OCT 2 1995

UNITED STATES GOVERNMENT
MEMORANDUM

FEDERAL BUREAU OF PRISONS
SOUTH CENTRAL REGIONAL OFFICE

DATE: September 20, 1995

REPLY TO ATTN OF: Michael D. Hood, Regional Counsel/Chairman
South Central Regional Office
Elizabeth Strack, Special Agent, OIA
Denver, Colorado
Gene M. Roffers, D.O.
Gene M. Roffers, D.O.
FCI Big Spring

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SUBJECT: Board of Inquiry Regarding Death of Inmate Vance Paul Brockway, Reg. No. 51098-098

TO: Wallace H. Cheney, Assistant Director/General Counsel

INTRODUCTION AND BACKGROUND

By memorandum dated August 24, 1995, a Board of Inquiry was appointed by the Director, Federal Bureau of Prisons, in connection with the death of inmate Vance Paul Brockway, Reg. No. 51098-098, at the Federal Transfer Center, Oklahoma City, Oklahoma (FTC OKC). Attachment 1, Appointing Order. Previously, Marie J. Carter, Acting Warden, FTC OKC, reported to the Office of Internal Affairs some concerns about possible staff misconduct in connection with Brockway's death. Attachment 2, Carter Memorandum. The possible misconduct referenced by the Acting Warden included a delay in properly attending to the body while it was hanging and not allowing a civilian emergency response team access to the body.

Criminal conduct in connection with Mr. Brockway's death was also a possibility. As a result, the FBI and the Oklahoma Medical Examiner's Office were contacted. Although the Board received no written documentation or report from the FBI, we were advised that the FBI's preliminary investigation concluded there was no criminal conduct. Thus, we were cleared to conduct our investigation. However, on September 6, 1995, FBI Special Agent Jeff Jenkins telephonically advised Chairperson Michael Hood that the FBI investigation was still open and that criminal conduct had not been ruled out. The Medical Examiner's Office has also advised that they have made no final assessment and that they are concerned about the extent of the injuries to the body and do not

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believe that the injuries were self-inflicted. Thus, this report will primarily address administrative concerns.

Office of Internal Affairs Special Agent Michael Smith, originally appointed as a member of this Board, was reassigned to another project prior to the Board's investigation.

On August 29, 1995, the Board members arrived at FTC OKC. Members met with Warden Tom Kindt, collected related documentation, visited the site of the incident, and interviewed witnesses. The Board also called the Medical Examiner's Office and the FBI. With one exception, the Board did not interview inmates because the FBI advised that they are in the process of following up on additional leads and may conduct these interviews. Inmate Jerry Walter Brenner, Reg. No. 94394-098, Brockway's cellmate prior to (Brockway's) commitment to the Special Housing Unit (SHU) was interviewed.

INMATE DATA

Inmate Vance Paul Brockway, Register Number 51098-098, was a forty-four year old white parole violator with 4,933 days remaining on his original 20 year sentence for Bank Robbery. He had been paroled from that offense, but on December 13, 1989, a warrant was issued for his arrest because, according to the warrant application, he had failed to keep appointments for urine testing, failed to submit monthly supervision reports, and used morphine and codeine. Attachment 3, Warrant Application. Mr. Brockway was eventually arrested on or about July 10, 1995. Attachment 4, Arresting Officer's Report. According to the Presentence Report prepared in connection with the bank robbery referenced above, Brockway had an extensive criminal record starting in 1969 which included convictions for possession and sale of drugs and armed robbery. Also, according to the PSI, Brockway's mother reported that Brockway had psychological problems since age 13 because of his small stature and suffered from comparisons to his older brother. Further, Brockway's mother indicated that, to her knowledge, Brockway first began to use drugs in the 10th grade. Attachment 5, Presentence Report.

