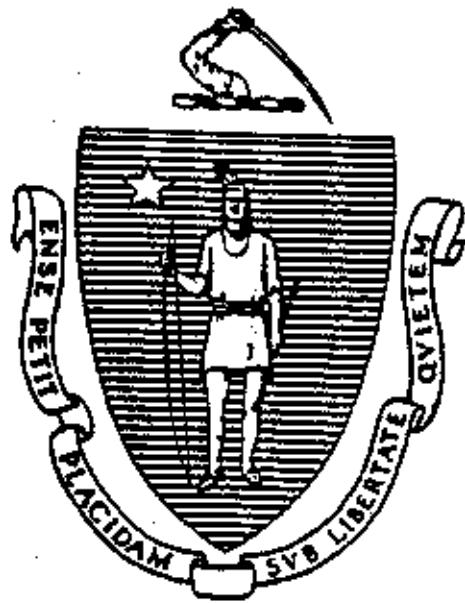


# Administrative Investigation

***The facts and circumstances  
surrounding the events, which led to  
Inmate John Geoghan's death on  
August 23, 2003.***



## PANEL

*Chairperson*  
Major Mark F. Delaney  
Division of Investigations  
Massachusetts State Police

*Member* Chief Mark Reilly  
Investigative Services  
Department of Correction

*Member* George Camp, Ph.D.  
Criminal Justice Institute  
Middletown, CT.

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## **EXECUTIVE SUMMARY**

### **PREMISE:**

One of the tenets of a just society is the protection of individual rights. This basic principle must be balanced with society's need to provide for the protection and security of all its citizens. The Judicial Branch of government determines this balance, maintaining this equilibrium through its constant vigilance and adherence to the protections provided by the Constitution. It is also the responsibility of a just and civilized society to reasonably provide for the safety, security and custody of individuals for whom our legal system has determined criminal guilt and remanded to the custody of the Commonwealth.

Accordingly, correctional officials are charged with the responsibility to provide for the care, custody, and control of inmates and must perform their duties with the utmost professionalism. All those who work in this field – from correction officer to Commissioner must demonstrate self-discipline, concern for the public's safety, respect for the rights of the confined, adherence to Department policies and the laws of the Commonwealth. It is important that they exercise patience and temperance, balanced with courage and fortitude. His or her ability to maintain order and control within a prison environment serves the Commonwealth's need for reasonable security and structured control of its inmate population.

### **THE TRIGGERING EVENT:**

On August 23, 2003 Inmate John Geoghan was murdered in his cell at the Souza Baranowski Correctional Center (SBCC) in Shirley, Massachusetts, by Inmate Joseph Druce (a/k/a Darrin Smiledge).<sup>1</sup> Inmate Geoghan was serving a 9-10 year sentence for the indecent assault and battery of a child under 14 years-of-age. At the time of the murder, both Inmates Geoghan and Druce were housed in the Special Housing Unit (SHU) J-1 block, at SBCC. The State Police Detectives Unit assigned to the Worcester County District Attorney's Office undertook a full and comprehensive homicide

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<sup>1</sup> Inmate Darrin Smiledge legally changed his name to Joseph Lee Druce in 1999.

investigation. That investigation ultimately led to the indictment of Inmate Joseph Druce for the murder of Inmate John Geoghan:

### **THE COMMONWEALTH'S RESPONSE:**

As a result of the death of Inmate John Geoghan, Massachusetts Secretary of Public Safety, Edward Flynn ordered the creation of a Panel and charged it with conducting an administrative investigation into the facts and circumstances surrounding the events, which led up to Inmate Geoghan's death.

At the time of Inmate John Geoghan's death, several complex and serious questions were raised which required investigators to delve into the Department of Correction's overall decision-making process regarding Inmates John Geoghan's and Joseph Druce's incarceration, classification, and subsequent transfer to the SBCC J-1 Special Housing Unit. Further, this Panel would examine the means and methods by which Inmate Druce accessed Inmate Geoghan's cell and committed this crime.

### **SUMMARY ANSWERS TO KEY QUESTIONS:**

In response to the following key questions, the Panel arrived at the following answers:

1. What factors contributed to Inmate John Geoghan's death?
  - First, the assignment of both Inmate Geoghan and Inmate Druce to the SHU at SBCC played an obvious and significant part, for without them both living in the same housing unit, at the same time, the opportunity for Inmate Druce to harm Inmate Geoghan would have been averted. The two inmates, with different backgrounds and criminal histories, should not have been assigned to the same housing unit where they would have direct contact with each other.
  - Second, the policies and procedures for operating the SHU at SBCC (as well as the SHU at MCI Concord) were based almost entirely on the court's order in *Blaney*, which, in our opinion gave unwarranted freedom of movement to prisoners in protective custody that constrained the Department's ability to sufficiently protect

these prisoners.<sup>2</sup> As well intended as the court was in seeking to ensure that inmates in protective custody had the same program opportunities as other inmates in the same prison, and as well intended as the Department was in trying to fulfill the court's order, the unintended consequences of such decisions in this case placed in harms way those the court was trying to protect, by allowing inmates out of their cells in groups.

- Third, the institutionalized practice at SBCC of "pulling" officers from housing units to assist in major prisoner movements outside their housing units, in this case "pulling" one of the two officers from the SHU to supervise general population inmates in the corridor when 26 inmates were out of their cells, created a situation that made it extraordinarily difficult for the one remaining officer to monitor the inmates and supervise the on-going out-of-cell activities, which led directly to Inmate Druce's ability to enter Inmate Geoghan's cell undetected.
- Fourth, the failure of the one remaining officer to follow the post orders to check each cell after the inmates are locked in their cells, allowed Inmate Druce to remain undetected for more than enough time to kill Inmate Geoghan in Inmate Geoghan's cell, and conversely for Inmate Druce to be absent from his own cell, where he should have been confined. Undoubtedly, Inmate Druce had observed this practice on prior occasions and counted on it in his planning of the murder.
- Fifth, to a lesser extent, the known ability of inmates to prevent staff from opening the cell doors in SBCC by obstructing the path through which the door was intended to slide to the open position also played a role. In this instance, Inmate Druce took this structural security weakness into account in choosing Inmate Geoghan's cell as the place to kill him. It is the Panel's opinion that Inmate Druce knew that should he be discovered in Inmate Geoghan's cell before he had killed him, he would have sufficient time to finish the act before staff could open the cell door.

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<sup>2</sup> *Blaney v. Commissioner of Correction*, 374 Mass. 337 (1978) (A civil case brought in 1974 by protective custody inmates at MCI Cedar Junction claiming they were being confined in a punitive condition because of their protective status.)

... the evidence that Inmate Geoghan or any other employee of the Department, or any inmate, or any other person ever knew of Inmate Druce's intention of harming Inmate Geoghan. Inmate Druce acted alone and in secret.

2. Was Inmate John Geoghan the subject of undue harassment or physical abuse at the hands of correction officers at MCI Concord?
  - Yes. Inmate Geoghan was both unduly harassed and physically abused. Inmate Geoghan received a disproportional number of trivial disciplinary reports compared to other inmates incarcerated at MCI Concord and in particular within the MCI Concord SHU. In addition, it is the Panel's conclusion that on Tuesday, March 19, 2002 Inmate Geoghan was the victim of physical abuse at the hands Correction Officer [REDACTED]. The facts clearly lead a reasonable person to conclude that [REDACTED] struck Inmate Geoghan in the face in the strip-search area of the visiting room at MCI Concord.
3. Were the Discipline reports received by Inmate John Geoghan at MCI Concord fairly issued and properly reviewed by institutional supervisors and managers?
  - No. The disciplinary reports received by Inmate Geoghan were, at best, minor in nature, and at worse, over zealous and unwarranted. Supervisory staff lacked any meaningful oversight of the process or qualitative review of disciplinary reports issued. Proper supervision, training and adherence to guidelines could have prevented this accumulation of disciplinary reports, which in many instances resulted in no sanctions being imposed by the Disciplinary Hearing Officer.
4. Was the classification process, which resulted in Inmate John Geoghan being transferred to SBCC handled appropriately?
  - No. The entire transfer of Inmate Geoghan was controversial among staff at MCI Concord from the start. The Classification Board recommended that Inmate Geoghan remain a Level 4 inmate at the MCI Concord SHU. The decision to reverse the Classification Board's recommendation and recommend the transfer of Inmate Geoghan to a Level 6 institution (SBCC SHU) caused consternation among some of the staff. The appeal process, as it applied to Inmate Geoghan, was flawed in its lack of objectivity and thoroughness.

