



# Lopez Escape Review

Texas Department of Criminal Justice

Final Report – September 2022

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## Executive Summary

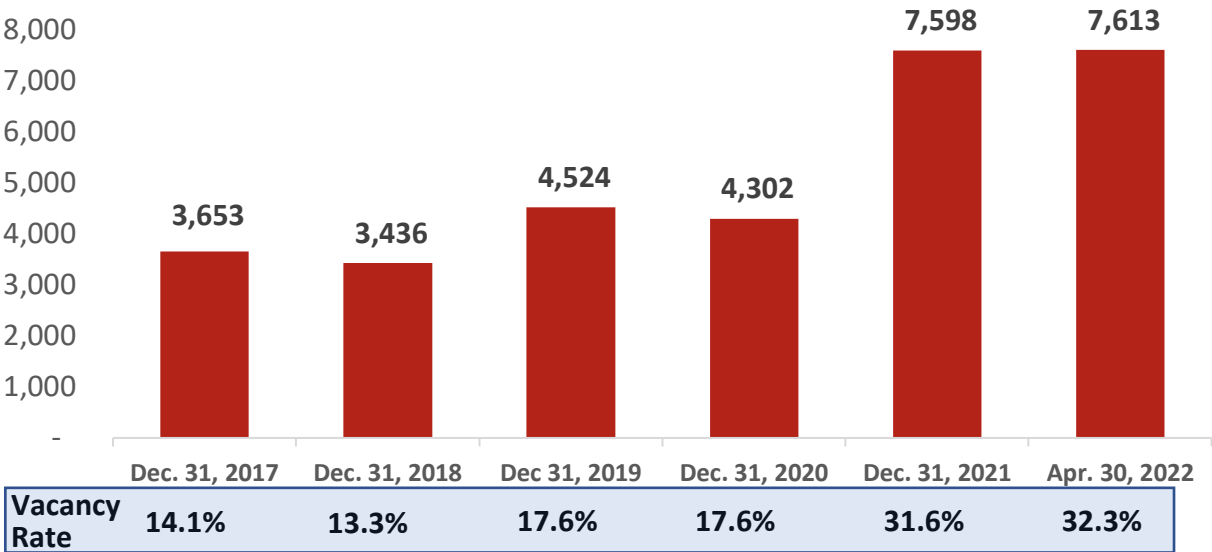
On May 12 at 10:21 a.m., inmate Gonzalo Artemio Lopez (ID# 1349716) was placed in a secure section of a Texas Department of Criminal Justice (TDCJ) bus for transport to the W. J. Estelle Unit for a routine [REDACTED] appointment. Slightly over 2 ½ hours later, inmate Lopez had removed his restraints, cut his way out of the secure section of the transport bus, attacked a transport officer, and escaped from custody. Twenty-one days later, inmate Lopez was located and killed in a shootout with authorities. The serious consequences of this escape cannot be understated. A correctional officer was attacked and stabbed multiple times and authorities report that five innocent citizens lost their lives at the hands of inmate Lopez.

Evaluating a serious incident such as the Lopez escape requires a detailed review of the appropriateness of applicable agency policies, staff practices related to the incident, as well as understanding the environment and conditions in which the incident occurred. CGL’s analysis indicates that short staffing resulting from unsustainably high vacancy rates and a series of lapses in compliance with TDCJ security practices were the primary factors in facilitating the escape of inmate Lopez.

**TDCJ Environment/Conditions.** Like most correctional systems in the United States, TDCJ has faced unprecedented challenges in the last 2 years. The COVID-19 pandemic has altered and stressed every aspect of correctional facility operations, from the acceptance of inmates into the system, to the housing, management, and programming of the inmate population.

The growing number of correctional officer vacancies, exacerbated by COVID, has reached crisis proportions in the state correctional system.

**Exhibit 1: Correctional Officer Vacancies/Vacancy Rate**

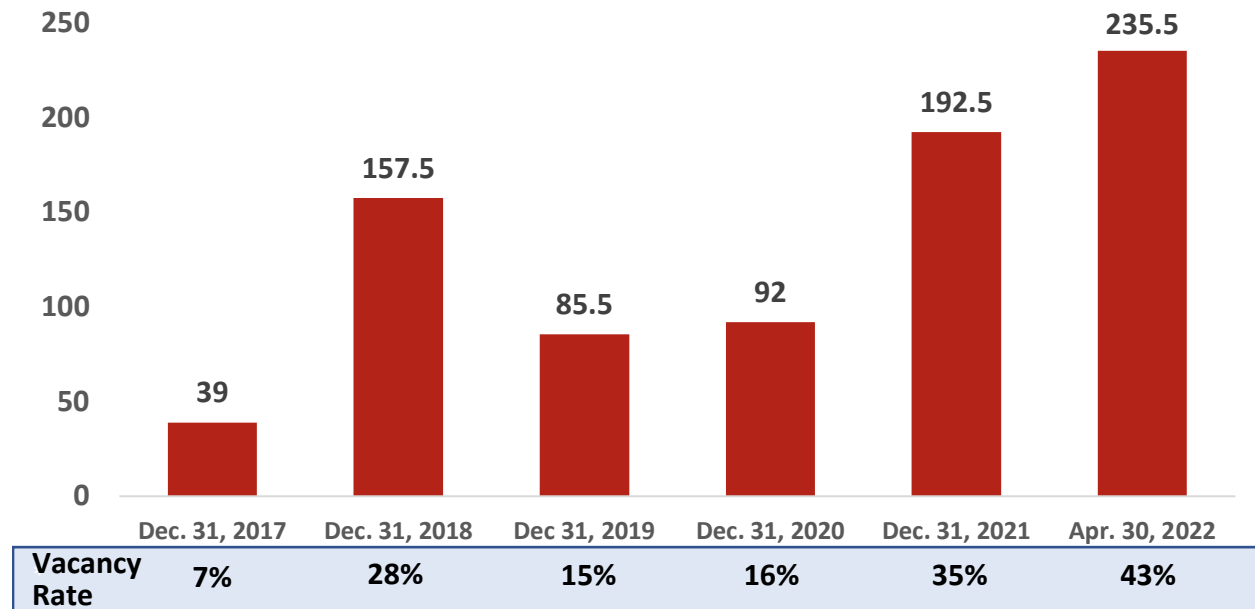




In the last 2 years alone, correctional officer vacancies have risen from 4,302 to 7,613, an increase of 77 percent. Over 32 percent of all correctional officer positions were vacant in April 2022.

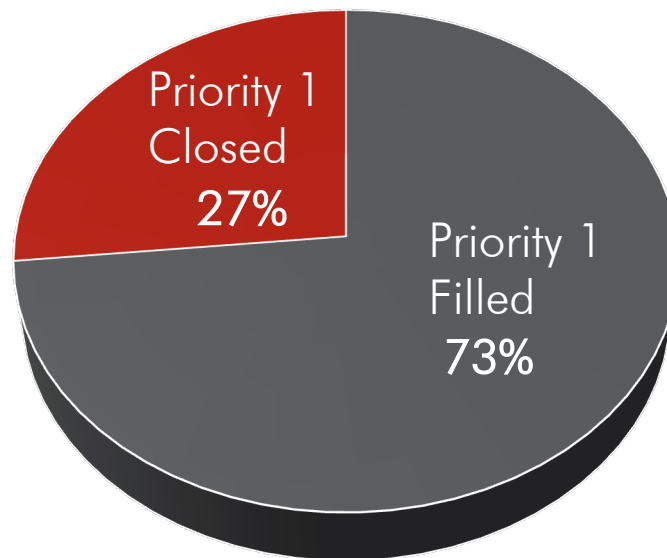
Correctional officer vacancy levels vary by facility and region of the state depending on the available labor market and the competition for jobs. At the Hughes Unit, where inmate Lopez was housed, correctional officer vacancies were even more pronounced (Exhibit 2).

**Exhibit 2: Hughes Unit Correctional Officer Vacancies/Vacancy Rate**



In the month prior to the escape (April 2022), 43 percent (235.5 out of 547.5 authorized positions) of the Hughes Unit correctional officer positions were vacant.

The reality of this severe correctional officer shortage is experienced on a daily basis by custody supervisors responsible for filling required security posts on each shift. TDCJ has identified “Priority 1 Positions” that must be filled on each shift at each facility. Per policy, Priority 1 Positions are those posts that must be filled by custody staff for the “basic security and operational needs” of the facility. Closing a Priority 1 Position requires the approval of a regional director. But because of inadequate levels of correctional officers, operating with a high number of closed Priority 1 Positions has become routine. This was especially true at the Hughes Unit on the day of the escape where 42 of the 160 Priority 1 Positions were closed due to staff shortages.

**Exhibit 3: Hughes Unit Priority 1 Position Vacancies**

Data for 2nd shift May 11 and 1st shift May 12, 2022

Due to correctional officer shortages, 27 percent of the Priority 1 Positions were closed on the 2 shifts that prepared inmate Lopez for transport (Exhibit 3).

These staff shortages required the remaining staff to carry a heavier workload and increased the amount of overtime they were assigned. This contributed to establishing a weakened security environment that better facilitated inmate Lopez's escape.

**Security Lapses.** While these staffing shortages, especially at the Hughes Unit, may have been a factor in inmate Lopez's ability to escape, they are not an excuse for the multitude of security lapses that occurred in preparing Lopez for transport. TDCJ, like most correctional systems, builds multiple redundancies into their practices to ensure that one single failure cannot have catastrophic results. History shows that when serious incidents of this type occur in a correctional setting, it is not a single failure that leads to the incident, but the compilation of multiple failures. That was the case with the Lopez escape. The combination of several inadequate strip searches, failure to search property, poorly applied restraints, and other security shortcuts improved Lopez's probability for a successful escape. The fact is that if one of these actions was followed in compliance with existing policy, it is likely that the escape could have been prevented.

**Lapses Appear Endemic.** TDCJ's internal review as well as our independent assessment found that staff at the Hughes Unit had become complacent, and circumvented security procedures in favor of hastily completing responsibilities in a cursory manner. These breakdowns appear to have become routine and a matter of regular practice rather than isolated incidents. Although we did not investigate practices at other TDCJ Units, it is possible that the complacency regarding security practices is occurring there also.

**Lack of Supervisory Oversight.** Supervisory oversight is key to ensuring staff compliance and preventing staff complacency. However, as noted in TDCJ’s Serious Incident Review, supervisory security staff had not been conducting regular inspections or routine rounds. Additionally, we found there is no policy that identifies when/where facility leadership are to conduct rounds and the frequency of those rounds. Also, existing surveillance systems can be better used to provide oversight, and the Hughes Unit has a significant number of remote surveillance cameras. But the ability to review the enormous amount of video captured on these cameras is difficult and makes it very time-consuming for supervisor’s to remotely observe staff compliance.

**TDCJ Response to Incident.** TDCJ implemented a multitude of corrective measures outlined in Chapter 6 to address the deficiencies found during their own internal review and also took the unconventional step of suspending inmate transports for a week so that it could dedicate its limited resources to reviewing transportation practices. CGL fully agrees and supports those corrective actions. The following recommendations would further address the conditions that made the escape of inmate Lopez possible.

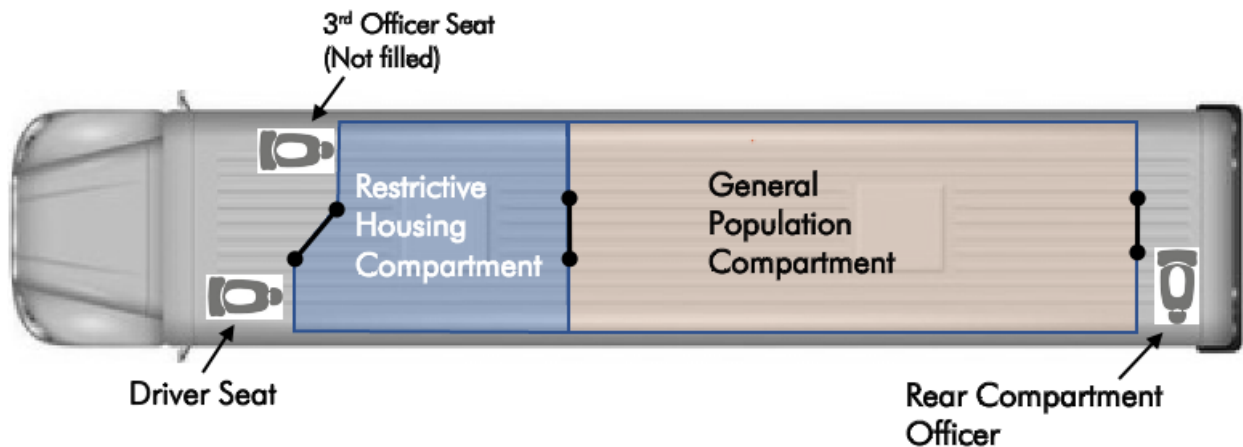
**CGL Recommendations.** The following 19 recommendations address additional issues required to improve facility and transport security:

1. **Recruitment and Retention.** Underlying many of TDCJ’s issues is the lack of staff in the correctional officer position. TDCJ and the State of Texas must continue their efforts to recruit and retain staff. The recent salary increase for line staff is a positive step.
2. **Focus Security Assessments on Search and Transport Procedures.** As TDCJ reimplements its security review process, it should focus these reviews on basic security practices and transportation security.
3. **Review Medical Transports with UTMB for Appropriateness.** TDCJ has begun efforts to reduce transports through increased telemedicine and expanding on-site services. Telemedicine equipment is reported to be outdated and should be upgraded. Additionally, TDCJ should conduct a data-driven analysis of past medical transports to determine areas where medical appointments could be conducted without transport.
4. **Reorganize/Streamline TDCJ’s Policy Structure.** Policies function as a rule book for staff conduct and performance and should be clear and easy to understand. TDCJ’s policy structure is one of the most complex we have found in any state correctional system, with requirements spread across a significant number of different policy sources. Simply finding a TDCJ policy requirement is an extremely time-intensive and difficult undertaking for any staff, or outside consultant. TDCJ should engage a study to streamline their policy structure, improve their clarity, and elevate those important requirements to require Executive Director approval.
5. **Revise Security Precaution Designator Policy.** The Security Precaution Designator policy identifies certain categories of inmates that require enhanced supervision including those with a past history of escape. The policy should be revised to establish more detail regarding transport requirements for those inmates with an escape history or other factors or circumstances that may indicate an individual has a higher risk of

escape. Currently the policy prescribes only very limited transport implications for inmates with a recent escape.

