizar, and Jonathan Mendoza responded to the incident. Inmate [redacted] began to assault the officers. COII's Huizar and Quintana deployed their hand held chemical agents in an attempt to gain compliance from the inmate. The inmate then struck COII Huizar in the shoulder area with his fist. The inmate was taken to the ground by staff to stop his assaultive behavior and placed into restraints. As the inmate was being escorted off the yard, a large group of inmates ran to the location and began to assault staff.

All the officers involved in the initial incident were able to secure themselves in the South area of Building 2 to avoid being assaulted by the large group of inmates. At the same time, most of the South Yard inmate population began participating in assaultive behavior by throwing rocks at staff. The incident continued to escalate into a major disturbance as inmates gained access to officer stations by breaking through the ceiling. Staff was given directives to get on top of the buildings using the emergency escape hatch and secure themselves. Two Designated Armed Response Teams (DART) were deployed, and the Tactical Support Unit (TSU) was activated. Outside Law Enforcement Agencies were contacted and responded to the Yuma Complex.

This disturbance continued until approximately 2100 hours when staff was able to gain control of the Unit. Ten staff members and twenty-five inmates were identified as sustaining injuries sufficiently serious to require medical treatment. One inmate, [redacted] was pronounced deceased on the scene as a result of injuries received from a gunshot wound.

As of March 7, 2018, 125 inmates have been moved off the Cheyenne Unit and transferred within the ASPC-Yuma Complex and to various other ADC facilities due to their participation in the disturbance. Due to pre-existing medical conditions, 29 inmates were moved off the Cheyenne Unit. As a result of the disturbance, 146 disciplinary reports have been issued. Additional inmates may receive disciplinary or further movement over the course of the ongoing investigation.

On Tuesday, March 6, 2018, ADC Director Charles L. Ryan appointed a team of Correctional Professionals to travel to Yuma to comprehensively investigate the disturbance and issue a formal report memorializing the evidence from an administrative, operation, and criminal perspective, including inmate and staff dynamics, programs, and other relevant aspects of the Cheyenne Unit. The Assessment Team was onsite at ASPC-Yuma from March 12, 2018 to March 15, 2018. The next several days were spent reviewing reports, interviewing staff and inmates, viewing relevant video and drafting this report.

The Assessment Team consisted of:

Warden Robert Patton (ASPC-Phoenix)

Deputy Bureau Administrator Ron Credio (Contract Beds Bureau)

Deputy Inspector General Sean Malone (Inspector General's Office)

Deputy Warden of Operations Norm Twyford (ASPC-Perryville)

Deputy Warden Ed Lao (ASPC-Eyman)

Auditor 3 Kelly Pierce (Inspector General's Office)

Auditor 3 Staci Ibarra (Inspector General's Office)

Major Dwayne Morman (ASPC-Tucson)

Correctional Officer IV Adam Young (Contract Beds Bureau)

The Assessment Team members' biographies are located in Tab C.

After review and consideration of all relevant and available evidence, the Assessment Team concludes that this disturbance was a spontaneous event.

KEY FINDINGS

Key findings by area are listed below. A comprehensive assessment of all items, including key findings, is located in Tab B.

Disturbance Key Findings

- From the onset of inmate violence and property destruction, it took approximately two hours to get control of the inmate population. Tactical decision-making was significantly affected by the incident complexity and size. The incident complexity was affected by the breached perimeter fence, inmates accessing officer work stations, and the inmates accessing the Health Unit. The incident size was affected by inmates breaching fences between the two sides of the unit.

- ICS Structure of Incident Commander, Operations, Branches, Divisions, and Groups were not established until after the incident was under control. During Assessment Team interviews, some staff believed that Sgt. Roach was the incident commander, while others believed either DW Zaragoza or Lt. Rosas was the Incident Commander.

- The ICS Principle of Unity of Command, which requires each individual involved in incident operations to be assigned to only one supervisor, was not deployed. During interviews, the Assessment Team learned that the Administrative Duty Officer, the Unit COIV, Sgt. Roach, Lt. Rosas, DWOP Hetmer, Major Yesenski, and the TSU Commander had given directives/orders to multiple staff outside their scope of control. Some staff believed that DW Zaragoza was in Command; however, none of the staff interviewed indicated that he provided any direction.

- The ICS Principles of Span of Control, which requires the ratio of individuals assigned to one supervisor to be limited to what is controllable by that supervisor, was not deployed. Multiple supervisors were issuing directives autonomously.

- Due to the issues in Size, Complexity, Structure, Unity, and Span of Control, communication failures occurred which contributed to the following:

    - Ingress/Egress on and off the Unit was unrestricted, allowing for Law Enforcement responders to enter the Unit with lethal munitions. During an Assessment Team interview, the Complex Chief of Security Major Yesenski was asked why Law Enforcement officers were inside the perimeter. Major Yesenski responded that he had no control of the responders. Upon Regional Operation's Director Diaz's arrival ingress/egress issues were immediately resolved.