Brockway was designated to FTC OKC for a parole violator's hearing. He arrived at that institution on August 18, 1995, after being held over at the Metropolitan Detention Center San Diego, California, since July 10, 1995. Attachment 6, Sentry Print Out, Inmate History. While at MDC San Diego, Brockway provided a list of family members which included a wife and mother. Attachment 7, Form SDC 5267.5. However, he specified that his mother was to be contacted in the event of death or serious injury. Attachment 8, Acknowledgement of Inmate Form. While incarcerated at MDC San Diego, Brockway received an abnormal blood test showing low white blood cell and platelet

counts. As a result, medical staff recommended additional blood work including an HIV test. However, Brockway refused this recommendation. Attachments 9 and 10, Medical Treatment Refusal forms dated 7/31/95 and 8/10/95. Upon arriving at FTC OKC, Brockway completed a mental health screening form indicating that he had never seriously considered or attempted suicide and was not now contemplating suicide. Attachment 11, Psychology Services Inmate Questionnaire. The Board found no evidence or information which indicated that staff at FTC OKC had any reason to believe that Brockway would attempt to hurt himself. In fact, on August 19, 1995, Brockway made four telephone calls to family members wherein he gave no indication of intending to commit suicide. Attachments 12, 13, and 14, Telephone Conversation Transcripts.

FINDINGS

On August 18, 1995, Brockway signed an intake screening form at FTC OKC by which he was cleared to go into general population. Attachment 15, Intake Screening Form. However, on August 20, 1995, Brockway approached Officer C. Russell stating he needed to be removed from his unit because he was afraid of something. Although Brockway provided no specific information regarding his fears, he was moved to the SHU. Attachments 16 and 17, Russell Memorandum and Administrative Detention Order. Sometime before being moved to SHU, Jerry Brenner, Brockway's cellmate, observed Brockway talking and laughing to himself. According to Brenner, Brockway indicated that ". . . everyone was talking about him and saying his name . . . and saying that [he was] going to die of aides." sic. Attachment 18, Brenner affidavit. The Board found no indication that FTC staff knew of this incident.

At 2:38 A.M. on August 21, 1995, Senior Officer Specialist Eric Ellis and Senior Officer Specialist Wiley Creasy were on duty as Morning Watch numbers 2 and 3 SHU officers when they conducted rounds on A range. Attachments 19, 20, and 21, Time Clock Record, Ellis Affidavit, and Creasy Affidavit. At that time, Brockway was observed lying on the bottom bunk in cell 709A with nothing noted out of the ordinary. Attachments 20 and 21. At approximately 3:00 A.M., Ellis and Creasy began the 3:00 A.M. count, starting on B range. Shortly after 3:00 A.M., at approximately 3:02 A.M., both officers entered A range. Starting at cell number 701, Ellis walked down the left side of the range, looking into each cell and counting inmates. As he approached Brockway's cell, at, according to Ellis, approximately 3:05 or 3:06, he looked inside and observed Brockway hanging by a sheet from the vent above the light fixture. Ellis notified Creasy of what he had found and Creasy went to get assistance and something with which to cut down Brockway while Ellis radioed Operations Lieutenant Stuart Lee. During the radio transmission, Officer Ellis said, "We've got one hanging in SHU," or words to that

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effect. In a very short time, Dennis Williams, the number 1 SHU officer, who had heard the radio transmission, arrived at the cell with the key to the cell door. Attachments 20, 21, and 22, Williams Affidavit.

While Creasy was away, and after Lt. Lee had responded verbally by radio, Officers Ellis and Williams discussed whether or not to open the door. They decided to wait for Lt. Lee to arrive. Attachments 20 and 22. Senior Officer Charles Morris arrived on the scene while Ellis and Williams were standing at the door and shortly thereafter, Officer Creasy returned with scissors. Attachments 21 and 23, Morris Affidavit.