5. What role did Inmate Geoghan's disciplinary reports play in his transfer to SBCC?
  - A significant role. The number of Discipline reports was cited by MCI Concord Deputy Superintendent Scott Anderson and by the Commissioner's Designee Lori Cresey as the primary factor in the reversal of the Classification Board's recommendation for Inmate Geoghan to remain at MCI Concord.
6. Should Inmate John Geoghan have been transferred to SBCC?
  - No. Based on the criteria used by the Department of Correction and in comparison to the classification of other inmates housed within the SBCC SHU, Inmate Geoghan should not have been transferred to a Level 6 SHU. It is the opinion of this Panel that Inmate Geoghan should have remained at the MCI Concord SHU.
7. Was Inmate John Geoghan fearful for his life while at SBCC?
  - No. Inmate Geoghan made statements to the SBCC Classification Board and to his family that he felt safe and wished to remain at the SBCC SHU.
8. How did Inmate John Geoghan adjust to SBCC?
  - Inmate Geoghan adjusted well. A review of Inmate Geoghan's telephone conversations revealed his praise of the staff at SBCC and is further evidenced by the total absence of disciplinary reports -- a remarkable difference from his incarceration at the MCI Concord SHU.<sup>3</sup>
9. Was the Department of Correction aware of any imminent danger to Inmate John Geoghan?
  - No. There is no evidence that Inmate Geoghan or any other employee of the Department, or any inmate, or any other person ever knew of Inmate Druce's intention of harming Inmate Geoghan. Inmate Druce acted alone and in secret.

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<sup>3</sup> The panel has reviewed numerous telephone calls made by Inmate Geoghan. From 2/21/2002 until 8/23/2003 Inmate Geoghan made 2,817 telephone calls for a total of 42,757 minutes.

10. Did the Massachusetts Correction Officer Federated Union (MCOFU) have any role in the transfer of Inmate John Geoghan?
- No. Although there was some speculation and rumor as to this possibility, no evidence was offered nor discovered to support such a claim.
11. Should Inmate Joseph Druce have been classified as a Level 6 inmate and transferred to the SBCC SHU?
- Yes. Inmate Druce was without doubt properly classified as a Level 6 inmate. He had a number of documented enemies in the general population at the two facilities for Level 6 inmates, hence his need for protective custody status in a Level 6 SHU.
12. Was Inmate Joseph Druce aware prior to his transfer to SBCC that Inmate John Geoghan was at the SBCC SHU?
- No. This investigation, which included a review of telephone calls made by Inmate Druce, found no evidence to support the notion that Inmate Druce was aware that Inmate Geoghan was at SBCC.<sup>4</sup>
13. Was Inmate Joseph Druce part of a conspiracy in the killing of Inmate John Geoghan?
- No. Inmate Druce acted alone. A review of inmate interviews conducted by State Police Homicide Detectives assigned to the Worcester County District Attorney's Office indicated that no one had any direct knowledge of Inmate Druce's intention to kill Inmate Geoghan, nor assisted him in any manner. This was also supported by Inmate Druce's own statement wherein he assumed sole responsibility, along with a review of Inmate Druce's mail and inmate account records.
14. Did the jamming of the cell door contribute to Inmate John Geoghan's death or hinder the response to rescue him?
- Yes. It is the opinion of the Panel that Inmate Druce jammed the cell door, for the express purpose of preventing anyone from stopping him in his efforts to kill Inmate

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<sup>4</sup> Shortly after Inmate Druce's arrival at SBCC, a telephone conversation was recorded which reflects Inmate Druce's surprise at learning that Inmate Geoghan was present in the SBCC SHU.



Geoghan. The physical jamming of the door prevented it from being opened immediately, and certainly delayed an effective rescue response. However, Inmate Druce was able to complete his attack on Inmate Geoghan before staff attempted to open the cell door.

15. Was staffing in the SBCC SHU sufficient at the time of Inmate Joseph Druce's assault on Inmate John Geoghan?

- No. Two correction officers were assigned to the SBCC SHU on August 23, 2003. However, inmates were let out of their cells after lunch, after one officer had been pulled out (posted-up) to assist in the general population movement of inmates to the dining hall. This left a single officer to control 26 inmates who were out of their cells. This span of control is far too wide for any meaningful and effective management of protective custody inmates and certainly contributed to Inmate Druce's ability to slip into Inmate Geoghan's cell undetected.

16. Was the response to the emergency alarm timely and appropriate?

- Yes. Once the emergency was declared, the response by correction officers and medical personnel was prompt, and efforts by correction officers were both urgent and exhaustive. The Halligan tool used to pry open the cell door was secured from another location, causing some delay in gaining entrance into Inmate Geoghan's cell. Medical staff arrived in a timely manner and had sufficient medical equipment available to begin life saving efforts once the cell door was opened.

## INTRODUCTION / OVERVIEW

On August 23, 2003, Inmate Joseph Druce murdered Inmate John Geoghan at the Souza Baranowski Correctional Center (SBCC) in Shirley, Massachusetts. The murder occurred within the Special Housing Unit J-1 (SHU) in Cell 2, the assigned cell of Inmate John Geoghan (#W70597). The State Police Detective Unit assigned to Worcester County District Attorney John Conte's office responded and conducted a comprehensive homicide investigation. Inmate Joseph Druce [REDACTED] was segregated, charged and subsequently indicted for the murder of Inmate John Geoghan.

On September 4, 2003, Edward A. Flynn, Secretary of Public Safety, ordered an administrative investigation into the circumstances, conditions, and related factors surrounding the death of Inmate John Geoghan. This investigation would review all pertinent practices, policies and procedures, as well as all systemic processes and decision-making procedures concerning Inmates Geoghan and Druce.

Secretary Flynn assigned Massachusetts State Police Major Mark Delaney to chair a three-member Panel to investigate the incident. This Panel included Mark Reilly, Chief of Investigative Services for the Department of Correction, as well as a former prison administrator and national consultant George M. Camp, Ph.D. of the Criminal Justice Institute in Middletown, Connecticut.

- **Major Mark F. Delaney**, Deputy Division Commander of Investigative Services is a 29-year veteran of the Massachusetts State Police and has a Masters Degree in Criminal Justice Administration. He is presently the Commanding Officer of the State Police Crime Laboratory System and Forensic Services. Major Delaney has been assigned to the Division of Investigative Services for the past 22 years. During this 22-year investigative career, Major Delaney was the Commanding Officer of the State Police Detective's Unit assigned to the Office of the Attorney General. Prior to that assignment, Major Delaney was the Commanding Officer of homicide and narcotic officers assigned to the Middlesex County District Attorney's Office.

- **Chief Mark Reilly**, Chief of Investigations, is a 21-year veteran of the Massachusetts Department of Correction, 17-years of which were dedicated to conducting investigations within a correctional environment. He began his career at the rank of correction officer in 1982 and rose through the ranks to Chief of Investigative Services in 2000. In that capacity, Chief Reilly is responsible for overseeing and supervising the Office of Investigative Services. He has provided technical assistance to other state correction departments in New England, as well as county departments throughout the Commonwealth.
- **George M. Camp, Ph.D.**, has over 41-years of experience in the correctional field. He is a former prison administrator and now a national consultant at the Criminal Justice Institute in Middletown, Connecticut. His public service includes assignments at three federal prisons – the U.S. Penitentiary at Terre Haute, Indiana; the U.S. Penitentiary at Lompoc, California; and the U.S. Penitentiary at Marion, Illinois. At the latter two he was the Associate Warden for Security and Programs. He also served as the Assistant Commissioner of the New York City Department of Correction, the First Deputy Commissioner of the New York State Division of Criminal Justice Services, and the Director of the Missouri Department of Corrections. He has written widely and directed national studies on issues including prison crowding, prison gangs, change management, prison staffing, prison riots among others. He is also the Co-Executive Director of the Association of State Correctional Administrators. He has a Ph. D. from Yale University in Sociology; a M.A. from Florida State University in Criminology and Corrections; and a B.A. from Middlebury College in American Literature.

The following report will chronicle this investigation from inception to conclusion. Furthermore, it will comprehensively detail the facts and circumstances from which the Panel reached their findings and conclusions and made their recommendations.

This report has been organized into sections that will answer the many questions surrounding the death of Inmate John Geoghan. The sections are as follows:

A. GOALS AND OBJECTIVES:

This section will inform the reader as to *WHY* this investigation was undertaken -- its purpose and importance.

B. APPROACH AND METHODOLOGY:

This section will describe *HOW* the investigative Panel organized its investigation. It will introduce the Investigative Team selected by Major Delaney to assist the Panel in conducting interviews, collecting and organizing data, reviewing documents, and analyzing findings.