6. **Pilot Policy Requirement Modifications that Consider Current Staff Shortages.** Developing corrective actions to the escape that load more work on already overtaxed staff can result in further failures. Given the low staff levels correctional officers are often required to perform the policy requirements of multiple positions. TDCJ must ask "Are these policy requirements impossible to achieve given the current staffing crisis." In certain circumstances we found this to be the case, and it likely contributes to staff taking security shortcuts. TDCJ should consider piloting the reduction of some of those requirements to a more reasonable level during the current staffing shortage.
7. **Reinforce Policy Concerning the Prior Notice of Transports.** It was discovered that inmates are routinely provided advanced notice of the date of their upcoming transports. The Executive Director should issue an order to all employees and contractors reinforcing that inmates are not to be given advanced notice of the dates/times of future transports. Policy should also reflect this requirement.
8. **Establish a Duty Warden Inspection Schedule.** Best practices support establishing requirements for wardens, assistant wardens, and majors at each facility to conduct scheduled and unscheduled rounds and personally visit all areas of their facility. No current TDCJ policy exists. We note that administrative staff did appear to be making regular rounds at the Hughes Unit, but these rounds were at their own discretion and were not documented.
9. **Require Documented Regional Director Inspections.** Likewise, TDCJ should establish a policy requiring regional directors make a minimum number of inspections on a quarterly basis in their facilities. This sets expectations for the regional directors. Additionally, policy should require that regional directors and staff conduct periodic formal inspections of their unit each quarter, unless a security audit is being conducted that quarter. These formal inspections should focus on vulnerability and policy compliance and use an instrument that can be regularly adjusted to meet the primary concerns of agency leadership.
10. **Conduct Desk Audit/Workload Analysis of Warden's Position.** Over the years, an increasing number of administrative duties have been added to TDCJ's wardens. These duties appear to require more and more time behind a desk, reducing the valuable time they have touring their facilities. TDCJ should audit wardens' workloads and make changes necessary to maximize their ability to be present in key areas of the facility and observe inmates and staff.
11. **Reconfigure Transport Buses to Improve Security.** The transport buses are equipped with three staff seats and two compartments:
  - Seats:
    - Driver Seat
    - Rear Compartment Officer Seat
    - 3<sup>rd</sup> Officer Seat
  - Compartments
    - Restrictive Housing Compartment
    - General Population Compartment

## Exhibit 4: TDCJ Transport Bus Configuration



## CGL Recommends:

- Turn 3<sup>rd</sup> Officer seat to face inmate compartment. Currently the seat faces forward, directing the officer's vision away from the inmate compartments.
- Relocate the Restrictive Housing Compartment to the back of the bus: TDCJ should consider placing the less controlled population (general population) at the front of the bus and the more controlled (restrictive housing) in back, in closer proximity to the rear compartment officer and further away from the driver.

- 12. Require Random Review of Strip Searches.** Failure to adequately perform a strip search was a major contributor to Lopez's escape. Random video reviews of strip searches by supervisors will provide a better understanding of compliance with this policy. This may require expanding the number of video surveillance staff through the use of qualified volunteers or others and improving the documentation of when strip searches occur.
- 13. Inspect Integrity of Restrictive Housing Cells.** During our tour of inmate Lopez's cell in the Hughes Unit we found gaps between the wall and the plumbing chase, which could have allowed for the storage or transfer of contraband. A documented inspection of every cell in Restrictive Housing units should be immediately conducted.
- 14. Prohibit Inmates from Retaining Personal Property on Transport.** Any inmate property should be limited and carried either in a chase vehicle or a secure area of the transport vehicle that does not hinder site lines or limit the amount of property inmates can take on a medical transport.
- 15. Require Supervisory Oversight (Lieutenant or Above) of Out-Processing of Any Inmate for Transport.** A lieutenant or above should be required to monitor the sallyport area where inmates are moved to the transport bus. This area should be secure and free of other inmates.
- 16. Enhance Publication Review Notification Practices.** TDCJ's internal review found that, prior to his escape, inmate Lopez had ordered several publications regarding survival techniques, weapons manufacturing, and manipulation that should have raised concerns about his future intentions. These books were shipped to the facility and appropriately denied upon review by mailroom staff. However, facility administrators



were not made aware of these publications as there is no policy requirement for supervisory notification. If this notification had been made, it is possible Lopez's security supervision may have been amplified and his method of transport altered.

17. **Eliminate Multiple Security Rosters at Correctional Facilities.** The existing practice of running multiple, separate turnout rosters at each facility can result in more critical posts being left unfilled in favor of less critical posts. Lopez was housed in the Restrictive Housing Unit at the Hughes Unit. The Hughes Unit has 2 primary rosters (general population and restrictive housing) on each shift and these rosters are siloed and staff were not shared across them to ensure the most critical posts were filled. We found that on these shifts prior to Lopez's escape, the general population rosters were better staffed than restrictive housing rosters. This left critical high-priority restrictive housing posts unfilled.
18. **Address Gaps in Annual In-Service Training.** TDCJ acknowledges past gaps in annual training due to the impact of the COVID-19 pandemic and has begun addressing those gaps. Also, as part of annual training, the agency should elevate training on key security lapses identified during the Lopez escape review. These include strip searches, application of restraints, managing inmates in restrictive housing, and transportation supervision.
19. **Institute Annual Refresher Training for Transportation Staff.** Staff hired into the Transportation Unit participate in the initial Offender Transportation Training Program, but no annual transportation-specific refresher training is required. TDCJ has recently implemented a corrective action after the Lopez escape that included requiring transportation supervisors regularly evaluate transportation officers while preparing and conducting transports. We recommend this evaluation include some time mentoring staff on transportation security requirements including searches, restraints, and supervision.

## Chapter 1: Background/Methodology

On May 12 at 10:21 a.m., inmate Gonzalo Lopez (1349716) was placed in a secure section of a Texas Department of Criminal Justice (TDCJ) transportation bus for his transport to the W. J. Estelle Unit for an [REDACTED] appointment. Slightly over 2 1/2 hours later, inmate Lopez had removed his restraints, cut his way out of the secure section of the transport bus, attacked a transport officer, and escaped from custody. Twenty-one days later, inmate Lopez was located and killed in a shootout with authorities. During his days on escape, authorities report Lopez killed 5 innocent individuals.

In June 2022, CGL Companies submitted a proposal relative to solicitation number 696-ES-22-P036 to conduct "*an independent review and comprehensive report of the factors, policies, and practices that may have contributed to the recent escape of TDCJ inmate Gonzalo Lopez.*" CGL was awarded the contract for this solicitation and the contract was established on June 20, 2022. The requirements of the contract were:

- Conduct a detailed review of the incident and any supporting materials including investigative reports, background materials and video recordings.
- Assess existing policies on classification, management and transport of high-risk inmates and evaluate their effectiveness in managing risk;
- Review all operational, security procedures, standards, practices, protocols, and the level of compliance with the Departments written security procedures as it relates to the search and the movement of inmates both internal and external to the Unit;
- Assess staff deployment, vacancy rates, training, and any system-wide factors that may have had a bearing on the incident; and
- Review Inmate Transportation policies, procedures, protocols, and practice related to movement of inmates involved in external transportation to courts, hospitals, transfers to other facilities, other scheduled appointments and the specific practices related to the transport of inmate Lopez.

This assessment reviews TDCJ's overall policies and practices, as well as the performance of staff involved in the housing, staging for transport, and the transport of inmate Lopez.

**Report Disclaimer.** Independent from CGL's review of TDCJ's policies and practices, the State of Texas is conducting an ongoing criminal investigation. This investigation may determine whether others (inmates, staff, or civilians) provided aid or support to inmate Lopez's escape. CGL's scope of work for this project was not directed at these criminal matters and therefore this report does not comment on whether other inmates or staff may have conspired in inmate Lopez's escape. Additionally, the scope of the project focuses on issues and actions that may have contributed to the escape and does not involve an assessment of TDCJ's emergency response after the escape occurred.

On June 27<sup>th</sup>, 2022, the CGL team was on-site at the TDCJ's administrative offices in Huntsville, Texas. The CGL on-site team consisted of:

- **Brad Sassatelli:** Mr. Sassatelli is a Senior Vice President with CGL and has over 35 years of correctional experience leading and participating in major systems needs assessments and evaluations. He served as the project manager for this effort.
- **Ken McGinnis:** Mr. McGinnis is a Senior Vice President at CGL Companies, and previously served as the Director of the Michigan Department of Corrections from 1991 to 1999 and Director of the Illinois Department of Corrections from 1989 to 1991.
- **Gary Maynard:** Mr. Maynard served as the Secretary of the Maryland Department of Corrections from 2007 to 2014, Director of the Iowa Department of Corrections from 2003 to 2007, Director of the South Carolina Department of Corrections from 2001 to 2003, and Director of the Oklahoma Department of Corrections from 1987 to 1992.
- **Jeff Beard:** Mr. Beard is a correctional expert who was the Secretary of the California Department of Corrections from 2012 to 2016, and Secretary of the Pennsylvania Department of Corrections from 2001 to 2010.

Additionally, **Dave Runnels** served on CGL assessment team, but was not present at the on-site meetings. Mr. Runnels has over 30 years' experience working in the criminal justice system culminating in his appointment as Undersecretary for the California Department of Corrections and Rehabilitation (CDCR). In this position he was responsible for oversight and management of all adult correctional operations within the CDCR.

The CGL team spent 2 days at the Huntsville offices meeting with Executive Director Bryan Collier and his administrative team, reviewing documents, interviewing staff, observing the operation of the Transportation Unit, inspecting the transport bus used in the escape, and examining video of Lopez's transport preparation at the Hughes Unit. The team spent the 3<sup>rd</sup> day at the Hughes Unit in Gatesville Texas to observe where inmate Lopez was housed, prepared for transport, and placed on the transport bus. Additionally, CGL conducted additional interviews at the facility relevant to the escape.

TDCJ was very forthcoming in this escape assessment, and openly recognized there were failures to follow proper procedures, as well as existing policy and practice issues. Additionally, they were responsive in providing a multitude of documents that the CGL team requested.

## Chapter 2: Escapee Information

Gonzalo Artemio Lopez was a 46-year-old Hispanic male serving a life sentence for Capital Murder from Hidalgo County, Texas, and a consecutive life sentence for Attempted Capital Murder from Webb County. He had a significant assaultive criminal history with convictions for Aggravated Kidnapping, and three counts of Aggravated Assault. He was confirmed as a member of the Mexican Mafia.

Also in his history is a documented escape attempt. Specifically, while in the custody of the Hidalgo County Adult Detention Center in 2004, Lopez's cell was searched, and it was found that tape was being used to cover a portion of the concrete cell wall that Lopez was attempting to "dig" through. Upon further inspection three metal pieces were found that were being used to aid in his effort.

After his conviction Lopez was admitted to TDCJ's Byrd Unit on February 23, 2006 and was subsequently transferred to the Connally Unit a few months later. He was later moved to the Ellis Unit where he was placed in the Gang Renouncement and Disassociation Program (GRAD) in 2013. He successfully completed the program receiving designation as an ex-gang member in 2014. He was subsequently transferred to the Hughes Unit in 2016 as the result of the Security Threat Group office investigation that determined Lopez could be a target of gang violence at the Ellis Unit.

In the Hughes Unit inmate Lopez was housed in Restrictive Housing in Level 1 Security Detention status. TDCJ's Restrictive Housing Plan establishes three separate levels, with Level 1 being the least restricting and providing the greatest number of privileges. The policy specifically outlines that Level 1 Security Detention is the lowest level used to "*designate offenders who generally maintain good behavior but require separation from general population offenders. Offenders assigned to this custody may have a history of assaultive behavior, but the offender's current behavior, within the last 90 days, is non-assaultive in nature.*"

The classification unit noted that in March 2022, Lopez refused to leave Restrictive Housing to be placed in general population. CGL requested clarification regarding this refusal and the Director of Classification and Records noted that while he did not recall the specifics of inmate Lopez's housing review, it was not unusual for restrictive housing inmates to refuse a return to general population as "many mentioned they were comfortable in restrictive housing where they could live alone without a cellmate. They expressed if they were forced to intermingle in a general population setting again, they would not be successful and would find a way back to restrictive housing." We also note TDCJ's "Restrictive Housing Plan" provides allowances for considering the "offender's expressed desire to remain in, or stated readiness to be released from, security detention."

During his incarceration Lopez received 22 minor disciplinary cases and six major cases. One of those major cases occurred in 2012 where he was found guilty of Sexual Misconduct when he exposed his genitals to an employee. Another two of those major cases involved

Fighting/Assaulting another inmate, one with a weapon in 2019 (piece of metal sharpened to a point) and one without a weapon in 2016. In the 2019 assault Lopez was named as an assailant in an investigation of the stabbing of inmate Winston Williams (TDCJ ID #704475). Lopez allegedly loaned Williams a cell phone and the inmate did not return it, which resulted in the assault where he slashed at Williams with a sharpened piece of metal.

TDCJ Administrative Directive 04.11, *Security Precautions Designators* allows for a specific designator to be placed in an inmates file whose behaviors warrant special considerations. These designators are flags to staff that may impact how that specific inmate is managed and housed. In classification records, Lopez had an existing security precaution designation of "ES" which would indicate he had a history of escape in the past 10 years. This was in error as his escape history occurred in 2004 which should have resulted in an "EZ" designation (Escape Precaution Designator More than 10 Years Old.). The impact of these designations on inmate management and transports is minimal. Those inmates with the higher designation (ES) are not eligible for assignment to a lower custody level. There are no defined implications on transport practices for inmates with either of these designations. The Security Precautions Designator policy and the Transport Officer Post Orders only indicate the need to ensure the transportation staff are aware of the designation.

