On May 24, 2022, a Serious Incident Review (SIR) team was formed at the request of the Texas Department of Criminal Justice (TDCJ) executive leadership based on a recent incident involving an inmate escape from Inmate Transportation Central Region Transportation (CRT) bus #153095, on State Highway 7 (SH7) west approximately two miles outside of Centerville, Texas.

The team convened on May 31, 2022, at the Alfred D. Hughes Unit in Gatesville, Texas and included Chairperson Cody Ginsel, Division Director, Facilities Division; Marvin Dunbar, Division Director, Administrative Review and Risk Management; Leonard Echessa, Deputy Division Director, Administrative Review and Risk Management Division; William Stephens, Director, Security Operations, Correctional Institutions Division; Daniel Dickerson, Senior Warden, Allan B. Polunsky Unit, Correctional Institutions Division; Dennis Crowley, Senior Warden, Huntsville Unit, Correctional Institutions Division; Tara Burson, Deputy Director of Operations, Private Facility Contract Monitoring / Oversight Division; Cliff Pegoda, Deputy Director, Manufacturing, Agribusiness and Logistics Division; Richard Bledsoe, Lieutenant of Correctional Officers, Region I Security Threat Group Management Office, Correctional Institutions Division; Dale Dorman, Registered Nurse, Health Services Division; and Lincoln Clark, Program Supervisor V, Facilities Division.

Scope:

- Review security protocols and processes at the Hughes Unit prior to the transport;
- Review security protocols and processes of Inmate Transportation during the transport;
- Review the initial staff response to the incident;
- Interview staff and inmates involved in, or with knowledge of the incident;
- Review supporting documentation, policy, procedures, and video surveillance;
- Identify measures that may prevent similar incidents from occurring; and
- Offer recommendations to the Executive Director for corrective action.

Inmate Information:

Inmate Lopez, Gonzalo Artemio (TDCJ #01349716), (Escapee) (Deceased) was a 46-year-old Hispanic male, S4/1A inmate. He had served 17 years, and 16 days of a life sentence for Capital Murder from Hidalgo County and a consecutive life sentence for Attempted Capital Murder from Webb County. He was received by the TDCJ on February 23, 2006, serving his second incarceration. Previous convictions include a discharged 15-year sentence for Aggravated Kidnapping from Hidalgo County, an eight-year sentence for three counts of Aggravated Assault, and a five-year sentence for one count each of Unauthorized Use of a Motor Vehicle, Failure to Stop and Render Aid, and Possession of Marijuana. Inmate Lopez had an initial parole eligibility date of April 26, 2045, and no minimum or maximum expiration date. During his incarceration, he received 28 disciplinary cases, including six major cases and 22 minor cases. Inmate Lopez was confirmed as an ex-member of the Mexican Mafia however he completed the Gang Renunciation and Disassociation process on August 4, 2014. Classification records reveal a Security Precaution Designator (SPD) Escape Attempt/Other Escapes (EA/EX) from Hidalgo County Jail, March 27, 2006. Two Inmate Protection Investigations were filed during his incarceration.

Staff Information

Correctional Officer V Randy Smith, CRT (Driver), is a 54-year-old White male with a hire date of May 21, 2009. He was assigned to Inmate Transportation on November 1, 2014. Officer Smith was issued a handgun loaded with ammunition that was secured in a holster fastened to his duty belt. His last firearms requalification date was December 13, 2021. During the event, Officer Smith sustained a puncture wound to his left palm and right hand. He was evaluated and treated by local Emergency Medical Services (EMS). Upon arriving at his residence on May 12, 2022, a puncture wound to his upper torso was discovered at which time he proceeded to obtain a medical evaluation and treatment.

Correctional Officer V Jimmie Brinegar, CRT (Rear Compartment Second Officer), is a 62-year-old White male with a hire date of June 21, 2007. He was assigned to Inmate Transportation on August 01, 2017. Officer Brinegar was issued a handgun

loaded with ammunition that was secured in a holster fastened to his duty belt. In addition, Officer Brinegar was equipped with a shotgun loaded with ammunition. His last firearms requalification date was September 16, 2021.

Incident Synopsis:

On Thursday, May 12, 2022, Officer Smith, and Officer Brinegar were assigned to the Robertson CRT bus #153095 (RB2) transport route. At approximately 0500 hours, RB2 transport picked up 15 general population and one restrictive housing inmate from the Byrd Unit in Huntsville, Texas. They departed at approximately 0530 hours, enroute to the Hughes Unit, arriving at approximately 0840 hours.

Upon arrival, a relay exchange of inmates took place between RB2 and transport buses from Huntsville and Abilene. Inmates were off loaded for unit assignment at the Hughes Unit. Officer Smith began the process of preparing the general population inmates assigned for the RB2 transport, who were located in the 12-building breezeway holding area, while Officer Brinegar began the process of preparing the restrictive housing inmates assigned to 12-building. At 1018 hours, Officer Brinegar proceeded to 12-building A/B legal booth where he performed a strip search of inmate Lopez. Upon completion, he applied all transport restraints (hand, black box with lock, restraint chain and leg). Inmate Lopez was then escorted to the 12-building sally port. His identification was verified, and he was given a sack meal. His carry-on property was placed inside his chain bag, which was secured underneath the bus. He was then escorted to the bus and placed in the restrictive housing compartment. The relay and transfer of inmates was completed at approximately 1111 hours. RB2 departed the Hughes Unit for a return trip to the Huntsville area units with nine general population and seven restrictive housing inmates.

At approximately 1315 hours, RB2 was traveling on SH7 east en route to the Estelle Unit. Four to six miles outside of Centerville, Officer Smith felt a tug on his handgun holster while driving. He looked down and witnessed inmate Lopez coming through the bottom of the restrictive housing compartment door, attempting to gain possession of his handgun. Officer Smith immediately covered his handgun with his right hand and attempted to stop the bus. Once the bus slowed to approximately 30 miles per hour (mph), Officer Smith engaged the air brake handle to lock the brakes and the bus came to an abrupt stop, thrusting inmate Lopez further into the driver's compartment of the bus. Officer Smith kicked inmate Lopez to the stairwell of the bus; however, inmate Lopez did not release his hold on the handgun, and Officer Smith fell forward to the stairwell of the bus with the inmate. During the fall, Officer Smith's elbow inadvertently struck the door release handle, causing both to tumble out of the bus onto the pavement of SH7. Inmate Lopez proceeded to gain possession of the handgun by stabbing Officer Smith with an eight-to-ten-inch metal weapon, then inmate Lopez pressed the quick disconnect on the holster and released the handgun from Officer Smith's duty belt.

