ARKANSAS DEPARTMENT OF CORRECTIONS
DIVISION OF CORRECTION
VARNER UNIT
P.O. Box 600
Grady, AR 71644

TO: Dexter Payne, Director

FROM: Critical Incident Review Committee for Incident 2025-06-137
James Gibson, Warden II, Varner/VSM, Chairman

DATE: August 8, 2025

On 6/16/2025 a critical incident review committee investigation was ordered by Director Dexter Payne (pursuant to AR-017), of the North Central Unit escape of inmate Grant Hardin # 168541 on May 25, 2025, in connection with NCU incident #2025-06-137.

The committee members:

James Gibson, Warden II, Varner/VSM, Chairman

Kenny Davis, Deputy Warden, Norris Unit

Emma Hamer, Mental Health

Lt. John Maples, Emergency Preparedness

Melissa Moore, Medical

Michael Lowe, Major, Ester Unit

John Haynes, Major, EARU

Melody Case and Daniel Golden, Internal Affairs Investigators
NOTE: These were added due to a training conflict with the original assigned investigators

Tawnie Rowell, Chief Legal Counsel, HQ

Thomas Burns, BOC

Nicholas Stewart, Deputy Chief of Staff, HQ, added by Secretary Wallace

On May 25, 2025, at approximately 2:53 PM, inmate Grant Hardin #1685410, was working his assigned job in the kitchen at the North Central Unit as a chemical clerk. Earlier, staff had allowed inmate Hardin to go out on the back dock unsupervised. He was also allowed to go into the room to the side of the

dock where some pallets were stored, as well as carts containing metal food cans for recycling. This room was also unlocked by kitchen staff.

At 3:08 PM, FPS Justin Delvalle, the kitchen supervisor who had allowed inmate Hardin into the area unsupervised, went to the back dock and could not locate Hardin. He asked the laundry supervisor if he had let Hardin in the building, and he stated he had not seen Hardin. Delvalle later went to the back dock looking for Hardin but could not locate him. At this time, he contacted the laundry supervisor again, and they continued to look for the inmate with no success. They then communicated with Corp. William Walker, who was working the tower at Sally port and asked him if he had seen inmate Hardin. Walker told them he had let an officer out the gate who walked across the parking lot to the ICC garage. Walker stated he answered a phone call and, when he finished, the man dressed as an officer was gone.

At 3:16 PM, Sgt. [redacted] was notified, and he contacted Captain [redacted] who notified Warden Tommy Hurst who was in the building as the Duty Warden. Captain [redacted] then went to review the cameras of the unit and perimeter revealing:

> At 2:53 PM, Hardin can be seen coming out from a blind spot from the camera on the back dock [redacted] He then walks to Sally Port gate pulling a cart, wearing altered clothes died black, a vest, and a black hat. The cart contained what appeared to be a home-made ladder made of pallets and a box. Hardin walks to the ICC garage and then around the south end where he is not seen again.

At this time, the unit was placed on lockdown, and the Command Center was opened. An emergency count was conducted confirming inmate Hardin was not present. Responding staff began to arrive at the unit and check points were placed in the area. The property of inmate Hardin was gathered and shaken down. The K-9 team arrived on scene and put out where Hardin was last seen. The box and home-made ladder were found behind the shop area along with the cart. Lt. [redacted] and Sgt. [redacted] began tracking with K-9 Gracie. They tracked Hardin west across free line road and into a wooded area. They continued tracking west for about .02 tenths a mile then turned south behind the Major's residence. They then turned back east then turned west along the edge of the yard at the Warden's house. The track doubled back heading west to Iuka Road where the track was lost. Despite several drags of the area, they could not pick up another track. They advised the Command Center and were placed on stand-by.

From May 25th through June 6th, the unit remained on lockdown as the search continued. On June 6th at approximately 3:45 PM, with the assistance of other law enforcement agencies, Hardin was located about one and one-half miles from the unit in a densely wooded area by the US Border Patrol. Hardin was returned to the unit where he was checked by medical staff, and his identity was verified. Hardin was then transferred and assigned to the Varner Super Max.

During the search and follow-up investigation there were several areas of concern and breeches that took place which allowed Hardin to get out of the secure facility.

> A main concern was the classification of Hardin as a C-3 inmate when he should have been a C-5. Hardin was convicted of 1st degree murder in Benton County in 2017. In 2019, he was convicted of two counts of rape after a DNA sample taken after his first conviction tied him to an unresolved rape which happened in 1997. He was given an additional 25 years at 70%. Apparently, his custody level was not reevaluated as it should have been.