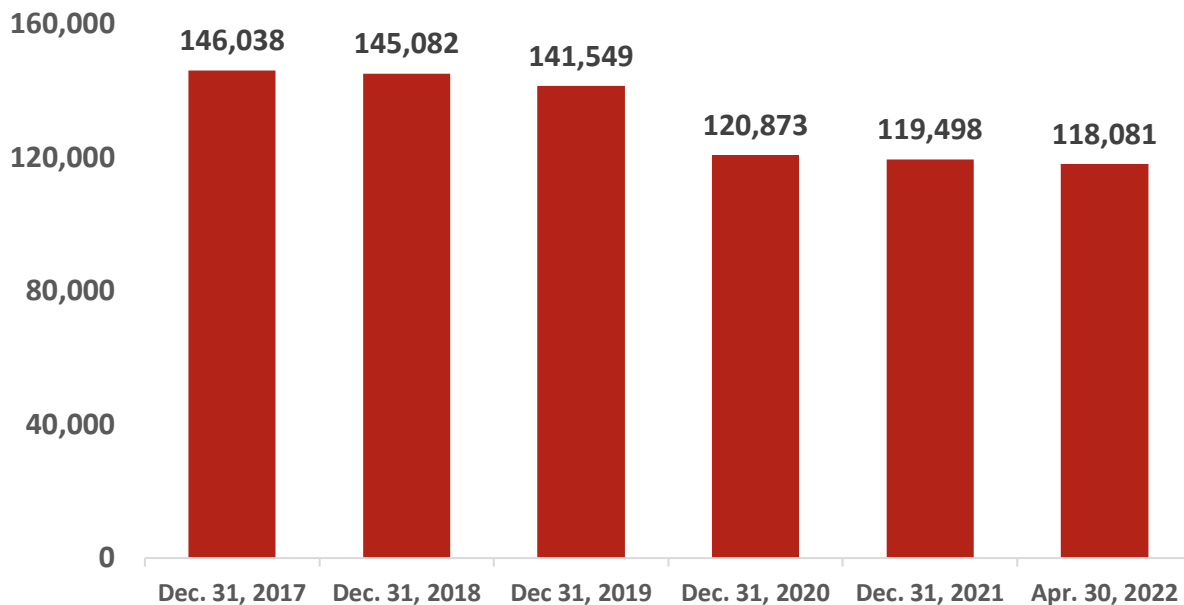
Lopez's medical history included [REDACTED] and [REDACTED] ([REDACTED]) after having [REDACTED] [REDACTED] in March 2021. He was being monitored by UTMB for [REDACTED] and had been [REDACTED] in 2014. He had recently been complaining of [REDACTED] and submitted a [REDACTED]. He was referred to the [REDACTED] clinic and an appointment was scheduled to occur at the Estelle Unit on May 13, 2022. On May 12, 2022, he was being transported to the Estelle Unit for this appointment when he escaped.

## Chapter 3: TDCJ Background

TDCJ is the largest state correctional system in the country, supervising over 118,000 inmates. The next largest prison systems are California (96,733 population – August 10, 2022) and Florida (80,495 – June 2021). TDCJ’s population is managed in 98 correctional facilities spread across Texas. These facilities operate under TDCJ’s Correctional Institutions Division (CID) and Private Facility Contract Monitoring/Oversight Division (PFCMOD).

Like most other correctional systems, TDCJ’s prison population levels have fallen since 2019 due primarily to the COVID-19 pandemic.

**Exhibit 5: Historical TDCJ Inmate Population**



Between 2017 and 2019, the inmate population fell gradually, before a substantial decrease in 2020. Overall, since 2017, the inmate population housed in TDCJ has decreased by a by 19.1 percent (27,957). This decrease has allowed TDCJ to idle or close multiple facilities.

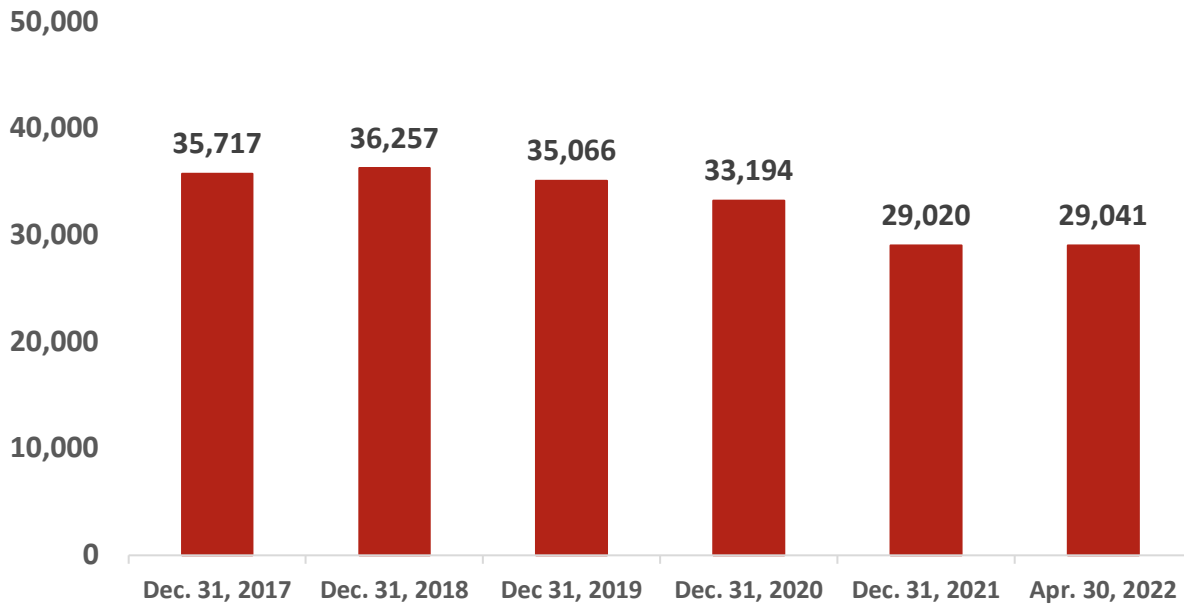
Inmate Lopez was housed in the Alfred D. Hughes Unit (Hughes Unit) located in Gatesville Texas. The prison was opened in 1990 and is in a rural section of central Texas, approximately 2 hours south of Dallas. The Hughes Unit is a 2,984 male multi-custody facility that can house general population inmates as well as restrictive housing and those that require safekeeping. The facility includes 12-Building where Lopez was housed, which has 420 mental health and 84 restrictive housing beds.

**Agency Staffing.** For the past few years, correctional systems across the US have faced a growing staffing crisis. While this issue began before the COVID-19 pandemic, it has grown worse in the past two years, partly fueled by virus-related absenteeism that has increased workload demands, created excessive levels of overtime, and ultimately made employment in

a correctional facility less attractive. When coupled with a national labor shortage, systems have struggled to meet their daily workload requirements.

TDCJ has experienced significant recruitment and retention issues in the last 2 years resulting in falling staffing levels.

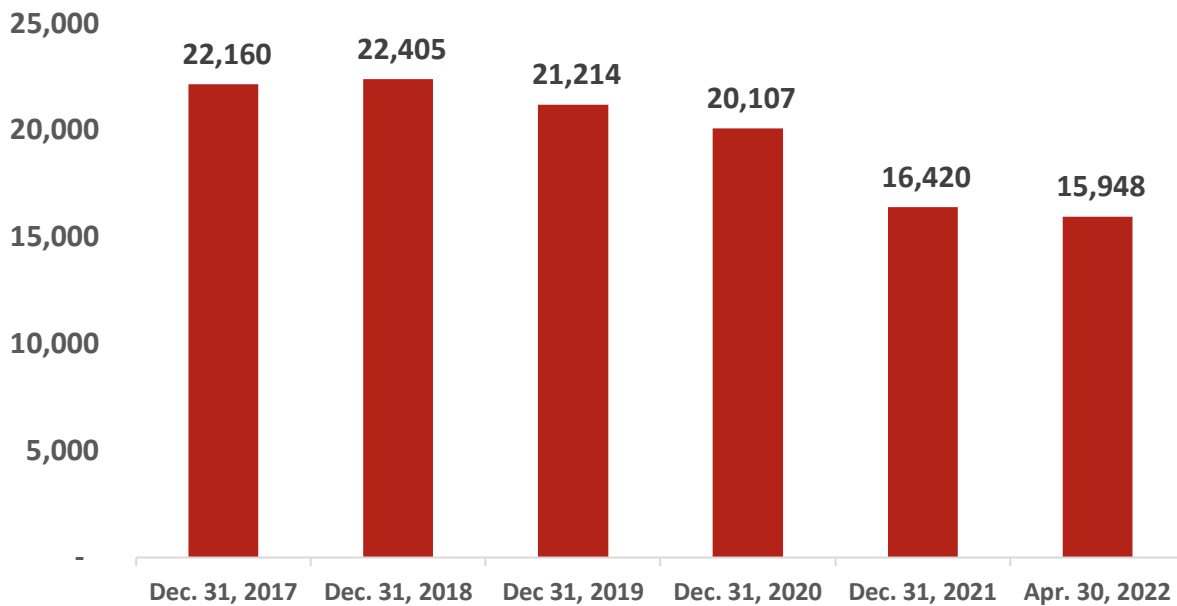
**Exhibit 6: Total TDCJ Staff**



Since 2017, total agency staffing levels have dropped by 18.7% (6,676) from 35,717 on December 31, 2017, to 29,041 on April 30, 2022, immediately before inmate Lopez escape.

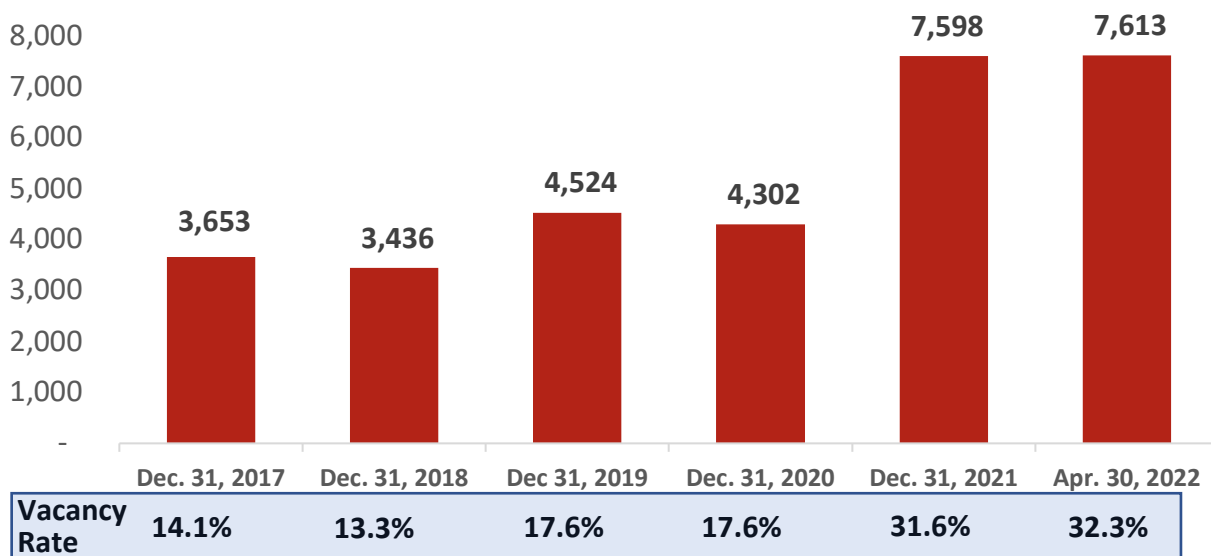
However, the decrease in overall agency staffing, understates the real staffing issue TDCJ is facing. Most of the vacancies in the agency are in the Correctional Officer position. Exhibit 7 provides the number of filled Correctional Officer positions since 2017.

Exhibit 7: TDCJ Filled Correctional Officer Positions



Correctional Officer staffing levels have dropped significantly in the past 5 years falling by over 6,000 full-time equivalent positions (FTEs). This decrease was at least partially attributable to facility closings. A metric that more accurately tracks correctional officer vacancies is shown in Exhibit 8.

Exhibit 8: Correctional Officer Vacancies/Vacancy Rate

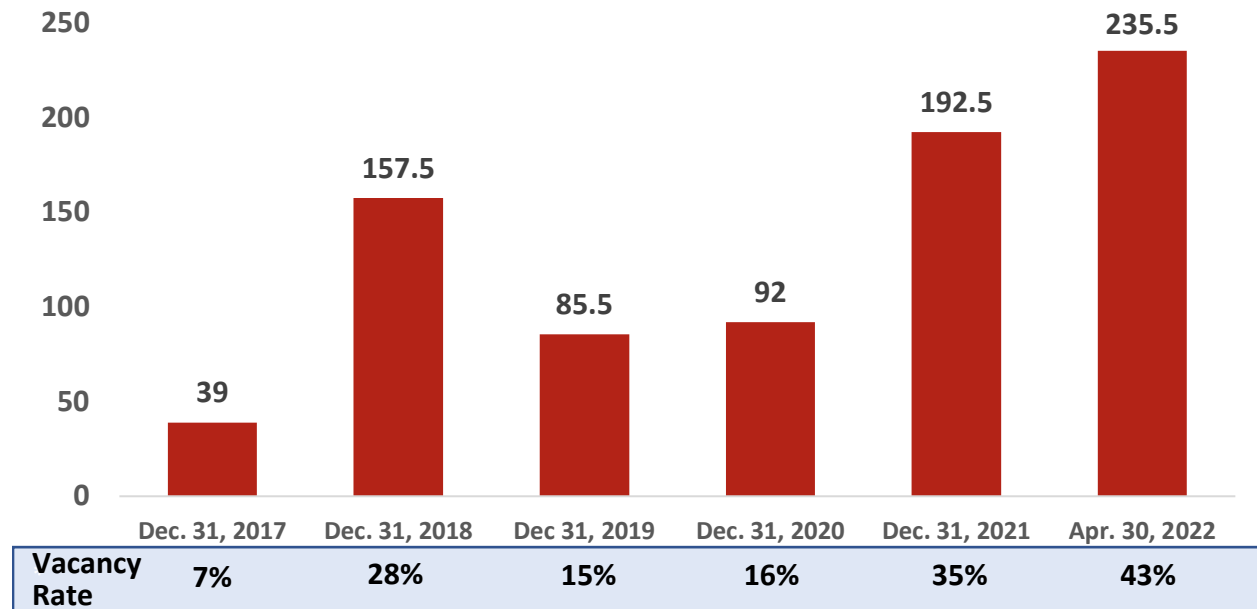




Since December 2020, correctional officer vacancies have risen from 4,302 to 7,613, an increase of 77 percent. Over 32 percent of all correctional officer positions were vacant in April 2022.

**Hughes Unit Staffing.** The correctional office shortages were even more serious at the Hughes Unit, where inmate Lopez was housed.

**Exhibit 9: Hughes Unit Correctional Officer Vacancies/Vacancy Rate**



In the month prior to the escape (April 2022), 43 percent (235.5 out of 547.5 authorized) of the Hughes Unit correctional officer positions were vacant. However, this 43 percent vacancy rate actually understates the seriousness of the issue at the facility. In addition to those vacant positions, high turnover further reduces the number of correctional officers who can fill a post. CGL was informed the Hughes Unit had 96 correctional officers leave employment in the first 6 months of 2022. These vacant positions must be filled with newly hired COs who must spend their initial 6 weeks in pre-service academy training. During time in pre-service training, they also are unable to fill a post.