C. BACKGROUND:

In this section, information will be provided that is necessary to understand the Panel's findings, conclusions, and recommendations. This section will detail the *WHO, WHAT, WHERE, AND WHEN.*

D. FINDINGS AND CONCLUSIONS:

This section will detail the Panel's findings and conclusions, based on the results of the Panel's investigation.

E. RECOMMENDATIONS:

This section will make recommendations for remedial action and for correcting deficiencies found, as a result of this inquiry.

F. PHOTOGRAPHS:

This section contains various photographs depicting points relevant this investigation.

G. TIMELINE:

This section contains a timeline of Inmate John Geoghan and Inmate Darrin Smiledge / Joseph Druce.

H. DOCUMENTS AND VIDEOTAPES REVIEWED BY PANEL:

This section contains a list of all documents and videotapes that were reviewed by the Panel.

F. ACKNOWLEDGEMENTS:

This section lists acknowledgements.

# **SECTION A**

## **GOALS AND OBJECTIVES**

The goals and objectives of this investigative Panel were to conduct a thorough administrative investigation into the circumstances, conditions and related factors, by which Inmates John Geoghan and Joseph Druce were classified, transferred and assigned to the Souza Baranowski Correctional Center Special Housing Unit (SHU J-1). The investigation was to narrowly and specifically trace the historical paths of Inmates Geoghan and Druce through the Department of Correction, evaluate and assess the systemic process and decision-making procedures that led to their common incarceration within the Special Housing Unit at the Souza Baranowski Correctional Center and further determine the means and methods by which Inmate Druce, accessed Inmate Geoghan's cell, and committed this murder.

These objectives required the Panel to review relevant documents, records and reports of the Department of Correction, as well as to examine and analyze the appropriateness, application of, and adherence to, the Department of Correction's Classification Policies and Procedures. A thorough review and examination of the disciplinary procedures, investigative procedures and related hearings concerning both Inmates Geoghan and Druce would be required for proper evaluation and assessment. Finally, the Panel would submit a report detailing its collective findings and conclusions surrounding Inmate John Geoghan's death and submit recommendations for appropriate remedial action to avoid such occurrences in the future.

# **SECTION B**

## **APPROACH AND METHODOLOGY**



The Investigative Panel met initially to establish a dialogue and to develop an investigative strategy. It was agreed that a coordinated approach would be required to achieve the objectives of this assignment.

Major Mark F. Delaney, acting as Chairman of the Panel, coordinated all investigative activities of the team and served as a liaison to the Office of the Secretary of Public Safety. Panel member Mark Reilly fulfilled the role of facilitator, providing access to correctional facilities, inmates, administrators, and correction officers. Additionally, he provided documents and records required of investigators and Panel members. Panel member George Camp provided expert advice and guidance throughout the course of the investigation. Mr. Camp assisted in conducting interviews of staff members at MCI Concord, MCI Cedar Junction, Souza Baranowski Correctional Center, and the Department of Correction's Central Office. He also analyzed documents and reports, and participated in the writing of the report. The Panel reviewed, examined, and analyzed an extensive list of documents, records, policies, procedures, rules, regulations, and other pertinent documents. The Panel then formulated conclusions and recommendations based on its findings.

It was collectively decided that the investigation would require numerous interviews of correction officers, administrators, and inmates from MCI Concord, MCI Cedar Junction, and the Souza Baranowski Correctional Center, as well as high-level administrators at the Department of Correction's Central Office. In order to accomplish this task, the Panel needed the services of additional investigators to assist in conducting these interviews. Major Delaney selected four State Police Detectives to assist in this endeavor. The officers selected were Detective Lieutenant William Powers, Detective Lieutenant John Tutungian, Lieutenant Francis Matthews and Sergeant Paul Petrino.

- **Detective Lieutenant William Powers** is a 29-year veteran of the Massachusetts State Police. He is currently the Commanding Officer of the State Police Detective Unit assigned to the Middlesex County District Attorney's Office. Detective Lieutenant Powers has more than 20-years within the Division of Investigative Services of the Massachusetts State Police. Formerly, he was the Commanding Officer of the State Police Detective Unit assigned to the Suffolk County District Attorney's Office.
- **Detective Lieutenant John Tutungian** is a 23-year veteran of the Massachusetts State Police. He has been assigned to the Division of Investigative Services for 15 years and is currently the Commanding Officer of the Special Service Section. Throughout his investigative career, Detective Lieutenant Tutungian has primarily been involved in long-term investigations of organized crime. Prior to his employment with the Massachusetts State Police, Detective Lieutenant Tutungian was employed by the Massachusetts Department of Correction as a correction officer.
- **Lieutenant Francis J. Matthews** is a 22-year veteran of the Massachusetts State Police and has a Bachelor's Degree in Criminal Justice. He has been assigned to the Division of Investigative Services for the past 20 years. Throughout his investigative career, Lieutenant Matthews has served in the Violent Fugitive Arrest Squad, the State Police Gang Unit, the Youth Violence Strike Force, and as a homicide supervisor in both the Middlesex County and Suffolk County District Attorney's Offices. Lieutenant Matthews is presently the Executive Officer at the State Police Detective Unit assigned to the Office of the Attorney General.
- **Sergeant Paul E. Petrino** is a 17-year veteran of the Massachusetts State Police and has a Masters Degree in Criminal Justice Administration. He has been assigned to the Division of Investigative Services for the past 11 years. During his investigative career, Sergeant Petrino was assigned to the Plymouth County District Attorney's Office as an investigator. As part of this assignment, Sergeant Petrino's duties included acting as the Plymouth County District Attorney's liaison to the MCI Bridgewater Prison Complex. Sergeant Petrino is currently assigned as the Division

of Investigative Services Liaison for the State Police Crime Laboratory System. Prior to his employment with the Massachusetts State Police, Sergeant Petrino was employed by the Massachusetts Department of Correction, as a correction officer.

The first action taken by the Panel and Investigative Team was to visit the Special Housing Unit's (SHU's) at both the Souza Baranowski Correctional Center and MCI Concord. The primary goal of each visit was to familiarize the team with the physical layout of both SHU's and to photographically document relevant areas. Numerous documents including policies and procedures, rules, regulations, post orders, disciplinary reports, and other documents germane to the management and operation of the special housing units were also obtained and reviewed.

It is important to note that the Panel was cognizant of the ongoing homicide investigation being conducted by State Police Officers assigned to the Worcester County District Attorney's Office. Major Delaney remained in constant communication with Captain Thomas Greene, Commanding Officer of the State Police Detective Unit in Worcester County, to avoid duplication or any interference with their criminal investigation and prosecution. Therefore, it was agreed that the Panel would rely on interviews conducted by the Worcester County Detective's Unit, if possible, and only re-interview witnesses, if required. In furtherance of this agreement, Captain Greene made available, for review only to the Panel all investigative and interview reports.

# **SECTION C**

## **BACKGROUND**

Initially, it was thought that the administrative review of Inmate John Geoghan's death would focus on the activities that occurred at the Souza Baranowski Correctional Center on August 23, 2003. However, the Panel rather quickly determined that the events of August 23, 2003, represented the end of the review, not the beginning. Much occurred prior to that date that was significant and relevant to a thorough investigation of what transpired on August 23. Events and decisions made well before that date greatly impacted what occurred on August 23. Consequently, the investigation led us back to Inmate Geoghan and Inmate Druce's initial incarceration, placement, care, and classification within the Department of Correction.<sup>5</sup> The Investigative Team conducted numerous interviews with inmates, correctional staff, lawyers, family members, as well as others. Additionally the team reviewed hundreds of documents pertinent to this investigation.

The background section will cover the following:

- Inmate John Geoghan's Death
- Biographical history of Inmate John Geoghan
- Biographical history of Inmate Joseph Druce
- Security levels of institutions within the Department of Correction
- Correctional Institutions pertinent to this investigation
- Special Housing Units
- *Blaney* and *Haverty* court decisions
- Department of Correction Investigations
- Physical abuse of Inmate John Geoghan on Tuesday, March 19, 2002

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<sup>5</sup> Refer to end of report for complete time line of both Inmate Druce's and Geoghan's incarceration within the DOC.