Approximately two to three minutes later, Lt. Lee, along with several other officers responded to the scene. Officer Ellis indicated that he asked Lt. Lee if the cell door should be opened and Lt. Lee responded by indicating, in essence, that they should wait for the video camera. Attachment 20. Although some witnesses indicated that the camera was already on site, Officer Creasy, who brought the camera to the site, stated Lt. Lee asked him (Creasy) to get a camera after he (Lt. Lee) arrived. Creasy further stated that when he returned with the camera from the SHU office, he discovered there was no battery. Creasy then returned to the SHU office, found a battery, and returned to the cell. Attachment 21. Virtually all witnesses indicate Creasy either stated he did not know how to operate the camera or he was having trouble with the camera. As a result, Inmate Systems Officer Groover took the camera and began to film the scene. Attachment 24, Groover Affidavit. Lt. Lee stated that he arrived on the scene at approximately 3:10 AM and that the camera was already on site, but not yet in operation. He also stated that he did not immediately order that Brockway be cut down or lifted up since he "knew" that the inmate was dead and he was concerned with scene preservation. Attachments 25 and 26, Lee Affidavit and Supplemental Affidavit.

Shortly after the camera became operational, the cell door was opened and Physicians Assistant (PA) Carlos Mier, who stated that he arrived on the scene at approximately 3:05 A.M., went into the cell and examined the hanging body. Mier also stated, along with Officer Groover, that Lt. Lee was on site at approximately 3:05 A.M. Attachment 24 and Attachment 27, Mier Affidavit. Although most witnesses indicated that they only saw Mier examine the body with a stethoscope on the left side of the chest, Mier indicated he also checked the inmate's left wrist for a pulse, listened for a heartbeat, and noted Brockway's skin in the facial area and upper extremities was pale and cyanotic. PA Mier also noted dried blood on Brockway's head and anterior chest. He also noted blood on his face and chin area but did not remember it looking

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fresh or dripping. The PA further noted a deep laceration, approximately 6 centimeters long, on the right side of Brockway's neck and a puncture laceration on the forehead. According to PA Mier, the body was still warm when he examined it at this time. Most other witnesses confirm, at least up until the body was removed from SHU, that the body was warm.

After the PA examined the body, there was an additional delay before the body was cut down. Neither CPR nor any other serious resuscitative efforts were attempted because both the PA and the Lt. concluded that the inmate was dead. No one ordered that Brockway be lifted in order to relieve the pressure from his neck. Attachments 25, 26, and 27.

Brockway's body was eventually cut down and placed on a gurney. PA Mier then conducted a second examination which, according to him, confirmed his conclusion that the inmate was already dead. The PA stated that during this exam, he checked the inmate's pupils with a pen light, felt for a pulse, and again listened to Brockway's chest. The PA further stated he performed two or three chest compressions, without applying any "real" pressure to Brockway's chest. Mier admitted that he did not administer CPR because he thought the inmate was already dead. He further admitted he should have administered CPR and that to not have done so was contrary to his medical training and accepted medical practice. The PA also stated that staff should have administered CPR when they first observed the inmate or at least relieved the pressure on the inmate's neck. Stating that this was the first time he had experienced a situation whereby he was the primary care giver in an emergency of this sort, he admitted that he assumed too quickly that the inmate was dead. The PA further admitted that he wrote two memoranda about the incident. According to the PA, both memos contained false information concerning the administration of CPR and the "series" of chest compressions he said he administered to Brockway once on the gurney. Attachment 27.

After the PA conducted the second examination in SHU, the body was taken to the urgent care room. A local emergency response team previously called arrived at the institution at approximately 3:30 a.m. Lt. Lee and PA Mier met the ambulance crew and, in essence, advised them that the inmate was dead. The emergency response team indicated that they did not transport dead bodies and left the institution. The team returned approximately 1 to 1 and ½ hours later, conducted an EKG, and found no indication of a heartbeat. Attachments 25, 26, 27, and 28, Sheffer Affidavit. Brockway was officially pronounced dead at 5:06 a.m. on August 21, 1995, by Fred B. Jordan, Oklahoma Medical Examiner. The immediate cause of death was listed as "consistent with asphyxia." The "manner" of death was listed as "pending." Attachment 29, Certificate of Death. The exact time

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of death cannot be determined. Attachment 30, August 31, 1995, Memorandum of Interview with Kevin Rowland, Chief Investigator, Medical Examiner's Office.