The high turnover also means less experienced staff. From August 2017 to May 2021, the average tenure of a CO at the Hughes Unit decreased by 25 months (from 86 months to 61 months), resulting in the facility being supported by an increasing number of inexperienced staff.

Shift supervisors, who are responsible for scheduling staff for each shift, face the reality of staffing shortages every day. Our review of shift rosters on the day of the Lopez escape clearly displays the challenges they face.

As background, prison shift rosters identify posts that are to be filled on each shift and are built from post plans developed for each facility by TDCJ's Corrections Institution Division. These post plans (also known as shift "turnout rosters") are developed for each shift, and list the security posts, and the priority in which each post should be filled. On each day's shift, the turnout roster is used as the guide for filling posts and serves as a record documenting the staff who were assigned to each post.

TDCJ's Administrative Directive AD-11.52, *Security Staffing* defines the priority in which posts are filled:

- **Priority 1 Positions.** Priority 1 positions are any post that is needed to meet the basic security and operational needs of the unit. Agency policy requires a regional director approval in instances where a Priority 1 post cannot be filled.
- **Priority 2 Positions.** Priority 2 positions are any post that the warden or designee may staff as needed that are deemed necessary based on the availability of staff. Therefore, Priority 2 posts are filled when a shift has excess staff for Priority 1 posts.
- **Position Deviation.** A position deviation occurs when staff are deployed to a post that is not designated on the turnout roster. These are typically intermittent posts for unplanned events such as unexpected transports, supervision of an inmate placed in a hospital, or supervision of inmates placed on some level of suicide watch. Position Deviations must be filled and, as a result, increase security staffing needs when they exist.

Due to the chronic correctional officer shortage in TDCJ, it has become commonplace for a significant number of Priority 1 posts to remain unfilled on each shift.

This was especially true at the Hughes Unit where the turnout roster for each of the two 12-hour shifts typically has fewer staff available than it has Priority 1 posts. CGL reviewed the Hughes Unit Restrictive Housing Turnout Rosters for the two shifts that had responsibility for preparing Lopez for transport (2<sup>nd</sup> shift on May 11 and 1<sup>st</sup> shift on May 12, 2022).

## Exhibit 10: Hughes Unit Restrictive Housing Rosters

	Restrictive Housing Turnout Roster 2 <sup>nd</sup> Shift, May 11, 2022	Restrictive Housing Turnout Roster 1 <sup>st</sup> Shift, May 12, 2022
<b><i>Post Requirements</i></b>		
# Of Priority 1 Posts	24	31
Number of Position Deviations on shift	6	3
<b>Total Posts Needing Filled</b>	<b>30</b>	<b>34</b>
<b><i>Staff Availability</i></b>		
Staff Assigned to Shift	16	21
<b>Staff Available to fill post</b>	<b>7</b>	<b>18</b>
Staff on Overtime	11	3
Priority 1 posts Filled	14.5*	18.5**
<b>% Of Priority 1 Posts Unfilled</b>	<b>40%</b>	<b>40%</b>

\*Staff alternate posts every 4 hours. On the 2<sup>nd</sup> Shift, May 11, 2022, 13 Priority 1 posts were filled for the entire 8-hour shift, while 3 were filled only for 4 hours.

\*\* On the 1<sup>st</sup> shift, May 12, 2022, 15 posts were filled for the entire 8-hour shift in addition to 7 posts being filled only for 4 hours.

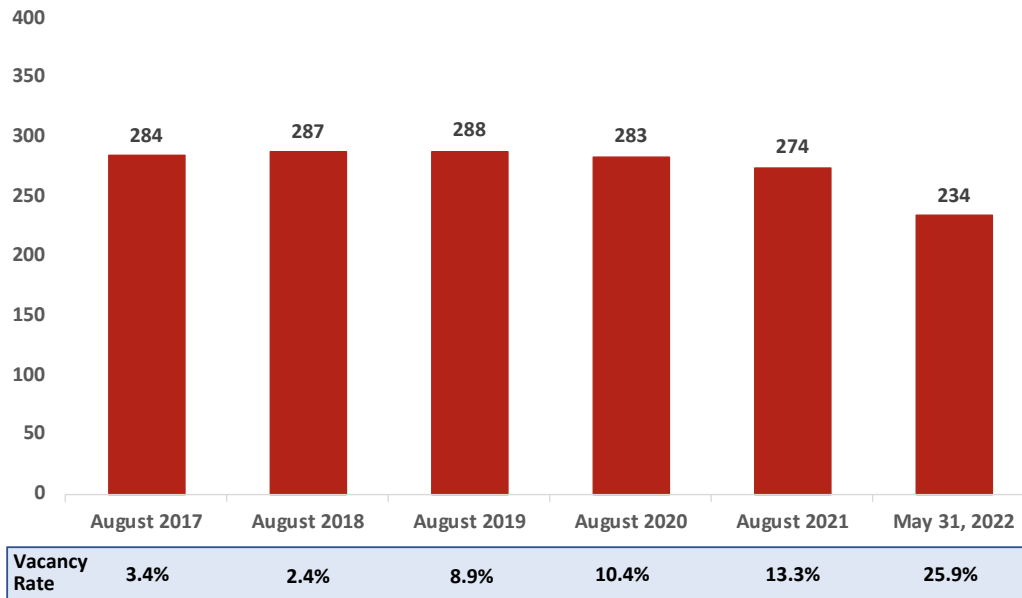
Staff began readying inmate Lopez for transport on the 2<sup>nd</sup> shift on May 11, 2022. As shown in Exhibit 10, that shift required 24 Priority 1 posts on the Restrictive Housing Turnout Roster. Six additional (deviation) posts had to be filled (mental health watches, hospital security, transports), bringing the total number of posts needed to be filled to 30. However, due to the staffing shortage, 16 COs were assigned to work that day, and only 7 of those were present for the shift. Essentially, there were only 7 COs on that shift to fill 30 posts.

To partially compensate for the lack of staff on this shift, 11 staff were brought in on voluntary overtime, which allowed for 14.5 of the 24 Priority 1 posts to be filled along with the 6 deviated posts. Forty percent of the Priority 1 Posts were left unfilled.

The 1<sup>st</sup> shift on the following day experienced similar shortages resulting in 40 percent of the Priority 1 posts unfilled. The staffing levels for these 2 shifts were typical of what the Hughes Unit had been regularly facing.

**Transportation Unit.** TDCJ's Transportation Unit is responsible for conducting all inmate transports across the agency. These include transports between facilities, transports to outside medical consults and transports from county jails. The Transportation Unit has also been impacted by correctional officer shortages.

**Exhibit 11: Transportation Unit Filled Correctional Officer Positions**



The number of filled CO positions in the Transportation Unit decreased by 50 since August 2017, a drop of 18 percent. By May 2022, over 1 in 4 transportation unit CO positions were vacant (25.9 percent vacancy rate).

However, the Transportation Unit workload also decreased during this timeframe as shown in Exhibit 12.

**Exhibit 12: Transportation Unit Workload Metrics – FY17 to FY22**

	Total Inmates Transported	Total Miles Driven
FY 2017	584,948.00	4,867,516.50
FY 2018	586,742.00	4,816,691.90
FY 2019	577,970.00	5,081,335.30
FY 2020	386,139.00	4,595,255.20
FY 2021	280,475.00	4,966,741.50
FY 2022* (annualized)	339,625.29	4,345,712.19
<b>Decrease since FY 2017</b>	<b>-245,332.71</b>	<b>-521,804.31</b>
<b>% Decrease since 2017</b>	<b>-42%</b>	<b>-11%</b>

From FY 2017 through FY 2022, the annual number of inmates transported declined by over 245,000, a 42 percent decrease. The number of miles driven by the unit decreased by a lesser amount (11 percent). These decreases are primarily due to the impact the COVID-19 pandemic had on inmate movement in the agency. The disparity between the decrease in number of inmates transported and the total miles driven is also a function of the pandemic

as TDCJ reduced the number of inmates on each transport to mitigate the transmission of the virus.

The organization of the Transportation Unit is divided into separate regions with the Central Region Transport (CRT) being responsible for the Lopez transport. CRT staffing levels on the day of the Lopez transport are provided in the following exhibit:

**Exhibit 13: CRT CO Staffing – May 12, 2022**

Allocated Positions	117
Vacancies	42
Filled Positions	75
Staff on Leave/Inservice/Duties Outside CRT	17
Staff Available to Fill a Post	58

On the day of the transport, CRT was allocated 117 COs but had 42 vacancies, a 36 percent vacancy rate. Seventy-five CO positions were filled but 17 of those were on some form of leave, in training, or providing support to Operation Lone Star (an intergovernmental task force to address issues with illegal immigration). This resulted in 58 CO's being available on that day, resulting in a functional vacancy rate of 51 percent.

CRT requires certain support posts be filled in its headquarters to serve as dispatchers and perform administrative duties. On May 12, 11 FTEs were dedicated to this support function leaving the remaining 47 CO's responsible for conducting 23 transports. Six of those 47 staff were newer employees who were in on-the-job training status.

It was reported to the CGL Team that transports formerly required 3 staff, but this was reduced to 2 staff several years ago. Our review of agency policies found the only reference to the number of staff required per transport is in the Transport Officer Post Order issued under the authority of the Director of the Correctional Institutions Division dated May 14, 2018, which states:

*“A minimum of two transport officers shall be used on any transport assignment. Additional transport officer or a security supervisor may also be used if warranted.”*

Given the CRT staffing levels of 47 COs for 23 transports on May 12, 2022, only two of the transports were able to have a 3<sup>rd</sup> officer, and in both cases that 3<sup>rd</sup> officer was a new employee who was in on-the-job training status (OJT). Which transports are selected to have a 3<sup>rd</sup> officer are more a function of the length of the run than the type of inmate transported. OJT officers are generally assigned as a 3<sup>rd</sup> officer to transports that of are an extended length and duration. This allows the two other officers to split driving responsibilities.

**Summary.** Staffing shortages at the line staff level (correctional officer) are at a critical level for TDCJ, with the potential to impact their ability to house and transport inmates in a safe



and secure manner and provide needed programs and services. This was apparent at the Hughes Unit where inmate Lopez was housed, which had 40 percent of their Priority 1 posts unfilled on the shifts that were responsible for ensuring the safety and security of his transport.

## Chapter 4: Escape Timeline/Description

**Transport Rationale/History.** Inmate Lopez's May 12, 2022, transport was predicated on the need for an [REDACTED] at the Estelle Unit. He had a history of a [REDACTED] and had recently identified concern with [REDACTED]. Medical clinics are provided regionally within TDCJ through their contract with the University of Texas Medical Branch (UTMB). The Estelle Unit provided a regional [REDACTED]. Lopez had several previous transports for medical needs.

**Description of Escape.** CGL understanding of the events leading up to the escape were the result of the following:

- A review of a considerable number of policies, procedures, and documents provided by TDCJ.
- Interviews with TDCJ staff.
- Review of video evidence from the Hughes Unit displaying the preparation of Lopez for the upcoming transport.
- Inspection of the Hughes Unit and the transport bus used in the escape.

**Preparation for Transport by Hughes Unit Staff.** In preparation for his off-site medical appointment, custody staff at the Hughes Unit arrived at inmate Lopez' cell early on May 12, 2022, to begin the process of readying him for that day's medical transport. Prior to transport, per the "Chain Officer" Post Order, an inmate's personal property must be inventoried in accordance with AD-03.72, "Offender Property." The Offender Property directive requires staff document the property in the offender's possession.

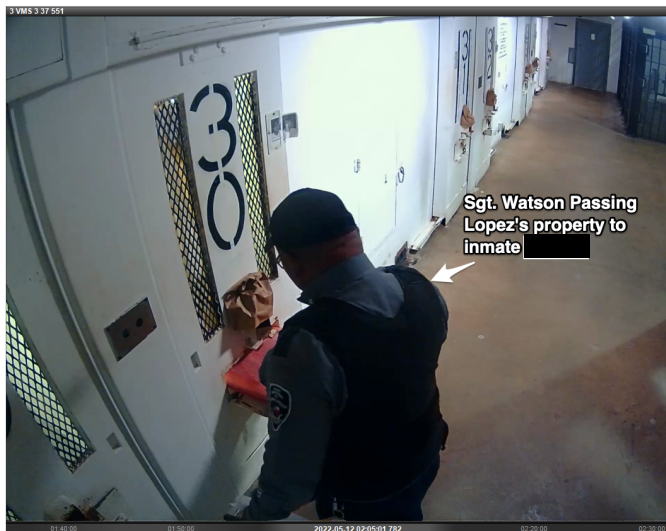
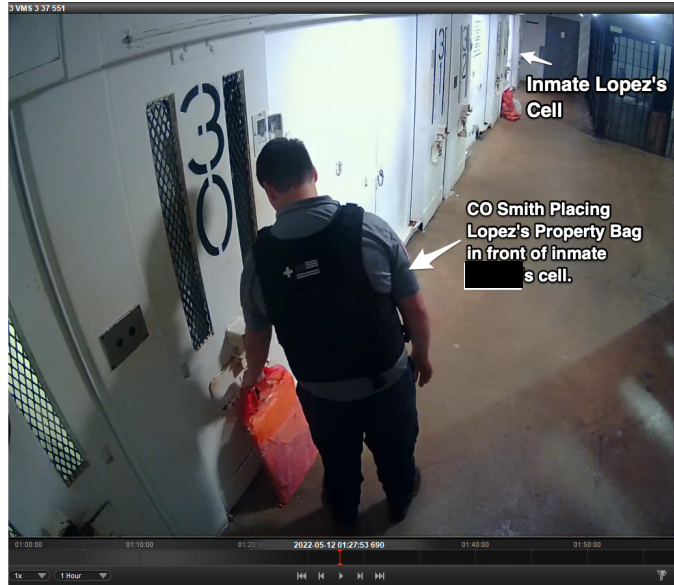
TDCJ policy requires that restrictive housing inmates are strip searched prior to leaving their cell and any property they have be thoroughly searched. TDCJ Policy<sup>1</sup> defines a "strip search" as the "observation of an offender with all clothing removed to permit a total visual inspection of the offender's body. Clothing shall be searched while removed from the offender." Policy also requires that any Restrictive Housing inmate must be strip searched prior to exiting their cell. This strip search is performed by staff who are to stand outside the cell and direct the inmate (who remains in the cell) through the strip search requirements.

