ESCAPE REPORT

THE PENNSYLVANIA DEPARTMENT OF CORRECTIONS

ALBION

DECEMBER 2007

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1.0 Executive Summary

On Sunday afternoon November 25, 2007 at approximately 1445 hours, Inmate Malcolm Kysor (AJ-1746) escaped from the State Correctional Institution at Albion (SCI-Albion) by hiding in a garbage can as a state employee (Dietary Food Service Instructor) drove the pickup truck through the vehicle sally port. Kysor was undetected by the Sergeant assigned to the sally port. The entire escape has been captured on recorded surveillance video that was eventually retrieved at approximately 2030 hours the same day. The officer assigned to monitor the surveillance cameras was monitoring other areas of the facility and did not observe the cameras that actually captured the escape at 1445 hours. SCI-Albion has a total of 140 cameras that are randomly monitored by the assigned officer. At the time of this report, the escaped inmate remains at large and a nation-wide search is underway.

The escape should not have occurred. Both DOC and SCI-Albion's procedure, if followed, would have prevented this escape. The Shift Commander should have ensured the assigned sally port Sergeant was aware of his post responsibilities. If the commissioned officer in Main Control would have observed the sally port operations via the CCTV system, he may have noticed the Sergeant's failure to perform a proper search.

Complacency is always a concern in DOC facilities. To combat complacency, the Department has incorporated alertness checks into policy, making it mandatory for each facility to conduct "alertness checks" of the staff monitoring the security systems and the inmates. This investigation did not reveal any evidence that meaningful alertness checks were conducted at the sally port.

Every post that corrections officers are assigned have post orders that outline the expectations of the assigned officer. The Sergeant assigned to the sally port did acknowledge that he read and understood the sally port post orders. He also signed a training roster indicating that he had been trained on the "heartbeat detector", however, he clearly failed to follow them and did not make any requests to the Shift Commander for assistance or clarification.

The Department of Corrections has also incorporated the use of Vulnerability Assessments (VA) at each facility. These assessments are intended to identify weaknesses in security, primarily to lessen the likelihood of an escape.

SCI-Albion's VA was conducted in October 2005 and the report identified a similar scenario to the escape that occurred on November 25, 2007, as a possible means of escape from the facility. Had SCI-Albion conducted a review of their trash procedures following the VA, the escape may not have occurred. The Regional Deputy Secretary is required by policy to review the VA findings and approve Plans of Action for identified discrepancies in the VA. In this particular case, there is no evidence of a Plan of Action being submitted or follow-up actions by the Regional Deputy Secretary (who retired in June 2007).

The investigation revealed that there were no written procedures regarding the removal of pig slop (food waste). Had there been written procedures, the larger gray garbage can may have never been utilized, thus making it less likely for Kysor to be able to escape. There was no evidence of any orders to hold the garbage through at least one inmate count prior to taking it through the sally port. The practice at SCI-Albion was to take the pig slop out through the sally port seven (7) days a week, even though the sally port is closed on weekends, thus requiring a potentially less experienced officer to

open the sally port. The Shift Commander did not put any additional security or safeguards in place when the sally port was opened on a weekend.

The Dietary Department has been an area of concern for some time, relative to various security concerns and complacency. The investigation revealed no evidence that the Food Service Manager, the Deputy Superintendent for Centralized Services or the Superintendent were effective in dealing with these issues. The dietary practice that permitted inmates to work on their off days and for lifers to work in the back hallway, in spite of written direction to the contrary, directly contributed to the escape.

Failure to comply with DOC policy regarding inmate movement whereby inmates are to be issued passes for movement other than major line movements, also contributed to the escape.

The institutional response to the escape was generally good, however, the investigation revealed that the activation of the Community Alert Network System (CANS), the escape siren, and the notification of the media were all delayed and should have occurred sooner. While no evidence that any of these delays had an adverse impact on the actual escape more prompt, notification may have allowed local citizens to spot unusual activity. The delay did have an adverse impact on public confidence.

The Department of Corrections' response to the findings in this investigation will be as follows:

- Discipline employees who failed to follow policy and procedure
- Add to policy, any trash and other such items must be searched and held through at least one inmate count
- Add to policy that weekend/holiday usage of the sally port is limited to emergency use only. If authorized to be opened, a Lieutenant or higher

authority must be physically present with the Sergeant assigned to the sally port in the absence of the regular/relief sally port Sergeant.

- Require that the local media outlets be included in the CANS notification broadcast.

This report will provide a description of SCI-Albion and a profile of the inmate involved. It will also outline the manner in which the escape was planned and executed. A review of operational procedures such as inmate accountability, inmate counts, vehicle security, and staff inspections will be discussed. The report will review and discuss issues where complacency or operational failures had an adverse effect that could have contributed to the escape and finally, the report will provide recommended actions to prevent future escapes.

As a result of the escape, there have been several questions and inquiries raised by the media and the local community regarding the timeliness of the notifications initiated by the institution. This report will closely look at the timeline of events from the time the inmate actually escaped until all appropriate entities and authorities were notified.

This is the first escape from the State Correctional Institution at Albion since its opening in 1993. The last escape from a secure facility that occurred from a Pennsylvania Department of Corrections facility occurred in August 1999. Two escapes occurred that year, one from the State Correctional Institution at Dallas that involved two (2) inmates, and one from the State Correctional Institution at Huntingdon. Both escapes resulted in the inmates being apprehended and the inmates are back in custody.

2.0 SCI-Albion

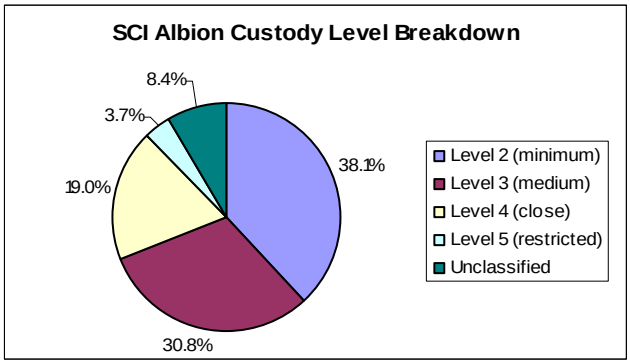
This section will present a description of the facility

2.1 Description of SCI-Albion

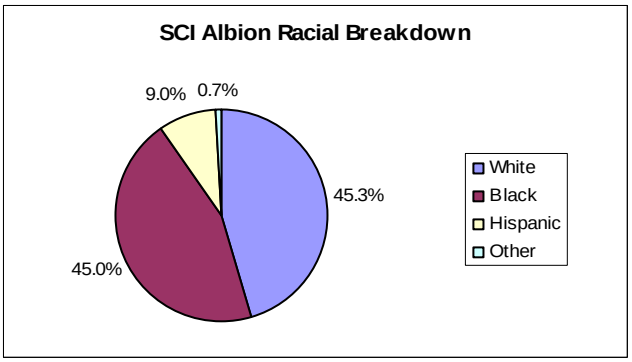
The State Correctional Institution at Albion was one of five prototypical institutions dedicated in 1993. The facility was built by a cooperative effort between state and county governments, in which the Erie County Prison Authority built the prison on a fast-track basis to accommodate quick expansion of the system. SCI-Albion is a medium-security facility designed to house and maintain adult male offenders. It is fully accredited by the American Correctional Association. The institution is comprised of 290 acres, 67 of which are inside the perimeter fence. There are a total of 25 buildings 10 of which are housing units.

SCI-Albion is a Security Level 3 (medium security) facility, located in the city of Albion, Pennsylvania, approximately 20 miles south of Erie, Pennsylvania. SCI-Albion houses approximately 2300 adult male inmates of all custody levels.

The breakdown of SCI-Albion's inmate population is as follows:



The racial breakdown of SCI-Albion is as follows:



SCI-Albion currently houses 196 inmates serving a life sentence and 106 inmates are serving a minimum sentence of 20 years or more (this does not include those serving a life sentence). SCI-Albion completed its first accreditation audit in June 1996 with the panel hearing completed in August 1996. Since then it has been re-accredited every 3 years. The last accreditation audit occurred in March 2005 and the institution is scheduled for re-accreditation in May 2008. SCI-Albion employs a total of 606 staff; 347 are Corrections Officers and 259 are support staff.

2.2 Institution Security

SCI Albion has two 14' fences. The bottom portion of this fence is constructed of 8-gauge 2" diamond mesh wire, with heavy gauge wire on the upper portion. The inner fence has one roll of razor wire installed halfway up the fence and one roll or razor wire at the top of the fence. The outer fence has six rolls of wire installed at the bottom and one roll at the top. These areas are heavily reinforced with razor wire to prevent an individual from climbing them. The perimeter is also protected by a Perimeter Intrusion Detection System (PIDS) that includes strategically mounted cameras. When a specific fence zone alarms, the cameras in the effected zone it automatically come up in the Central Control monitor.

There is a continuous mobile perimeter patrol. The armed Mobile Patrol officer is equipped with a mobile graphic map of the perimeter fence and all of the designated zones. In the event that the Perimeter Intrusion Detection System (PIDS) alarms, the Mobile Patrol officer receives a visible and audible alert on the mobile map and immediately responds to the affected zone to determine the source of the alarm. They are instructed to check the affected zone and the adjoining zones for evidence of escape or tampering. The Main Control Center has a larger graphic map of the perimeter and camera monitors that automatically capture a camera view of the activated zone. The Control Center officer immediately contacts the Mobile Patrol Officer in the event of an alarm and monitors the perimeter cameras until the officer assigned to the Mobile Patrol reports the area "all clear." At that time the alarm is reset.