Officer Brinegar exited the back of the bus with the shotgun, under the assumption the bus had been involved in an accident. Once he rounded the rear right side of the bus, he observed Officer Smith engaged in a ground altercation with inmate Lopez. Officer Brinegar yelled for inmate Lopez to get off Officer Smith, at which time inmate Lopez jumped up and reentered the bus. Officer Brinegar proceeded to the front of the bus, helping Officer Smith to his feet. Officer Smith took possession of the shotgun from Officer Brinegar. Officer Smith informed Officer Brinegar inmate Lopez was attempting to escape and had gained possession of his handgun. Officer Brinegar drew his handgun and yelled at inmate Lopez, who was in the driver's seat, to stop or he would shoot. Inmate Lopez placed the bus in forward gear and Officer Brinegar discharged his handgun two times in an attempt to stop him. With Officer Smith's handgun in hand, inmate Lopez pointed the holstered handgun towards Officer Brinegar, resulting in him stepping out of the direct line of fire. Officer Brinegar then discharged two additional rounds through the right passenger compartment window to strike and stop inmate Lopez. As inmate Lopez continued to drive away from the scene, Officer Smith discharged one round from the shotgun, striking the right rear outside tire of the bus, causing it to go flat. Inmate Lopez then continued to drive east on SH7 towards Centerville.

Chief of Police for the City of Jewett Police Department, Sean O'Reilly, arrived on the scene moments after the incident. He drove up to Officer Smith and inquired about the situation. Officer Smith informed Chief O'Reilly an inmate had obtained his handgun and was escaping on the bus. Chief O'Reilly pursued RB2; however, he did not transport either officer with him.

Officer Smith and Officer Brinegar followed on foot in the direction of the bus. An unidentified civilian in a pickup truck traveling west bound from the opposite direction stopped and asked Officer Smith if they were with the bus that had just wrecked towards Centerville. The civilian then provided a ride to Officer Smith to that location. Upon arriving, Officer Smith observed law enforcement officers already on-scene. Officer Smith was notified inmate Lopez was on foot in the woods and law enforcement was in pursuit. Officer Smith retrieved the TDCJ cellular phone from the back of the bus and notified Lieutenant Patrick Daniel, CRT, of the escape. Officer Brinegar, who obtained a ride to the scene by an unidentified civilian 18-wheeler driver, arrived shortly after. Upon inspection of the bus, the handgun taken from Officer Smith by inmate Lopez was located inside the driver compartment, still in the holster. Activation of the TDCJ Escape Plan was initiated.

Local law enforcement established an initial perimeter. At approximately 1322 hours, upon notification of incident, Assistant Warden Shawn Pinney and Captain Charlton Greene, Inmate Transportation Headquarters (ITH), responded to the scene. Notifications were made to the Boyd Unit at 1331 hours, Ferguson Unit at 1334 hours, and Northern Region Transportation at 1335 hours for assistance. Staff were deployed immediately to SH7 west in Centerville. Manufacturing, Agribusiness and Logistics (MAL) Division Director Billy Hirsch arrived on scene at 1415 hours and took over as Incident Commander. Deployment of additional staff resources began as they arrived on scene along SH7.

CRT arrived with additional staff and rescue bus #153107 at 1450 hours. At 1537 hours, all 15 remaining inmates, nine general population and six restrictive housing, were loaded onto rescue bus #153107 and departed for the Huntsville Unit, arriving at 1620 hours. Upon arrival, all inmates were evaluated by unit medical staff with no injuries reported.

Upon notification of the incident, at approximately 1345 hours, Correctional Institutions Division (CID) Deputy Director John Werner established a 24-hour command center in Huntsville, Texas. This command center provided logistical and intelligence support to Director Hirsch in the field from the Brad Livingston Administrative Headquarters.

Pack and scent specific canine response teams were deployed to the area of the escape, and perimeter containment zones were established on SH7, County Road (CR) 318, CR 317, CR 320, and Interstate 45 service road. The perimeter was maintained 24-hours per day with an average of more than 350 staff assigned on a rotating schedule.

At approximately 1445 hours, a pair of socks were collected from Lopez's personal property stored on the bus and utilized as a scent article. The Boyd Unit pack canines were the first pack canines to arrive on scene and were deployed at the bus wreck location at 1450 hours. The pack canines picked up the track of inmate Lopez heading in a northeastern direction. A brief time later, inmate Lopez was sighted running in a dry creek bottom northeast of the wreckage site. The canine track was lost east of that location. The Beto Unit pack canines were deployed to search an area where Boyd Unit's pack canines had lost track but had negative results. The Estelle Unit scent specific canines were then deployed at the sight location and pursued north to northeast before losing the track in a dense brushy area. Inmate Lopez's scent was not picked up again. Throughout the remainder of the search, pack, scent specific, and cadaver canines were utilized inside and outside the perimeter with negative results.

Building structures located inside the search perimeter were cleared by law enforcement during the search period. On May 15, 2022, a search team consisting of law enforcement and TDCJ officers conducted grid searches of the inside perimeter on both horseback and foot. The search continued with surge teams on May 16-17, 2022, with negative results. On May 18, 2022, suspicious calls continued. Canines were utilized to continue searching, while the inside perimeter was allowed to settle for scent purposes. On May 19-20, 2022, 12 pack canine teams were deployed inside the perimeter as a grid from south to north with negative results.

On May 31, 2022, law enforcement received information concerning a burglary of a previously cleared cabin within the search perimeter. Deoxyribonucleic Acid (DNA) and fingerprints were collected on June 1, 2022, by law enforcement officers. On June 2, 2022, at approximately 1610 hours, a positive match to inmate Lopez was returned.

