FINDINGS

1. It is not possible to conclude how the shackles were removed. Video recording prior to the escort clearly shows that the shackles and handcuffs were applied to offender Jermaine Carvery.

2. Staff appeared credible in their statements when they claim that they were not involved in the removal of the shackles.

3. Information regarding a previous escape attempt by Carvery from court cells in Toronto on 31 December 1998 was not properly filed.

4. Offender Carvery's admission information was not entered on the Justice Enterprise Information System (JEIN) on 13 December 2007. The information was therefore not available when this incident occurred.

5. The offender information that was assessed at the time of the escort, did not place the level of risk as "high" based on the criteria described in the assessment tool.

6. The Escort Plan prepared on the April 2 night shift was inadequate and incomplete.

7. The Escort Plan was not properly reviewed and validated during day shift of 3 April 2008.

8. Procedures were deficient regarding staff duties during exit form vehicle at hospital.

9. Procedures were deficient regarding regarding the sign-out of required security equipment.

10. Contrary to policy, escorting officers did not access a facility cell phone or mobile trunk radio and used a personal cell phone.

11. Contrary to policy, no person search of offender Carvery was completed prior to leaving the facility. Offender Carvery was required to walk through the metal detector located in the discharge area.

12. The walk-through metal detector was tested to see if it would detect a handcuff key, and it did not. A portable device confirmed the presence of a key during testing.

13. Offender Carvery was placed in the rear seat of a secure transport vehicle, directly behind the officer on the passenger side. Such placement inhibited view by the officer.

14. Staff did not observe the offender tampering with the shackles and did not notice that the offender did not have shackles on when exiting the vehicle.

15. One officer pursued offender Carvery on foot, while the second officer attempted to pursue in the vehicle.

16. The physical stature of the officers involved in the escort was a factor in not being able to overtake the offender during the pursuit.

17. The time line for notifying the police about the escape was excessive. Procedures state the escorting staff should have contacted the police via 911. The officers indicate they were not aware of the procedures.

18. Post incident reports were deficient.

19. Continuity of evidence regarding the shackles was not followed at the scene of the escape or back at the facility. The shackles were handled by at least three (3) staff before the Halifax Regional Police took them as evidence.

20. There was an overall lack of management oversight regarding compliance with policy and confirmation of staff awareness of policy.

21. The carrying of OC (pepper spray), Taser®, or a Baton would not have prevented this escape or have enabled his immediate apprehension.

RECOMMENDATIONS

1. Review management oversight process to ensure staff compliance with procedures and awareness of procedures related to their duties.

2. Implement a sign off procedure to ensure that all staff review and understand Policy and Procedures (P&P), Standard Operating Procedures (SOP) and post orders upon commencement of a post assignment.

3. Review incoming mail process to ensure that all documents are date stamped, distributed and filed to ensure proper consideration.

4. Amend the Escort Policy to include crimes of notoriety and previous escape attempts in the Class “3" category.

5. Review training and experience requirements for staff who are required to do offender escorts.

6. Review fitness level requirements for staff who conduct escorts.

7. Ensure that person searches are completed and documented prior to each escort, as per Policy and Procedures.

8. Require that portable hand held metal detectors are used in addition to the walk-thru metal detector.

9. Review procedures for provision of vehicle keys, facility cell phone and mobile trunking radio for all escorts.

10. Require that vehicle searches are completed and documented immediately prior to and following all Temporary Absences.

11. Review procedures for designation of secure vehicle, staff placement in vehicle and use of surveillance equipment for all escorts.

12. Review standard operating procedures and related training regarding general and site-specific escort processes at each correctional facility.