SCI-Albion only has one (1) vehicle entry into the facility that is referred to as the “sally port”. The sally port is staffed by a Corrections Officer II (Sergeant) and is the only ingress/egress point for vehicular traffic. The sally port is equipped with a “heart beat detector” to aid staff in the detection of unauthorized inmates hiding in vehicles and surveillance cameras that are monitored by an assigned officer in the Main Control Center. There is also a “crash gate” located on the inside of the inner vehicle gate that the Sergeant must manually unlock and open to permit passage through the sally port. The “crash gate” was installed to prevent an inmate from overpowering a staff member or vendor, commandeering their vehicle and ramming the sally port gates in order to escape. The sally port is routinely used by institutional staff to deliver institution supplies or for vendors to pick up garbage compactors or deliver supplies. The sally port is only staffed and operational Monday through Friday between the hours of 0800 and 1600. If the shift commander deems it necessary to open it on a weekend/holiday or after hours, an available Sergeant is assigned for the time needed to open and secure the sally port.

The sally port consists of two (2) mechanically operated gates that are never to be opened at the same time. The assigned Sergeant is the only staff member authorized to have the gates opened or closed. According to Pennsylvania Department of Corrections Policy and the SCI-Albion Post Orders for the sally port Sergeant, the Sergeant is to ensure that all vehicles are properly searched both entering and exiting the facility.

Department of Corrections Policy 6.3.1 Facility Security Manual Section 11 - Vehicles: ***"… all vehicles shall be searched, both entering and leaving in accordance with Department policy 6.3.1 "Facility Security," Section 11, Vehicles"***

SCI-Albion Post orders state: ***"**…**All vehicles entering or leaving the Institution must be thoroughly searched by Correctional Staff as follows:***

The Sergeant will proceed to search the glove compartment and passenger area thoroughly, including lifting the seats when appropriate.

Unlock and search the cargo area or trunk.

Inspect the top and undercarriage of the vehicle. The undercarriage will be searched utilizing the wheeled mirror.

When appropriate, loads such as liquid waste barrels or other deep containers shall be probed with a sharpened probe to ensure that an inmate is not concealed inside the container.

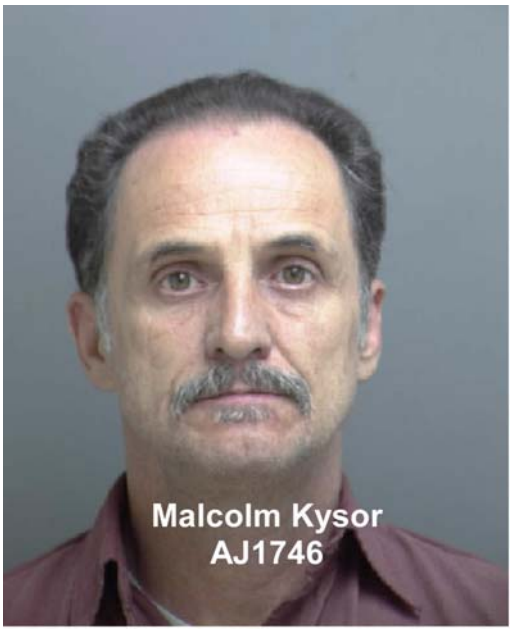
Inspect all packages and equipment.

Clear vehicle through Micro Search System. Any discrepancy will be reported to the Central Control immediately……."

3.0 Inmate Profile

3.1 Malcolm Kysor (AJ-1746)

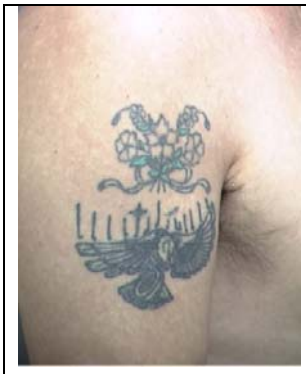
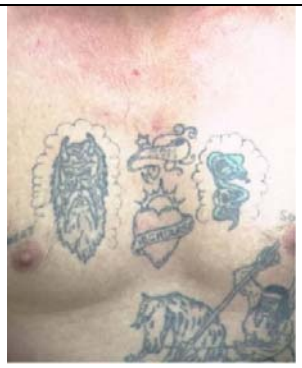
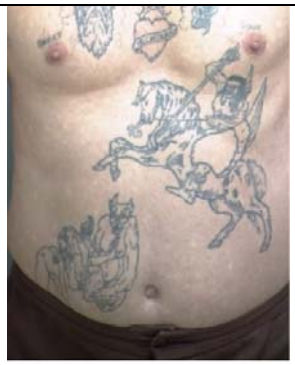
At the time of his escape Malcolm Kysor, Pennsylvania Department of Corrections Inmate Number AJ-1746 was age 53. He was serving a Life sentence for Criminal Homicide. The Honorable Fred P. Anthony, from Erie County Pennsylvania, imposed the sentence. There are no detaining sentences associated with his charges. In 1974 he served a 2-year sentence in Alabama for Burglary. In 1977 he served an 8-month commitment in Warren County, Pennsylvania for Retail Theft. In 1984 he served a 4-year to 8-year sentence in Pennsylvania as AP-6480 for Receiving Stolen Property. This sentence was connected to the murder conviction he is currently serving.



3.1.1 Physical Description

At the time of his escape, Malcolm Kysor was 5’8” tall, and weighed

160 pounds. He has brown eyes and brown hair. He is Caucasian with a light complexion and slim to medium build. His date of birth is 7-20-54. He has a flower and an Eagle tattoo on his right arm. He has a rose with 2 hearts and a flower tattooed on his left arm. His chest has a devil, a heart, and a snake tattoo. On his abdomen is a devil with a woman and an angel on a horse.

			
Right Arm	**Left Arm**	**Chest**	**Abdomen**

3.1.2 Institutional Adjustment

His institutional adjustment during his years of incarceration had been generally good. After serving 10 years of his sentence without incident, he qualified for and received an incentive based transfer from SCI-Fayette to SCI-Albion where he had been housed since April 3, 2007.

Pennsylvania Department of Corrections Policy 11.2.1 Reception and Classification Procedures Manual Section 8 Transfer Petitions System states:

"…Subsection E.3.c. The inmate must meet the following criteria to be considered for an incentive based transfer:

be in compliance with his/her Correctional Plan, DC-43;

must be a CL-2;

not be scheduled for parole review within the next six months;

free of Class I misconducts for one year and have no more than one Class II misconduct in the past year;

an inmate transferred away from his/her home region for disciplinary reasons (including assault, escape, and drug related misconducts) shall not be eligible for transfer back for a minimum of five years;

must have served at least one year of his/her sentence…"

"……A Lifer must meet the criteria listed in Subsection E.3.c. Above, as well as the following: …has served a minimum of 10 years in the Department with overall positive adjustment and; may be a custody level 2 or custody level 3."

Inmate Kysor received only one minor misconduct report (behavior infraction) during his incarceration in the Pennsylvania Correctional system. This infraction was for Refusing an Order and Failure to Report the

Presence of Contraband for which he received a sanction of 30 days of cell restriction.

4.0 Chronology of Events and Contributing Factors

This section will describe the chronological details of the escape from SCI-Albion. It will also present a discussion of the operational failures that contributed to the escape. (See the fold-out timeline.)

4.1 The Escape

On Sunday, November 25, 2007 inmate Malcolm Kysor (AJ-1746) escaped from the State Correctional Institution at Albion by hiding in a forty-gallon plastic trash can that was used for transporting wet food waste (pig slop). Intelligence gathered has proven that this was a well-planned escape dating back to at least February 2007 when he was housed at the State Correctional Institution at Fayette.

Inmate Kysor arrived at SCI-Albion on April 3, 2007. At the time of his escape, Kysor was making $.42/hour as a garbage worker in the Dietary Department. Inmate Kysor worked Tuesday through Saturday from 1300 to 1900 hours. On the day of the escape (Kysor's scheduled off day), at approximately 1300 hours, he made his way from his housing unit to the Dietary Department during the general line movement to work, and "volunteered" to work. His supervisor collected his I.D. card and permitted him to remain in the Dietary Department.

Every day at approximately 1430 hours, the pig slop is taken out of the kitchen to the rear loading dock and loaded on a Department of Corrections pickup truck (see Fig 1, 2, & 3).

Fig 1: View with doors closed, from back hall to dock

Fig 2: View from doors to loading dock

Fig 3: Rear view of loading dock

On this particular day, Inmate Kysor was in the back hallway in the loading dock area with two other inmates, John Gromer (GL-4861) and another inmate. From interviews with staff and his accomplice (Gromer) it has been determined that he had been spending considerable time watching the sally port operations through the windows of the Dietary Department (see Fig 4) and had performed the garbage duties many times prior.

Fig 4: View through loading dock door window

From interviews conducted, it appears that Inmate Kysor watched the same Sergeant perform his duties at the sally port the day prior and allegedly told another inmate that if the same Sergeant was working at the sally port on Sunday, it was “good for him”. At approximately 1433 hours, Inmate Kysor brought an

Fig 5

Fig 6

empty gray trash can and other unidentified objects in a trash bag into the hallway adjacent to the loading dock area (see Fig 5 & 6). Kysor walked to the double doors where his accomplice was standing with a food service instructor and another inmate.