On June 2, 2022, law enforcement officers also received a call from an individual who had become concerned after not hearing from a relative in the area. Law enforcement officers responded to the residence and discovered the deceased bodies of five individuals, later identified as two adult males and three minor children. A 1999 white Chevrolet Silverado pickup, license plate DPV4520, was missing from the residence. It was believed inmate Lopez committed the murders and fled in the vehicle. A "Be on the Lookout" (BOLO) was issued for law enforcement agencies statewide.

Shortly after 2200 hours, on June 2, 2022, Atascosa County law enforcement officers located and followed the stolen vehicle traveling on SH16 in Jourdanton, Texas until positive identification was made. The vehicle was disabled with spike strips, and the exchange of gunfire broke out between inmate Lopez and Atascosa County deputies. At 2230 hours, the TDCJ received information that inmate Lopez had been shot and was deceased. No law enforcement was injured during the exchange of gunfire.

Throughout this incident, TDCJ coordinated and collaborated with many law enforcement agencies to include the Leon County Sheriff's Department, Centerville Police Department, Jewett Police Department, Texas Department of Public Safety, Texas Rangers, Federal Bureau of Investigation, United States Marshall Service, Drug Enforcement Agency, and Office of the Inspector General (OIG). Deactivation of the Centralized Command Center was conducted at 1730 hours on June 3, 2022, day 23 of the incident. The Texas Rangers and the OIG are continuing their investigation into the incident.

Investigation Summary:

Hughes Unit

Hughes Unit staffing on May 12, 2022, was at 57%. The unit was allocated 556 officers with 318 filled positions. Staffing available for operations on May 12, 2022, was 34 general population and 19 restrictive housing positions. Twenty-one general population and 12 restrictive housing priority one positions were not staffed. CID Region VI Director Garth Parker was advised and approved of staffing for this date.

Inmate Lopez was assigned to the Hughes Unit on September 2, 2016 and was appropriately assigned as a 1A custody inmate based on his incarceration history. A classification review was conducted on inmate Lopez using the Current Institutional Adjustment Record screen. Incomplete and inaccurate information was found. Two data entries on the screen were documented incorrectly. The EX SPD stating inmate Lopez walked away from Hidalgo County Jail should have been an EZ, the precaution designator for escapes more than 10 years old in accordance with *Administrative Directive (AD) 04.11*, *Security Precaution Designators*. The EA designator had an incorrect date of occurrence. The inmate photo on the Classification Profile was dated March 18, 2016. All inmates should have an updated photo every three years per *Unit Classification Procedures (UCP) 6.01, "Updating Offender Photographs*." There were two State Classification Committee hearings not documented on the computer or documented incorrectly as per *UCP 1.01, "Unit Classification Committee (UCC) Composition and Proceedings*." The hearing on May 19, 2020 was not documented. The hearing on May 4, 2021 was not added to the computer until June 18, 2021. A review of inmate Lopez's history of transports for medical appointments revealed three transports to the Byrd Unit, seven to the Estelle Unit, and five to Hospital Galveston since March 5, 2021. Inmate Lopez was being transported to the Estelle Unit for a scheduled medical appointment on May 13, 2022.

According to information obtained through the Mail System Coordinators Panel, six books at the Hughes Unit were denied for inmate Lopez. The books listed are *Mind Control*, *Truth Detector*, *The Ninja Mind*, *Ultimate Survival Manual*, *Unlocking Secrets*, and the *U.S. Army Survival Manual*. Each book contained either manipulation techniques, offensive and defensive fighting techniques, or the manufacture of weapons. There currently is no required mechanism in place for unit administration notification when denials of this nature are made.

A comprehensive review of the video surveillance footage at the Hughes Unit, prior to transport activities, revealed that on May 12, 2022, at 0048 hours, Correctional Officer IV Randall Smith issued inmate Lopez two red chain bags to pack his personal property in preparation of the outgoing chain that morning. At 0126 hours, Officer Smith was observed returning to

the cell and the door was opened by Correctional Officer IV Bernard Guishard, who was assigned as the 12F Housing Picket Officer. Officer Smith failed to conduct a proper strip search or place hand restraints on inmate Lopez prior to opening the inmate's cell door. Officer Smith was observed retrieving one bag of property from inmate Lopez without searching the property to determine the contents of the bag and placing it in front of a neighboring cell. Officer Smith then proceeded back to Lopez's cell, where he removed the remaining bags of inmate Lopez's property and transported them to the 12F Housing Picket for inventory by Officer Guishard. Inmate Lopez's door remained unsecured with him unrestrained during this process. The investigation revealed inmates were documenting what items they had in a bag on a piece of paper and Officer Guishard was using their notations as inventory instead of conducting a property inventory as outlined by policy. At 0204 hours, Sergeant Joshua Watson was observed making security rounds. When Sergeant Watson approached the neighboring cell, he opened the food tray slot and handed the contents of inmate Lopez's property, that was previously placed in front of the neighboring cell, to him without searching the contents or checking for ownership.

A review of the May 11, 2022 Second Shift Restrictive Housing roster along with staff interviews revealed 12-building A-F pods were assigned three rovers out of the total seven required: Officer Smith, Sergeant Watson, and Sergeant Kristopher Sharp. However, Sergeant Watson and Sergeant Sharp were conducting cell moves and rounds outside the assigned pods from the shift roster, leaving Officer Smith to conduct rounds in all 36 sections. In addition, a review of the *Daily Activity Log* (I-216) revealed rounds were documented at 30-minute intervals, but not all rounds were physically conducted. Cell inspections were notated as being completed when they were not.

At 0934 hours, Correctional Officer IV Gerardo Velasquez was observed approaching the cell of inmate Lopez with Correctional Officer II Dillion Miller, On the Job Training (OJT), and then opening the food tray slot in preparation to conduct a strip search of inmate Lopez. Video surveillance reveals Officer Velasquez failed to conduct a proper strip search of inmate Lopez by not instructing inmate Lopez to complete the required steps and not maintaining direct line of sight following the search. At 0941 hours, hand restraints were applied to inmate Lopez, he was removed from the cell in full clothing and footwear, and inmate Lopez then dropped his mattress and blanket off in front of a neighboring cell. OJT Officer Miller retrieved a brown paper sack from the cell and assisted with escorting inmate Lopez to 12-building A/B legal booth. The content of the paper bag was later identified as a radio.