I asked Tawnie Rowell, Chief legal Counsel for the ADC, to review and explain what had been done to correct this issue. SEE BELOW:

Classification issue:

- Mr. Hardin had not had his custody classification score reviewed since October of 2019. On October 25, 2019, classification scored him as Medium and assigned a "continue until date" of January 23, 2020. He was not reviewed in January of 2020.
- There were some notable errors in his 2019 classification scoring:
    - He was given 10 points for offense severity when he should have received 15 points. I have asked the eOMIS team to look into what caused those points to be inaccurately assigned.
    - He was given 0 points for prior conviction for a violent offense. Regardless of whether the rape or the murder was considered the prior offense, he should have received 20 points here. As discussed below, eOMIS programming does not and would not have captured this issue due to the timing of the offenses and convictions.
    - He was given 0 points for being a sex offender. There is some internal conflict as to whether the sex offender points were intended to be a floor or whether they were intended to be applied as additional points. However, eOMIS would have applied it as an additional 20 points had the classification been re-computed. This was confirmed through simulation in eOMIS test prior to Hardin's capture.
    - These additional 45 points would have increased Mr. Hardin's score to 71. Even if the 20 points for being a sex offender were interpreted as being a floor instead of additional points, Mr. Hardin would have scored at a 51 if the other two metrics were scored correctly. An offender with a score of 51 or 71 is not eligible to be at the North Central Unit unless granted an override.
- The custody classification policy is unclear. The Division classification coordinator has provided notes on the administrative directive, and the legal team is working diligently to incorporate those suggestions as appropriate.
    - The policy does not set clear guidelines on how often a classification score should be re-computed.
    - The language in AD 2019-39 contemplates that a manual override may be made by the office making the determination of whether an offender has a prior violent offense, but the discussion section mentions out of state offenses specifically, which could lead to confusion on the part of unit classification staff. While eOMIS programming can be a valuable tool, any effort to capture points in this scenario would likely result in hundreds of occurrences of points being incorrectly assigned.
    - The scoring criteria for a sex offender states "+20 points (add points as necessary to reach a minimum of 20)". Other scoring factors utilizing the structure of "+X points" are applied as additional points, not as a floor. However, the language in parenthesis indicates that the sex offender scoring is simply a floor, meaning that regardless of other scores, a sex offender MUST have a minimum score of at least 20. However, eOMIS applies 20 additional points and does not treat this as a floor. This ambiguity needs to be addressed.

Recommendation:

- The Division Classification administrator indicated that she has provided significant guidance on many of these issues to unit level classification staff. She does not have the authority, however, to issue disciplinary action for those classification employees who do not follow her guidance.
- I also recommend additional training for unit level classification staff- potentially including mandatory training with the division classification administrator as part of the employee's initial training.

Another concern raised during the initial inquiries, regarded who was overseeing the Command Center at the beginning of the incident.

Our committee reviewed documentation and conducted interviews with the numerous staff involved in the Command Center. The initial incident commander was Captain [redacted] The ultimate commander was Warden Hurst until 3:43 PM on Monday, 5/26/2025, when he was replaced by Superintendent Jared Byers of ORCU for the night shift. After that, Warden Hurst was in command on all day shifts until Monday, 6/2/2025, when he was relieved by several different Wardens on a rotating basis.

There were also some questions concerning Chairman of the Board Benny Magness being in charge. Again, we interviewed everyone from the Wardens to the Sergeants who worked in the Command Center. I did not have a single person tell me that they thought Mr. Magness was in charge at any time. Everyone denied he ever stated or implied he was in charge.

The were also questions about when other agencies were notified.

We do know that Benny Magness was notified by K-9 Lt. [redacted] who requested assistance from the helicopter that Mr. Magness flies for Baxter County. Lt. [redacted] also contacted the State Police helicopter for assistance, which is standard practice during a man hunt, however, other ASP were not immediately notified.