Fig 7

Fig 8

He tapped Inmate Gromer on the back (see Fig 7) and the two of them walked to the area where Kysor previously placed the gray garbage can (see Fig 8).

Fig 9

Fig 10

Kysor climbed into the garbage can (see Fig 9) and his accomplice placed plastic bags over his head to conceal Kysor's identity (see Fig 10).

Fig 11

Once Kysor was concealed inside, Gromer pulled the garbage can to the loading dock (see Fig 11) and eventually placed it onto the pickup truck, against the cab on the passenger side (see Fig 12).

Fig 12

A third inmate removed empty garbage cans from the pickup truck. Gromer was observed (on recorded surveillance video) making sure the plastic was in place on top of Kysor so that he would remain concealed. After the remaining cans were loaded onto the back of the pickup, Gromer and another inmate returned to the inside of the Dietary building with the food service instructor. The other food service instructor got into the pickup and departed for the sally port (see Fig 13).

Fig 13

The assigned Sergeant called Main Control via the radio and requested for them to open the inside gate. The pickup was driven inside the sally port between the two gates (see Fig 14).

Fig 14

The Sergeant called Main Control via the radio to, “close the inside gate.” Pennsylvania Department of Corrections Policy, 6.3.1 Facility Security Procedures Manual Section 11, E. (Vehicles) and SCI-Albion’s operating procedures and Security post orders are very specific as to the type of search to be conducted on all vehicles departing the secure perimeter. The assigned Sergeant walked around the vehicle, searched the under-carriage and opened the engine compartment. It was learned from recorded surveillance video that he neglected to use the metal poker to probe the garbage cans and did not use the “heartbeat detector”. He then notified the Main Control officer via radio to “open the outside gate”. The food service instructor drove out of the sally port toward the institution’s warehouse. He parked the vehicle next to the corner of the warehouse with the garbage cans left on the back of the pickup for the pig farmer to retrieve later that afternoon (see Fig 15).

Fig 15

The food service Instructor got out of the pickup and returned to the institution with Kysor still in the back of the pickup, hiding in the garbage can. The time that the pickup truck departed the sally port was approximately 1447 hours. It is unknown exactly what time Kysor climbed out of the garbage can and continued his escape from SCI-Albion but we do know (as a result of recorded surveillance video) that it occurred sometime after 1447 hours. According to interviews with the pig farmer, he arrived at the institution at approximately 1605 and off loaded the cans on to his pickup. When questioned, he stated that he did notice an empty can but did not report it to the institution.

4.2 Institutional Detection, Response and Notification

On Sunday, November 25, 2007 at 1615 hours SCI-Albion began its regularly scheduled inmate count. The Shift Commander ordered that the institution “cease all movement” and commence with the count. Like every other day, the housing unit officers announced count and ordered all inmates to turn their lights on and stand for count. The dietary supervisors counted the inmates who were permitted to be out of their cells for the 1615 hrs count, to prepare the evening meal.

At 1650 hours the individual counts were all collected by the Main Control staff and tabulated. The count revealed they were one inmate short. The Shift Commander ordered a "re-count" of the inmates. The results of the recount were the same as the prior count, one inmate short. The recount was completed at 1724 hours. The Shift Commander ordered a recall of all inmates to their housing units for a 3rd count at 1735 hours. At the same time, he sent officers to search the loading dock area behind the Dietary Department and also dispatched officers to search the Activities building. He wanted to make sure that an inmate wasn't hiding behind the Dietary building or in the Activities building. Religious services were conducted in the Activities building earlier that day and he wanted to be sure the missing inmate was not hiding there.

Re-counts are not a frequent occurrence at SCI-Albion; in fact, a review of the "miscount log" indicated that only 12 miscounts have occurred since the beginning of 2007. A third count (recall) is a very infrequent occurrence at any of the Department's facilities, especially on a weekend. Officers were sent to conduct an inspection of the perimeter fence looking for any evidence of breach or attempted breach.

The Shift Commander notified the Superintendent of the count situation at 1755 hours and passed on information about the missing inmate (Kysor AJ1746). The recall count was completed at 1758 hours with Kysor still being unaccounted for. The Superintendent ordered the CERT team (Corrections Emergency Response Team) to be activated and all SCI-Albion senior staff were called to report to the institution. The Shift Commander ordered all housing unit officers to, again go cell-to-cell making a positive identification of every inmate, in every cell.

At 1815 hours the Pennsylvania State Police were notified of a "possible escape" of Inmate Kysor AJ-1746. At approximately 1816 hours, corrections officers were

mustered and dispatched to pre-determined escape checkpoints and sent out to conduct roving escape patrols. A call was placed to the Central Office duty officer that SCI-Albion's count did not clear and they had a "possible escape". Corrections Officers continued to search the inside of the facility since there were no visible signs of the perimeter fence being breached and there were no perimeter fence detection alarms indicating that an inmate breached the secure perimeter of the facility.

The Superintendent arrived at the facility at approximately 1815 hours and according to a review of command post logs and checklists, "activated the Incident Command System" at 1852 hours. The Community Alert Network System (CANS) was activated at 1916 hours to notify all surrounding residents via phone of the "possible escape". The recorded message that the Albion resident's heard was as follows: *"This is an Emergency Message from the State Correctional Facility at Albion. There has been an escape. You are being advised to stay indoors and secure your vehicles. If you have any information or observe any suspicious individuals, contact the Pennsylvania State Police at number 814-774-9611. For updated information, please watch your local news."* At approximately 1935 hours, the Superintendent directed the escape siren to be activated for one (1) minute.

It wasn't until approximately 2030 hours that the Corrections Electronics Tradesman Instructor was able to retrieve pre-recorded video that confirmed Inmate Kysor did actually breach the secure perimeter by hiding in a garbage can. At that time all institutional resources were directed to focus their search outside of the facility.

At approximately 2154 hours, the Public Information Officer arrived and put out a press release to officially notify the media of the escape of Inmate Malcolm Kysor. The CERT teams from surrounding facilities (SRCF-Mercer and SCI-Cambridge Springs)

were activated and assisted in searching the grounds and the wooded areas surrounding SCI-Albion.

5.0 Policies, Procedures and Practices and Recommended Corrective Action

This section will address the areas reviewed as a result of the escape of Malcolm Kysor. It will examine the Department of Corrections policies and procedures, the written operating procedures in place at SCI-Albion and the "SCI-Albion practice". Finally, this section will reveal investigative findings and suggest recommended actions that, if in place, could have prevented the escape, and/or lessen the likelihood of a similar type of escape from occurring in the future.

5.1 Areas Reviewed and Inspected

5.1.1 Sally Port

The sally port at the State Correctional Institution at Albion is located on the south side of the institution. The sally port building is constructed of cement block, with an additional room added for the purpose of inmate processing. Staffing for the sally port is one (1) Sergeant posted from 0800-1600 hrs. five (5) days a week, Monday through Friday. The sally port is closed on weekends and holidays unless authorized to be opened by the Shift Commander due to emergency or other occurrence. The sally port has two 14' wide x 15'3" high vehicle gates along with two 36"x 80" walk through gates for pedestrian traffic. The institution's Main Control officer, using cameras and voice recognition prior to opening the gates, electronically controls each of the gates. Main Control operates the gates with an electronic panel with four camera monitors located above the panel. The Main Control officer monitors the cameras and the sally port Sergeant.

A fixed camera is positioned to monitor each of the two vehicle gates, with an additional pan-tilt-zoom (PTZ) camera mounted on the Dietary building facing the sally port area. The sally port is equipped with a walk-thru metal detector as well as a "Heartbeat Detector" system, and a Biometrics (fingerprint identification) system. The sally port has crash barriers installed for the protection of the sally port vehicle gates/perimeter.

5.1.1.1 Pennsylvania Department of Corrections Policy regarding Sally Port Construction 6.3.1 Facility Security Procedures Manual Section 3 – Perimeter Construction states…….

"Each facility shall have no more than two access/egress points in the security perimeter unless otherwise approved by the Secretary/designee. Entrances to the facility security compound shall be limited to one pedestrian sally port and one vehicular sally port. Both entrances shall be with sally port arrangements, with gates, permitting only one gate to the sally port to be opened at one time. The access/egress points shall be monitored and controlled via closed circuit television cameras by the facility control center or controlled from a secure control station located at the access point. Vehicular traffic, particularly, shall be kept to an absolute minimum, and all vehicles shall be searched, both entering and leaving in

accordance with Department policy 6.3.1 "Facility Security," Section 11, Vehicles…"

5.1.1.2 Pennsylvania Department of Corrections Policy 6.3.1 Facility Security Procedures Manual Section 11 – Vehicles states:

"…Facility vehicles must be searched when they enter and exit the facility enclosure…."