After the body was removed from SHU and Lt. Lee was satisfied that sufficient video taping of the area had occurred, Lt. Lee took the camera (with the film in it) from ISO Groover. Lee stated that he kept the camera in his custody until leaving it in the SHU office with instructions to leave it alone until Special Investigative Supervisor (SIS) Ken W. Freeman took custody of it. Attachments 25 and 26. The video tape has virtually no footage of the incident.

SIS Freeman arrived at Brockway's cell at approximately 5:30 a.m. on August 21, 1995. An officer on duty in SHU opened the locked cell door for Freeman who then spent about 15 minutes examining the cell and taking pictures. During his examination of Brockway's cell, Freeman found blood and blood stains on the walls, the floor, and on various pieces of bedding and other items in the cell (see Attached Affidavit 31 for more detail). He also found crusted blood on the ends opposite the opening of two tubes of toothpaste and a sheet hanging from the vent above the light fixture on the wall. Although the sheet had blood on it, there was no blood on the floor underneath the sheet. Freeman found a puddle of blood on the floor a few feet across the room from the hanging sheet and a patch of hair on the wall near the puddle of blood. On the wall near the hanging sheet, Freeman found a note written in pencil which read, "My mind is no longer its friend, Love Paul." Freeman also viewed the body and found blood on the face and upper torso, a gash approximately three inches long running from the forehead to the center of the head, a large bruise on the right hand, and a cut on the neck. According to observations from other witnesses, the cut on Brockway's neck was approximately six centimeters long. Attachment 31, Freeman Affidavit with pictures.

In a memorandum dated August 21, 1995, SIS Freeman also reported that blood was coming from what appeared to be a blunt-type trauma injury on the back right side of the skull towards the top of the head. Also in this memo, Freeman opined that Brockway first attempted suicide by diving off the sink head first. According to Freeman, this could account for the injuries found on the body. Attachment 32, Freeman Memorandum.

Staff members Ellis, Creasy, Lee, and Mier received annual refresher training (ART) in 1995. Attachments 33, 34, 35, and 36. The Board could find no record that Williams received ART in 1995. Suicide Prevention and Medical Issues are topics covered in annual training. The Suicide Prevention outline from FTC OKC

contains no information concerning specific response procedures to an apparent suicide by hanging. Attachment 37.

A lesson plan utilized in the Introduction to Correctional Techniques course at the Federal Law Enforcement Training Center, Glynco, Georgia, specifies that, when responding to a hanging victim, assistance is to be summoned and the victim is to be lifted up. The lesson plan also indicates that, for a hanging victim, brain damage can occur in four minutes and death in five to six minutes from the start of hanging. The training outline cautions that while staff in regular housing areas may enter a cell, four staff members must be present in order to enter a cell in SHU. Attachment, 38.

On September 18, 1995, the Board telephonically contacted the Oklahoma Medical Examiner's Office a second time. During this conversation Kevin Rowland, Chief Investigator, advised that their investigation is still not completed, but that there are "suspicious findings." Mr. Rowland specifically mentioned the violent nature of the death and the tremendous amount of bruising "from head to toe." Mr. Rowland also stated that there was bruising found under Brockway's arms which could have been caused by someone holding Mr. Brockway with some force. Additionally, it was Mr. Rowland's opinion that the trauma and bruising he observed on the body would not all have been caused by Mr. Brockway diving headfirst into the wall or falling onto the floor. Attachment 39, September 18, 1995, Memorandum of Telephone Conversation.