## JOHN GEOGHAN'S DEATH:

On Saturday, August 23, 2003, Correction Officers David Lonergan and Michael Kasperzak were assigned to manage the 26 inmates in the Special Housing Unit (J-1) at the Souza Baranowski Correctional Center. Both Officers Lonergan and Kasperzak began their shift at 0700 hours and were assigned to the SHU until 2300 hours.<sup>6</sup>

Saturday, August 23, 2003 would later be described as a relatively quiet day and operationally, everything appeared routine. Throughout the morning, the two correctional officers alternated their duties. While one officer remained on the desk, the other performed the assigned rounds.<sup>7</sup>

At approximately 1140 hours, Officer Kasperzak notified Officer Lonergan that he was leaving the SHU to cover the chow line on Level 1 South. This departure from the SHU was, at the time, a routine function.<sup>8</sup> As Correction Officer Kasperzak was leaving the SHU, there were only a few inmates out on the block. These inmates were returning from obtaining their medications and were getting their meal trays before returning to their cells. Officer Lonergan was left to monitor the SHU alone.

At approximately 1152 hours, Officer Lonergan was allowing the SHU inmates out of their cells to return their food trays. Some of the inmates also came to the officer's podium to schedule their gym time. Presumably, all the inmates returned to their cells, whereupon the cell doors were electronically closed and locked. Two inmates remained on the block floor conducting janitorial duties. These inmates are referred to as "runners."<sup>9</sup> After securing all the inmates, Officer Lonergan adjourned to a small room out of sight of the cell doors to prepare his own lunch. This room is located directly behind the officer's podium. One of the inmates was replacing a trash bag in a barrel, when he noticed a head bobbing in Cell [REDACTED]. This inmate's attention was drawn further to

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<sup>6</sup> Officers Lonergan and Kasperzak were both working a "double shift", which required them to be on duty from 0700 to 2300 hours, a total of sixteen (16) hours that day.

<sup>7</sup> Rounds is a term used to describe the checks (count) of inmates and must be performed hourly per General Post Orders.

<sup>8</sup> Prior to August 23, 2003, the practice of having the second officer assigned to the J-1 SHU leave his assigned area and assist other officers with large prisoner movements (such as meals) was common place.

<sup>9</sup> "Runner" is a slang term used to identify inmates who have been chosen by a correction officer to perform custodial duties during a shift.

Cell 2 by the movement of shadows. This inmate went and looked directly into Cell 2 and witnessed Inmate Druce in Cell [REDACTED] with Inmate Geoghan. This inmate observed Inmate Druce remove a long white item from the inside of his shirt. This inmate walked away from the door for a short moment and then returned to look through the cell door window again. At that time, this inmate witnessed Inmate Druce laying on top of Inmate Geoghan, twisting this long white material tightly around Inmate Geoghan's neck. Inmate Druce motioned to this inmate to get away from the door. This inmate also witnessed Inmate Druce jam an item in the door tracks.

This inmate went directly to the staff bathroom behind the officer's podium, where the other inmate "runner" was working. The first inmate reported to the second inmate what he had just witnessed in Cell [REDACTED] and stated that he thought Inmate Druce was choking Inmate Geoghan. After a short discussion as to what to do, the two inmates went to Officer Lonergan and informed him that Inmate Druce was locked in Cell [REDACTED] with Inmate Geoghan and something appeared to be wrong.

At this time Officer Lonergan's attention was drawn to Cell [REDACTED] where he heard a thumping sound. Officer Lonergan ordered the two "runners" to return to their cells. Officer Lonergan attempted to electronically open the door to Cell [REDACTED] but the door would not open. Officer Lonergan then ran over to Cell [REDACTED] and looked in through the glass window, whereupon he witnessed Inmate Druce on top of the bed jumping around. Officer Lonergan also observed Inmate Geoghan on the floor, bound and gagged.

At 1157 hours, Officer Lonergan called in the emergency that two inmates were fighting in a cell. Officer Lonergan returned to the officer's podium and electronically opened the main doors to the SHU to allow the response team to enter.

At 1158 hours, the emergency responders arrived on the SHU and attempted to open the door to Cell [REDACTED]. All initial attempts to open the cell door failed. A request was made for a Halligan tool and emergency keys to be brought to the SHU. The Halligan tool arrived at 1159 hours, and efforts to open the cell door continued. While attempting to forcefully open the cell door, correction officers were demanding of Inmate Druce to remove the

obstacles, which he had placed along the door track to prevent the door from opening.<sup>10</sup> Inmate Druce eventually removed only the nail clippers from the cell door. At 1207 hours, the door to Cell [redacted] was opened and Inmate Druce was removed. Inmate Druce, after being secured with handcuffs, was brought to the Health Services Unit (HSU). Simultaneous to the removal of Inmate Druce, the Medical Response Team arrived on scene.

The Medical Response Team, consisting of registered nurses and corrections personnel, immediately entered Cell 2 and removed all visible restraints and ligatures from Inmate Geoghan's person. Inmate Geoghan's vital signs were assessed and Cardio Pulmonary Resuscitation (CPR) commenced. This effort continued uninterrupted until the arrival of the paramedics attached to the Med Star Ambulance Service at 1234 hours.

At 1301 hours, as advanced life support efforts continued to be administered by paramedics, Inmate Geoghan was removed from the SHU and was transported via ambulance, arriving at the Leominster Hospital at approximately 1315 hours.

Inmate Geoghan was brought to Emergency Trauma Room 1, where additional life saving methods were employed, without success. At 1317 hours, Dr. Richard Freniere of the Leominster Hospital pronounced Inmate John Geoghan dead. The body was moved to Emergency Room 11 to await the arrival and subsequent custodial transfer of the body to the Medical Examiner's Office.

At 1345 hours, the Superintendent of the Souza Baranowski Correctional Center, Edward Ficco attempted to notify Inmate John Geoghan's next of kin, his sister Catherine Geoghan. Catherine Geoghan returned a call to Superintendent Ficco at 1405 hours, at which time she was informed of her brother's death.

At 1420 hours, State Troopers assigned to the Worcester County District Attorney's Office began arriving at the Leominster Hospital, as well as at the Souza Baranowski Correctional Center to commence the homicide investigation. Interviews of correction

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<sup>10</sup> Inmate Druce jammed a paperback book into the top track and a pair of nail clippers into the bottom track.



officers, inmates, and medical staff were conducted, and appropriate crime scene protocol and evidence recovery procedures were performed. A statement was taken from Inmate Druce by State Troopers David Napolitano and Wayne Gerhardt. In essence, Inmate Druce took complete and sole responsibility for the death of Inmate John Geoghan.

On Monday August 25, 2003, an autopsy was performed by Dr. Richard J. Evans at the Medical Examiner's Office, 720 Albany Street, in Boston, Massachusetts. Dr. Evans ruled the cause of death to be ligature strangulation and blunt chest trauma. The manner of death was ruled to be a homicide.

## **BIOGRAPHICAL HISTORY OF INMATE JOHN GEOGHAN:**

John Geoghan was born on [REDACTED], in Boston, Massachusetts, where he resided for the majority of his life. He graduated from the Cathedral High School in Boston's South End and went on to receive a degree in History/Philosophy at the College of the Holy Cross, in Worcester, Massachusetts. He would later receive a Masters Degree in Theology from Harvard University, as well as a Masters in Divinity from St. John's Seminary.

John Geoghan was ordained a Catholic Priest on February 2, 1962. Over the next 36-years, he was assigned to various ministerial and clerical positions within the Archdioceses of Boston. In February 1998, as a result of numerous parishioners claiming sexual abuse, John Geoghan was dismissed from the priesthood.

In November 1999, a Middlesex County Grand Jury returned a single indictment against John Geoghan charging him with indecent assault and battery on a child under the age of fourteen. Geoghan was arraigned on this charge and remained free pending his trial. On January 18, 2002, following a four day trial in Middlesex Superior Court, John Geoghan was convicted of a single count of indecent assault and battery on a child under fourteen years of age, and remanded to the custody of the Middlesex County Sheriff's Office. Geoghan would remain at the Cambridge Jail for a period of five days and ordered to undergo 30 days of observation at the Bridgewater State Hospital.

On February 21, 2002, John Geoghan appeared before Judge Sandra Hamlin in Middlesex Superior Court and was sentenced to a 9 to 10 year term of incarceration at MCI Cedar Junction, six of those years to be served, the balance suspended for the remainder of the defendant's life. As a condition of the suspended balance, the defendant was to have no contact with children under the age of sixteen and to participate in sexual offender counseling and treatment.

On February 22, 2002, at 66 years of age, Inmate John Geoghan was sent to MCI Concord, a Level 4 secure facility to begin his term of incarceration. Inmate Geoghan underwent his initial classification and due to the high notoriety of his case, he was

classified a Level 4 inmate and placed in the Special Housing Unit (SHU J-4), - the Department's only unit for inmates in protective custody status. Inmate Geoghan's classification status was again reviewed on April 3, 2002, at which time the Classification Board recommended unanimously that Inmate Geoghan should remain at the MCI Concord SHU. This recommendation was supported by then MCI Concord Superintendent William Coalter's designee and supported by Department of Correction Commissioner Michael Maloney's designee.