At 12:48 a.m. on May 12, 2022, Officer Randall Smith (CO Smith) arrived at Lopez's cell (33) in unit 12F and issued Lopez two red bags for transport (chain bags) to pack his personal property prior to the transport. At 1:26 a.m. CO Smith returned to Lopez cell front along with CO Bernard Guishard (CO Guishard). CO Guishard opened the cell door allowing Lopez out of his cell. This action violated TDCJ policy and sound security practices requiring all restrictive housing inmates be strip searched prior to being allowed out of their cell. Additionally, no hand restraints were placed on Lopez prior to opening the cell door.

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<sup>1</sup> AD-03.22, Offender Searches

Lopez then handed CO Smith a bag of his (Lopez's) property. CO Smith then, apparently at the request of inmate Lopez, walked to the front of inmate ██████'s cell (#██████) who was 3 cells away and sat the property in front of the cell, while gesturing at ██████. This action is also in non-compliance with TDCJ policy and sound security practices. Transferring property between inmates is considered "trading and trafficking" and could be in support of payment for some form of debt. Additionally, staff did not search the property.



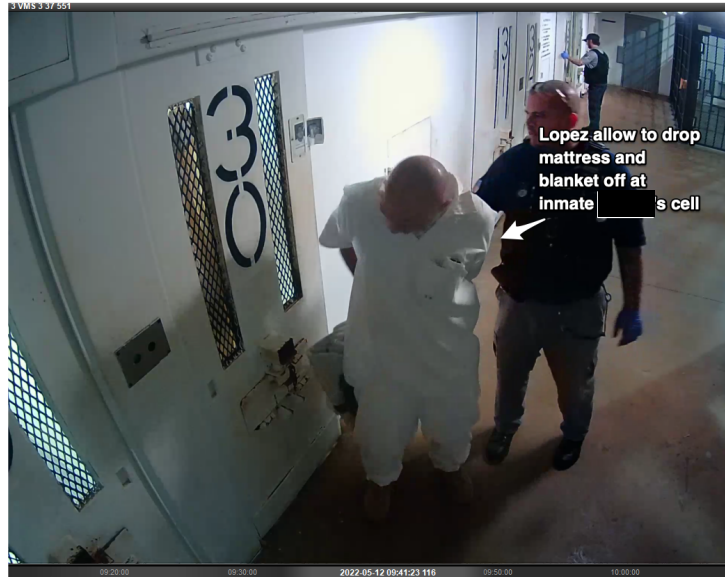
At 2:05 a.m. Sergeant Joshua Watson (Sgt. Watson) came to the front of inmate ██████'s cell where he opened the pass-through on the cell front and handed Lopez's red property bag through. Again, this was done without any search of the property bag and in non-compliance with agency policy.

At 9:34 a.m. Correctional Officers Gerardo Velasquez (CO Velasquez) and Dillon Miller (CO Miller) approached inmate Lopez's cell to prepare him for removal. These officers begin the strip

search process, but video evidence reveals they only conducted a cursory search and fail to follow required strip search procedures. Specifically, staff did not maintain constant observation of Lopez in his cell during the search. The staff can be seen talking among themselves and looking away from the cell. Additionally, Lopez' clothing was not thoroughly searched.



A short while later, video shows inmate Lopez passing his hands through the door pass-through and hand restraints are applied by CO Velazquez. Lopez is removed from his cell by the officers and is seen on video carrying his mattress and blanket behind his back (while handcuffed from behind). In violation of policy, he is allowed to walk in front of inmate ██████'s cell and drop off the items.



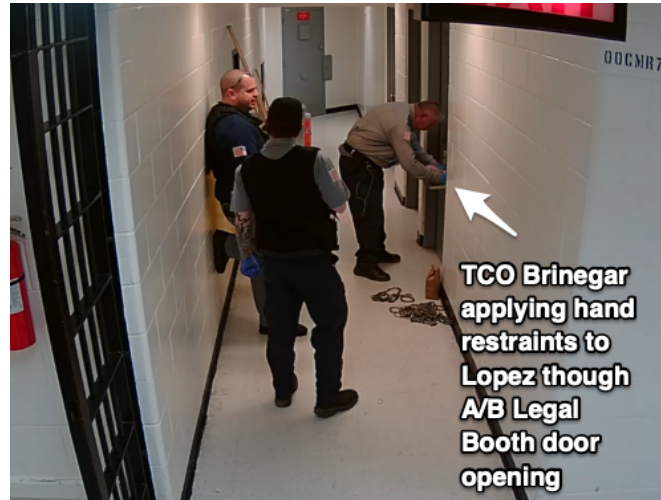
Lopez is then escorted to a small room in 12-Building by CO's Velasquez and Dillon typically used for legal visits (A/B Legal Booth). He is secured in the room.



At 10:18 a.m., Transportation Correctional Officer Jimmie Brinegar (TCO Brinegar) and CO Miller arrive at the A/B legal booth. TCO Brinegar initiated the strip search of Lopez by standing outside the room, opening the pass-through and having Lopez hand him his clothing for search. The search of clothing was not as thorough as required, as TCO Brinegar

also did not instruct Lopez to complete all the required elements of a strip search, and constant observation of Lopez was not maintained. Part of the issue was that the room was not appropriate for observing a strip search through the door given the door's construction which obscures the line of sight. CO Miller and another correctional officer were also present outside the room but were not observing the strip search while it took place.

At the completion of TCO Brinegar's strip search (10:21 a.m.) Lopez passed his hands through the door pass-through and hand restraints were applied. Additionally, TCO Brinegar applied a "cuff protector". Cuff protectors (also called "black boxes") are placed between the handcuffs to block inmates from manipulating the hand restraints and having access to the keyhole. An internal review after the escape found that some cuff protectors did not fully cover the keyholes in the hand restraints, which may have allowed inmate Lopez to manipulate the mechanism in his escape.



After the A/B legal booth opened, leg restraints were applied to Lopez over his pantleg, causing them to fit loosely around inmate Lopez's leg. Lopez is allowed outside the AB Legal Booth and escorted out of the building by TCO Brinegar and CO Miller. During this escort out he is directed past a device that screens inmates for the presence of metal on their person. This device, known as the Body Orifice Security Scanner or "BOSS Chair" is designed to quickly detect metallic contraband within body cavities of inmates. Agency Policy requires restrictive housing inmates be scanned in the BOSS chair prior to be placed on a transport. This device was not used on inmate Lopez.

At 10:24 a.m. Lopez was escorted outside of 12-Building into a sallyport area, where inmates are placed on the bus. This area should be free of other inmates during transport preparation, but video review found a large number of inmates in this area at the time Lopez was being escorted through it. In this area, his identity was verified by staff, and he was provided a sack meal for transport.



Immediately following, Lopez is escorted onto the transport bus by TCO Brinegar and CO Miller and reported to be placed in the restrictive housing compartment that separates those inmates from general population. This section is immediately behind the bus driver's seat, and is secured by a front and back door, metal supports, expanded steel, and Plexiglas.



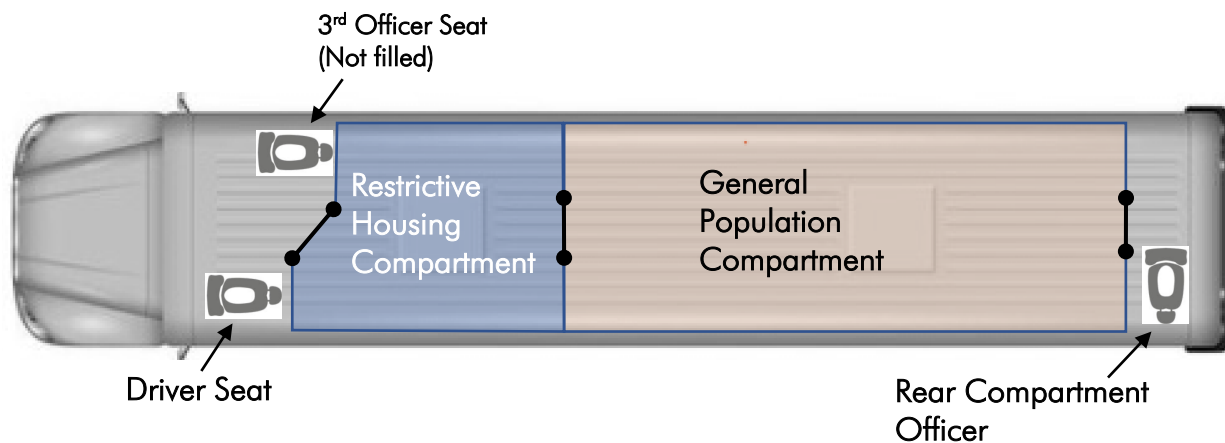
Both CO's left the area while Transportation Correctional Officer Randy Smith (TCO Smith) remained behind loading property into the underbody storage of the bus. TCO Smith then departed from the area for an extended period, leaving the bus and its occupants

unsupervised. This is in violation of TDCJ's Transport Officer Post Orders that states *"At no time during the transport of offenders shall the vehicle be left unattended."*

At 10:56 a.m. the transport bus was fully loaded with 9 general population and 7 restrictive housing inmates and exited the 12-building sallyport heading for the Hughes Unit back gate. When the bus pulled between the double sallyport back gates, the Back Gate Officer used a mirror to search under the vehicle and within the engine compartment. However, the Post Orders for the Back Gate Office require they *"maintain an accurate count of all offenders entering and exiting the unit."* Video review did not find the Back Gate Officer conducting any count of inmates on the bus.

During our time on-site, CGL team members inspected the bus that was used to transport Lopez. It was manufactured by the Blue Bird Body Company with a manufacture date of April 2014. The interior layout of the bus and the restrictive housing and general population compartments are common for TDCJ's transport buses.

**Exhibit 14: Transport Bus Configuration**



The transport buses have 3 officer seats:

- Driver seat
- Rear Compartment Officer seat separated from the general population seating by metal and Plexiglas
- 3<sup>rd</sup> officer seat – only filled if 3<sup>rd</sup> officer is on transport (vacant during Lopez transport)

The inmate seating areas are broken into two separate compartments. The Restrictive Housing compartment is located immediately behind the Driver and 3<sup>rd</sup> Officer seat. A larger compartment for general population inmates is located behind the Restrictive Housing compartment. To access the general population compartment, inmates must pass through the restrictive housing compartment.

At 11:11 a.m. the bus departed the Hughes Unit on route to the Estelle Unit near Huntsville, Texas. On board were two Transportation CO's. TCO Smith served as the driver while TCO Brinegar was the rear compartment officer. Per policy, both were issued firearms that were on their duty belts.

The available video for CGL's review ceases at this point as at that time, TDCJ did not have any video capabilities on their transport buses. They have since begun piloting adding video equipment on buses. The description of further events in this narrative is based on interviews and review of TDCJ documents.



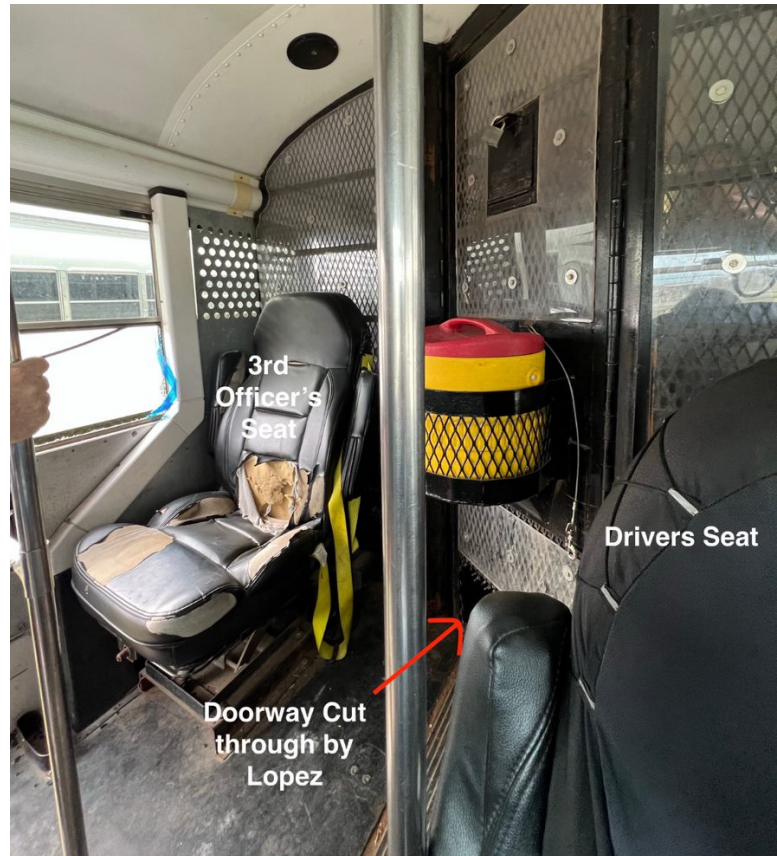
**Lopez Escape:** TDCJ interviews with other inmates on the transport bus indicated that Lopez had given indications while on the bus that he might be escaping and asked if they were “ready to rock and roll.” TDCJ reports that upon departing the facility, Lopez showed two long metal weapons with string tied to them and what resembled a handcuff key in his mouth. Other inmates reported that Lopez was asking them how long their sentences were and if they wanted to escape with him. Inmate [REDACTED] (# [REDACTED]) initially expressed interest, but this changed when he realized Lopez planned to kill the transport officer, then hijack a car and kill the driver.

Once the transport left the Hughes Unit, it was reported the noise level increased as several inmates began “instigating a loud rapping noise, banging” while blocking the view of rear compartment CTO Brinegar. Witnesses reported that Lopez quickly was able to remove his restraints and that the cuff protector placed over them did not obscure access to the hand restraint keyhole. Inmate witnesses further indicated that once out of the handcuffs, it took

Lopez approximately 90 minutes to break through the bottom of the restrictive housing compartment door using the 2 metal weapons. These metal items have never been recovered.

Other interviews of inmates found it was common not to be properly searched for transport and that they often are provided advanced notice of transports by medical staff.

At 1:15 p.m. the transport bus was traveling east on State Highway 7 and between four and six miles outside of Centerville, when TCO Smith (the driver) felt a tug on his handgun. He looked down to see Lopez coming through the bottom of the restrictive housing compartment door. In interviews TCO Smith reported he responded by covering his handgun and attempted to stop the bus by actuating the air brake. This immediate stop pushed Lopez further into the drivers compartment of the bus and a struggle ensued between the inmate and TCO Smith. During the struggle Lopez continued to try to access CTO Smith's handgun and both fell into the stairwell area causing the bus doors to open and both to fall on the pavement. Lopez began stabbing CTO Smith with what was reportedly an 8-10 inch metal weapon. At that point, Lopez pressed the quick disconnect on CTO Smith's holster and gained control of the handgun from Smith's duty belt.