At approximately 1018 hours, CRT Officer Brinegar and OJT Officer Miller proceeded to 12-building A/B legal booth. Video surveillance revealed CRT Officer Brinegar failed to conduct a proper strip search of inmate Lopez by not instructing Lopez to complete the required steps and not maintaining direct line of sight following the search. The booth also did not provide for clear and direct sight of inmate Lopez during the search due to a partially solid door. Upon completion of the search, CRT Officer Brinegar applied all transport restraints (hand, black box with lock, restraint chain, and leg). However, the application of the leg restraints was improper as the restraints were placed over inmate Lopez's pants leg. Therefore, the restraints fit loosely around inmate Lopez's legs. CRT Officer Brinegar double locked the hand restraints. Inmate Lopez was also observed in two-piece white clothing and personal boots (commissary purchased) versus a traditional TDCJ white jumper and slide type shoes used to transport restrictive housing inmates. CRT Officer Brinegar and OJT Officer Miller escorted inmate Lopez through the exit of 12-building and did not utilize the Body Orifice Security Scanner (BOSS) chair. Inmate Lopez was then escorted to the 12-building sally port, identified, and provided a sack meal for transport, while his carry-on personal property was secured in his chain bag underneath the bus. He was escorted to the bus and placed in the restrictive housing compartment. CRT Officer Brinegar returned to 12-building to retrieve additional restrictive housing inmates assigned to the transport, leaving CRT Officer Smith with the bus. When this is reviewed on the surveillance system, CRT Officer Smith is observed leaving the bus unattended for approximately 30 minutes. Surveillance footage also revealed that additional inmates loaded onto the bus at the Hughes Unit on May 12, 2022 were not properly searched or examined for restraint placement by a supervisor. The parcel scanner was discovered as inoperable during the team's visit and had been down since April 2022, due awaiting a technician to fix a software issue. Therefore, no property was scanned prior to loading it onto the bus. After relay and transfer of inmates was completed at approximately 1111 hours, the RB2 bus departed en route to Huntsville area units with nine general population and seven restrictive housing inmates.

The review of video surveillance footage at the Hughes Unit and the Employee/Visitor Log signature book did not support weekly administrative rounds by the Major or Captain assigned to 12-building.

All staff interviewed accepted responsibility for improper searches, application of restraints, trafficking of inmate property, failure to utilize contraband detection equipment, and failure to make supervisory rounds.

Inmate Transportation

Interviews conducted with inmates on the RB2 transport indicated that upon inmate Lopez boarding the bus and Officer Smith stepping away, inmate Lopez asked them if they were, "ready to rock and roll," or something similar in nature, and made the comment it was their "lucky day." Upon leaving the 12-building sally port and departing the back gate, witness inmates indicated that inmate Lopez presented two eight-to-ten-inch metal weapons with nylon string attached and what resembled a handcuff key in his mouth. Witnesses stated inmate Lopez asked how long the inmates in the restrictive housing compartment sentences were to determine, if any, wanted to escape with him. One inmate initially indicated he wanted to go but changed his mind when he realized inmate Lopez planned to kill Officer Smith and Officer Brinegar, drive the bus to Interstate 45, hijack a car, murder the occupant, and drive to San Antonio to hold up until the search scaled down. He stalled by telling Lopez he could not get out of his restraints and stated he was not ready for the "needle," meaning execution, if caught. Once departed from the unit, witnesses described the noise in the restrictive housing compartment as increasing while en route. Three inmates were instigating loud rapping noises, banging, and blocking the view of Officer Brinegar who was holding security at the back of the bus. Witnesses indicate it did not take inmate Lopez long to remove the restraints, as the black box did not cover the hand restraint keyhole. This was confirmed by reviewing the restraints secured in evidence at the OIG Huntsville headquarters. The hand restraint model utilized with a black box did not completely cover the keyhole, allowing access to open and tamper with the equipment. Once the restraints were removed, witnesses indicated it took inmate Lopez approximately one hour and 30 minutes to break the expanded metal welds free on the bottom of restrictive housing compartment entrance door utilizing the two metal weapons. None of the inmates assigned to the transport alerted either Officer Smith or Officer Brinegar of inmate Lopez's actions on the bus prior to initiating the assault on Officer Smith and escaping.

Additional interviews with inmates revealed they take advantage of not being properly searched and state they are often told in advance by medical staff of their upcoming scheduled off unit medical appointments, providing them improper knowledge of when they will be transported.

During an interview with Officer Brinegar, he stated both he and Officer Smith conducted a pre-trip inspection of the bus prior to departure on the morning of May 12, 2022, which consisted of vehicle operation checks such as damage, locks, integrity of the expanded metal, and bars. He felt he had done a proper strip search and had placed the leg restraints higher over inmate Lopez's pant legs because he was wearing higher ankle boots. At or near the four-way stop in Marquez, Texas, he could tell the inmates in the restrictive housing compartment were becoming increasingly louder, at which time he contacted Officer Smith via the bus phone system to ensure he was okay. A short while later when Officer Smith hit the air brake and the bus came to an abrupt stop, Officer Brinegar believed the bus had been involved in an accident, so he exited the back of the bus. He proceeded towards the back right side to the front of the bus and was shocked to see an inmate on top of Officer Smith stabbing him in the middle of SH7. Officer Brinegar stated he yelled for inmate Lopez to get off Officer Smith. He did not fire at inmate Lopez immediately, fearing he would strike Officer Smith. Once inmate Lopez saw Officer Brinegar, he moved towards the entrance of the bus. Officer Brinegar proceeded to Officer Smith's location and assisted him to his feet. Officer Smith took possession of the shotgun as he told Officer Brinegar that inmate Lopez had his handgun, was attempting to escape in the bus, and to shoot him. Officer Brinegar then fired two rounds toward the stairwell at inmate Lopez on the bus. Inmate Lopez pointed the holstered handgun at him, not noticing the handgun was still holstered, and Officer Brinegar immediately stepped out of direct fire. Officer Brinegar fired two more rounds into the driver's compartment through the passenger side window, directly at inmate Lopez as he drove away. No additional shots were fired from Officer Brinegar, as he stated he felt the angle of the shots would potentially endanger the lives of the inmates in the restrictive housing compartment. Officer Smith fired one round from the shotgun, blowing out the back right tire.