    - Unregulated delivery and issuance of weapons and munitions including 00 Buckshot. During Assessment Team interviews and review of reports, staff reported going to the Armory with the direction "bring all of the ammunition," and once the ammunition was on the Cheyenne Unit, it was delivered to the spline and "whoever needed it, took it."

- Responders failing to write reports within prescribed time frames. During Assessment Team interviews, multiple staff gave descriptions of having significant roles in the disturbance, to include the use of force, but had not written any reports at the time of the interview. All reports have been completed at this time.

- Full accountability of munitions didn't occur until seven days after the incident. During Assessment Team interviews, the Complex Armorer had been attempting to reconcile the Armory munitions since the day after the incident; however, munitions from both DART lockers, Dakota Tower, and Yuma Control had to be restocked prior to a complete reconciliation. Fifteen rounds of 00 Buckshot were not immediately returned to the Armory which furthered the delay.

- TSU responders engaged prior to having a briefing and tactical plan. During an Assessment Team interview the TSU commander stated that under normal circumstances, he would have assembled his team and planned for a tactical assault; however, due to a portion of his team already being engaged in defensive tactics, he was relegated to using what TSU members were near him in Building 1 as well as DART and other armed officers.

- Inmate [redacted] was part of a group of inmates who advanced toward staff responding to the incident. A staff member fired 00 Buckshot at the advancing group of inmates. Two pellets struck [redacted] Inmate [redacted] death is being investigated by ADC Criminal Investigation Unit (CIU) in conjunction with the Yuma County Attorney Office. The final autopsy report from the Office of the Medical Examiner has not yet been received.

Physical Plant Damage Key Findings

- The internal fencing throughout the Unit has significant damage from corrosion. The damage to some fences is extensive. The lower tension bars in some areas are corroded or entirely damaged by rust.

- The fence posts in some internal fences are rusted through. The fence between building 5 & 6 that was knocked down broke off at the base where heavy corrosion was present.

- The locking device in front of the Health Unit is incorrectly installed. There is a significant gap between the strike plate and the latch bolt. This gap is large enough to manipulate the lock in the open position.

- The locking device at the mail and property room has a significant gap that allows manipulation of the lock into the open position with a handcuff.

- There were no ladders available to the officers who evacuated to the rooftop of the buildings.

- The internal roll gates were compromised. The gates lack vertical tension bars and tabs as well as anti-lift guides. This design failed to maintain its structural integrity.

- The internal swing gates leading to "no man's land" are missing vertical latch bolts into the ground. The absence of latch bolts allows for significant play and space between gates even when secured with a chain.

- CCTV cameras were mounted on drywall. The camera enclosures are not designed for the correctional environment.

- There was a lack of comprehensive security device inspections of the fences at the Unit. There are no records to indicate that the above deficiencies were noted. An inspection of work orders for the past six months did not reveal any work orders relating to the fence structures.

- The Physical Plant Manager and his team swiftly addressed Unit maintenance issues. The progressive damage of the fence from corrosion was not reported to the maintenance staff. The absence of a work order request did not trigger dispatching maintenance personnel.

- The gates throughout the facility were misaligned, sagging, or difficult to open. A review of the key control report does not indicate a physical inspection of locking devices was conducted monthly.

- There were 145 inmate televisions that had physical damage consistent with intentional acts of destruction by staff. Most televisions that were inspected had boot prints. In addition, several other items of inmate property (food items, blankets, fans, etc.) were damaged or destroyed.

- Six Correctional Officers were identified by the Yuma Criminal Investigations Unit as having engaged in intentional destructive criminal behavior against inmate property.
  COII Ricardo Acosta EIN [redacted] **COII Karlo Rivas EIN** [redacted]
  COII Eduardo Bojorquez EIN [redacted] **COII Julio Ledezma EIN** [redacted]
  COII Ricardo Tapia-Villa EIN [redacted] **COII Alberto Leon EIN** [redacted]

Administration Key Findings

- On the night of the disturbance, Swing Shift was staffed with 33 Correctional Officers. This required the collapsing of three posts. Based on normal staffing patterns and vacancies having only three collapsed posts is considered very good staffing numbers. **Staffing played no negative role in this disturbance.**

- The Warden established critical minimum numbers for the entire Complex, and in particular the Cheyenne Unit, that are unrealistic. For Cheyenne Unit Swing Shift, staffing becomes critical after collapsing only two posts. As a comparison, ASPC-Eyman/Cook Unit, which has the same physical plant and staffing, does not reach critical staffing until they have collapsed 8 posts on Days/Swings and 6 posts on Graves.

- A review of Significant Incidents Reports generated at the Cheyenne Unit for the last six months revealed no significant pattern.

- The Cheyenne Unit scored below the Complex average on the last three Inspector General Audit Reviews.

- Tour reports by Deputy Warden Zaragoza revealed:
    - The Inspection Summary portion of the forms was completed identically for the last six months.

