Prevention and mitigation analysis essay

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Prevention and Mitigation Analysis In this paper the subject to discuss is the prevention and mitigation analysis of the Arizona Department of Correction's Morey Unit hostage situation. This incident was very terrible in the United States history in escapes made from prisons. In Buckeye, Arizona at the Lewis Prison Correction facility in the Morey, on January 18, 2004, Ricky Wassenaar and Steven Coy made an attempt to escape from the unit by taking two correctional officers hostage and took over Morey's unit tower, causing a 15-day hostage and standoff incident.

The following discussion is an analysis of issues, prevention, and mitigation recommendations for future incidents aiming at fiscal, operational, and administrative problems regarding the Arizona Department of Corrections. Discussing the Arizona Corrections Department Using the SWOT method to find the strengths, weaknesses, opportunities, and threats in each of the following categories; security, defensive tactics, communications, individual unit response, delivery of tactical and intelligence/negotiations, resolution of hostages, and Administrative police/budget.

Security Investigation into the Morey Unit's hostage incident the security measures in relation to the inmates, the yard, kitchen, and tower found issues of policies and procedures not followed through during the departure from their cell and to the kitchen area. The Inmate security discoveries during the investigation include the searching of inmates leaving the cell but failed to conduct a search when arriving at the kitchen. By not conducting a search on the person could have been the cause of inmates to gain access of weapons from the yard.

The officers conducted the searches in a quick manner than taking their time to search the inmates the right way. The pat downs should be in detail manner. Also the searches of the same sex were not mandated and rarely conducted. Inmate security recommendations are to conduct detail pat downs from the departure of the cells to the arrival to the kitchen. The cross gender and same sex pat downs should be a requirement and conducted on a regular manner. Every department of corrections should develop a special squad to go around the facility conducting searches on each inmate.

Inmates gathering contraband is a continual problem so to increase the searches and scanning to inmates cells, mail, yard, and person could help reduce the risk of inmates gaining access of lethal weapons. The department should conduct searches with unpredictability, thoroughness, and consistency. Yard security discoveries include that the inmates may have hidden the weapons used in the escape under some gravel or other soft material out in the yard while walking to the kitchen. The only recommendation is to remove all gravel or objects that would give inmates the ability to hide weapons in or under.

The yard should stay empty at all times. Kitchen security discoveries include the officers working each shift were not changed and the behavior was the same every day. The officer’s actions were in a routine manner, so the inmates studied the behavior constantly before attempting the escape. For the two inmates to have such a violent background should not have been able to work in the kitchen. Also the inmate’s kitchen duties were taken away weeks before the escape because of the guards hearing about the plan but found no evidence of the plan and was given back kitchen duty.

The kitchen area did not have any cameras, the doors were unlocked most of the time, and the procedures of handling the utensils were delivered by hands. Acquiring one officer to guard the inmates in the kitchen gave easy access for the inmates to overpower the officer. Kitchen recommendations are to rotate the officers work shift constantly to make it difficult for inmates to catch on to a routine. The inmates that have violent backgrounds should have a limit on their work assignments. There should be more than one guard covering the inmates to reduce the chance of inmates overpowering the guards.

All doors should remain locked and secure. In handling the kitchen utensils there should be a sliding opening in a locked door so no access to kitchen staff civilians. There should be cameras with audio and video in every room. The procedures in searching the kitchen staff should be constantly and in a detail manner. The Tower security discoveries include several points of entry and no positive identifications of guards. The Tower was also used for storage and medication distribution to the inmates. Using the Tower for medication distribution gave the inmates access to study the layout and functions of the Tower.

The tower gave poor observation of the inmate’s behavior and movements from the housing area to the kitchen area. The Tower gave the guards inadequate ability to gain access to weapons needed to defend themselves against the inmates. Recommendations for security in the Tower include placing cameras, both audio and video, showing all hidden areas so the guards can observe all movements of the inmates. The architecture of the Tower needs a change so there will be only one or two entry ways and for

use of the guards to observe inmates instead of using the Tower for medication distribution and storage.

So that, way the inmates would not have access of the layout and functions of the Tower. The identification procedures should be in detail maybe consists of fingerprint scanners instead of badges because any inmates can get a hold of a guards badge. In the Tower there should be easy access for armed guards to obtain their weapons to defend themselves from such attacks. The security policies and procedures in the Tower should in practicing constantly. Defensive Tactics The defensive tactics found in the investigation of the incident are that the correctional guards could not defend themselves and using little defensive tactics.

Because of the little defensive tactics for the guards to defend themselves against the inmates was a major factor in subduing the guards, escaping, and gaining access to the Tower. The guard’s use of OC spray was ineffective and impossible to defend themselves against an attack with lethal weapons. The policy of authorizing the usage of lethal force was not updated in Department order 804-behavior of inmate control. Recommendations for defensive tactics are updating the policy and procedures of authorizing when to use deadly force.

The department should improve the defensive tactics and weapons so the guards are better at defending themselves from an attack. There should also be refresher training classes for all correctional employees. The training should on involve defensive tactics of hand to hand, small defensive tactics, and weapons. Communications The Communications discoveries are that all

the cameras throughout the facility are not taken advantage of with the improved technology. Some of the rooms did not have cameras inside to monitor the inmates. Also some hidden areas where the cameras could not gain access of view gave inmates easy access to areas.

The two officers which were taken hostage had little ability to request for assistance and gave false indication of as secure. The communication process of even giving knowledge of the escape were in the inmates advantage because the time between the beginning of the escape and gaining access to the tower was too much time lost. Recommendations for communication should be improving the use of the technology. To take advantage of all the cameras, radios, and phones in the facility. For the department conduct reviews of the benefits of distress capability, encryption, durability of radios, and the dependency of batteries.