During an interview with Officer Smith, he confirmed he and Officer Brinegar conducted a pre-trip inspection and he personally checked all doors, locks, and integrity of expanded metal and bars. The vehicle proceeded to the Byrd Unit for pick-up of outgoing chain and departed for the Hughes Unit. Upon arriving at the sally port of the Hughes Unit, Officer Smith states they pulled in and made relay exchanges with other transport buses on scene. He then pulled RB2 out of the sally port to allow for relay exchange of inmates between the other transports. Once completed, RB2 re-entered the sally port, and Officer Brinegar proceeded to 12-building to retrieve restrictive housing inmates for the return to Huntsville units, while he began the process of identifying the general population inmates scheduled for the transport. Officer Smith stated he knew the return trip was going to be loud due to the number of restrictive housing inmates assigned on the transport. Once the vehicle departed from the Hughes Unit, the inmates in the restrictive housing compartment became increasingly louder while en route, as they were beating, banging, rapping, and stomping. At or near Marquez, Texas, Officer Brinegar called him on the bus phone system and asked if he was okay, to which he replied he was, and they discussed how loud it was in the restrictive housing compartment. He remembers stopping at the stop sign in Robbins and, after accelerating back up to approximately 60 mph, he felt a tug on his handgun located on the right-hand side of his duty belt. He looked down and observed inmate Lopez lying on his back tugging on his holstered handgun. Officer Smith began slowing down, attempting to maintain control of both the vehicle and his handgun. Once the bus speed reduced to approximately 30 mph, he engaged the air brake, bringing the bus to an abrupt stop within 100 to 150 ft. slide. Inmate Lopez slid forward into the dash when the air brake was engaged but did not let go of Officer Smith's holstered handgun. Officer Smith released the seatbelt harness and attempted to kick inmate Lopez several times trying to break his grip, but it resulted in both of them falling into the stairwell. While falling, he felt his elbow strike the door release, and they both fell out onto the pavement of SH7. Inmate Lopez landed on top of Officer Smith and stabbed him with, what he described as, an eight-to-ten-inch metal object with a circumference comparable in size of a pencil. Officer Smith heard Officer Brinegar yelling but could not discern what was said. Inmate Lopez jumped up and ran back onto the bus with Officer Smith's handgun still holstered. Inmate Lopez had managed to obtain Officer Smith's handgun from the quick release attachment worn on his duty belt. Officer Brinegar assisted him to his feet, and he told Officer Brinegar inmate Lopez had his handgun, was escaping, and to shoot him. Officer Smith then obtained the shotgun from Officer Brinegar, chambered a round, and Officer Brinegar was yelling for the inmate to stop. Officer Brinegar then fired multiple shots towards inmate Lopez as the bus began driving away. Officer Smith stated he then fired one round from the shotgun into the rear right tire of the bus, blowing it out. As the bus began heading east on SH7, he heard a siren approaching, which he identified as a law enforcement officer from Jewett Police Department. He informed the officer an inmate had just escaped in the bus and had his handgun. He stated the Jewett officer then drove off in the direction of the bus without transporting either Officer Brinegar or himself. Officer Smith then proceeded in the direction of the bus on foot, and an unidentified civilian driver in a pickup heading west on SH7 stopped and asked if he was with the bus that wrecked a short way down the road. The driver then provided him a ride to the bus location. Upon arriving, law enforcement officers were already on the scene and surrounding the bus. He asked law enforcement officers where the inmate was that had been driving the bus, and was told he took off running across the field and officers were in pursuit of him. Officer Smith then retrieved the cell phone from the rear of the bus and called Lieutenant Daniel at ITH to advise him of what had occurred. He stated Officer Brinegar and other TDCJ staff arrived, and he was hyperventilating with no energy and needed to catch his breath. A unit sergeant on scene told him to sit down in the van and cool off. He was later directed to the ambulance that had arrived to be evaluated. Sergeant Kelvin Leigh, CRT, transported him to the Byrd Unit for evaluation before proceeding to the ITH to complete documentation of the incident. When he arrived home that evening and removed his shirt, his spouse noticed a wound on his chest, which he did not know he had sustained. He proceeded to obtain a medical evaluation and treatment.

During interviews with ITH administrative staff consisting of Assistant Warden Pinney, Major Everardo Gonzalez, and Captain Brian Nye, each stated upon notification of the incident their collective immediate response was to notify the Boyd and Ferguson Units to request assistance in responding to the bus accident in Centerville, Texas. Assistant Warden Pinney and Captain Greene responded to the accident scene with Captain Nye initiating the Transportation Command Center. A brief time later, Major Gonzalez arrived, and they began accounting for staff, handguns, and identities of the inmates assigned to the transport.

Supervisory oversight by transportation staff in the field consisted of roving sergeants spot checking at various times when available. However, when questioned when this practice last occurred, it had not been practiced recently due to staffing shortage, as available sergeants were filling correctional officer positions on transports. In addition, ITH Administration has not made routine field rounds throughout the state, nor is there a mechanism in place to document such rounds by either administration or roving field sergeants.

Inmate Transportation currently maintains an inventory of approximately 3,500 restraints and was not aware of any altered black boxes. However, upon inspection of random samples of black boxes and hand restraints, it was revealed there were combinations that allowed the keyhole to be exposed.

Staffing for ITH, CRT was 64% on the day of the incident. CRT is allotted 117 staff members with 75 positions filled and 42 positions vacant. Four staff were assigned to Operation Lone Star, and thirteen staff were not available for assorted reasons, bringing the operational staffing level to 49.5%. On May 12, 2022, 23 transports were scheduled with a total of 47 staff available. There were two OJT staff available that were assigned as third security officers on a transport that day for their OJT ride along. Nine of the 23 transports had restrictive housing inmates, and staffing did not allow for all nine to have a third officer assigned. A requirement for Inmate Transportation staff is to have Class B Commercial Driver License (CDL) with passenger endorsement, with a minimum of two CDL licensed per transport for relief factors.