According to Warden Hurst, there was a communication conflict pertaining to proper notification of staff and supporting agencies. On 5/25/2025, Warden Hurst was notified by Capt. [redacted] of the escape and additional staff responded to the Unit Command Center to assist. Cpl. [redacted] was instructed by Capt [redacted] to begin calling Sgt [redacted] and the ERT staff from the Red Manuel in the Master Control Center. He began making calls from page 1 in the NCU Emergency Escape Plan and, shortly thereafter, he was reassigned to the Command Center by Capt. Brandon to perform the scribe duties in the log before all notifications were made. The EPC Red Manual was retrieved by Sgt. [redacted] from the EPC office and brought to the Command Center. At this time, Warden Hurst contacted the On-Call Duty Director A. Culclager and advised her of a confirmed escaped inmate, Grant Hardin #168541. Lt. [redacted] reported to the Command Center and asked Capt. [redacted] if the Emergency Escape Plan checklist had been initiated. Warden Hurst confirmed that notifications were made to Duty Director A. Culclager. Warden Hurst was unaware that the external notifications had not been made.

During this time, additional staff were being dispatched to their assigned escape posts and numerous telephone calls were coming to the Command Center from staff and other agencies. Local residents were contacted to advise them of the incident. It was later determined that the responding law enforcement agencies were alerted and had responded to the Command Center. It was also determined on 5/26/2025 that the Escape Notification Checklist was started but, due to

the misunderstanding of the communication of the question, "Have the Notifications been made?" and new staff arriving at the Command Center to assume post it was not completed. It was also determined that the NCU policy pertaining to escape notification had been changed to reflect that the Pine Bluff Radio Room would make notifications to the outside law enforcement agencies and the Management Team. This documentation conflict was discovered after a review of notification procedures and has been corrected.
NOTE: The families of inmate Hardin's victims were notified by Tawnie Rowell, Chief Legal Counsel.

Recommendation: Any DOC employees at the unit that could be assigned to an incident Command Center needs more detailed ICS training such as Command Center operation, logistics handling and incident coordination.

After the capture of inmate Hardin, he has been interviewed no less than five times. The first time by Internal Affairs, then by both Director Dexter Payne and Secretary Lindsay Wallace then three different interviews by various members of this committee including Thomas Burns, Melissa Moore and myself.

During his interview with Director Payne, he told them he had been planning the escape for about six months. Prior to the escape, he started preparing his clothes by using black markers (Sharpies) he had taken from the kitchen and laundry which he found lying around because staff were not keeping up with them. Hardin stated he would hide the clothes and other items he was going to need in the bottom of a trash can in the kitchen due to no one ever shaking it down. The trash can was in the back of the kitchen by the chemical room. He also stated no kitchen supervisor ever monitored him while he was working on the back dock. Hardin stated that on the 25th it was raining and he decided to try to escape. He stated he had also heard DW Bolden tell one of the kitchen supervisors that IC inmates could no longer go outside by themselves on the dock. When he got to work on the 25th, he gathered up everything he had been hiding, including his clothes and food from various areas around the kitchen and dock area. When he was let out on the dock, he made his move. He stated the ladder from the pallets was a secondary plan in case he was not let out. He was going to use it as a ladder to go over the fence. He stated when he walked up to the gate he just directed the officer to "Open the gate", and he did. Hardin went to the ICC building and pretended to place something in a vehicle parked in the area then went behind the building and crossed the road to Deputy Warden's house and down a trail into the woods. He denies trying to go into anyone's house. He stated on the first night he stayed in one spot and dodged the K-9 team that was searching for him. The second night he moved around some and laid his bag down with his food but could not get back to it because the search team cut him off from it. He stated he ate whatever he could find including berries, bird eggs and ants. He drank water from the creek in the area. He also had some distilled water he used for his CPAP machine he got from the Infirmary. He stated the new kitchen staff was very lax on security allowing him to get what he needed. Hardin denied having any help from other inmates or staff. He also stated that he stayed away from houses or cars and laid low planning to wait everyone out then try to get to northwest Arkansas.

During inmate Hardin's interview with the committee members, he was questioned about the incident. Inmate Hardin was inconsistent and deceptive in answering all questions. He stated that on multiple occasions while hiding in the wooded areas, he could see and hear the search teams, vehicles and perimeter personnel. Due to the geographic location, dense vegetation, landscape and weather, inmate Hardin was able to avoid capture. He said his plan was to hide in the woods for 6 months if need be and begin moving west out of the area. Inmate Hardin said, only when he began to get very hungry and concerned about how close the search teams consistently were getting to him, that he began trying to leave the area. This is what led to the search teams spotting him and capturing inmate Hardin.