On October 15, 2002, the Classification Board met to review the status of Inmate Geoghan. The Board again unanimously recommended that Inmate Geoghan remain in the Special Housing Unit (J-4). This decision was supported by MCI Concord Superintendent Michael Grant's designee and upheld by Commissioner Maloney's designee.

On February 20, 2003, the MCI Concord Classification Board met to conduct a third four-month-review of the classification status of Inmate Geoghan.<sup>11</sup> The Board, consisting of Chairman CPO III Jaymie Derderian and board members CO I Philip Horton and CPO I David Stack, unanimously recommended that Inmate Geoghan remain in the Special Housing Unit (J-4) at MCI Concord. However, on February 24, 2003, citing Inmate Geoghan's overall poor adjustment and the issuance of two very recent disciplinary reports, Deputy Superintendent Scott Anderson overruled the Classification Board and recommended that Inmate Geoghan be classified as a Level 6 inmate and transferred to the Special Housing Unit (J-1) at the Souza Baranowski Correctional Center -- a Level 6 secure facility in Shirley, Massachusetts.<sup>12</sup>

Inmate Geoghan appealed this reversal of the Classification Board's recommendation to MCI Concord Superintendent Michael Grant. It was reviewed by the Superintendent's designee, Deputy Superintendent Anderson, who had just reversed the Board's

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<sup>11</sup> Inmates classified to a SHU are required to be reclassified every 4 months.

<sup>12</sup> Prior to his February 20, 2003 classification hearing, Inmate Geoghan had accumulated 13 disciplinary reports. He would receive two additional reports, one issued by Officer Haley, and the other by Officer Bisazza, prior to Deputy Superintendent Anderson's review and recommendation.

recommendation for Inmate Geoghan to remain at MCI Concord. Not surprisingly, Deputy Superintendent Anderson denied Inmate Geoghan's appeal.

On March 24, 2003, Inmate Geoghan wrote a letter to Commissioner Maloney seeking his help in remaining at MCI Concord. Subsequently, on April 15, 2003, after his transfer to SBCC, Inmate Geoghan received a response to his letter written to Commissioner Maloney. Acting Deputy Superintendent Karen DiNardo authored this response. This letter stated that Commissioner Maloney had received his correspondence regarding his placement within the Department of Correction. It further stated, "Your classification appeal was reviewed and not supported at the Commissioner's level. The Commissioner's Designee is the final sign-off authority".

On March 28, 2003, Acting Deputy Director of Classification, Lori Cresey, approved Deputy Superintendent Anderson's recommendation to reclassify and transfer Inmate Geoghan to SBCC. On April 1, 2003, Inmate John Geoghan was physically transferred from MCI Concord to SBCC. Inmate Geoghan was assigned to the Special Housing Unit (SHU) J-1, Cell 2.

Upon notification of the Superintendent's designee's denial of his appeal, Inmate Geoghan also appealed that recommendation, via the Classification Board's review process to the Commissioner of Correction. The Commissioner's Designee, Lori Cresey, who upheld Superintendent Grant's recommendation, reviewed his appeal and on June 16, 2003, not surprisingly rejected it. This rejection was some ten weeks after his transfer to SBCC. Acting Deputy Director Lori Cresey upheld Deputy Superintendent Anderson's decision to reclassify Inmate Geoghan, citing his failure at Level 4, as well as numerous disciplinary reports, including the two reports he received following the Board's recommendation that he remain at MCI Concord.

On June 26, 2003, Inmate Geoghan, now at SBCC, underwent a required and routine classification review. The SBCC Classification Board consisted of Chairperson CPO III Jack Fionda and Board Members CPO II Pamela O'Dell and CO I Jason Grasso. Interviews of the board members by this Panel's investigators revealed that Inmate

Geoghan felt comfortable and secure within the SHU at SBCC and wanted to remain at that location. Inmate Geoghan further stated to the Board that he did not like MCI Concord and he had been treated "unfairly" there. Inmate Geoghan said, "It's like heaven here (SBCC), and Concord was like hell." Inmate Geoghan further stated, "Coming here was like going from hell to heaven," and that he wanted to stay at SBCC. Inmate Geoghan stated that he wanted to stay in the SHU, that he liked the correction officers, and he had no problems with the inmates.<sup>13</sup> Based upon this review, the Board unanimously (3-0) recommended continued placement on the SHU at SBCC, citing, "his recent arrival and sentence structure."

On June 30, 2003, SBCC Director of Classification Michael Rodrigues, concurred with the Board's recommendation, citing Inmate Geoghan's, "recent return and refusal to participate in the sexual offender treatment program."<sup>14</sup> Inmate Geoghan did not appeal this decision, and of note, for the first time signed the classification report.<sup>15</sup>

On August 23, 2003, Inmate Geoghan was murdered at SBCC in his assigned cell within the Special Housing Unit J-1.

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<sup>13</sup> It is interesting to note that Inmate Geoghan received no disciplinary reports while incarcerated in the SBCC SHU.

<sup>14</sup> As part of his overall sentence structure, Inmate Geoghan was ordered to participate in the Sexual Offenders Treatment Program (SOTP). However, he refused to participate throughout his entire incarceration.

<sup>15</sup> Prior to signing this classification report Inmate Geoghan had refused to sign any previous ones.

## **BIOGRAPHICAL HISTORY OF INMATE JOSEPH DRUCE:**

On December 18, 1989, Darrin Smiledge (a/k/a Joseph Lee Druce), at age 24, was ordered into the custody of the Massachusetts Department of Correction (DOC) following his conviction in Essex Superior Court for Murder in the First Degree and related charges. He was sentenced to life imprisonment, and he remains in custody on those charges today. During his fourteen years of incarceration he has been held at several different institutions, both in and out of Massachusetts, at varying levels of confinement.

In August of 1999, while being held at MCI Walpole in the Departmental Disciplinary Unit (DDU), Inmate Smiledge filed documents with the Norfolk Probate Court to legally change his name to Joseph Lee Druce. In his formal application he listed his reason as "Safety and enemy issue's, very important to change identity."<sup>16</sup> The Court granted his request and his name was officially changed.<sup>17</sup>

On Saturday, August 23, 2003, Inmate Smiledge, now Inmate Druce, was being held in the Special Housing Unit (SHU) at the Souza Baranowski Correctional Center in Shirley, Massachusetts. On that date, another inmate assigned to the SHU, Inmate John Geoghan, was beaten and strangled to death in his cell. When correction officers were alerted to a problem in Inmate Geoghan's locked cell, they discovered Inmate Druce sitting on top of Inmate Geoghan's body. Inmate Druce, in a statement to police later in the day claimed responsibility for the killing. He was formally charged with the murder of Inmate John Geoghan in Worcester District Court on August 25, 2003.

Darrin Smiledge, was born in Danvers Massachusetts on [REDACTED]. He left high school [REDACTED] and according to court and Department of Correction records, worked as a truck driver and a mechanic. His criminal history began as a juvenile in 1979 and escalated once he became an adult. From the time he was seventeen until he was charged with murder at the age of twenty-two, Smiledge appeared

<sup>16</sup> The DDU is the restricted area(s) designated by the Commissioner, to which an inmate has been sentenced by a Special Hearing's Officer.

<sup>17</sup> While this event may seem rather unusual, it appears to be a rather common practice for an inmate to petition a court for a change in their name, and for the courts to grant their request.

in court to answer a total of thirty-nine charges ranging from assaults, to motor vehicle violations, to property crimes, and drug related offenses. These charges resulted in a combination of dismissals, restitutions, fines, probation and two short commitments to county houses of corrections.

According to Department of Correction records, Smiledge stated [REDACTED]  
[REDACTED]  
[REDACTED]

In the early morning hours of June 1, 1988, Smiledge was hitchhiking in Gloucester when a 51-year-old male picked him up. A few minutes later a third party joined them in the car, and they drove to a secluded location where the driver made sexual advances towards Smiledge. According to police reports and eyewitness testimony at trial, Smiledge reacted in a violent manner to the unwanted, unsolicited touching. He beat the man into unconsciousness, tied him up with rope and put him in the trunk of the car. The victim regained consciousness while in the trunk and began pleading for his life. Smiledge and the other man drove to the rooming house where Smiledge was living and got some beer. They eventually brought the vehicle to a wooded area near the North Shore Music Circus in Beverly. They removed the man from the trunk and forced him into a secluded section of the woods. Smiledge untied him and made him remove his clothes. The man was pleading for his life. Smiledge promised the man that he would not kill him, but then put a rope around his neck and strangled him. He then threw the body over an embankment and covered him with brush and tree limbs. Smiledge then drove to his apartment and went to sleep. On the following day the police investigators located Smiledge who was still at his home. The victim's car was parked in front of his house. At the time of his arrest, he was wearing the victim's tee shirt that was covered in the victim's blood and body fluids.