CTO Brinegar, seated in the officer's chair in the rear compartment, initially assumed the bus stopped due to an accident. He exited through the bus's back door with a 12-gauge shotgun. He observed CTO Smith struggling with Lopez and reported he yelled at Lopez to stop at which time Lopez jumped up and reentered the bus. CTO Brinegar proceeded to CTO Smith's location and helped him up and Smith indicated Lopez was trying to escape and had possession of his handgun. Brinegar drew his own handgun and instructed Lopez to stop, or he would shoot. Lopez placed the bus in forward gear. At this point Brinegar discharged his handgun 2 times at the bus.

Lopez had possession of CTO Smith handgun but apparently was unable to remove it from its holster. He pointed the holstered handgun at TCO Brinegar however did not fire the weapon. Brinegar stepped out of the probable line of fire, then fired 2 additional rounds through the right passenger compartment window. Lopez began to drive away as CTO Smith took the shotgun from Brinegar and yelled for Lopez to stop. Smith fired one round, blowing out the right rear tire. Lopez continued to drive east on State Highway 7 toward Centerville.

CGL's inspection of the bus after the incident found shattered glass on the passenger side and a bullet hole through the front window.



A brief time after the incident Sean O'Reilly, Chief of Police for the City of Jewett arrived on the scene and was informed by CTO Smith of the incident. Chief O'Reilly then pursued the bus, while Smith and Brinegar proceeded on foot. A civilian passing by stopped and asked CTO Smith if they were with the bus that had wrecked near Centerville. The civilian drove Smith to that location where law enforcement officers were already on scene where the bus was located. Smith retrieved the TDCJ cellular phone from the bus and notified the Central Transportation Unit of the escape. Upon inspection of the bus, Lopez was not present, and the handgun Lopez had removed from CTO Smith's belt was in the driver compartment of the bus still in its holster.

TDCJ initiated its escape plan.

Over the next several weeks, efforts were made by law enforcement and TDCJ to track and capture inmate Lopez. On May 31, 2022, 19 days after the escape, law enforcement was informed of a burglary of a property in the area where Lopez escaped. Fingerprints were taken from the scene along with DNA samples. On June 2, 2022, the samples were positively matched with inmate Lopez. On the same day, law enforcement was notified by an individual who had grown concerned after not hearing back from a relative in the area. Law enforcement responded to the residence and found the bodies of five individuals (2 adult males and 3 minor children). A 1999 white Chevrolet Silverado pickup was discovered missing and a "Be on the Lookout" was issued to law enforcement agencies statewide.

A short while later law enforcement deputies in Atascosa County identified the missing pickup and followed it. The vehicle was disabled using spike strips. Gunfire broke out between Inmate Lopez and the deputies, ending with inmate Lopez being shot and killed.

TDCJ's own internal review found additional failures in practices/policy compliance by staff including:

- **Lack of Supervision.** Custody supervisors were not appropriately monitoring staff or making their required supervisory rounds through the facility.



- **Falsification of Documents.** Certain staff were found to have falsified documents regarding cell searches, or security rounds performed.
- **Advanced Notice of Transports.** Inmates interviewed reported it is not uncommon for UTMB staff to provide them advanced notice of upcoming medical appointments/transports.
- **Other Search Issues:** A small home-made tool kit was found in the Lopez's boot raising concern for both the search procedures and the allowance if inmates to wear their personal boots and shoes on transport.

The serious consequences of this escape cannot be understated. Five citizens lost their lives at the hands of inmate Lopez. Correctional Officer Randy Smith was attacked and stabbed multiple times by Lopez. CO Smith fortunately was treated and released from the hospital.

## Chapter 5: Evaluation of Policies/Training Practices

As part of the escape review, CGL sought to evaluate both the agency-wide training requirements for custody staff, and the individual training provided to those staff that were involved in the preparation/transport of inmate Lopez.

### TDCJ Training Requirements

TDCJ's statewide training plan is issued in the *FY 2022 Correctional Training Department Training Plan* dated September 1, 2021. This comprehensive plan outlines the training goals, training requirements, and curriculums for all levels of staff. TDCJ's training plan for custody staff is consistent with American Correctional Association (ACA) standards.

The training plan defines three components of training for newly hired uniformed correctional staff:

- **Phase I. Pre-Service Academy Training.** All newly hired staff in correctional positions must attend TDCJ's Pre-Service Training Academy and complete a physical agility test prior to completing the academy.
- **Phase II. On-the Job Training (OJT).** Phase II OJT is designed to bridge the employee between pre-service training and their unit-specific work environment.
- **Phase III. Shift Assignment/Mentoring.** In Phase III staff are assigned to a post with a mentor who provides direct supervision. Both the mentor and the Phase III trainee are assigned to the same post.

**Phase I.** Phase I consists of 240 hours of training. All newly hired correctional officers are required to successfully complete this training. It should be noted that TDCJ Training and Leadership Development Division Corrections Training Department has received 100 percent ACA accreditation since 2005. The major modules covered in Phase I training are:

- Agency Overview
- Employee Professionalism
- Unit Tour of Duty Posts
- Inmate Rights
- Safe Prisons
- Report Writing/Disciplinary Procedures
- Restraint and Escort Procedures
- Legal Responsibilities
- Incident Management
- Communication with Peers
- Go Home to Your Family – How to maintain safe environment and avoid mishaps/injury.
- Mental Health
- Communication
- Understanding Inmate
- Security Concerns
- Risk Management
- Chemical Agents/Exposure

- First Aid/CPR
- Hostage Situations
- Officer Post Orders/Duties
- Firearms/Perimeter Security
- Physical Agility Test
- Physical Training
- Owning Your Wellness

TDCJ's *On-The-Job Training (OJT) Program Procedures Guide* issued November 2019 serves as a detailed guide for OJT training for new custody staff. This guide delineates the mandatory OJT program and outlines procedures to implement Phase II and Phase III training.

**Phase II.** The goal of Phase II is to begin to apply what was learned during Phase I pre-service training to an actual work environment. As a result, Phase II training occurs at a correctional facility. In Phase II correctional staff complete the following training segments:

- **Segment 1.** Basic Unit Operations Training: (minimum of 24 hours) Trainer reinforces policies and procedures as they apply to basic operations of a unit.
- **Segment 2.** Observation of Housing or Specific Specialty Housing Training (minimum of 24 hours). OJT trainees observe practices and operations of housing units.
- **Segment 3.** Shadowing Mentor (minimum of 48 hours) Each OJT trainee is assigned a mentor on post and mentor provides guidance and direction.
- **Segment 4.** Practical Application Competency Skills (minimum of 8 hours) Field Training Officer evaluates OJT trainee on their competencies and abilities to practically apply job-related skills.

At the completion of Phase II, a correctional major is required to conduct an interview with the officer and assign them to a shift and post.

The *On-The Job (OJT) Program Procedures Guide* also denotes what competencies the OJT trainee should exhibit as part of the Segment 1 training, and these competency requirements are listed in extensive detail. Many of the competency requirements in Phase II provided clear understandings of security procedures that Hughes Unit and transportation staff failed at when preparing inmate Lopez for transport. We can therefore assume that all custody staff have received training in these proper procedures during Phase II. The relevant requirements include:

- **Cuff Protectors.** Procedures for applying the hand restraint protector (cuff protector or black box) indicate "*When the protector is closed around the hand restraint housing and chain, the keyhole should not be exposed in any way.*"
- **Leg Restraints.** "*A leg restraint should not be placed on any part of an offender's footwear or pant leg.*"
- **Strip Searches & Restrictive Housing:** The strip search competencies are thoroughly described, and the Restrictive Housing Escort notes fundamental requirements for those in Restrictive Housing status:

- Requires inmate be strip searched “every time they are escorted from their assigned cell.”
- It also notes staff should “Never turn away or look off while the offender is redressing (after a strip search) because they could easily hide contraband in their mouth or in the already inspected clothing.”
- It also requires a restrictive housing inmate be “in hand restraints anytime they are escorted from an assigned cell.” Additionally, these restraints should be placed on the inmate “through the food slot” in the door.

**Phase III.** Phase III is a shift assignment/mentoring program that typically begins upon completion of Phase II training. It also consists of a minimum of 40 hours of training where an assigned mentor guides and advises the employee while observing their performance. On the roster, the trainee and the mentor are assigned to the same post. Phase III is provided by the local institution.

**In-Service Training.** Annual In-Service Training requires 40 hours annually which is offered at six regional training academies and 32 unit based sites. This training is also consistent with ACA requirements. The modules covered in In-Service Training are as follows:

- Pre-Test
- Physical Training (30 min/day except PAT day) Peer Communication
- Core Values and Ethics
- Crisis Intervention Training
- Mental Health First Aid/Suicide Prevention and Response
- Employee Survival and Use of Force
- Offender Management: Special Populations
- Owning Your Wellness
- Observing, Assessing, Reporting Behaviors
  - Defensive Tactics
  - Firearms, Range/Unit Safety, Chemical Agents
  - Incident Command System and Emergency Procedures Infection Control, First Aid/Medical Emergency and CPR/AED Orientation and Testing Standards
- Physical Agility Test
- Safe Prisons/PREA Program
- Security Issues
- Security Issues Practical Application: Restraints, Pat Search
- Go Home to Your Family
- Discretionary Block
- Testing Standards/Post Test/Critiques

The “Offender Management: Special Populations” component of the in-service training addresses needs/behaviors when supervising those in Restrictive Housing. How to properly conduct a strip search is part of pre-service training, but not formally included in annual training. We note that TDCJ recently revised their strip search “how to” video and required all staff who may conduct strip searches verify review of the video. The CGL team reviewed this video and found it was comprehensive and easy-to-understand.

Also outlined in the Training Plan are training requirements for specific post assignments within the TDCJ system, such as Transportation Officer, administrative segregation, etc.

**Transportation Unit Additional Training.** The Transportation Unit has its own additional OJT training requirements for new staff in the Unit. This requires 40 hours of classroom training that includes weapons training and defensive driving followed by 4 weeks of shadowing with a mentor. No annual transportation-specific retraining is required for transport staff; however, transportation staff do participate in the agency's annual in-service training as well as completing annual firearms qualification and a tactical firearm course.

**Individual Staff Training Review.** CGL reviewed training records of those staff assigned to the Lopez transportation bus and those who had some role in the preparation of Lopez for the transport.

**Transportation Staff.** Two staff were responsible for the transport of inmate Lopez. Their training appears to be current.

Transportation Correctional Officer IV Jimmie Brinegar;

- Completed Phases I, II, and III training between 7-27-2007 to 8-24-2007.
- Last annual training received on 9-16-2021
- Offender Transportation Training Program received between 9-11-2017 to 10-20-2017.
- Last weapons qualification appears to be 9-16-2021 during annual training.
- Texas class B driver's License is valid until 8-08-2030.

Transportation Correctional Officer IV Randy Smith;

- Records provided do not include information regarding Phase I, II and III training.
- Last annual training received on 12-16-2021
- Offender Transportation Training Program between 11-3-2014 to 12-17-2014.
- Last weapons qualification appears to be 12-16-2021 during annual training.
- Texas class B driver's License is valid until 7-14-2028.

**Other Staff.** Several other staff were either involved in the preparation of Lopez for transport or were found to have violated agency policy in TDCJ's review of the escape. It should be noted that COVID and staff shortages appear to have negatively impacted TDCJ's ability to provide annual in-service training to all employees. Documentation provided for 22 staff (including the two transportation staff) found that 6 had not received annual training since 2020. These records also show that all 6 of these staff had been rescheduled for annual training, but 2 of those were listed as "No Show" for the rescheduled dates (Exhibit 15). We cannot verify whether the other 4 had attended their training as the rescheduled date was after the time of our records review.

**Post Orders.** CGL reviewed post orders that provide the responsibilities of staff assigned to each post. While most are very detailed, we found that many had not been reviewed in

several years. ACA standard 4-ALDF-2A-04 indicates that post orders be reviewed annually and updated as needed. TDCJ acknowledged that during the COVID pandemic, policy/post order review functions were halted to redeploy staff to critical needs. Also, their recent internal review of the Security Manual Policy in February 2022 found that 89 of 90 post orders need revised while the other nine were under revision.

### Exhibit 15: Staff Training Documentation

Employee	Position	Phase I	Phase II & III	Last Annual In-Service Training	Next Scheduled In-Service Training
White, Aaron	Correctional Officer V	10/18/11	09/19/17	10/21/21	
Guishard, Bernard	Correctional Officer IV	10/16/20	11/23/20	06/10/22	
Stewart, Brantley	Correctional Officer II	02/18/22	03/25/22	-	
Lawson, Damion	Correctional Officer IV	11/16/18	01/21/18	11/12/21	
Miller, Dillon	Correctional Officer II	5/13/22	06/16/22	05/25/22	
Defreitas, Gerald	Correctional Officer V	02/12/10	09/02/15	03/11/22	
Velasquez, Gerardo,	Correctional Officer IV	04/20/18	06/27/18	04/12/19	07/29/22 No Show
Haws Jr., Harvey	Lieutenant	01/15/09	02/17/09	02/18/22	
Brinegar, Jimmie	Correctional Officer V	07/27/07	08/24/07	09/16/21	
Watson, Joshua	Sergeant	02/10/12	09/19/17	04/22/22	
Jones, Karl		06/12/17	03/27/18	07/05/19	07/08/22 No Show
Sharp, Kristopher	Sergeant	01/15/07	03/07/08	04/22/22	
Thomas, Mark		08/11/17	09/25/17	07/15/22	
McElhaney, Michael	Correctional Officer IV	04/02/21	05/29/21	-	
Akinsiku, Morakinyo	Correctional Officer II	04/08/22	09/19/22	-	
Walton, Nicholas	Correctional Officer IV	01/18/19	02/22/19	01/10/20	01/05/23
Taylor, Pamela		02/03/97	07/29/97	10/14/19	09/09/22
Smith, Randall	Correctional Officer IV	02/12/21	04/01/21	04/01/21	
Martin, Shane	Captain	05/02/14	07/21/16	05/17/19	07/15/2022
Miller, Tanya	Correctional Officer IV	01/18/19	03/19/19	12/10/22	
Hocutt, Treyvon	Major	02/09/09	02/10/09	03/22/19	09/09/2022
Smith, Randy	Correctional Officer V			02/16/21	

\*Highlighted reflect those who are past due on annual in-service training.