Recent history of the 2015 Blue Bird Bus #153095, assigned to the Abilene Hub, Western Regional Transportation (WRT), was reviewed. The bus was assigned to John M. Wynne Mechanical on April 21, 2022, placed back in service to CRT on April 29, 2022, back to WRT on May 03, 2022, returned to CRT May 09, 2022, returned to WRT May 10, 2022, and returned to CRT on May 11, 2022.

An inspection of transport buses, to include RB2, revealed the plexiglass covering the expanded metal areas was discolored, scratched, and difficult to see through. The dark expanded metal also makes it difficult to see into the inmate compartment. The overhead driver's mirror is adjusted for view into the inmate occupant sections but does not view directly at the bottom of the restrictive housing compartment door unless manually placed in that position and you would then not be able to view into the occupant compartment. Without the mirror, it is extremely challenging to turn around and view through the restrictive housing compartment door as it is slanted away from the driver's seat view. The restrictive housing compartment door base where inmate Lopez crawled through was approximately 8 1/2" x 19" and the expanded metal was bent or pried apart with jagged edges on the ends, consistent with inmate witness reports. The rear officer compartment seat sits low, and the view can be obstructed by inmates in the general population compartment. Excessive truck mail in the rear officer compartment area was also determined to be a safety and security issue. The number of bags block the placement and securing of the shotgun, fire extinguisher, and back exit door release.

Initial Response

A review of the initial response to the escape was evaluated along with establishment of command structure. Initial response was immediate by local law enforcement in the vicinity, and a roving law enforcement perimeter was quickly established. Due to the centralized location being within an hour or so from TDCJ units, response from staff was swift. Initial coordination was to identify and transfer the remaining 15 inmates to the rescue bus for transit en route to the Huntsville Unit. Director Hirsch remained as the Incident Commander on scene and directed TDCJ staff while simultaneously coordinating with law enforcement. Security Operations Director William Stephens began deploying TDCJ staff to positions around the initial established perimeter. Later that evening, a centralized command location was established on private property approximately 500 yards from where the bus wrecked, located on SH7 west. Law enforcement established a command on the northern side of the property, while TDCJ established command at the southern entrance. CID Director Bobby Lumpkin arrived at the Centerville TDCJ command site and assisted Director Hirsch throughout the incident as relief. At times, both division directors were together on scene and there was confusion noted by staff as to which one of the two they should report as there was no distinguishing credentials of who was in command at the time.

Deputy Director Werner established the Central Command Center in Huntsville, at the Brad Livingston Administrative Headquarters at 1345 hours, on May 12, 2022, and served as a support to the Incident Commander in the field. Personnel from the Security Threat Group Management Office, Office of Emergency Management, and Information Technology Division provided support as well in the Command Center. The review revealed an expanded incident command structure in the command center to support the field, to include logistics and finance sections would have been beneficial.

A review of the canine deployment strategy highlighted the necessity to allow pack canines to thoroughly work the area prior to deploying staff on foot with a scent specific canine. It is believed the right call was made to bring in the Beto Unit pack canines when the Boyd Unit pack canines lost inmate Lopez's track. However, when there were negative results, scent canines were deployed, and the creation of inner perimeters led to cross contamination of odors for the pack canines. It is reasonable to believe the Boyd Unit pack canines lost the original track by making a wrong turn, thus the Beto Unit pack canines were potentially searching the wrong area. Pack canines should be utilized in a wooded area repeatedly with different teams before deploying scent specific canines.

A review of environmental conditions for the search period indicated weather conditions were extremely challenging. The conditions were hot, windy, and dusty, limiting the amount of time canines could be utilized before dehydration and overheating set in.

Findings:

1. Correctional Officer V Jimmie Brinegar, failed to properly strip search inmate Lopez, failed to utilize the BOSS Chair or Handheld Metal Detector during course of search, and failed in calling for supervisor to examine placement of restraints prior to loading inmate Lopez on the bus, in violation of *Post Order 07.070 (rev 9) Transport Officer and Security Memorandum 03.05 (rev 3) Contraband Detection Equipment.*

2. Correctional Officer V Randy Smith left the bus unattended for approximately 30 minutes after inmate Lopez was loaded into the restrictive housing compartment, in violation of *Post Order 07.070 (rev 9) Transport Officer.*

3. Correctional Officer IV Randall Smith, failed to properly search or apply hand restraints prior to opening the cell door of inmate Lopez, walking away from cell front, and leaving cell door unsecured. In addition, failed to search inmate Lopez's property, knowingly placing this un-inventoried property in front of a neighboring inmate's cell, in violation of *Post Order 07.006 (rev 6) Administrative Segregation Officer and Administrative Directive AD 03.72 (rev 6) Offender Property.*

4. Correctional Officer IV Bernard Guishard, failed to properly inventory inmate property prior to departure of medical chain, in violation of *Administrative Directive AD 03.72 (rev 6) Offender Property.*

5. Sergeant Joshua Watson, failed to search property and passed contraband to an inmate in a neighboring cell, in violation of *Administrative Directive AD 03.72 (rev 6) Offender Property.*

6. Correctional Officer IV Gerardo Velasquez, failed to conduct a proper strip search of multiple inmates to include inmate Lopez, in violation of *Post Order 07.006 (rev 6) Administrative Segregation Officer.*

7. Major Treyvon Hocutt, failed to document administrative rounds in inmate housing areas of 12-building, in violation of *Post Order 07.002 (rev 10) Major of Correctional Officers.*

8. Captain Shane Martin, failed to document administrative rounds in inmate housing areas of 12-building, in violation of *Post Order 07.003 (rev 10) Captain of Correctional Officers.*

9. Lieutenant Harvey Haws, failed to ensure supervisory inspection of restraint placement on departing restrictive housing assigned inmates, in violation of *Post Order 07.006 (rev 6) Administrative Segregation Officer.*