On December 18, 1989, an Essex County jury convicted Smiledge of Murder in the First Degree and he was given a life sentence. He was subsequently convicted in Suffolk Superior Court on unrelated charges of Armed Robbery, Larceny of a Motor Vehicle and

Assault and Battery by Means of a Dangerous Weapon. On these charges he was sentenced to 3 to 5 years, to be served concurrently with his life sentence.

Smiledge's initial introduction to the state correctional system was at MCI Cedar Junction. He was assigned Inmate Identification Number: W47601. That number has never been changed and remains in effect.

During an intake interview shortly after his arrival at MCI Cedar Junction, Inmate Smiledge related to the interviewer that [REDACTED]

[REDACTED] He stated he [REDACTED] He also related that as a [REDACTED]

[REDACTED] Inmate Smiledge further told the interviewer that [REDACTED] He listed a [REDACTED]

[REDACTED] In addition he claimed he [REDACTED]

[REDACTED] He also revealed that in [REDACTED] He claimed that he was [REDACTED]

[REDACTED] He also stated that he had [REDACTED]

In his initial classification at MCI Cedar Junction on January 8, 1990, the board recommended an out-of-state placement. This recommendation was later modified on April 25, 1990 and Inmate Smiledge remained at MCI Cedar Junction. In a period of slightly more than five months, he received 13 disciplinary reports for [REDACTED] He was placed on Awaiting Action (AA) status because he incurred numerous enemies.<sup>18</sup>

<sup>18</sup> AA is a form of separation from general population in which an inmate may be placed pending; a hearing on a disciplinary offense; an investigation of a possible disciplinary offense; transfer or reclassification to higher custody; imposition of disciplinary isolation time; or clarification of protective custody needs.



May 3, 1990, Inmate Smiledge was transferred to MCI Norfolk. During a two-month stay he participated in [REDACTED] received no disciplinary reports and received what appeared to be fair and appropriate evaluations.

On July 30, 1990, Inmate Smiledge was transferred to MCI Concord and assigned to the SHU to await an out-of-state federal placement. While in the SHU he went on a hunger strike, [REDACTED]

As a result of his behavior, Inmate Smiledge was transferred to the Bridgewater State Hospital for observation on September 7, 1990. He reported [REDACTED]

The Department of Correction initiated the process to send Inmate Smiledge back to the MCI Concord SHU. When he learned of this effort, Inmate Smiledge [REDACTED] in order to block any transfer. On September 27, 1990, he was moved to the MCI Norfolk Hospital. After treatment, he was transferred to MCI Concord, where he was housed on AA status. His disruptive behavior continued, and [REDACTED]

Inmate Smiledge was transferred to the South East Correctional Center (SECC) on December 7, 1990, to await out-of-state placement at the Adult Correctional Institution (ACI) at Cranston, Rhode Island. The reason given for the transfer was his numerous enemies within the Massachusetts' correctional system.

Inmate Smiledge's stay in Rhode Island lasted less than two years. He was returned to the Commonwealth of Massachusetts, on August 11, 1992, as he had become a management problem at the ACI in RI.

He was held at MCI Cedar Junction in Awaiting Action (AA) status due to his numerous stated enemies in the Department of Correction system. The Classification Board again recommended an out-of-state placement. The Commissioner's office modified the

recommendation and sent Inmate Smiledge to the MCI Concord SHU, while he awaited screening for another out-of-state placement.

While at MCI Concord, Inmate Smiledge maintained a disciplinary report free adjustment, and his housing officers reported he did not pose a management problem. He worked in the kitchen and received acceptable reports. Due to his housing restrictions, he had limited program involvement. He also attended [REDACTED]

Inmate Smiledge remained at MCI Concord for nine months and then was transferred to the Old Colony Correctional Center (OCCC) and again, on the same day, to the SECC. He signed a waiver requesting he be placed in population because he had no enemies there and was not in fear of his life. He did not attend any programs or work while at SECC. On June 24, 1994, he was locked down pending an investigation into an assault on the prison's ball field. An investigation was conducted by Department of Correction personnel, and it was determined that Inmate Smiledge had been assaulted by an unknown inmate.

On July 6, 1994, the Administrative Reclassification Board recommended that he be transferred back to OCCC. This was modified, however, because Inmate Smiledge had detailed a list of stated enemies that were currently at OCCC. On August 9, 1994, he was transferred to the Bridgewater State Hospital due to [REDACTED]

[REDACTED] He claimed he had [REDACTED]  
[REDACTED] As a result, he was returned to MCI Cedar Junction on September 6, 1994.

While at MCI Cedar Junction, Inmate Smiledge was placed in the West Wing Segregation Unit (WWSU). On December 30, 1994, he was moved into the MODS, Phase III, SHU because of his extensive enemy issues. While there he received average housing evaluations and one disciplinary report for [REDACTED]

On October 15, 1995, Inmate Smiledge was again transferred out-of-state, this time to New Mexico. He remained there for a little under two and a half years. [REDACTED]

[REDACTED] He received five disciplinary reports for [REDACTED]. He was returned to Massachusetts's custody on February 24, 1998, after [REDACTED]

Upon his return he was assigned to MCI Concord and was immediately placed into a [REDACTED] he was placed in the SHU at Concord, per orders from the Commissioner's Office.

While being held in the SHU, Inmate Smiledge received a major disciplinary report on May 8, 1998, for [REDACTED]

[REDACTED]<sup>19</sup>

At the next classification hearing, the Board recommended that Inmate Smiledge again be screened for another out-of-state placement. The Concord Superintendent, however, recommended that Inmate Smiledge be transferred to the Bay State Correctional Center. The Superintendent based his decision on the evidence that Inmate Smiledge had no identifiable enemy issues there and that Inmate Smiledge had requested in writing that he be transferred to that location. While this recommendation was waiting the approval of the Commissioner, Inmate Smiledge [REDACTED] He subsequently received six new disciplinary reports for [REDACTED]

On July 3, 1998, Inmate Smiledge received two major disciplinary reports. The first was for [REDACTED]. The second was for [REDACTED].

<sup>19</sup> All disciplinary reports are categorized as either "Major" or "Minor" and determined by the Disciplinary Hearing Officer at an institution.

[REDACTED] He was removed immediately and taken to MCI Cedar Junction.

While at MCI Cedar Junction, Inmate Smiledge was confined in segregation while awaiting a hearing for possible placement in the Departmental Disciplinary Unit (DDU). While there, he received two additional disciplinary reports for [REDACTED]. According to Department of Correction records, Inmate Smiledge had, to this point, accumulated seventy-seven disciplinary reports during his Massachusetts' incarceration. He had also personally listed in excess of 50 "known enemies" within the system.

In January of 1999, Inmate Smiledge was still being held in segregation. [REDACTED]. He also put [REDACTED]. [REDACTED]. Investigators from Department of Correction, the State Police, FBI and U.S. Marshal Service conducted investigations [REDACTED]. When questioned, Inmate Smiledge [REDACTED]. [REDACTED].

During the course of the Department of Correction's investigation into [REDACTED] a Department of Correction investigator and an agent from the Secret Service interviewed inmate Smiledge. Inmate Smiledge told them that he was a member of [REDACTED].

[REDACTED]<sup>20</sup> Following the interview, Inmate Smiledge's cell was searched and several documents were located. Two of them concerned the [REDACTED]. [REDACTED].

Inmate Smiledge was transferred briefly to the Bridgewater State Hospital (BSH) on March 25, 1999, and then was returned to MCI Cedar Junction on April 6, 1999 and held in the West Wing Segregation Unit (WWSU).

On May 13, 1999, while still residing in the WWSU, Inmate Smiledge [REDACTED]

[REDACTED] Photographs were taken and a disciplinary report was written.