## Chapter 6: TDCJ Corrective Actions

In reaction to the escape and findings from its own internal investigation, TDCJ has made a substantial number of improvements to past practices and policies that may have contributed to inmate Lopez's ability to escape. The agency ordered a Serious Incident Review that clearly identified staff security failures throughout the preparation and transport of Lopez.

Additionally, in early June 2022, TDCJ took the unconventional step of suspending inmate transports for a week so that it could dedicate its limited resources to reviewing transportation practices. During this shutdown, TDCJ found several issues that could have contributed to security issues during transport. The following represent the major policy and practice changes implemented by TDCJ since the escape. These changes were issued across the organization by a variety of methods (emails, policy changes, meetings, etc.)

- **Transport Staffing.** TDCJ increased to three (3) the required number of security staff on every transport. If 3 staff cannot be provided for the transport, the transport will not occur. This direction was issued in a June 10, 2022, agency meeting. Changes include:
  - Bus Transports now require 3 staff in the vehicle.
  - Van Transports will now require 3 staff in a van. Two officers will be armed, and the 3rd will be unarmed. If there is not enough room for a 3rd officer in the van, they will follow in a chase vehicle. If the 3rd officer is following in a chase vehicle, they will be armed.
  - The mobile correctional officer team and correctional officers from correctional facilities will continue to augment transport staffing until transportation staffing levels are sufficient.
  - Clarified that if an inmate becomes disruptive during transport, the transport should be diverted to the nearest facility or county jail. The disruptive inmate will be removed from the vehicle with the aid of staff and/or law enforcement. Also, the nearest facility will respond and remove the inmate from the transport.
- **Transport Vehicle Video Surveillance.** TDCJ has begun piloting the implementation of video surveillance systems in transport buses. To date, four buses have been outfitted and these systems place cameras within the buses and allow for transport staff on the bus to more clearly monitor inmates held in secure portions of the vehicle. Additionally, transportation headquarters staff can remotely view these cameras while a transport is occurring. TDCJ indicated all transport vehicles will be outfitted with a video surveillance system.
- **Expand Inmate Transportation Supervision.** Supervision of transport practices has been expanded to require:
  - Supervisors are now required to review surveillance videos of officers conducting their duties on units and Transportation supervisors are required to inspect and

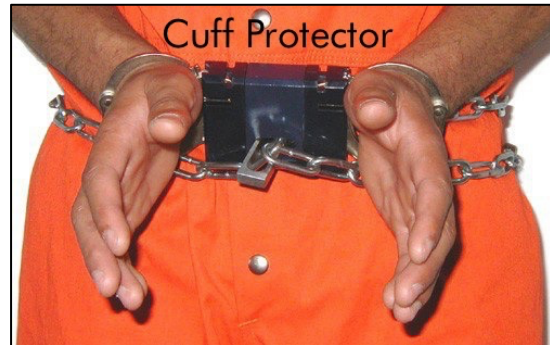
- evaluate transport staff searches, restraint procedures, identification of inmates, etc.
- Supervisors will review and monitor live video from video surveillance systems being installed in transport vehicles.
  - Inmate Transportation supervisors will regularly evaluate officers conducting inmate searches, applying restraints, identifying inmates, loading, and unloading transport vehicles and on-road transport practices.
- **Improve Understanding of Strip Search Requirements.** In response to the multiple failures in the strip searches of inmate Lopez, the agency has developed a revised training video that more clearly explains and demonstrates the requirements of a proper strip search. This video was issued to all supervisors in a June 22, 2022, email and any applicable staff who conduct strip searches were required to verify they viewed the video by July 20, 2022. All of those completed the training at this time, except for those out on leave.
  - **Expanded Search Requirements for Transport Inmates.** New search requirements were issued:
    - Use of Body Orifice Security Scanner (BOSS chair) for all transports. Previously only restrictive housing inmates were required to be scanned by the BOSS chair prior to transport. In light of the failure to use the BOSS chair in the Lopez transfer, this was reinforced, but was expanded to be required for all inmates, including those in general population. If a BOSS chair is not available, the inmate will be searched with a handheld metal detector or a ferrous metal detector. If no equipment is available to screen the individual, the Inmate Transportation Hub officer will call the transportation hub supervisor for direction on whether to proceed with the transport. (June 10, 2022, inter-agency meeting)
  - **Change In Transport Clothing/Property Requirements.**
    - To reduce their ability to hide contraband, male restrictive housing inmates exiting their cell for transport, are only to be in boxers and shower shoes (“slide-on shoes”). Female restrictive housing inmates will be issued a gown when strip searched. (June 10, 2022, inter-agency meeting)
    - Restrictive housing inmates are no longer allowed to have boots in their possession given the ability to hide contraband in them. This change was issued on June 15, 2022 and will be reflected in updated Restrictive Housing Plan and Administrative Directives.
    - Inmates to be transported (including those in general population) will not be allowed to wear any personal clothing on transport. They are required to change into newly issued clothing after being strip searched and prior to boarding the transport vehicles.
    - All restrictive housing inmates will be transported in orange jumpsuits, boxers, socks, and slide-on shoes. These jumpsuits have been deployed and are in use.
    - General population inmates will receive a new set of clothing after being searched and prior to transport.



- Inmates will be limited to one (1) bag of property for transport. Property is stored in the under-storage space or other space on the bus that is inaccessible to inmates. Property will be stored outside the occupied inmate cage during van transports.

- **Hand Restraints/Cuff Restraint Protector.**

The internal review after the escape revealed that some cuff protectors (black box) did not fully cover the keyholes in the hand restraints which may have allowed inmate Lopez to manipulate the locking mechanism. At the time of the escape, Inmate Transportation policy 03.05 outlined the procedure for applying the cuff protectors but did not require they be inspected to ensure they cover the keyhole in the hand restraints. The following changes were made regarding use of cuff restraint protectors and the inspection of those items.



- On June 1, 2022, a security bulletin was issued that:
  - Directed an inspection of all cuff protectors.
  - Required a security supervisor check restraints prior to loading inmates on transport vehicles and ensure that the hand restraint keyholes are not exposed after the cuff protector is applied. This was also added to transport post orders. Inmate Transportation staff are requiring Inmate Transportation Hub supervisors and unit supervisors to print and sign their name on the back of the inmate transportation Driver's Vehicle Inspection Report (TN-28) indicating they checked restraints.
- It was found that some additional cuff protectors were insufficient in covering the hand restraint keyhole. These were removed from service.
- To further reduce inmates' ability to act alone, all general population inmates are paired and restrained by hand, restraining two inmates, side by side, with one hand restraint. Odd number inmates are restrained by themselves with hand restraints only.
- Restrictive Housing inmates are restrained with hand restraints, cuff protector, leg restraints, pad lock and connecting chain. Each inmate of this custody is restrained individually.
- Reinforced that leg irons (leg restraints) are to be placed on skin and not over the pantleg or boot-top of individual, thus ensuring a more secure application. This was added to the transportation officer post orders as well.
- **Enhance Vehicle Security Package.** The physical security of the interior of transport buses is being improved.
  - Plexiglas: Buses have been inspected to ensure visibility through the Plexiglas partitions (much of the Plexiglas inside the transport bus used in the escape was scratched and obstructed clear view of different areas of the bus). Where needed, Plexiglas is being replaced.

- Reinforcement Bars: Metal bars in security doors and screens are being added to reduce the size of the unreinforced expanded metal areas that Lopez was able to cut through.
- Removed mail from transport vehicles: Existing policy allowed for institutional mail to be transported in the vehicle. This can obstruct line-of-sight. Mail will no longer be transported in the transport vehicle.
- **Holster Requirements.** Prior to the escape, transport officers were allowed to wear quick-disconnect holsters for their weapons. This could allow for an inmate to easily remove an officers' handgun. The quick connect/disconnect holster will be replaced with holsters that are not detachable from the belt. (June 10, 2022, inter-agency meeting)
- **Reducing Transports.** TDCJ transports over an average of 1,300 inmates per day. Efforts are being made to evaluate options to reduce transports. In the area of medical services, more on-site services, and telemedicine options are being explored with UTMB.
- **Established High-Risk Inmate Categories.** On June 23, 2022, TDCJ's Classification and Records department issued an email outlining two additional high risk inmate categories added to the offender management system:
  - Security Risk Transfer (SRTF) Inmates who meet all four of the following statuses must be transported alone in a van with 3 officers:
    - Housed in restrictive housing
    - 20+ year sentence length
    - Committed on violent offense
    - Is assigned a Security Precautions Designation per existing Administrative Directive AD.04.11
  - Capital Murder Offenses: The agency created a code so they can be easily identified. Inmates with a capital murder offense code can ride on normal transport, according to their custody and will only be transported alone if they meet other requirements (SRTF, high profile, etc.)
- **Visitation Cancellation.** In a June 17, 2022, email, to ensure proper staffing levels for transports, Senior Wardens were provided the full authority to cancel their in-person or video visitation based on staffing levels and security needs.
- **Other TDCJ Changes.** TDCJ also made several other changes to policy and officer post orders to enhance security of transports. These included changes to the weapons custody staff carry on transport, their pre-transport inspection requirements, and requirements while in-transport.



**Staff Disciplinary Actions:** As a result of its own internal investigation, TDCJ initiated disciplinary action against more than 20 staff and supervisors whose performance failed to comply with TDCJ policy.

## Chapter 7: CGL Recommendations

**Staffing Shortages.** Our review found that TDCJ's staff shortages are at critical levels, especially in the correctional officer ranks. This is clearly shown in the Hughes Unit Turnout Rosters for the day of the escape where only a small portion of the Priority 1 Positions at the facility could be filled with the limited staff available. The few staff available carried a heavier workload and were working increased levels overtime. These shortages led to a security environment that better allowed Lopez to escape.

**Security Lapses.** While these staffing shortages, especially at the Hughes Unit, may have been a factor in inmate Lopez's ability to escape, they are not an excuse for the multitude of security lapses that occurred in preparing Lopez for transport. TDCJ, like most correctional systems, builds multiple redundancies into their practices to ensure that one single failure cannot have catastrophic results. History shows that when serious incidents of this type occur in a correctional setting, it is not a single failure that leads to the incident, but the compilation of multiple failures. That was the case with the Lopez escape. The combination of several inadequate strip searches, failure to search property, poorly applied restraints, and failure to use the BOSS chair improved Lopez's odds for a successful escape. The fact is that if one of these actions was followed in compliance with existing policy, it is likely that the escape would have been thwarted. For example, the escape could have likely been prevented if staff would have scanned Lopez in the BOSS chair prior to transport, a task that would have added less than a minute onto the process.

**Lapses Appear Endemic.** TDCJ's internal review as well as our independent assessment found that staff at the Hughes Unit had become complacent, and circumvented security procedures in favor of hastily completing responsibilities. Given TDCJ's internal investigation as well as the number of failures during this single transport preparation, these breakdowns appear to have become routine at the Hughes Unit and a matter of regular practice rather than isolated incidents. Although we did not investigate practices at other TDCJ Units, it is possible that the complacency regarding security practices is occurring there also.

**Lack of Supervisory Oversight.** Supervisory oversight is key to ensuring staff compliance and preventing staff complacency. However, as noted in TDCJ's Serious Incident Review, supervisory security staff had not been conducting regular inspections or routine rounds. Additionally, we found there is no policy that identifies when/where facility leadership are to conduct rounds and the frequency of those rounds. Also, surveillance systems can improve oversight, and the Hughes Unit has a significant number of remote surveillance cameras. But the ability to review what is captured on

these cameras is difficult and makes supervisory staff's ability to remotely observe staff compliance more time-consuming.

CGL agrees with the corrective steps taken by TDCJ noted in the earlier chapter, however, additional actions are needed.

One particular challenge exists when providing additional recommendations. Correctional systems are very good at conducting post-incident reviews after a serious incident. The corrective actions that result from post incident reviews often add responsibilities to staff post orders. However, in times of severe staff shortages, those additional responsibilities may not be achievable. Therefore, our recommendations are cognizant of the need to provide long-lasting solutions that do not further overload staff.

The following represent CGL's additional recommendations:

- 1. Continue to Develop Strategies to Reduce Vacancies/Address Staff Recruitment/Retention.** Although this review was not a staffing assessment, it was clear that severe staffing shortages have impacted staff and facility performance. Asking employees to do more with less is difficult during this shortage and can result in further retention issues. TDCJ and the legislature have recently increased line staff salaries to stem the loss of employees, and TDCJ has implemented other practices to reduce hiring lag and expand their recruiting base. CGL recommends TDCJ continue efforts to improve staff retention.
- 2. Focus Upcoming Security Assessments on Searches and Transports.** TDCJ's internal security assessment process paused during the pandemic and is being restarted. This compliance monitoring should initially focus on basic security practices and transportation security.
- 3. Review all Medical Transports with UTMB for Appropriateness.** TDCJ has already begun to reduce transports through increased telemedicine and providing more on-site services. As stated in discussions with the UTMB Medical Director, the existing telemedicine equipment is outdated and needs to be upgraded to the current standard. Upgrading equipment would allow for enhanced telemedicine usage as the quality of telemedicine services are increased. This would result in the need for fewer medical transports. To go further TDCJ should consider assembling the past year's inmate transport data to show the why, when, how, and where of each transport. In the case of medical transports, the data could be analyzed in conjunction with UTMB to determine alternatives to transporting the inmate.
- 4. Reorganize/Streamline TDCJ's Policy Structure.** We found the policy structure within TDCJ to be overly complex and decentralized. Formal policies serve multiple purposes for an organization. Most importantly, they act as a uniform rule book for staff conduct and performance. By delineating expected standards, policies help

establish consistency across staff and better ensure compliance with expectations. Staff should be able to quickly find a policy and then understand its requirements. Within TDCJ, however, just finding a policy requirement is complicated given there are a number of different sources. CGL requested clarification regarding the policy structure and policy sources in TDCJ and was provided with the following delineation:

- Department Policy Operations Manual (DPOM) is TDCJ's manual that contains all board policies, executive directives, (excluding personnel directives), administrative directive and board rules.
  - Board Policies are approved by the Texas Board of Criminal Justice (TBCJ) under the coordination of the Office of the General Counsel and signed by the TBCJ chairman. These policies reflect the intent of the TBCJ regarding the internal management or organization of the TDCJ and do not affect private rights and procedures.
  - Executive Directives are statements of the executive director's principles, philosophy, and executive intent regarding the executive director's duty to administer and enforce laws relating to the TDCJ and responsibilities as designated by the TBCJ. These directives grant authority to the appropriate designee to implement a procedural directive as required and are signed by the Executive Director.
  - Administrative Directives may apply to more than one division and are signed by the Executive Director. These directives are more procedural than executive directives.
  - Board Rules are statements of general applicability that prescribe, establish, or interpret policy or describe the procedure or practice requirements of the TDCJ, and generally affect people or entities outside the TDCJ. These rules are approved by the TBCJ.
- Personnel Directives are executive directives that establish procedures regarding human resources issues, are contained in the TDCJ Personnel Manual, and are signed by the executive director. The Human Resources Division is the proponent for all personnel directives.
- The Corrections Institutions Division (CID) Security Manual is a four-volume set of manuals containing operational plans, post orders, security memorandums, and emergency procedures relating to correctional staff and security operations at units, including contract facilities.
  - Operational Plans are guidelines designed to provide uniform rules defining organizational and administrative requirements related to a

specific operation.