10. Correctional Officer IV Nicholas Walton, failed to conduct a proper strip search on an inmate being transported, in violation of *Post Order 07.006 (rev 6) Administrative Segregation Officer.*

11. Correctional Officer V Gerald Defreitas, failed to conduct a proper strip search of an inmate being transported in violation of *Post Order 07.006 (rev 6) Administrative Segregation Officer.*

12. Correctional Officer V Aaron White, failed to conduct a proper strip search of an inmate being transported in violation of *Post Order 07.102 (rev 6) Chain Officer.*

13. Correctional Officer II Brantley Stewart, failed to search property and passed contraband to an inmate in a neighboring cell, in violation of *Administrative Directive AD 03.72 (rev 6) Offender Property.*

14. Sergeant Kristopher Sharp, during the investigation, was discovered to have falsified the cell search log indicating inmate Lopez's cell had been searched when it had not, in violation of *Security Memorandum 03.02 (rev 7) Security Searches.*

15. Correctional Officer IV Michael McElhaney, during the investigation, was discovered to have falsified the cell search log indicating inmate Lopez's cell had been searched when it had not, in violation of *Security Memorandum 03.02 (rev 7) Security Searches.*

16. Correctional Officer IV Damion Lawson, during the investigation, was discovered to have failed to search property and passed contraband to several identified cells, in violation of *Administrative Directive AD 03.72 (rev 6) Offender Property.*

17. Correctional Officer IV Tanya Miller, during the investigation, was discovered to have failed in the application of restraints on a restrictive housing inmate, failed to search property, and passed contraband to several identified cells, in violation of *Administrative Directive AD 03.72 (rev 6) Offender Property and Post Order 07.006 (rev 6) Administrative Segregation Officer.*

18. Inspections of 12-building I-216, *Daily Activity Logs*, revealed the documentation to be falsified concerning the security rounds made, in violation of the Restrictive Housing Plan.

19. Inmate Lopez had an SPD indicator code of EX instead of EZ, in violation of *Administrative Directive (AD) 04.11 (rev 6) Security Precaution Designators*.

20. Inmate Lopez's Classification Profile photo was older than three years, in violation of the *Unit Classification Procedures (UCP) 6.01.*

Recommendations:

1. MAL leadership should review Correctional Officer V Jimmie Brinegar, for possible policy violations of *Post Order 07.070 (rev 9) Transport Officer and Security Memorandum 03.05 (rev 3) Contraband Detection Equipment,* to determine if disciplinary action is warranted.

2. MAL leadership should review Correctional Officer V Randy Smith, for possible policy violation of *Post Order 07.070 (rev 9) Transport Officer,* to determine if disciplinary action is warranted.

3. CID leadership should review Correctional Officer IV Randall Smith, for possible policy violation of *Post Order 07.006 (rev 6) Administrative Segregation Officer and AD 03.72 (rev 6) Offender Property,* to determine if disciplinary action is warranted.

4. CID leadership should review Correctional Officer IV Bernard Guishard, for possible policy violation of *AD 03.72 (rev 6) Offender Property,* to determine if disciplinary action is warranted.

5. CID leadership should review Sergeant Joshua Watson, for possible policy violation of *AD 03.72 (rev 6) Offender Property,* to determine if disciplinary action is warranted.

6. CID leadership should review Correctional Officer IV Gerardo Velasquez, for possible policy violation of *Post Order 07.006 (rev 6) Administrative Segregation Officer,* to determine if disciplinary action is warranted.

7. CID leadership should review Major Treyvon Hocutt, for possible policy violation of *Post Order 07.002 (rev 10) Major of Correctional Officers,* to determine if disciplinary action is warranted.

8. CID leadership should review Captain Kristopher Martin, for possible policy violation of *Post Order 07.003 (rev 10) Captain of Correctional Officers,* to determine if disciplinary action is warranted.

9. CID leadership should review Lieutenant Harvey Haws, for possible policy violation of *Post Order 07.006 (rev 6) Administrative Segregation Officer,* to determine if disciplinary action is warranted.

10. CID leadership should review Correctional Officer IV Nicholas Walton, for possible policy violation of *Post Order 07.006 (rev 6) Administrative Segregation Officer,* to determine if disciplinary action is warranted.

11. CID leadership should review Correctional Officer V Gerald Defreitas, for possible policy violation of *Post Order 07.006 (rev 6) Administrative Segregation Officer,* to determine if disciplinary action is warranted.

12. CID leadership should review Correctional Officer V Aaron White, for possible policy violation of *Post Order 07.102 (rev 6) Chain Officer,* to determine if disciplinary action is warranted.

13. CID leadership should review Correctional Officer II Brantley Stewart, for possible policy violation of *AD 03.72 (rev 6) Offender Property,* to determine if disciplinary action is warranted.

14. CID leadership should review Sergeant Kristopher Sharp, for possible policy violation of *Security Memorandum 03.02 (rev 7) Security Searches,* to determine if disciplinary action is warranted.

15. CID leadership should review Correctional Officer IV Michael McElhaney, for possible policy violation of *Security Memorandum 03.02 (rev 7) Security Searches,* to determine if disciplinary action is warranted.

16. CID leadership should review Correctional Officer IV Damion Lawson, for possible policy violation of *Administrative Directive 03.72 (rev 6) Offender Property,* to determine if disciplinary action is warranted.

17. CID leadership should review Correctional Officer IV Tanya Miller, for possible policy violation of *Administrative Directive 03.72 (rev 6) and Post Order 07.006 (rev 6) Administrative Segregation Officer,* to determine if disciplinary action is warranted.

18. A review of video surveillance should be compared to documented security rounds to determine if disciplinary action is warranted on staff falsely documenting rounds.

19. Classification and Records should review SPD codes for inmates with "EX" to determine if they are correctly coded.

20. Classification and Records should review Classification Profiles to ensure all inmate photos are updated every three years.