On [REDACTED] 1999, Inmate Smiledge was brought to an office where the Shift Commander met him. They met in private for a short period of time, during which they discussed Inmate Smiledge's behavior. After the meeting, Inmate Smiledge was returned to his cell. Later that day, Inmate Smiledge refused his dinner meal and a short while later indicated to a correction officer that he was [REDACTED] Inmate Smiledge was removed from his cell and at the time the officer noted there were facial injuries to Inmate Smiledge. He was then transported to the [REDACTED]

An investigation was conducted by the Superintendent's Investigator into the circumstances surrounding Inmate Smiledge's injuries. According to the investigator's report Inmate Smiledge initially reported that his injuries were the result of a fall and not inflicted by anyone else. In a later interview, he changed his story and said he was beaten by the Shift Commander, [REDACTED] for writing the racial slurs. The Shift Commander denied that he caused any injuries to Inmate Smiledge and referred to their conversation as being short and without incident. The investigator ruled that the allegations against the Commander were inconclusive. He based his findings on the fact that the statements of the corrections employees were consistent, while Inmate Smiledge's recounting of the events changed completely during his interviews.

On May 19, 1999, Inmate Smiledge was sentenced to the Department Disciplinary Unit (DDU) at MCI Cedar Junction for a period of forty-eight months. This was in response to his [REDACTED]

[REDACTED] His initial projected release date was April 27, 2003.

Shortly after he was placed in the DDU, Inmate Darrin Smiledge filed the necessary paperwork to have his name legally changed to Joseph Druce.

While in the DDU, now Inmate Druce had [REDACTED] that resulted in disciplinary action. His release date was extended by one month. His disciplinary reports reflected that he [REDACTED]

[REDACTED] He also [REDACTED]  
[REDACTED]  
[REDACTED]

During his years in the correctional system, Inmate Druce had expressed hate for many individuals and groups. He has been very outspoken on his beliefs and offered commentary to anyone he encountered, be they inmates, staff, clergy, etc. He not only verbalizes his opinions, but he often puts them in writing. He is alleged to be a member of the [REDACTED]

In October 2001, Inmate Druce commenced an [REDACTED] He targeted [REDACTED] He mailed his [REDACTED] [REDACTED] There was also [REDACTED] He made no attempt to disguise the fact that the correspondence was from him. He mailed the materials from the prison and put his name and address in the upper left-hand corner of the envelopes. The letters were mailed to lawyers and government officials throughout the country. Once the incidents were discovered, the Department of Correction, the State Police and the FBI began an investigation.

At the same time this investigation was being conducted, a chaplain at MCI Cedar Junction wrote a report regarding a visit he had with Inmate Druce. The chaplain described the hate that Inmate Druce expressed towards Jews, blacks, homosexuals and their supporters. Inmate Druce told him that he "hates anyone who is not pure white and straight." The chaplain wrote in his report that during their conversations, Inmate Druce was often "verbally abusive and disrespectful," and the chaplain would walk away when Inmate Druce would not control himself.

In February 2002, a letter was intercepted from Inmate Druce to a woman in Gloucester, Massachusetts. In the letter he advises her [REDACTED]. He asks her to have stationary designed, and he provides a logo and lists his title as "Reverend Joseph L. Druce." He also asks that she start a website for the organization. This information was provided to the Department of Correction Intelligence Unit and was one of several factors used to classify Inmate Druce into a [REDACTED].

At the conclusion of his sentence to the DDU, the Classification Board recommended that Inmate Druce be transferred to the Souza Baranowski Correctional Center and held in protective custody status in the SHU. Their recommendation was partially based on the fact that Inmate Druce had several documented enemies within the system and he feared for his safety. Inmate Druce was in accord with the recommendation and signed off on the classification form.

The Board's recommendation was upheld by the MCI Cedar Junction Superintendent and further approved by the Commissioner's office.

On May 28, 2003, Inmate Druce was transferred from MCI Cedar Junction to the Souza Baranowski Correctional Center and assigned to the SHU. He was housed in Cell [REDACTED] immediately next to Cell [REDACTED] where Inmate Geoghan resided.

On August 1, 2003, Inmate Druce was involved in a [REDACTED] with another inmate during an activity period. [REDACTED]

[REDACTED] Both were issued disciplinary reports. They pled guilty at their Disciplinary Hearings on August 6, 2003, and received [REDACTED]

On August 22, 2003, Inmate Druce was released from isolation and returned to the SHU, and was assigned to a different cell - Cell [REDACTED] across the tier and several cells down from Inmate Geoghan's cell.

On August 23, 2003, at the end of the lunch period, Inmate Druce entered Inmate Geoghan's cell unnoticed. After the cell doors were secured closed, Inmate Joseph Druce beat and strangled Inmate John Geoghan to death.



## **CORRECTIONAL INSTITUTIONS AND SECURITY LEVELS:**

The Massachusetts Department of Correction, which falls under the auspices of the Massachusetts Executive Office of Public Safety, is comprised of eighteen correctional facilities. The Massachusetts Department of Correction is governed by 169 policies and procedural statements. Beyond these policies and procedural statements, staff members are required to abide by the Employee Rule Book, which governs all employees of the Massachusetts Department of Correction. The Massachusetts Department of Correction currently employs approximately 5,000 correction officers, correctional program officers and other security, support, and training staff.

Approximately 10,000 criminally sentenced inmates are incarcerated in the Massachusetts Department of Correction prison system. During 2003 66 percent of the inmate population was incarcerated for violent offenses.<sup>21</sup>

### **SECURITY LEVELS:**

To manage these 10,000 inmates, the Department requires a variety of facilities to meet the varying needs and requirements of the offender population. Offenders are assigned to these facilities based on the degree of need for supervision and observation. A superintendent is responsible for the management of each facility, and these facilities range in security from Level 1 to Level 6, with security Level 1 being the lowest security level and Level 6 being the highest security level. These facilities may be described as follows:

- **Level 1 Facility** -- A security level that is the least restrictive in the department and is reserved for only those inmates who are at the end of their sentence and have been identified as posing little to no threat to the community.
- **Level 2 Facility** - A security level in which both design/construction, as well as inmate classification reflect the goal of restoring to the inmate the maximum responsibility and control of their own behavior and actions prior to release. Direct supervision of these inmates is not required, but intermittent observation may be appropriate under certain conditions. Inmates within this security level may be permitted to access the community unescorted to participate in programming to include, but not limited to, work release, educational release, etc.

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<sup>21</sup> It is worth noting that 97% of all inmates are eventually released back into society.

- **Level 3 Facility** - A security level in which both the design/construction, as well as inmate classification reflect the goal of returning to the inmate a greater sense of personal responsibility and autonomy, while still providing for supervision and monitoring of behavior and activity. Inmates within this security level are not considered a serious risk to safety of staff, inmates or the public. Program participation is mandated and geared towards their potential reintegration into the community. Access to the community is limited and under constant direct supervision.
- **Level 4 Facility** - A security level in which both the design/construction, as well as inmate classification, reflect the goal of restoring to the inmate some degree of responsibility and control of their own behavior and actions, while still ensuring the safety of staff and inmates. Design/construction is generally characterized by high security perimeters and limited use of internal physical barriers. Inmates within this security level have demonstrated the ability to abide by rules and regulations and require intermittent supervision. However, behavior in the community, (i.e., criminal sentence and/or the presence of serious outstanding legal matters), indicate the need for some control and for segregation from the community. Job and program opportunities exist for all inmates within the perimeter of the facility.
- **Level 5 Facility** - A security level in which design/construction, as well as inmate classification reflect the need to provide maximum external and internal control and supervision of inmates. Inmates within this security level may present an escape risk or pose a threat to inmates, staff, or the orderly running of the institution, however, at a lesser degree than those at Level 6.
- **Level 6 Facility** - A security level in which design/construction, as well as inmate classification reflect the need to provide maximum external and internal control and supervision of inmates primarily through the use of high security perimeters and extensive use of internal physical barriers and check points. Inmates within this security level present serious escape risk or pose serious threats to themselves, other inmates, staff, or the orderly running of the institution.

## **DEPARTMENT OF CORRECTION FACILITIES:**

The following is a description of Massachusetts Department of Correction facilities pertinent to this investigation.

- **MCI CONCORD**

MCI Concord is a medium security, Level 4 prison located in Concord, Massachusetts. This prison was originally opened in 1878. Since 1980, this facility has been designated as a medium security facility, and serves as the Massachusetts Department of Correction's Reception and Diagnostic Center for male offenders. Effective October 1995, MCI Concord began receiving all new male court commitments. After a specified period of time following an inmate's initial arrival into the prison system, usually twelve to sixteen weeks, an inmate will appear before the Classification Board, which will determine or recommend both a security rating and an institutional placement. The Classification Board will also make a treatment recommendation(s) designed to address the factors that may have led to the commission of a crime.

- **SOUZA BARANOWSKI CORRECTIONAL CENTER**

The Souza Baranowski Correctional Center (SBCC) is a maximum security, Level 6 prison for male offenders located on 18 acres of land at the Shirley Correctional Complex in Shirley, Massachusetts. Officially opening on September 30, 1998, this 500,000 sq. ft., high-tech, maximum-security facility consists of 1,024 general population cells, 128 special management cells, and 24 health service beds.