The department should place improvements of cameras to have audio and video, sensors in place, and having distress signals in place. Individual Unit Response The individual unit response discoveries in the investigation are the unawareness of the situation among the correctional officers. By the officers being unaware of the incident affected the security of the facility and placed harm to officers and employees. The response time to the incident was inappropriately of the guards on duty. No codes to differentiate between the actual incident and the IMS simulation.

Most of the correctional officers were just starting out on the job with little experience and training. Recommendations in the individual response should have codes and procedures to differentiate between an actual crisis and a

practice exercise. The training simulations should never be seen by inmates and realistic as possible. All correctional officers should never have to question if the incident is a practice or an actual incident. There should be DOC sergeants on duty being able to identify the deficiencies in training, performance, and operational issues. The sergeants should conduct inspections on several osts to make sure the inexperienced officers are following the policies and procedures of searches and observation of inmates to reduce the chances of inmates attempting to escapes by taking advantage of inexperienced guards. There should be daily training classes available for new inexperienced correctional officers. Interagency delivery of tactical and intelligence/negotiations The delivery of tactical and intelligence/negotiations discoveries in the investigation are that the Department of Corrections do not participate with law enforcement agencies in tactical maneuver training.

When local and state law enforcement agencies along with the Department of corrections do not participate in the practicing of negotiations and do not have the knowledge about the state’s correctional facilities’ intelligence gathering of tactical maneuvers and technologies. Recommendations of the delivering of tactical and intelligence/negotiations are to have state and local law enforcement agencies and DOC to work together in practicing tactical and intelligence/negotiations scenarios.

With the assistance from federal, state, and local law enforcement agencies DOC should analyze the physical structures of events to intelligence gathering and tactical maneuvers by keeping the information onsite and update regularly. Resolution of Hostage The resolution of hostages found

that the DOC’s policy states there are no negotiations with the takers of hostages but despite policy negotiations were constant for the entire 15 days. The knowledge that the tactic team had opportunities to use lethal force but was told by their superiors not use the lethal force but later refuted by many tactical members.

The transfer of the inmates out of the Morey unit and sent to out of state prison facilities is a common management practice. Recommendations for the resolution of hostages are the updating of the negotiations policies and procedures. The negotiations should not become ongoing for so long. The use of lethal force from the tactical team should be in use when negotiations are no longer in affect. The department of correction should do away with the policy for non-negotiations. The DOC should implement a negotiation policy consistent with state and local law enforcement agencies.

Administrative Policy/Budget The administrative policy/budget discoveries in the investigation are not up to date. The classifications of the inmates were not reliable and last evaluated in the 1980s. The civilian staff was undertrained in many areas in the correctional facility. Placing inexperienced officers was working in high risk areas. Paying of the correctional officers is underpaying, which leads to low morale, high attrition, and family hardships. It was found that most sergeants were paid less than the officers they would supervise.

Lack in professionalism during the incident there was evidence of many deficiencies in performance and supervision that was in contribution to the hostage incident. Recommendations include updating the classifications of

the inmates; too make sure the violent offenders do not have access to work in sensitive areas. The department should provide levels of programming of drug treatment, education, and mental health treatments. The policies and procedures of protective segregation should consist of an assessment and to request national assistant in the enhancement and replacement of the system.

The department needs to place improvement in training the civilian staff in all areas of a correctional facility. There should be a supervisor or experienced officer working with the inexperienced officer if the assignment is to a high risk area or to not have inexperienced officers working in high risk areas. The DOC should analyze their pay scale with a comparison of federal, state, and local correctional facilities in Arizona. The DOC should reinstate longevity pay and merit increases. The department needs to understand that good communication and professionalism is important when operating a correctional facility.

SWOT Method The SWOT method is a good tool to use when analyzing the operating of an agency. The Morey Unit hostage incident gives the Arizona department of corrections the knowledge to learn from the mistakes that led to the incident. By using the SWOT method the department can gain the knowledge of knowing their strengths, weaknesses, opportunities, and threats. The strengths during the incident are the officers when aware of the incident did take charge and the incident commander unified structure and communication among state and local law enforcement agencies.

The officers and leaders response was quickly and effectively in establishing the conditions that resulted in a successful capture of the two inmates and releasing of the hostages. The weaknesses were that the department did not take advantage of the new technology systems that were available, the officers conducting of the searches of inmates were poorly, inexperience officers were working high risk areas, and inadequate identifications accessing the Tower. The opportunities are to invest in taking advantage on the technology available in regard to cameras, radios, and alarm systems with sensors.

The department should conduct training of policies and procedures of searching inmates and defensive tactics. The threats should consist of an analysis of other inmates attempting to escape, riots, and inmates trying to overpower the officers. Prevention and Mitigation The prevention and mitigation consists of improvement in the policies and procedures of searching the inmates from departing one area of the facility to arriving at another area. The DOC should imply the searching of inmates to be constant and in detail to reduce the risk of inmates picking up weapons.

Improvements in the identification process of correctional officers should use fingerprinting scanners for more protection. Improvements in cameras, radios, defensive tactics, and intelligence gathering will help reduce future attempts of prison escapes. Conclusion The Morey Unit hostage incident was a terrible incident that placed many changes to correctional officers and facilities. The incident showed the United States how dangerous and challenging the correctional officers must face daily.

The two inmates that attempted to escape showed the gaps of security within the facility and the lack of situational awareness. The leaders and officers responded effectively and the establishment of a successful ending to the tragic incident. The lessons learned from the incident resulted in the importance in acquiring the essential qualities in operating a correctional facility. The Department of Corrections cannot guarantee that inmates would not attempt escapes. The correction facilities can learn from this incident and reduce the risk of inmates attempting to scape a correctional facility.

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