Observations:

1. A third seat was available for an additional correctional officer to provide security on the transport but was not filled due to staffing. Consideration should be given to require a third correctional officer on all transports involving restrictive housing and capital murder sentenced inmates. In addition, consideration should be given to allow non-CDL carrying correctional officers to hold security as a third correctional officer on transport buses and/or as drivers for van transports to ease the staffing burden.
2. The transport bus driver's mirror does not provide a full visual of what is directly behind the driver. Consideration should be given to add an additional mirror at the bottom of the dash to face the bottom of the restrictive housing compartment door to enhance the visual monitoring of the area behind the driver.
3. Expanded metal along the bottom of the divider between the restrictive housing compartment and front compartment needs to be enhanced. Consideration should be given to install jail steel mesh or square tubing for additional strength.
4. Transport buses are not equipped with video monitoring capabilities. Consideration should be given for a comprehensive video surveillance system with recording capabilities and a monitor in the rear officer compartment for viewing during transport for an enhanced visual of the inmate compartments during transport, as well as video surveillance documentation in the event of an incident.
5. With the expanded metal security package, age of plexiglass sheeting, and a fully loaded occupancy of inmates, visual observation is impeded. Consideration should be given to the implementation of a scheduled (3 year vs. 5 year) replacement program for plexiglass when visibility becomes impaired.
6. The seat located in the rear officer compartment of the bus faces the right side of the bus and sits low. Consideration should be given to rotate the rear officer seat 90 degrees and raise it higher to aide in the visual observation of the passenger area.
7. Truck mail at times becomes a safety and security issue in the rear of the bus. Truck mail bags were observed as excessive and blocked the full view of the rear assigned officer; limited access to movement; and obstructed access to the fire extinguisher, the shotgun during transport, and the back exit door. Consideration should be given to transport truck mail via freight or first-class mail.
8. The current tracking system of all transports at ITH are through a cellphone-based system, which does not provide clear, real-time data due to signal strength in rural areas of the state. Consideration should be given for the installation of a permanent GPS tracking and monitoring system on each transport bus for enhanced safety and security purposes.
9. The Transport Card does not accurately depict the current look of the inmate. Consideration should be given to allow Inmate Transportation staff to have a tablet or device to take a current photo of inmates transported as they load the bus for potential positive identification in the event of an incident.
10. A sampling of restraints reviewed at ITH resulted with a discovery of three models of hand restraints utilized by inmate transportation, along with three different black boxes. When examined side by side, it was noted the models' connecting chain vary in length slightly. Each combination, when crossed with another, potentially exposed the access to the keyhole on the restraints. One black box model was noted as being altered, with the edge (notch) of the interior outline to facilitate restraint housing. Consideration should be given for a systemwide review of all black boxes and transport restraints of various models and replacement with one model of hand restraint that matches one design of black box.
11. Inmate Transportation administration expressed there is a road sergeant or mobile supervisor program to randomly observe field operations quarterly. However, sergeants are often utilized to conduct scheduled transports, therefore routine observations have not taken place. Administrative rounds of captain through assistant warden also could not be

identified as taking place either through verbal confirmation or documentation. Consideration should be given to create a system to document rounds being completed for evaluation of operations with these random observations and to ensure they are being completed. These rounds should include the review of video surveillance, when applicable, at unit locations to ensure transporting staff are compliant with transportation policies and procedures. Consideration should also be given to add verbiage to post orders for sergeant through major outlining the requirement for Inmate Transportation supervisors to perform unannounced observations for transports, to include procedures for loading and unloading of inmates to ensure adherence agency protocols, as well as video surveillance review.

12. Restrictive housing inmates were allowed to wear two-piece whites and personal shoes during transport. Consideration should be given to require restrictive housing inmates to wear a jumper and slide type shoes for all future transports.
13. Restrictive housing inmates were allowed to maintain their full clothing upon being strip searched and exiting their designated housing to a holding cell to await transport. Consideration should be given to require inmates exit their assigned cells in their boxers and slides only en route to the holding cell to reduce the opportunity for hiding of contraband. Consideration should also be given to modify existing search holding cells with thick Lexan to allow for an unobstructed view.
14. Strip searches of outgoing inmates were being performed utilizing the 12 building A/B legal booth. Consideration should be given to conduct strip searches in an area with a clear and direct view of the inmate, free from obstruction.
15. Interviews with inmates leaving on chain May 31, 2022 revealed they were aware of the transfer a minimum of two days prior to transport to include layover duration. Consideration should be given for all departments with knowledge of future appointments and transports to be required to train staff on the importance of confidentiality for security purposes.
16. Conversations with responding entities to the field command operations indicated it was difficult, at times, to determine the identity of field incident commander. Consideration should be given to utilize a lanyard type system to recognize the incident commander.
17. Inmate Transportation staff do not currently carry any type of Carry-on-Person (COP) chemical agents. Consideration should be given to issue foam COP to all Inmate Transportation staff as a secondary measure of defense while in transport status.
18. Inmate Transportation staff are issued a quick release clip for the assigned holster. Consideration should be given to modify the holster to one that is directly attached to the duty belt.
19. There is currently not a SPD code for inmates being sentenced as Capital Murder. Consideration should be given to the addition of a new SPD code for Capital Murder.
20. Current mail procedures do not require a notification process to unit administration of denials of publications. Consideration should be made to add the requirement of unit administration notification for denied publications that are of security concerns.
21. Pack canines were utilized during this incident with limited success. Consideration should be given to refocus agency efforts to strengthen the pack canine program by improving staff knowledge and training capabilities.
22. Scent specific canines were utilized inside the perimeter, but potentially contaminated the track. Consideration should be given to allow for some scent specific canines, outfitted with a GPS tracker, to be tracked by handlers on horseback in situations where cross contamination could be an issue.
23. Each CID region conducts kennel drills throughout the year, and unit-based site locations participate in tabletop drills regarding escapes periodically. Consideration should be given for an annual agency tabletop exercise of an escape exercise to address and root out potential shortcomings.

24. The number of transports conducted daily by Inmate Transportation is high. Consideration should be given to allow a selected team to review the necessity of all transports to include, but not limited to, non-routine, unit assignment, and medical appointments. Consideration should also be given to transport identified high risk restrictive housing inmates by special transport.

25. Technology is available to place GPS trackable ankle monitors for each high-risk restrictive housing inmate being transported. Consideration should be given to extend an opportunity for outside vendors to make presentations at the next Technology Review Team meeting to show product availability and performance.