The SCI-Albion Post Orders for the sally port Sergeant state:

"…All vehicles entering or leaving the Institution must be thoroughly searched by Correctional Staff as follows:

- ***Have engine turned off.***
- ***All vehicle occupants shall exit the vehicle.***
- ***Raise the hood and inspect the engine area.***
- ***The Sergeant will proceed to search the glove compartment and passenger area thoroughly, including lifting the seats when appropriate.***
- ***Unlock and search the cargo area or trunk.***
- ***Inspect the top and undercarriage of the vehicle. The undercarriage will be searched utilizing the wheeled mirror.***
- ***When appropriate, loads such as liquid waste barrels or other deep containers shall be probed with a sharpened***

probe to ensure that an inmate is not concealed inside the container.

- ***Inspect all packages and equipment***.
- ***Clear vehicle through Micro Search System. Any discrepancy will be reported to the Central Control immediately…… "***

5.1.1.3 SCI-Albion Practice – Sally Port Operations – Vehicles Departing from the Facility

The practice at SCI-Albion for searching and clearing vehicles to exit the secure facility through the sally port are the same regardless of the time of day or the day of the week. When the vehicle pulls up to the inner gate, the sally port Sergeant contacts the Main Control Center via radio and requests the inner gate to be opened. The driver of the vehicle is directed to drive through the inner gate and the sally port Sergeant contacts the Main Control officer to "close the inside gate". The driver is instructed to shut off the vehicle and depart the vehicle for search and inspection. If the driver is a DOC employee, he/she is directed to log out of the biometric fingerprint identification system. The sally port Sergeant is responsible to search the vehicle to ensure that unauthorized items or unauthorized inmates are not hidden in or on the vehicle. This is accomplished by utilization of mirrors, cameras, a sharpened poker for garbage cans and other containers, and a "heartbeat detector" to detect the presence of a heartbeat on the vehicle. The use of the

metal probe and the “heartbeat detector” are not optional and must be used to determine if the vehicle is “cleared” to depart the facility.

On Sunday 11-25-07, the Sergeant assigned to the sally port did not follow Department of Corrections Policy or SCI-Albion local procedures and post orders. He did not use the “poker” to probe the garbage cans nor did he utilize the heart-beat detector. He did walk around the vehicle, search the under carriage with a mirror, and was observed opening the engine compartment of the pickup truck. (Upon being interviewed, he admitted to not utilizing the “heartbeat detector” on several other occasions when he was previously assigned to the sally port).

5.1.1.4 Findings and Recommendations

Issue

The Sergeant assigned on 11-25-07 did sign a training roster indicating he was trained on the heartbeat detector system. During the investigation, it was determined that not all of the sergeants assigned to the sally port are familiar with sally port operations and the use of associated equipment.

Recommendation

It is strongly recommended that all Sergeants and their supervisors (Lieutenants) receive hands-on training on the use of the “heartbeat detection” system. They should also receive training on the operation of the sally port and the associated security equipment; this training should be conducted, at a minimum, once each year. Shift

Commanders must ensure that sergeants assigned to this post are qualified and familiar with sally port operations.

Issue

The computerized “heartbeat detection” system did not have vehicle data entered into the system in order to generate an activity report. If such a report were generated, it would provide a means of comparing the heartbeat detector log with the vehicle log to ensure that the system is being utilized on all vehicles.

Recommendation

The system must have data entered and a printer installed to print the daily activity report. This will enable supervisors to compare the sally port vehicle log with the heartbeat detector log to ensure the equipment is being utilized as directed. This will be a system-wide recommendation.

Issue

The sally port post orders do not contain specific instructions on the use of the “heartbeat detector”.

Recommendation

The post orders should be amended to include step-by-step instructions (including illustrations) on the operation and use of the “heartbeat detector”. This will be a system-wide recommendation.

Issue

The sally port Sergeant completely disregarded the DOC policy and the SCI-Albion post orders and neglected to properly search the pickup and the garbage cans in the back of the pickup truck.

Recommendation

Sally port operations should be limited to only Emergencies on weekends/holidays and after hours. In the event that the Shift Commander authorizes the sally port to be opened at a time other than normal business hours (0800 – 1600 Mon. through Fri.), a commissioned officer should be dispatched to the sally port with the assigned sergeant to ensure proper search procedures are conducted. DOC policy should be amended to ensure all garbage and slop being removed through the sally port must sit through at least one count prior to being permitted out of the facility.

5.1.2 Main Control Center / CCTV Camera Monitoring Officer

All Pennsylvania Department of Corrections facilities have surveillance cameras (intended to supplement the observation provided by corrections officers) and a dedicated officer assigned to monitor them, 24 hours a day, 7 days a week. The location of the monitoring equipment is at different locations at each facility, due to the physical construction and space limitations. The officer assigned to the Closed Circuit Television System (CCTV System) monitoring post is only assigned for a maximum of two (2) hours. This practice is mandated so that complacency is minimized and the assigned officer remains vigilant during his/her assignment.

The CCTV monitoring equipment at SCI-Albion is located in the rear of the Main Control Center and consists of five (5) DVR's. Each DVR has a DVD recorder and can record up to 30 cameras. The average amount of recorded time is 15 days per camera.

5.1.2.1 Pennsylvania Department of Corrections Policy 6.3.1 Facility Security Security Procedures Manual Section 2 – Facility Control Center outlines the duties of the Shift Commander and the staff assigned to the Main Control center as follows:

"…..Each Shift Commander shall be responsible for the operation of the Control Center. In the absence of the Shift Commander, during tours of the facility and meal periods, a Commissioned Officer will be designated as the Control Center supervisor…."

The policy goes on to state:

"…..monitor the status of internal and external security systems, i.e. housing unit control centers, electronically controlled locks and internal systems, facility security towers/ observation posts, and roving perimeter patrols …."

"…a Commissioned Officer shall be present in the Control Center at all times…"

The staffing in the Main Control Center consists of one (1) Commissioned Officer, one (1) Corrections Officer 2 (Sergeant) and two (2)

Corrections Officer 1's. One of the Corrections Officer 1's is assigned to the CCTV cameras to monitor the institution's surveillance cameras. There are a total of 140 cameras installed throughout SCI-Albion that are randomly and systematically monitored by the CCTV officer; 75 are fixed position cameras, and 65 have pan, tilt, zoom (PTZ) capabilities. Assigned officers randomly view selected cameras based on institutional activities and the presence of inmates.

The CCTV post is located at the rear of Main Control, adjacent to the Shift Commander's office. This post consists of four seventeen-inch monitors that are used to monitor all interior and exterior cameras of the institution. There is a VCR that may be utilized for instantaneous recording as directed by the Shift Commander. The computerized perimeter intrusion detection system is also operated from this post. The computer monitor displays a map of the institution and delineates the alarmed zones for the perimeter. The assigned officer must assist with investigating alarms and re-setting them once determined "all clear".

Post Order

A specific set of Security Post Orders for the CCTV Post officer outlined the following specific duties:

"…To remain alert for all emergency transmissions, fire calls, emergency alarms, and to dispatch officers to the scene of an emergency as directed by the shift commander…."

"…To record patrol and security checks as necessary…"

"…To monitor all security systems in the Control Center and to inform the shift commander of any pertinent information…."

"…To notify the shift commander immediately if an emergency occurs within the Control Center. Video monitoring officers will not leave his/her post until properly relieved except in a life-threatening situation…."

"…To perform duties as directed by the Control Sergeant.."

"…To be familiar with the operation of the equipment designated to this post…."

"…Primary duty is monitoring the cameras located around the perimeter that are an integrated part of the perimeter intrusion detection system…."

"…To maintain constant observation of video monitors…."

"…Other duties as assigned…."

5.1.2.2 SCI Albion Practices for CCTV Monitoring (specifically on 11/25/2007)

The investigation revealed that the CCTV officer assigned to the post on 11-25-07, at the time of the escape, was monitoring yard activities and inmate movement on the sidewalks. The officer did not monitor the rear of the Dietary building where the pig slop was being loaded on to the pickup truck and ultimately driven out through the sally port. There are 140 cameras and only 4 monitors. Since there are no specific directions in the post orders as to which cameras are to be monitored at specific times, the assigned officers are left to their own discretion and have the freedom to choose which cameras they wish to monitor.

5.1.2.3 Findings and Recommendations

Issue

The post orders for the CCTV officer are very vague and non-descriptive. Even though the post orders list the monitoring of the perimeter cameras as the primary function of this post, when observed, the post officers paid more attention to the interior cameras monitoring the yard and walkways.

Recommendation

The post orders should be re-written to establish more specific orders for the assigned officer. During specific events (opening and closing of the sally port, loading and unloading at the rear Dietary dock, etc.) the post orders should mandate that the officer be

required to monitor specific activities that are deemed “high security areas or activities." More specific direction needs to be given regarding the cycling of cameras through the Control Center monitors. Shift Commanders should ensure that the assigned officers are familiar with the monitoring equipment and the associated responsibilities.

Issue

The CCTV monitoring officer has other duties such as equipment inventory, radio battery maintenance, operation of the PIDS computer, etc. These extra duties have the potential to distract the officer from their primary duty to monitor the cameras.

Recommendation

The CCTV monitoring officer should not be assigned duties not associated with the post. The duties assigned to the CCTV monitoring officer should be reassigned to other Control Center staff. Shift Commanders must ensure that this occurs.

5.1.3 Inmate Accountability and Count Procedures

One of the primary functions of all correctional employees is to maintain the accountability of the inmates. This is accomplished in a variety of ways outlined in Pennsylvania Department of Corrections policy. Reference the section outlined below.