During other interviews, Hardin is consistent in his story except for one major difference. During one of my interviews, he told me he hid his clothes in his mat in the barracks and colored them in the barracks. On the day of the escape, he claimed he put them on and walked down the hallway to work under his clothes. He also claimed he colored the clothes on his bed in the barracks.
NOTE: I told him he was changing his story, and I did not believe he took two months to color his clothes in the barracks in front of 50 other inmates, and no one reported him.

Inmate Hardin stated to the committee that besides coloring his clothes with the markers he also colored the hat. He also had on what appeared to be an officer's stab vest and had the word POLICE on the back He told us when he colored the tee shirt, he had the police word outlined and left it white. He also said the vest was made from black aprons which were in the kitchen.
NOTE: This was verified that the black aprons were being used in the kitchen, the question was then asked where the black aprons came from and who approved of anything black to be used in the kitchen?

> After searching records, we found 10 black aprons were bought on 5/4/2021 and 20 more were bought 5/27/2022. Both requisitions were approved by former Warden Michelle Gray who transferred to the Delta Regional Unit July of 2024. [redacted] the business manager at the time, has since retired.
>
> CORRECTIVE ACTION: All black aprons were confiscated and removed from the unit. Only white aprons or any other clothing are allowed and will be bought from ACI.
> NOTE: All other units were ordered to check for these black kitchen aprons and removed if found. It is unknown to this committee if any others were found. I can only speak for the Varner/VSM kitchen, and we had none.

Inmate Hardin also had what appeared to be wearing a badge that was silver in color. According to him, he made the badge out of the top of a kitchen can that food comes in. He stated he took the cut-off top and molded it to look like a badge.
NOTE: This home-made badge was found by the K-9 team during the initial track hanging on a bush.

When the committee made one of our trips to the NCU on 7/21/2025, we observed these cans, washed and stored in bins, to be turned in for recycling. These were in the room off to the side of the back dock where inmate Hardin changed his clothes and gathered his supplies. The kitchen officer had unlocked this room for him also.

While at the unit on 7/21/2025, we toured the kitchen and back dock area as well as the path he took and the capture area. We did notice that [redacted] blocked both the camera and the tower from being able to see the entire dock. We recommend additional cameras be placed there to eliminate the blind spot. Some members went to the tower to look back towards the dock which confirmed the above statement. We also noted the in the chemical room in the back of the kitchen Inmate Hardin had been allowed to have a small desk inside the room and had access to the mechanical room behind it where he hid some of his items. This should never have happened and has been removed. The door to the mechanical room has also been reenforced to prevent tampering.

A follow-up investigation was conducted by the unit (not by this committee) which reviewed all video cameras from the back dock from 5/13/2025 until 5/25/2025, the day of the escape. These videos resulted in finding four other staff from Food Service including the Food Production Manager, allowing inmates out on the back dock unsupervised. All employees were suspended; the supervisor was demoted.
(SEE ATTACHED LETTERS).

Melissa Moore, the Medical Administrator, was asked to review the medical issues concerning this incident including Hardin's gathering of distilled water intended for his CPAP machine. See below.

Treatment Call

- Treatments were being ordered by the provider in the plan section of the encounter. When the nurses took off the orders, treatments were placed on a spreadsheet. The nurses would refer to the spreadsheet when conducting treatment call.
    - **Treatment Call process has been updated.** Jason identified this during a conversation with Marjorie a week or so before the incident in question. Change was implemented and currently orders are being placed as a treatment order in eOMIS. The nurses running the "Pending Treatment Order Search" when conducting treatment call.

CPAP Water Administration

- Water for CPAP machines is issued by the CNAs Monday-Friday. On weekends and holidays water is issued to the patients during treatment call by the nursing staff. Patients are provided with a script for the CPAP water and that allows them to report to treatment call.
    - Nurses were documenting in eOMIS using the treatment call encounter when administering the water.
    - CNAs were documenting on paper (OPM medication form) that the water was administered. Documentation was not scanned into the EMR. It was maintained in a binder.
        - Documentation process has been updated. CNAs and Nursing now document in eOMIS using the Dispensing Equipment encounter. Paper documentation is still completed and kept in a binder.
- 8/31/24 and 9/9/24 Inmate Hardin submitted HSRs stating he was not getting his water. To be proactive and prevent a grievance, HSA Hall sent the staff an email 9.10.24 directing them to add him to the treatment call spreadsheet. Inmate Hardin was then called down to medical daily during treatment call to ensure he had received his water. Nurses would document with a treatment call encounter whether or not the water had been administered.