CONCLUSIONS:

1. As indicated above, the Board was originally advised that the FBI had determined that there had been no criminal conduct. As a result, we concentrated primarily on administrative matters. As is turns out, the FBI and the Medical Examiner's Office are still investigating the matter and have significant concerns because of the nature and extent of the injuries to the body. The Board notes that, except for Inmate Brenner, no one observed any unusual behavior or saw any indication that Brockway intended to kill himself. The Board also notes that Brockway expressed concern over his safety and, as a result was moved to Special Housing where he was locked up and accessible only if someone unlocked the cell door. All of the individuals who were interviewed by the Board, with the exception of Lt. Lee, volunteered to take a polygraph examination. Consequently, the Board believes that further investigation is necessary in order to determine whether criminal conduct occurred.

2. The Board concludes that Lt. Lee, the Officer-in-Charge, used poor judgement in not directing that Inmate Brockway be

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either cut down immediately or that the pressure be relieved from his neck immediately. Lt. Lee stated that he "knew" that Brockway was dead and thus he was not concerned with taking any immediate emergency action. Lt. Lee has no medical training or authority which qualifies him to make conclusive judgements regarding whether a person is dead. Lt. Lee should also have ordered that CPR be administered. The Board notes that there is a discrepancy among the witness' recollection of when Lt. Lee arrived at the scene. Some witnesses, including Lt. Lee, indicate that Lt. Lee arrived at approximately 3:10 A.M. Other witnesses, including PA Mier, indicate that Lt. Lee arrived at approximately 3:05 A.M. Regardless, Lt. Lee clearly indicated that he took no immediate action with regard to Brockway. The Board is unable to determine whether or not the lack of immediate action made any difference with regard to Brockway's death.

3. The Board concludes that PA Mier used poor judgment in not employing CPR or other appropriate resuscitative efforts. The PA admitted that, contrary to his training and accepted medical practice, he assumed the inmate was clinically dead and thought it unnecessary to attempt any life saving efforts. In the absence of any such order from the Operations Lieutenant, the PA also should have directed that the inmate be cut down or that the pressure be relieved from his neck.

4. The Board concludes that the PA tried to cover up his poor judgement by submitting two separate memos, both of which contained false information.

5. The Board concludes that SHU staff attempted to respond immediately to the emergency. Ellis appropriately summoned assistance and Williams responded immediately with a key to the cell door. Also, Creasy immediately sought assistance and went to obtain scissors. Morris, who was in the SHU office, immediately responded to the scene once he heard the radio transmission and Creasy returned to the scene, At this point sufficient staff members were present in order to enter the cell and hold the inmate up, but the decision was made to wait for the Operations Lieutenant. Within a short time, approximately one to two minutes, Lt. Lee arrived on the scene.

6. The Board concludes that Lt. Lee and PA Mier should not have advised the Emergency Response Team that Brockway was dead. However, since approximately 30 minutes had elapsed from the time Brockway was found hanging and no resuscitative

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measures had been attempted, the Board believes that this did not affect the outcome.

RECOMMENDATIONS:

1. The Board recommends that the Office of Investigative Affairs coordinate further with the FBI in terms of whether or not criminal conduct occurred.

2. The Board recommends that Lt. Lee be provided with specific training regarding the appropriate response to hanging victims and other types of suicides.

3. The Board recommends that PA Mier be provided with specific training regarding the necessity to implement CPR and other resuscitative efforts in all appropriate cases.

4. The Board recommends training for all SHU officers and lieutenants in responding to medical emergencies.

5. The Board recommends more specialized training to all FTC staff during Annual Refresher Training regarding responding to suicide victims. This is based on statistical evidence whereby a high percentage of suicide victims occur in the SHU and with pretrial inmates.

6. The Board recommends that SHU officers and Lieutenants be provided with CPR training.

7. The Board recommends that all SHU officers and Lieutenants be trained in the use of video camera equipment and that such equipment be periodically checked for operational readiness.

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