- Post Order (PO) is a policy documenting specific job duties and responsibilities for posted security positions. POs shall provide guidance for correctional officers in performing their job functions.
  - Security Memorandums are policies outlining operational and security procedures for all TDCJ units to ensure correctional staff consistently perform essential functions, such as armory operations.
  - Emergency Procedures are pre-determined plans to manage an emergency. Emergency procedures are implemented during times other than normal operations, with the intent to return a unit to normal operations.
- The Correctional Managed Health Care policies are developed in accordance with procedures implemented by the Joint Health Services Policy and Procedure Committee and are approved by the respective university medical directors.
  - Division Directives establish procedures that apply to individual divisions and may be referred to as department policies. Each division is responsible for its own internal review process, maintenance, and distribution. Divisions may have more detailed department or division operational manuals or standard operating procedures manuals.

Additionally, we were provided procedures from a separate Security Operations Procedure Manual and several Operational Plans including a Restrictive Housing Plan, Incident Management Plan and others that set policy requirements.

As a result of this complex structure, it is extremely difficult to locate a policy requirement, which we experienced to be true in this escape review. For example, early in the project we sought to find the policy governing the number of staff required per transport. We had been informed that in prior years, TDCJ required three staff per transport, but this changed to two per transport several years ago. We wanted to understand specifically what the agency policy required, and by whose authority the reduction in staff per transport was approved. In most correctional systems, the number of staff required per transport is a critically important policy decision and therefore, would require agency leadership approval to change. We looked through several sources including TDCJ's Administrative Directives, Transportation Unit Standard Operating Procedures, Security Operations Procedures and Security Memorandums, all with no success. Finally, we noticed the requirement while reviewing the Transport Officer Post Order. Post Orders are an unusual location for a major requirement of this type. A Post Order is intended to list the duties and responsibilities of staff assigned to a specific post. The number of staff required per transport is not a post responsibility, but rather, is administrative guidance. It is a

responsibility of someone other than the Transport Officer to ensure the appropriate number of staff per transport.

Additionally, because this requirement is in a Post Order, it can be changed without the Executive Director's approval. In this case the post order was issued in 2018 under the authority of a past Director of the Correctional Institutions Division.

TDCJ should engage a study to improve their policy structure that achieves the following:

- Streamlines the policy structure.
  - Improves the clarity of policy requirements.
  - Elevates those important requirements to the agency level that requires any policy deviation be approved by the Executive Director/Designee.
  - Ensure post orders are annually reviewed and up to date.
5. **Revise the Security Precaution Designator Policy.** The Security Precaution Designator policy should be revised to establish more detail regarding transport requirements for those inmates with a past history of escapes or other factors or circumstances that may indicated an individual has a higher risk of escape. Currently the policy prescribes only very limited transport implications for inmates with a recent escape. This revision should be consistent with any changes made to the Security Risk Transfer or High-Profile designations.
6. **Pilot Policy Requirement Modifications that Consider Current Staff Shortages.** Correctional officer staffing levels are very low in TDCJ, and this has created an environment where the limited remaining staff are attempting to perform the policy requirements of multiple positions. The honest question to be asked is "Are these policy requirements impossible to achieve given the current staffing crisis." This appears to be the case, and we clearly found a large number of staff take security shortcuts to get the work done. Rather than continuing to ask staff to do the impossible, which in reality means staff continuing to make shortcuts, another option is to right-size policy requirements to be consistent with the current staffing reality. So as an example, instead of unreasonably requiring 10 cell searches be conducted by a correctional officer, only 5 would be required. The benefit could be that 10 poorly conducted cell searches would be replaced with 5 that were appropriately conducted. TDCJ should consider piloting the reduction of some of these requirements to a more achievable level during the current staffing shortage.
7. **Reinforce Policy Concerning the Prior Notice of Transports.** The Executive Director should issue an order reinforcing that inmates are not to be given advanced notice of the dates/times of future transports. This should be provided to all employees and contractors. Correctional Managed Health Care Policy E-42-1 should also be modified to include similar language.



8. **Establish a Duty Warden Inspection Schedule.** Establish a duty warden policy that requires administrative rounds at each facility. This policy should define the frequency at which facility administrative staff (wardens, assistant wardens, majors) should personally visit and conduct scheduled and unscheduled inspections of the facility. The frequency for these inspections should depend on whether the space is an “inmate activity area” (housing units, kitchens/dining, health care units, recreational areas, educational, vocation, maintenance, and industry buildings) or non-activity area (towers, perimeter security administration building, warehouses, commissary, etc.) Inmate activity areas should require more frequent inspections. These inspections also should be documented.
9. **Require Documented Regional Director Inspections.** TDCJ should establish a policy that requires regional directors make a minimum number of visits to the units under their authority. Additionally, policy should require that regional directors and staff conduct periodic formal inspections of their unit each quarter, unless a security audit is being conducted that quarter. These formal inspections should focus on vulnerability and policy compliance and use an instrument that can be regularly adjusted to meet the primary concerns of agency leadership.
10. **Conduct Desk Audit of Warden’s Position.** It was reported that many supplementary administrative responsibilities have been added to the warden position in TDCJ over the years. It appears these duties have result in facility managers having less time to spend inside their facilities to observe inmate activities and staff practices. Based on this audit, TDCJ should make any changes necessary to maximize a warden’s ability to be present in the key areas of their facility to observe inmate and staff morale, operations, and security practices.
11. **Consider Reconfiguring Transport Buses to Improve Bus Security.** We recommend TDCJ implement one or both of the following changes to their configuration:
  - **Turn 3rd Officer Seat to Face Inmate Compartments.** The current 3<sup>rd</sup> officer seat faces forward, directing the officer’s vision away from the inmate compartments.
  - **Relocate the Restrictive Housing Compartment to the Back of the Bus.** The current bus configuration places general population inmates at the back of the bus, with restrictive housing at the front. We recommend TDCJ consider reversing this, placing the less controlled population (general population) in the front, and the more controlled at the back, in closer proximity to the rear compartment officer and further away from the driver.
12. **Require Random Review of Strip Searches for Policy Compliance.** Failure to adequately perform a strip search was a major contributor to Lopez’s escape. Random video reviews of strip searches will provide TDCJ with a better understanding of staff compliance with this important policy. Findings should be reported to the facility

administrator. Implementing this recommendation will be difficult given current practices in the facilities due to two reasons:

- **Limited Video Review Staff.** Facilities have one video surveillance sergeant and an assistant to monitor and review video footage. There are over 1,000 cameras installed at the Hughes Unit making comprehensive monitoring impossible. Other states have addressed this issue using volunteers. These volunteers often include past agency staff who have retired in honorable conditions or retired law enforcement personnel. The volunteers could be trained by the Surveillance Sergeant and observe real-time searches, looking for policy violations. They could make those reports of violation to the Sergeant as they occur so corrective action could be implemented immediately.
  - **Documentation of Strip Search Events.** Housing staff do not log when strip searches occur resulting in the need for video surveillance staff to spend considerable time manually scrubbing through videos to locate strip search events. To remedy this, housing staff should document the time and location of every strip search and that information should be provided to video surveillance staff. This will provide a guide of where to focus video search efforts and improve their efficiency.
13. **Inspect Integrity of Every Restrictive Housing Cell in the Hughes Unit.** During our tour of inmate Lopez's cell in the Hughes Unit we found gaps between the wall and the plumbing chase, which could have allowed for the storage or transfer of contraband. A documented inspection of every cell in Restrictive Housing units should be immediately conducted.
14. **Do Not Allow Inmates to Take Personal Property with Them on Bus.** Any inmate property should be limited and carried either in a chase vehicle or a secure area of the transport vehicle that does not hinder site lines or limit the amount of property inmates can take on a medical transport.
15. **Require Supervisory Oversight (Lieutenant or Above) of Out-Processing of Any Inmate for Transport.** A lieutenant or above should be required to monitor the sallyport area where inmates are moved to the transport bus. This area should be secure and free of other inmates.
16. **Enhance Publication Review Notification Practices:** Establish a procedure requiring reporting to facility warden/associate wardens of any book/publication ordered by or sent to an inmate that may be detrimental to security, might facilitate criminal activity, or that might aid in a potential escape. TDCJ's internal review found that, prior to his escape, inmate Lopez had ordered the following publications that could have indicated he was planning the escape.
- U.S. Army Survival Manual – How to Manufacture Weapons

- Unlocking Secrets – How to Manipulate
- Ultimate Survival Manual – How to Manufacture Weapons
- The Ninja Mind -Offensive and Defensive Fighting Techniques
- Truth Detection – Manipulation Techniques
- Mind Control – How to Manipulate.

These books were shipped to the facility and upon review by mailroom staff, were appropriately denied. However, there is no policy requirement that facility administration be made aware when denials of publications that could impact facility safety and security. If this notification had been made, it is possible his security supervision may have been increased and his method of transport altered.

17. **Eliminate Multiple Security Rosters at Correctional Facilities.** The existing practice of running multiple, separate turnout rosters at each facility can result in more critical posts being left unfilled in favor of less critical posts.

We found the multiple rosters at the Hughes Unit may have contributed to the understaffing in restrictive housing, where inmate Lopez was housed.

The Hughes Unit operates with 3 separate and distinct security rosters (turnout rosters):

- **Building Turnout Roster.** The Building Turnout Roster covers security staffing for the general population housing section of the facility as well as some support areas. Staff assigned to the Building Turnout Roster generally work one of two 12-hour shifts (5:30 a.m. to 5:30 p.m., 5:30 p.m. to 5:30 a.m.). The Building Turnout Roster has a listing of posts designated as either Priority 1 or Priority 2.
- **Restrictive Housing Turnout Roster.** The Restrictive Housing Turnout Roster covers those posts needed in the Restrictive Housing/Mental Health housing areas. Staff assigned to the Restrictive Housing Turnout Roster generally work one of two 12-hour shifts (5:00 a.m. to 5:00 p.m., 5:00 p.m. to 5:00 a.m.). The Restrictive Housing Roster also has a listing of posts designated as either Priority 1 or Priority 2. In general, those posts on the Restrictive Housing Turnout Roster are more complex to manage, more critical to security, and require a higher level of staff supervision than those on the other turnout rosters.
- **Non-Shift Turnout Roster.** The Non-Shift Roster are those additional posts that are not assigned to a shift. These posts may typically provide administrative support and/or have specialized responsibilities (e.g., kitchen supervision, therapeutic escort team). Staff assigned may work an 8-hour, 10-hour or 12-hour shift. The Non-Shift Turnout Roster does not have any Priority 1 posts.

Each of these turnout rosters operates independently, with a shift supervisor and a cadre of assigned staff dedicated to each. Each is responsible for finding staff in their own cadre to fill their posts.

In times where ample staff exist, having 3 separate rosters may have provided shift supervisors with a more manageable number of posts and staff for which they were responsible. However, when severely short staffed, we found the 3 separate rosters creates issues with the ability to ensure the most critical posts are filled.

The staffing imbalance this practice creates was apparent for the shifts that were responsible for preparing inmate Lopez for transport (2<sup>nd</sup> shift May 11, and 1st shift May 12<sup>th</sup> 2022). On those shifts the Restrictive Housing Turnout Roster had a much higher percent of Priority 1 positions left vacant than the Building Turnout Roster. Exhibit 16 provides the comparison over these two shifts.

**Exhibit 16: Turnout Roster Comparison**

	<b>Restrictive Housing Priority 1 Posts</b>	<b>Building (General Population) Priority 1 Posts</b>
<i>2<sup>nd</sup> Shift, May 11</i>		
# Of Priority 1 Posts	24	50
# Not Filled or Deviated	9.5	14.5
<b>Percent Not Filled/Deviated</b>	<b>40%</b>	<b>29%</b>
<i>1<sup>st</sup> Shift, May 12</i>		
# Of Priority 1 Posts	31	55
# Not Filled/Dev	12.5	6
<b>Percent Not Filled</b>	<b>40%</b>	<b>15%</b>

On the 2<sup>nd</sup> shift on May 11, 2022, 40 percent of the Restrictive Housing Turnout Roster Priority 1 Posts were left vacant, while 29 percent of the Building Turnout Roster were vacant. The disparity was even greater on the 1<sup>st</sup> shift on May 12, 2022 where 40 percent of the Priority 1 posts on the Restrictive Housing Turnout Roster were vacant and only 15 percent of the Priority 1 posts on the Building Turnout Roster were vacant.

The separation of these rosters has created staffing silos that do not facilitate the correct deployment of staff away from less critical posts (Building Turnout Roster) to more critical posts (Restrictive Housing Turnout Roster).

In a follow-up interview with the Hughes Unit warden, he acknowledged issues with this past practice and indicated he has recently personally begun moving staff between rosters to allow for a better staffing balance.

To address this concern, CGL recommends the elimination of multiple turnout rosters at facilities in favor of a single combined roster.

18. **Address Gaps in Annual In-Service Training.** TDCJ acknowledges past gaps in annual training due to the impact of the COVID-19 pandemic, and as staffing levels grow, the agency should make every effort to address these gaps and ensure staff receive in-service training as required. As part of annual training, the agency should elevate those key security lapses identified during the Lopez escape review. These include training regarding strip searches, application of restraints, managing inmates in restrictive housing, and transportation supervision.
19. **Institute Annual Refresher Training for Transportation Staff.** New staff hired into the Transportation Unit participate in the Offender Transportation Training Program, but no annual transportation-specific retraining is required. TDCJ has recently implemented a corrective action after the Lopez escape that included requiring transportation supervisors regularly evaluate transportation officers while preparing and conducting transports. We recommend this evaluation include some time mentoring staff on transportation security requirements including searches, restraints, and supervision.