5.1.3.1 Pennsylvania Department of Corrections Policy 6.3.1

Section 9 - Counts and Inmate Movement states:

"…The DSFM/DSIS is responsible for maintaining the count system on an ongoing basis and ensuring compliance with the inmate pass/movement procedures.

"….In addition to formal counts, all staff with inmates under their supervision shall make irregular but periodic (at least hourly) census checks of the inmates under their supervision. Any discrepancy in a census check must be immediately reported to the Control Center.

"…Procedures shall be established for announcing and supervising general line movements. Movement shall be by specific purpose such as work lines, school lines, yard-out, etc. to ensure that movement is controlled, and that staff know the destination of each line movement. Staff shall maintain direct and indirect supervision/observation or point-to-point observation of all general line movements…"

"…Inmate Pass System (IPS)
Except when under direct escort or for general line movements, the IPS shall be employed to regulate inmate movement.
If an inmate is scheduled on the DMS (Daily Movement Sheet) a pass will be issued by staff prior to the inmate's scheduled appointment.

Staff who need to see an inmate not listed on the DMS will contact the appropriate area and inform the staff person that the inmate(s) has been called…."

"…Accountability

All employees share the responsibility for inmate pass control and accountability. Random checks of inmate passes at points other than the origin and destination shall be conducted and verified by staff completing the "Trip Pass Verification" form. (Attachment B)…"

"…Staff who receive or detect unauthorized inmates in their area (by pass or otherwise) must immediately report the matter to the Control Center and take corrective action…."

5.1.3.2 SCI-Albion Practice

Inmates were observed leaving the housing units without passes for destinations unknown to the housing unit officer. The general line movements that are conducted upon the clearing of the noon count permit any inmate to leave the housing unit whether he is authorized or not. This practice enables inmates to be unaccounted for up to 3 to 4 hours if unit officers do not take an informal census of the inmates assigned to their unit.

In the case of Kysor, he was able to leave the housing unit and report to work on his off day. His Dietary work supervisor permitted him to work, which was unknown to the housing unit officer. He should not have been permitted off the unit with work lines and the supervisor should have issued him a pass and sent him back to the housing unit and called his unit officer.

Several officers related that they did not issue passes to inmates on the Daily Movement Sheet (DMS), which is a violation of policy. Inmate passes that contain a time of departure, time of arrival both departing the housing unit and then returning to the housing unit from the authorized appointment, are the primary means of maintaining accountability for inmates. Inmates who have scheduled appointments and are “no shows” are to be reported to the housing unit officer by the individual who scheduled the appointment. Likewise, if an unauthorized inmate shows up at an unauthorized location, the housing unit officer is to be notified. The investigation revealed that several of the housing unit officers did not have a good understanding of “inmate accountability”.

5.1.3.3 SCI-Albion Count Procedures

The actual count procedures used are in accordance with policy. If there is a miscount, it is logged into a designated logbook. The staff who miscount must complete a DC-121 Report of Extraordinary Occurrence. There have only been twelve miscounts

for the entire year, indicating that this procedure emphasizes the importance of having a good count.

The first count established the absence of the missing inmate and the housing unit officer's last known location of the inmate, which was the food service area where the inmate was employed.

SCI-Albion's count procedures require all housing units to list the inmate name, number, and location of inmates assigned to their unit who are counted off of the housing unit during a count period. The officer verifies the presence of the inmate at a non-housing unit area by phone conversation with the staff member who is supervising the non-housing unit area. The name of the staff member contacted to verify the out count is included on the unit count sheet. In this instance, the officer was unable to verify the presence of the inmate with food service. This was due to food service staff not knowing who was present in the area. The procedures in place at SCI-Albion for inmates working in the Dietary department during count, involve the work supervisor collecting the inmate's identification card when he reports to work. When the direction is given to count the inmates, a physical count is compared to the identification cards. The investigation revealed that Inmate Kysor's I.D. card was never located, which would indicate: 1) he never turned it in; 2) it was given back to him; or 3) the I.D. cards were left unsecured and someone removed it.

5.1.3.4 Findings and Recommendations

Issue

The Deputy Superintendent for Facility Management is responsible for maintaining the count system on an ongoing basis and ensuring compliance with the inmate pass/movement procedures. Discussions with several unit officers indicate that pass procedures are not being followed.

Recommendation

Ensure that all staff members who issue passes do so in accordance with the aforementioned policy. Direct the commissioned officers and department heads to conduct follow up training with their respective staff members.

Issue

All staff members with inmates under their supervision are not making irregular but periodic (at least hourly) census checks of the inmates under their supervision. Any discrepancy in a census check must be immediately reported to the Control Center. This includes inmates in their area that should not be present. In this specific instance, an inmate was at work on his day off.

Recommendation

Ensure that all staff members who supervise inmates are responsible for accountability of inmates under their supervision. Direct the commissioned officers and department heads to conduct follow up

training with their respective staff members. Alertness checks should be conducted to test the staff.

Issue

Movement shall be by specific purpose such as work lines, school lines, yard out, etc. to ensure that movement is controlled, and that staff knows the destination of each line movement. Line movements at the clearing of the noon count are not controlled in a manner so that staff members know the destination of each movement.

Recommendation

Segregate work lines, school lines, and yard out in accordance with policy. The unit staff must know which inmates they are sending out of their unit for work, school, groups, and activities. Most affected times would be at the start of morning lines following the breakfast meal, and again following the clearing of the noon count. Work schedules, school rosters, callouts are available on the unit as a reference for tracking inmates. These rosters and schedules must be utilized to appropriately track their inmates. Any deviations from the established schedules must be cleared with the Shift Commander**.**

Issue

Inmate passes are not being utilized in accordance with policy. Inmates listed on the daily move sheet (DMS) are to be issued passes prior to reporting to their scheduled appointment. This is not occurring. Staff members who need to see an inmate not listed on

the DMS are not contacting the appropriate area to inform the staff person that the inmate(s) has been called.

Recommendation

Staff must issue a pass in accordance with policy. DOC Policy should be amended to state that staff who need to see an inmate not listed on the DMS, a pre-established roster, or work schedule must be approved by the Shift Commander.

Issue

The Trip Pass Verification forms that are mandated by policy to ensure the pass system is being administered properly are not being used sufficiently. Staff members are not being held accountable for the presence of unauthorized inmates in their area.

Recommendation

Shift Commanders must be held accountable to ensure that a minimum and maximum range of random checks are completed at housing units, non housing units areas such as the program services area, and outside at the pedestrian gates. The respective zone lieutenants and unit managers must review the forms daily to ensure compliance. The shift commanders to ensure compliance on their respective shift assignments should then collect these forms for subsequent review. Managerial staff members, when completing their required rounds should complete periodic “spot checks”.

Issue

Inmate Kysor should not have been able to leave the housing unit for the purpose of reporting to work on his day off.

Recommendation

The work schedules should be adhered to in accordance with policy. This inmate was not scheduled to work overtime at any period while confined at SCI-Albion. This was confirmed through a review of his pay records for May-November 2007.

5.1.4 Managerial Visits and Inspections

Pennsylvania Department of Corrections Policy mandates the number and frequency of managerial visits and inspections of all areas of the facility. The responsibility to inspect the facility is vested with the Superintendent, Deputies, Majors, CCPM (Corrections Classification and Program Manager), Intelligence Captain, and Shift Commanders. Each Facility is required to establish local procedures to ensure that the managerial inspections are conducted per policy.

5.1.4.1 DOC policy 6.3.1 Section 19 Pennsylvania Department of Corrections Policy 6.3.1 Section 19 Managerial Visits and Inspections states:

"….Visits/inspections shall focus on reviewing security practices and safety and sanitation procedures. Issues to be reviewed include, but are not limited to: tool control; key control; inmate movement and pass system; security equipment and radios; fence, cell and bar checks; inmate

searches; cell block/facility searches; staff searches; cell content policy; coverings on walls, bars, windows; general cleanliness of all areas; caustic/flammable/toxics; inmate and staff morale. These visits/inspections/reviews, along with the regular facility reports, annual inspection reports, and SCAN information will be used to determine if correctional facilities/boot camp(s) are functioning properly…."

The policy goes on to state:

"….The Facility Manager, DSCS, DFSM/DSIS, Majors, Intelligence Gathering Captain or Security Lieutenant and the Corrections Classification Program Manager (CCPM) shall inspect each housing unit once per week, to include unoccupied areas. In addition, he/she will each inspect all other major areas of the facility, at least once per month. Visits should occur at different times on different days, and the noted individuals should not all visit at the same time…."

"…The Facility Manager shall establish sign-in logbooks which will be bound books with sequential page numbers, in all housing units and each major area of the facility (maintenance, correctional industries, education, food services, activities, construction sites, etc.). Each manager required by this policy to inspect any area, shall annotate the appropriate logbook. . . "

"…Each housing area shall be inspected daily by either the Shift Commander or Alternate Shift Commander and all other areas of the facility will be inspected on at least a monthly basis. The Shift Commander or Alternate Shift Commander shall annotate the log in each area visited and note findings and deficiencies on the daily Shift Commander's report.