    - Each of these forms marked Security, Sanitation, Staffing, Programs, Written Directives, Supervision, Scheduling, and Professional Behavior as "Needs Improvement." There is no explanation in the comment section as to what was discovered. In addition, several of the comments in the comment section of the form are mirrored month to month.

    - In December and January, DW Zaragoza notes that staff has expressed concerns with how the Integrated Housing Program Process and Procedures will be implemented. He does not note what actions, if any, he took.

    - In November, December and January, DW Zaragoza notes that the inmate population has concerns with the frequency of Unit searches. He does not note what actions, if any, he took.

- During interviews with staff, they expressed concern that two Correctional Officer III's were disciplined for informing Administration of a potential disturbance. The investigation revealed that during a meeting between Programs staff and Administration in January, the two COIII's in question made statements about inmates having a "green light" on staff and the yard was "ready to go off" over IHP. Neither of these staff had informed their chain of command of this information. In subsequent interviews, one staff member admitted that she had heard this from another staff member who had heard it from a third staff member. The other staff member stated that he had heard it from an inmate on a different unit. As a result of the inquiry, the issue was handled informally, and a MAP entry was given. No formal discipline was issued. SSU conducted several interviews based on this information, and no relevant evidence was discovered that would substantiate these claims.

- During interviews with staff, several claimed that Administration had prior knowledge of the disturbance and took no actions. They based this claim on a report written by a COIII after he received an inmate letter stating that the inmates were going to riot on March 1st over IHP. The investigation revealed that a COIII did receive an inmate letter under his door from a fictitious inmate on February 28, 2018. The letter alleged that the Whites and Hispanics were collecting weapons and were going to riot over IHP. This information was given to Administration and SSU. Interviews were conducted on February 28, 2018,

and March 1, 2018, by SSU and did not reveal any tension on the yard. It is important to note that the inmate letter did not list a specific date that this disturbance was to occur.

- Homemade alcohol appears to be a significant issue at the Cheyenne Unit. During a six month period, approximately 120 gallons were removed from the yard.

- To combat this, Deputy Warden Zaragoza instituted homebrew sweeps of housing units. Under these sweeps, if a staff member found or had reason to believe homebrew may be in a particular housing unit, they were authorized to lock down that housing unit to search it. Over time, this was increased to the authorization to lock down one entire side of the yard. This was often done without initiating the Incident Command System or documenting the lockdown on an Information Report. These lockdowns often were for two hours or more and were authorized to be conducted on Days and Swings. Staff state that these lockdowns occurred three to five times a week. Since there was no documentation generated, staff state that at times the same yard may be locked down on Days and Swings.

- Throughout the review, most staff assigned to Officer Stations was found inside the stations. Upon interviews, all stated that they remain in the station most of the shift and generally come out once an hour to do a round. If there is a floor officer assigned to the building they may not come out at all.

Inmate Programs Key Findings

- COIII's are completing required work assignments and are seeing inmates as required, but they report being disgruntled and disengaged with Unit Administration.

- According to the COIII's and COIV's, the Unit Deputy Warden was not touring the facility on a regular basis prior to the disturbance.

- The COIV's have a good working relationship with the COIII's.

- The COIII's believe the disturbance was due to IHP.

- Inmate [redacted] was involved in a riot at ASPC-Lewis in December 2017. The ticket was dismissed, and the inmate was subsequently sent back to medium custody on February 22, 2018. According to SSU, this inmate played a direct role in the recent Cheyenne Unit disturbance.

- The Unit is receiving a normal amount of grievances for a comparable ADC facility.

- The Unit is receiving a normal amount of disciplinary for a comparable ADC facility.

- The Unit demographics are normal for a comparable ADC facility.

- The Unit currently has approximately 74% of the population working. This is normal for a comparable ADC facility.

- There are an inordinately high number (263) of inmates on some form of restrictive visitation.

Staff/Inmate Interviews Key Findings

- Majority of staff expressed a perception that this incident was caused by the implementation of IHP.

- All inmates stated that this was a spontaneous incident resulting from a perceived excessive use of force.

- Inmates identified as active participants and removed from the yard unanimously stated this was a spontaneous incident unrelated to IHP.

- Some inmates and staff stated they have not been properly briefed and/or trained on IHP.

- Multiple staff participated in formal IHP training at Tucson and Eyman Complexes on three separate occasions.

- Two inmate Community Meetings were conducted to educate the inmate population on IHP implementation.

- Lock downs are frequently used by staff to conduct searches for prison-made alcohol, which affected recreation and phone time.

- Most staff/inmates stated that they rarely saw Unit Administrators touring.

- Interviews revealed that Sergeants and Lieutenants toured the yard on a regular basis. When journals were reviewed, it was verified that a supervisor toured twice per shift to all posts.

- Staff rarely enter the recreation yard unless observing suspicious activity or responding to an incident.