Disciplinary Action

- Nurse [redacted] received a disciplinary action for violation of code of conduct 6.2.25 due to his behavior during the investigation.

BELOW ARE OTHER ISSUES WE WERE ASKED TO ADDRESS AS A COMMITTEE:

1. When was the last holiday shake down?

   May 12-22, 2025

2. What areas of the kitchen and back dock (including the side rooms) were searched?

   The back dock area was not searched

3. Who performed the search?
   Field and utility staff

4. Who was in charge of the search?
   The Field Captain

5. Who ordered the black aprons? Who completed the receivers?
   The purchase orders reflect that 10 aprons were ordered on 5/4/2021 and 20 were ordered on 5/27/2022. Both were approved by former Warden Michelle Gray who transferred to the Delta Unit in July of 2024. [redacted], a former business manager since retired, signed the receivers.

6. Was the unit policy signed with a stamp or an actual signature from Warden Hurst? If a stamp, who stamped the document? Did Warden review and approve the policy?
   Warden Hurst reviewed, approved, and signed the policy.
   NOTE: In all my years as a Warden I have never seen a signature stamp for a Warden.

7. Was the tower advised no inmates were allowed on the back dock unsupervised after the directive was made?
   Yes, during shift briefings.

CORRECTIVE ACTIONS TAKEN:

All units have been instructed to remove the electric locks off the walk-through gates at sallyport. This will prevent someone from being able to get out of the gate without an officer being present with a key when the gate is closed. We have also been instructed to place a lockout or cover over the switch for the drive through gate to also make sure an officer with the key is present to open it. The key will be kept in master control in the restricted key box and will have to be signed out by a supervisor.

The committee is also recommending that during any shakedown all side rooms and mechanical rooms should be shaken down for contraband as well as their structural integrity to make sure no one has been or can get inside without supervision.

All policy revisions are attached.

It is obvious there was a lot of confusion during the beginning stages of opening the Command Center and of notifications being made. Corrective action and policy changes have already taken place. However, this committee feels that a command center drill should be added to the many drills already done during training and practice.

Disciplinary recommendations from Tawnie Rowell:

- Follow up investigation revealed that the terminated food services officer was not the only officer who allowed Hardin on the back dock unsupervised, even after the meeting in which it was specifically discussed.
- Each person who failed to follow the express instruction given to them should be disciplined. Given the severity of the potential security breach and the temporal proximity of the instructions to not allow inmates on the back dock, anything less than a suspension would be inconsistent with other disciplinary actions taken across the Department.
- In addition, Hayden Grady (Food Preparation Manager), when asked by IA why he was on the phone all the time at work, stated that he was on the phone with his girlfriend "almost every hour." He was also inconsistent in his statements. During an IA interview he admits to using the phrase "business as usual" to FPS Delvalle with the caveat that he believed Devalle knew what he meant. In a statement on May 25, 2025, he states "At no time did I tell FPS Delvalle that it was business as usual." Mr. Grady was a manager. This combined with his inconsistent statements and his lax attitude regarding speaking regularly on the phone with his girlfriend lends itself to the conclusion that he should receive a more severe disciplinary sanction than other food preparation staff.
- In addition, [redacted] should be referred to for potential discipline to determine whether her utilizing the phone was inconsistent with her job functions and constituted excessive personal use of telephone under the conduct policy.
- Finally, security leadership should be given corrective action plans regarding their failure to follow up and ensure that their directives regarding the known security breach of allowing inmates on the back dock were being followed. The level of corrective action should be narrowly tailored to the level of responsibility the employee has exercised over these functions.

As pointed out by Ms. Rowell, Supervisor Grady made important conflicting statements when he stated he did not tell Mr. Devalle it was business as usual but later admitted that he did. There is also an issue where he admits to being on the phone a lot with a female officer, who he identified as his girlfriend, almost hourly.

NOTE: The unit did a follow-up investigation checking the back dock area for the time frame of 5/13/2025, when the memo came out until, 5/25/2025, the date of the escape, to see if any other violations occurred. It was discovered that every kitchen supervisor, including Lt. Grady, the Supervisor, allowed unsupervised inmates on the dock several times. This has resulted in the suspension of the other supervisors and the suspension and demotion of Lt. Grady.

NOTE: A disk and an external hard drive of all the camera footage from the back dock were provided to the committee and will be given to Director Payne as part of this report.

If there are any questions regarding this report or additional concerns, please communicate those for further information from the committee.

JG/lt