Each Area/Zone Lieutenant shall inspect each housing unit on a daily basis in his/her area/zone of responsibility…"

5.1.4.2 SCI-Albion Practice

The investigation revealed that managerial staff were not making their visits and inspections as required by Department of Corrections policy. Many of the logbooks were reviewed for the last several months from the housing units, program areas and other institutional buildings including the sally port. The Commissioned Officers appeared to be making their rounds with few exceptions, as were the majors. The rounds by the Deputy Superintendents were sparse in some areas and those required by the Superintendent were practically non-existent. The logbook from the sally port did not contain the Superintendent's signature for the last several months. The investigation revealed that the Superintendent is not leading by example or following policy in this area and the remaining managerial staff is not being held accountable for making required visits and inspections.

5.1.4.3 Findings and Recommendations

Issue

The Deputy Superintendents are missing housing units during their weekly rounds. The Superintendent is not completing weekly and some monthly rounds.

Recommendation

Establish a checklist for the above listed staff to fill out and sign indicating that they have/have not made their required visits/inspections. This list will specifically reflect those areas that require weekly rounds and monthly rounds. This will serve as a reminder for staff to make their mandated tours and inspections. It will also serve as a tracking form and will provide a means of accountability.

Issue

The monthly report required by DOC policy indicating that managerial staff were making their weekly/monthly inspections was not correctly reported to the Regional Deputy Secretary. The current procedure of spot checking log books was inadequate and provided false information.

Recommendation

The Corrections Superintendent's Assistant should utilize a form that is submitted to her monthly by the Superintendent, Deputy Superintendents, Majors, CCPM, and Intelligence Captain. This form must be used to document the completed weekly and monthly

rounds in accordance with policy. The staff members who submit the forms must sign to attest the date of the completed rounds. It will serve as documentation of compliance with policy. The form may also be utilized to check directly against the housing units logbooks to ensure compliance.

5.1.5 Dietary Operations

An extensive review of the Dietary operations and the general security of the Dietary Department was conducted since this was the area where Inmate Kysor was able to move about freely and was assigned to a job in the back hallway, processing garbage.

5.1.5.1 Dietary Management and Supervision

During the course of our review and investigation of the Dietary Department it was found that there were very few of the daily operations and procedures committed to writing as local procedures. It was discovered that several memos and emails as opposed to local procedures, had been written over the past few years informing Dietary Staff of various operating procedures, however, very few of them were being followed by staff assigned to the Dietary Department.

For instance, multiple memos were reviewed directing Dietary Staff to not permit inmates to work in the Dietary Department other than their pre-established workdays and shifts, but the practice was to permit inmates to report to work on their days off. In fact, Inmate

Kysor was a Tuesday through Saturday worker and the investigation revealed that he worked seven (7) days a week.

Another email from the Corrections Food Service Manager directed the Supervisors to not permit Custody Level 4 inmates and “Lifers” to work in the back hallway, adjacent to the dock area. Inmate Kysor, who was serving a life sentence, worked in the back hallway every day that he worked. Due to the disregard for the verbal direction given by the Dietary Manager, a set of written orders, referred to as “Areas of Responsibility” for each of the Food Service Instructors and Food Service Supervisors were established but never finalized and disseminated to staff. It was stated that the Human Resources Director deemed them to be too specific and therefore the process stopped.

A review of the Dietary Department and reports generated from this area indicates that this has been a “problem area” for some time. Approximately one month prior to the Kysor escape, a general search of the area turned up several homemade weapons and other contraband items hidden in the ceiling and other hiding places throughout the Dietary Department. SCI-Albion recently developed a plan-of-action to address the complacency in the Dietary Department after the search that yielded the weapons cache and other contraband.

During the course of the investigation it was both observed and confirmed through interviews of staff and inmates that the

inmates spent a considerable amount of time just standing at the rear windows looking at the sally port operations and the outside warehouse. The Dietary building has large windows along the entire length of the rear wall with an unobstructed view of the sally port, Utility Plant, garage and outside warehouse. The proximity of the sally port to the Dietary Department enables the inmates to easily observe the vehicle search procedures and all other operations occurring at the sally port.

From interviews conducted, it was found that this has been a permitted practice for years in the Dietary Department. In fact, a smoking area has been established next to the windows where inmates were observed continually smoking and staring out of the windows. Interviews conducted with Security staff and other administrators revealed that the Dietary Department has been a troubled area for quite some time and many of them have made attempts to enhance the security in this area without success.

5.1.5.2 Removal of Food Waste (Pig Slop)

One of the procedures reviewed was the procedure for processing food waste (pig slop) from the collection point to the delivery/staging area where the local farmer picked it up. It was found that only verbal direction for the entire process had been given and that no written procedures existed. When the process began approximately two years ago, trash containers were purchased, specifically for the removal of the pig slop. They were all yellow

containers and they were thirty-two (32) gallon capacity. According to the staff interviewed, everyone knew that the yellow garbage cans were intended for transporting the pig slop.

Sometime over the last weeks or months, gray cans began being utilized due to a “shortage” of the yellow cans. They were the same size and type and it appeared that the practice wasn’t questioned and became common. On the day of the escape, Kysor cleaned out a larger forty-gallon gray garbage can, climbed into it with the assistance of Inmate Gromer, rode out of the facility undetected. It is quite possible that Kysor initiated the introduction of the gray cans to determine if they would go through the process unchallenged and when staff became accustomed to using them, he substituted a larger can that he was able to fit inside more comfortably. This entire event, which has been captured on pre-recorded surveillance video, happened within a few feet of a Corrections Food Service Instructor and another inmate who we have not determined to be an accomplice or that he was even aware of what was occurring. The Office of Professional Responsibility (Special Investigations) continues to interview staff and inmates as of the writing of this report.

5.1.5.3 Findings and Recommendations

Issue

Inmates are permitted to report to work in the Dietary Department at times or days other than when they are scheduled.

Recommendation

Strict enforcement of the inmate accountability policy starts at the housing unit whereby the Unit Officer must know which inmates are being left out of their cells and subsequently permitted to exit the housing unit to other areas of the facility. A system needs to be developed for the Unit Officers whereby they have an easy reference as to who is permitted off the unit and when. In conjunction with housing unit accountability, all other areas must be required to enforce the established facility practices. Managerial Inspections and supervisory visits should focus on whether the written procedures are being followed. Ultimately, staff should be held accountable for their actions and progressive discipline should be utilized for acts of non-compliance and complacency.

Issue

Only verbal orders could be confirmed regarding the procedures for the removal of food waste (pig slop) from the Dietary Department.

Recommendation

An immediate review of the various security procedures that are conducted in the Dietary Department needs to be conducted and written procedures must be developed and disseminated to staff. Staff must receive training on the various procedures and must be held accountable to enforce them as written.

Issue

Inmates working in the Dietary Department have an unimpeded view of the sally port and other outside areas and activities. This allowed Kysor to gain valuable intelligence on security procedures that ultimately facilitated his successful escape.

Recommendation

The windows in the Dietary Department should be “frosted” from the seven (7) foot level down to the bottom of each window. Windows in security doors having a view of the sally port should be evaluated and if not in a restricted area under direct staff supervision, consideration should be given to “frosting” them.

Issue

There was a general atmosphere of complacency in the Dietary Department that has existed for a long time. Several memos were collected from the Deputy Superintendent for Centralized Services and the Food Service Manager that recognized areas where staff complacency existed and gave orders for corrective action but our investigation has shown that the “accepted practice” has not changed. Written orders and emails from the Food Service Manager were totally disregarded.

Recommendation

The Management and Supervision of the Dietary Department should be given a very close review. Realizing that the production of the

inmate meals is vitally important, security is being overlooked and complacency has become the norm as opposed to the exception. A performance review of the current manager and supervisor needs to be conducted immediately and specific benchmarks and expectations need to be established. Staff must be held accountable for not following orders whether they're verbal or written.

5.1.6 Alertness Monitoring – Complacency Drills

Most of the duties performed in a correctional facility are routine and repetitive. Prisons run on a "daily routine" that becomes, at times, boring and mundane. One of the biggest challenges facing today's Corrections managers is combating complacency with their staff. Although Emergency Preparedness training is essential for all corrections employees, dealing with emergencies or crises is a very small part of the Corrections employees' job. The Pennsylvania Department of Corrections has recognized the battle against complacency to be of utmost importance and has issued policy on the subject.

5.1.6.1 Pennsylvania Department of Corrections Policy 6.3.1 Facility Security Manual Section 28 – Alertness Monitoring states:

"…each Facility Manager shall ensure that a series of alertness monitoring checks are developed to monitor the alertness of staff. These checks are not intended as a means to evaluate an individual's job performance or every aspect of a particular

function, but rather to evaluate key components of a function as they relate to the security of the facility. …"

"…Each of the checks must be conducted in a controlled manner under the supervision of the Facility Manager, Deputy Superintendents, Majors, Intelligence Gathering Captain, or Shift Commander to ensure that staff is alert to certain situations that could indicate a potential or actual problem. Samples of proposed drills are contained in the Alertness Monitoring Example Guide. Each check is to have a measurable goal and a minimum timetable for checks to be conducted…"

"…One or more of the following shall be used monthly to check sally port Officers' alertness:

> ***An employee can be placed in a vehicle wearing a tag that clearly states "Alertness Check - Escapee" to see if the individual is detected.***
>
> ***A package clearly marked as "Alertness Check - Contraband" can be placed in a vehicle that is to enter/egress the facility to see if it is detected.***
>
> ***An employee can try to bring an unauthorized vehicle into the facility…"***

5.1.6.2 SCI-Albion Practice

SCI-Albion practice is not in compliance with DOC policy 6.3.1 section 28. While the documented reports were completed, they were generally reports of observed staff behavior, and not actual drills in accordance with policy.

5.1.6.3 Findings and Recommendations

Issue

The Security Office is responsible to conduct a certain number of complacency drills both quarterly and/or monthly. Per Policy 6.3.1, Section 28, a monthly complacency drill shall be conducted at the sally port. Checks of the quarterly complacency drills show that this has not been done. Simply observing the heartbeat detection system being used does not qualify as a drill.

Recommendation

Ensure that the Security Office comes into compliance with the policy.

Ensure that an actual sally port drill is held monthly.

5.1.7 Vulnerability Analysis

Each facility must undergo a vulnerability analysis once every three (3) years. This inspection is conducted by a team of trained DOC employees and is utilized to identify weaknesses in the Institution's Security by testing systems and staff to determine the likelihood of escape. The report is very detailed and lists possible scenarios where an escape could most likely occur due to physical

construction, perimeter detection, lighting, etc. The report is forwarded to the Superintendent who is required to submit a plan of action to the Regional Deputy and a follow-up progress report within six months of the analysis.

5.1.7.1 Pennsylvania Department of Corrections Policy 6.3.1

Section 8 Vulnerability Analysis states:

"…A vulnerability analysis is a systematic performance-based approach used to determine the type of threats that exist within a facility. This analysis attempts to evaluate practices, procedures, and policy compliance and test the physical protection systems in place, in an effort to prevent or limit opportunity for the threat to occur. A vulnerability analysis includes planning, facility characterization, threat definition, and identification of undesirable events, performance testing the physical protection systems, generation of path sequence diagrams, scenario development, timelines development, and determination of risk for worst-case scenarios…."

"…Ensure that the corrective plan-of-action for addressing issues or recommendations disclosed by the vulnerability analysis team as outlined in Vulnerability Analysis Deficiencies/Plan-of-Action (Attachment 8-A) is prepared and submitted to the Regional Deputy Secretary and the VA Team Leader within 30 calendar days following receipt of the vulnerability analysis report. The corrective plan-of-action must

describe corrective action(s) to be taken, staff responsibilities, and a timetable for completion of each task…."

"…Ensure a corrective plan-of-action progress report is prepared and submitted to the Regional Deputy Secretary six months following the date of the analysis…."

5.1.7.2 SCI-Albion Practice

The vulnerability analysis was conducted in October of 2005 and the report identified a scenario similar to the actual escape that occurred on November 25, 2007. A plan-of-action or a six-month progress report could not be located. The Superintendent could not produce either report.

5.1.7.3 Findings and Recommendations

Issue

Potential weaknesses were identified in the vulnerability analysis report that should have been addressed in a plan-of-action. A plan of action and a progress report was not located nor could one be provided by the Superintendent. Had the areas in the report been addressed, the escape could have possibly been averted.

Recommendation

Systems need to be reviewed to ensure that vulnerability analysis discrepancies and weaknesses are addressed at the facility level and by the respective Regional Deputy Secretary.

5.1.8 Incident Command System – Emergency Procedures

It is mandatory for every corrections employee to receive annual training on the Incident Command System. Superintendents are also charged with having drills and exercises to test the Emergency Preparedness of the staff. Even though the Pennsylvania Department of Corrections has very few "major incidents", staff must be aware of the Incident Command System to be able to understand their role and the role of Command Staff in the event of a facility emergency. Each facility maintains a set of "Emergency Plans" that have guidelines and checklists for specific types of emergencies.

5.1.8.1 Pennsylvania Department of Corrections Policy 6.7.1 "Incident Command System", states:

"…In the event of a critical incident within a Department facility, the highest-ranking official in the Chain of Command present at the facility at the time of the incident shall assume initial command of the emergency…."

This means that in the absence of the Superintendent, the Shift Commander is in charge of the facility until the Superintendent arrives on scene and receives a full briefing of the incident.

5.1.8.2 Official Timeline of Events

The following is the "official timeline" of events that have been verified by a comprehensive review of all Command Post logs, Extraordinary Occurrence Reports, logbooks, and other related checklists, beginning at the time Inmate Kysor climbed into the forty

gallon garbage can and ending with the official notification of the media (via fax) at 2154 hours.

- **1440 Hours:** Camera footage obtained by the SCI-Albion Security Office shows inmate Malcolm Kysor, AJ-1746, being assisted into a forty-gallon plastic pig slop refuse can by inmate John Gromer, GL-4861. Inmate Gromer then placed plastic over the can to hide Inmate Kysor. The can was then loaded onto a green institutional truck and driven by a CFSI into the sally port.
- **1429 – 1444 Hours:** According to the sally port log, a CO2 arrives to the sally port and logs the truck in and out. The CO2 issues verbal direction to open the sally port and admits in his DC-121 Part 3, Employee Report of Incident, that he used neither the heartbeat monitor nor a sharpened poker. He was observed on camera using only a rolling mirror to check the undercarriage of the truck.
- **1605 Hours:** The pig farmer picks up the pig slop and notices an empty can. Although he thought it strange, he does not notify anyone.
- **1615 Hours:** An institutional count is conducted.
- **1645 Hours:** A corrections officer in F/A-Unit reports that they are unable to locate inmate Malcolm Kysor, AJ-1746. Inmate Kysor is assigned as a dietary worker but is supposedly off on this date.
- **1650 Hours:** 1400-2200 Shift Commander is notified by a Shift Lieutenant that the institutional count did not clear indicating they were one (1) inmate short. A subsequent recount is directed.

- **1708 Hours:** A Main Control officer is directed to initiate an emergency log.
- **1715 Hours:** 1400-2200 Shift Commander directs a search of the Activities Building.
- **1724 Hours:** The recount did not clear showing inmate Malcolm Kysor, AJ-1746, as missing. Yard officers are deployed to the housing units to verify inmates returning to their housing units for a recall count.
- **1729 Hours:** A second Outside Security Perimeter Patrol is deployed.
- **1730 Hours:** An Activities Specialist and a corrections officer are assigned to search the Activities Building again.
- **1735 Hours:** All inmates are returned to their housing units and a recall and staff accountability count is initiated. Yard officers are deployed to search the loading dock and trash dumpsters behind the Dietary Department.
- **1745 Hours:** A perimeter fence check is conducted to ensure the integrity of the fence and to look for signs of a breach or attempted breach.
- **1755 Hours:** The 1400-2200 Shift Commander notifies the Superintendent at her residence. Details regarding the recall count and search actions taken to that point, including the identification of the missing inmate, are relayed. The Superintendent orders a senior staff recall and activates SCI-Albion CERT.

- **1758 Hours:** The recall count does not clear and again shows Inmate Kysor as missing. All housing unit officers are directed to conduct a cell-by-cell inspection to verify the identity of each inmate.
- **1806 Hours:** All senior staff and CERT personnel are notified to report to the institution. Critical Incident Manager (CIM) is called and/or paged.
- **1815 – 1816 Hours:** A staff accountability count is successfully completed. Team "A" responders are directed to report to Main Control to deploy escape patrols. PSP is notified of a possible escape and provided a description of Inmate Kysor. The Superintendent reports to the facility.
- **1818 Hours:** Central Office is notified of a possible escape.
- **1830 Hours:** The 1400-2200 and 2200-0600 Shift Commanders report to the Superintendent's Office to receive a briefing with the Superintendent and both Deputies.
- **1835 Hours:** Escape patrols are deployed, as well as a search undertaken of the institutional grounds and surrounding woods by SCI-Albion CERT. **Note: Search is hampered by cold/windy/rainy conditions.**
- **1837 Hours:** An officer is dispatched to secure the front gate and limit access to authorized personnel only. The parking lot and all vehicles are searched.
- **1844 Hours:** PSP arrives at the institution and are escorted to the Command Post.

- **1852 Hours:** The Superintendent activates the Incident Command Post. The Critical Incident Manager (CIM) arrives at the institution and assists the Superintendent with setting up the Incident Command Post.
- **1916 Hours:** The Community Alert Network (CANS) and escape whistle are activated for Albion and the surrounding areas. **(ICS Log 214 denotes this time for both actions). (The actual CANS report sent the calls at 1943 Hours).**
- **1930 Hours:** A Unit Manager is directed to contact the Office of Victim Services.
- **1935 Hours:** Per the Extraordinary Occurrence Report (EOR), the institutional emergency whistle is activated for one (1) minute per the Superintendent. **(ICS Log 214 states this occurred at 1915 Hours).**
- **1955 Hours:** The Unit Manager re-calls the Camp Hill Duty Officer to assure the identity of the Duty Officer and verify that the Office of Victim Services was contacted.
- **2000 Hours:** A thorough search of all remaining buildings and the perimeter fence is conducted with negative results.
- **2030 Hours:** (Approximately) The Corrections Electronics Tradesman Instructor retrieves recorded video that confirms Kysor escaped by hiding in a garbage can and being transported, undetected through the sally port.

- **2043 Hours:** The ICS 214 Unit Log states that the local media is at the front gate being briefed by the PIO. **(This time is in dispute with 2154 Hours reported on the extra ordinary occurrence report when the press release was faxed).**

5.1.8.3 SCI-Albion Practice

A review of the incident from the time Inmate Kysor was identified as "missing" revealed that SCI-Albion staff performed as expected and followed the guidelines as established in Department of Corrections Policy. After comparing various reports, minor discrepancies were noted with regard to the times listed on various reports. Those discrepancies did not have a direct bearing on the escape but did, however, affect the level of community sensitivity and confidence.

5.1.8.4 Findings and Recommendations

Issue

The third count did not clear at 1758 hours. The Community Alert Network System and the escape siren was not activated until approximately 1916 hours. Even though the automated message on the Community Alert Network System informed residents to tune into their local news for additional information, the press release was not sent to the media until 2154 hours. The Office of Victim Services was notified at 1930 hours of a "possible escape" and a follow-up call was never made to confirm that an "actual escape" had occurred.

Recommendation

The media should have been notified shortly after the third count (recall) did not clear. The Community Alert Network System and the escape siren should have been activated at that time (1758 hours). Although a follow-up call to Victim Services should have been made to confirm the escape, it is recommended that Victim Services notifies the registered victims upon initial notification of a “possible escape” to ensure they are made aware at the earliest possible time. If it is found that the inmate did not escape, a follow up call should be made. DOC Policy should be amended to include language on prompt notification, eliminating managerial discretion.

Issue

According to Extraordinary Report #ALB-186-07, the escape siren was activated at 1935 hours; the ICS Unit log shows that this occurred at 1915 hours. The Office of Victim Services was notified at 1930 hours on the Unit log; but not until 1955 hours on the SCI-Albion Critical Incident Checklist (Volume #1, Section #9(C), Escapes). The Community Alert NetworkSystem was activated at 1915 hours as per the Unit logs; however, the actual CANS Report show that the calls were activated at 1943 hours. It appears that unfamiliarity with the CANS created approximately a 30-minute delay in community notification.

Recommendation

Accurate times need to be ensured on all ICS documents. According to Exercise/Drill requirements, CANS test activations are to be done quarterly. Familiarity with the CANS system is crucial. All Commissioned Officers should be familiar with CANS activation. The Critical Incident Manager (CIM) is the only individual that tests/activates the CANS for the quarterly drills. All Commissioned Officers, or all shifts, need to be trained on the system. Add phone numbers for media notification to CANS. This is a system-wide recommendation.

Issue

An initial ICS Worksheet was never completed**.** An initial ICS Worksheet has been formulated by Central Office to assist initial Incident Commanders and contains numerous benchmarks for any type of emergency; this sheet would aid a Shift Commander in a Transfer of Command/Operational Briefing and assure that timelines were accurate.

Recommendation

Incorporate the use of an initial ICS worksheet in both training exercises and actual emergencies. A supply of ICS worksheets were in the Main Control Center at the time of the incident.

6.0 Conclusion

The escape that occurred at the State Correctional Institution at Albion on Sunday November 25, 2007 at approximately 1447 hours should not have occurred. The investigation revealed that there were physical barriers, detection systems, and written Department of Correction Policy that should have prevented it.

One of the greatest concerns of the Pennsylvania Department of Corrections is complacency. Most days in a correctional facility are mundane and even boring; the same routines are faced day after day. There's a saying that is frequently heard by Correctional Staff, "A boring day in Jail is a good day". Superintendents are challenged to keep their staff working at peak performance. The unfortunate reality of the Corrections profession is that the longer a facility (or Department) goes without experiencing an emergency or significant event, the more complacent they become. In essence they become victims of their own successes. Since the last breach escape in Pennsylvania occurred in 1999, many of the newer employees have never experienced such an event, or any type of emergency for that matter. Complacency was the major contributor to the successful escape of Malcolm Kysor; from the Sergeant who permitted the truck to exit the sally port without properly searching it, to the Managers who didn't make required inspections and conduct follow up to ensure policy and procedure were being followed. The PA Department of Corrections recognized the seriousness of the complacency factor and has spent millions of dollars over the last several years adding staff and technology such as heartbeat detectors, additional cameras, and more sophisticated perimeter detection systems. Another initiative the Department took was creating policy that made it mandatory for facility managers to conduct realistic alertness

checks (complacency drills) to help their staff combat complacency. This investigation has revealed that regardless of the systems and physical barriers in place, if the managers and line staff are not following established policy and procedure, critical incidents can and will occur.

The concerns raised by the Albion community and the media that the Facility did not make notifications in a timely manner are valid, but after a closer review, the notifications were not as untimely as it originally appeared. Kysor escaped at approximately 1447 hours and the community was not notified by the Community Alert Network System and the activation of the escape siren until 1916 hours (approximately 4.5 hours later). This time frame, at first glance, appears extremely excessive but in reality he was missing from 1447 hours until approximately 1758 hours (approximately 3.5 hours) without SCI-Albion staff being aware that he had escaped.

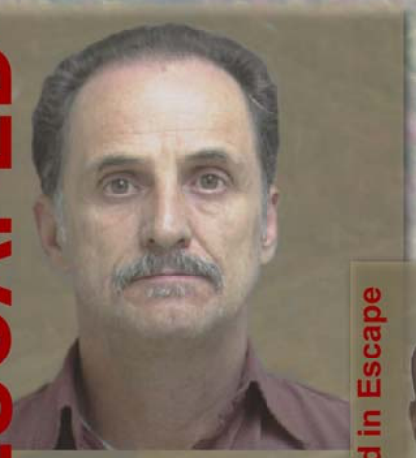
Pennsylvania Department of Corrections Policy mandates that all staff is to conduct an “informal” census at least once each hour to determine the whereabouts of the inmates assigned to them. This did not occur and it wasn't until the formal standing count that commenced at 1615 hours that staff became aware he was missing. Department of Corrections Policy for counting inmates also states that if the count doesn’t clear on the first count, the Shift Commander shall initiate a recount. If after a recount, the count still doesn’t clear, a third count (referred to as a recall) is to be conducted. A recall involves inmates being returned to their cell for a standing count. This was all done according to policy and as a result the official confirmation that Kysor was missing came at 1758 hours.

The Community and the Media should have been notified shortly after the official confirmation, (1758 hours) but a feeling that Kysor was still inside the secure perimeter

hiding, as opposed to escaped, delayed the notification to the community. The manager's decisions were based on the fact that the perimeter fence inspection did not reveal any signs of breach or attempted breach and the Perimeter Intrusion Detection System did not alarm. It wasn't until approximately 2030 hours when the recorded surveillance video was retrieved from the digital recording system that Command Staff confirmed Inmate Kysor escaped through the sally port hiding in a garbage can.

As a result of this very unfortunate incident, changes have already been made to the operations at SCI-Albion and changes are pending to Pennsylvania Department of Corrections policy and procedure. As with other similar occurrences in the past, this one will serve to make Department of Corrections Staff more vigilant and aware of just what can happen if the basics are not followed and made part of their daily routine.

ESCAPED



Malcolm Kysor
AJ1746

Assisted in Escape

John Gromer
GL4861

1

Inmate Kysor brings an empty trash can(1.a) and objects/items in a trash bag(1.b) into the trash room adjacent to the loading dock area. The open door to the corridor partially obstructs the view of the security camera. Kysor gets inmate Gromer's attention and both proceed to the trash room containing the empty trash can(1.c). Kysor climbs into the trash can(1.d). While checking the position of the Food Service Instructor, Gromer covers Kysor with the trash bag(1.e). Gromer pulls the trash can through the loading dock area(1.f) out onto the loading dock(1.g).

2

A third inmate removes empty trash cans from the pickup truck at the loading dock as Gromer slides the trash can with inmate Kysor inside to the end of the loading dock(2.a). Picking up the trash can, Gromer places it at the front of the bed in the pickup(2.b). After loading the remaining trash cans that were already on the loading dock(2.c), Gromer and the third inmate return inside the loading dock area and the pickup departs the loading dock(2.d).

3

Loading dock

Sally Port

Warehouse

The pickup truck proceeds to the Sally Port(3.a and 3.b). At the Sally Port the pickup is inspected underneath and under the hood. The trash cans were not inspected(3.c). The pickup exits the Sally Port(3.d) and proceeds to the warehouse where it is parked(4.a).

4

How he escaped....

These still shots taken from security cameras throughout the institution show how Malcolm Kysor escaped. *(Photo 4 is the exception. It was taken after the fact to show the final location of the truck.)*

1. With the aid of inmate John Gromer, Kysor climbed into a trash can and was covered with trash. The trash can was taken to the loading dock.
2. At the loading dock, the trash can was loaded with other trash cans onto a pickup truck.
3. The trash cans, not being inspected, allowed Kysor to pass through the Sally Port undetected.
4. The truck proceeds to the warehouse where it is parked.

November 25, 2007 Escape Timeline

14:00 | 15:00 | 16:00 | 17:00 | 18:00 | 19:00 | 20:00 | 21:00 | 22:00

- Escape attempt begins
- Kysor is in the trash can and is loaded onto truck
- Truck leaves the loading dock
- Truck passes thru Sally Port
- Institution count
- Institution recount
- Recount not cleared
- 2nd mobile perimeter posted, activity buildings searched
- Fence integrity check
- Supt. notified
- PSP. notified
- Central Office notified
- Community Action Network Initiated
- Additional building search
- Media Notification