- **MCI CEDAR JUNCTION**

MCI Cedar Junction, formally known as MCI Walpole, is a maximum-security, Level 6 prison for male offenders located in Walpole, Massachusetts. MCI Cedar Junction also houses the Departmental Disciplinary Unit, or DDU.

### SPECIAL HOUSING UNITS (SHU):

The Massachusetts Department of Correction has established two protective custody units within the Department. One unit is located at MCI Concord, and the other is located at the Souza Baranowski Correctional Center. These units are called Special Housing Units (SHU's). An inmate may be classified into one of these units after the Commissioner or his/her designee makes a determination that the inmate cannot be safely placed in the general population of any state correctional facility. Once an inmate is classified into the SHU, he is housed there his entire sentence, unless as the result of the Classification Board processes a change in status is found to be warranted, which might result in placement in the general population, or in transfer to another institution.

Department of Correction staff provided a range of explanations as to how, for whom, and why a second SHU for inmates in Protective Custody status was established at the SBCC. The Department's intent was aimed at addressing concerns at MCI Cedar Junction where a number of Level 6 inmates could no longer be legitimately confined in segregation or disciplinary status. At the same time, because they had identified enemies they could not be placed in the general population of a Level 6 facility. Based on the *Blaney* decision and the more recently decided *Haverty* case, the Department was obligated to provide inmates in Protective Custody status with programming similar to inmates in the general population of that same security level.

In early November of 2002, the Commissioner directed the establishment of a Special Housing Unit at SBCC for Level 6 protective custody inmates. Some staff also thought that the creation of a Level 6 SHU would enhance the Department's chances of gaining accreditation of MCI Cedar Junction because the continued confinement of protective custody status inmates at MCI Cedar Junction would be held against them when the audit team from the American Correctional Association arrived at MCI Cedar Junction.<sup>22</sup>

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<sup>22</sup> The ACA is a worldwide organization setting accreditation standards for the correctional profession.

- **MCI Concord's SHU**

MCI Concord's Special Housing Unit was established in 1979, as a result of the court order, in accordance with the "*Blaney*" decision. The SHU is located in the J-4 housing unit at MCI Concord, a Level 4 security level. The inmate capacity in the SHU is 60 inmates. Inmates housed in this unit eat, recreate, access the law library and conduct other activities separate from the general population of inmates. These activities occur at specific times to ensure the SHU inmates have no contact with general population inmates. Inmates housed in this unit go to the visiting room at the same times as the general population inmates and are not separated by physical barriers from the general population inmates while in the visiting room, although they are kept as far apart as possible. They are seated in a separate row of chairs less than ten feet away from general population inmates

- **Souza Baranowski Correctional Center's SHU**

Souza Baranowski Correctional Center's Special Housing Unit was opened on February 10, 2003, and is a self-contained unit. The SHU is located in the J-1 housing unit and contains 64 one-man cells, two of which are handicap accessible and are climate controlled year round. The Souza Baranowski SHU is a Level 6 security level housing unit.

## **BLANEY AND HAVERTY COURT DECISIONS:**

It is important to understand the impact that the *Blaney* and *Haverty* decisions have on the Department of Correction. Throughout this investigation the panel and Investigative Team were constantly informed of the impact of these court decision on their ability to house protective custody inmates. The following describes the impact of both the *Blaney* and *Haverty* court decisions on the Massachusetts Department of Correction.

### **Blaney v. Commissioner of Correction, 374 Mass. 337 (1978)**

This was a case brought in 1974 by protective custody inmates at MCI Cedar Junction. They complained that they were being confined in punitive conditions in Block 10, and that they were not provided sufficiently similar or equal services to those inmates in general population. The Supreme Judicial Court ("SJC") held that protective custody inmates, not guilty of disciplinary violations, are entitled, in principle, to the standard of treatment they would receive in their ordinary classification, modified to the extent necessitated by security measures taken on their behalf. The SJC affirmed the judgment of the Single Justice of the SJC and a Special Master assigned to the case, both of whom stated that "protective custody requires (a) safe confinement, (b) some opportunity to associate and eat with non dangerous prisoners, (c) access to recreational and religious facilities, television, radio, and books, and (d) opportunities for study, work, exercise, and proper medical care." The Final Amended Agreement for Judgment requires that protective custody inmates be provided at least five hours of "meaningful activities" daily, defined as "activity calculated to provide inmates with the opportunity to participate in educational, work/vocational, or recreational pursuits." The provisions of the judgment have been incorporated in the Department Protective Custody Units policy, 103 DOC 422.00 et seq.

Haverty et al. v. Maloney, et al., 446 Mass. 1 (2003)

Haverty, et al. v. Maloney, et al., 437 Mass. 737 (2002)

Haverty, et al. v. Maloney, et al., Suffolk Sup. No. 95-3631

In Haverty, the Supreme Judicial Court ("SJC") held that the East Wing housing units at MCI Cedar Junction were substantially similar to the former Department Segregation Unit ("DSU"), and consequently, prior to any inmate being housed in these restrictive units for any more than a minimal time period (days, not weeks), he must be afforded a hearing pursuant to 103 CMR 421.00 et seq. The SJC remanded the case to the Superior Court for implementation of the decision. At the Superior Court level, a time frame was established for all inmates presently housed in the East Wing to receive a hearing pursuant to 103 CMR 421.00. In addition, copies of all East Wing hearings, including 90-day hearings, for the first six months were forwarded to MCLS.<sup>23</sup>

As a result of this decision, staff at MCI Cedar Junction must provide a hearing to every inmate prior to placing him in restrictive housing in the East Wing. Each inmate must be provided 72 hours notice prior to his hearing and his correctional counselor must be available to discuss his case. At the hearing, the correctional counselor and any witnesses requested by the counselor or the inmate (provided that it does not pose a threat to the safety and security of the institution and the witness has relevant information) present evidence regarding the inmate's behavior. The hearing board, consisting of three members, must then determine whether the inmate poses a "substantial threat to the safety of others; or . . . of damaging or destroying property; or . . . to the operation of a state correctional facility." 103 CMR 421.09. The decision is then reviewed by the Assistant Deputy Commissioner and Commissioner (or designee). Every thirty days thereafter, each inmate must receive a 30-day review regarding his behavior. Furthermore, every 90 days each inmate must receive a full subsequent hearing similar to the first hearing. An on-going schedule must be maintained, and each new inmate being placed in this restrictive housing must be afforded the same protections.

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<sup>23</sup> Established in 1972, the Massachusetts Correctional Legal Services (MCLS) is state funded to provide civil legal services to people in Massachusetts's prisons and jails.

The Supreme Judicial Court, in considering appropriate relief to the plaintiff class, declined to award earned good time credit. The Court reasoned that awarding such credits was contrary to the statutory language of G.L. c.124, §129D. Specifically, the Court held that equitable relief "should be confined within narrow limits," and that an award of good time as an equitable remedy should not have been fashioned solely because no other remedy of law existed.



## **DEPARTMENT OF CORRECTION INVESTIGATIONS:**

Investigations are a necessary function of the Department of Correction. Unusual events, crimes, escape attempts, rule violations, inmate complaints, and staff misconduct necessitate the timely, thorough gathering of facts and evidence so that informed decisions can be made. There is, within the Department of Correction, a "Chief of Investigations" who reports directly to the Commissioner. This Chief of Investigations is Mark Reilly, who is a Panel member of this investigative review committee. An understanding of the means and methods by which investigations are conducted throughout the system was essential for the members of this Panel in order to understand and evaluate this important function. Accordingly, Chief Reilly was interviewed by George Camp, along with Detective Lieutenant William Powers and Sergeant Paul Petrino.

During August of 2003, the Department of Correction had several facility-based investigative units. These various investigative units were located both at each individual institution and centrally out of the Commissioner's Office. Some units were specialized and conducted investigations that were not particular to any one institution or involved outside agencies.

The various investigative units that are tasked with performing certain types of investigations are as follows:

- **INNER PERIMETER SECURITY (IPS)**

Each facility has an Inner Perimeter Security Team. The size of the team varies, depending on the size and security level of the facility. The Superintendent of each facility selects the members of the team. Each IPS team is led by an IPS Commander who reports to the Director of Security in their respective facility.<sup>24</sup> IPS teams are responsible for conducting investigations, gathering intelligence and information, conducting searches, as well as other duties within the facility. Primarily, IPS

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<sup>24</sup> The Director of Security (DOS) in general is responsible for all security aspects of the institution, all correctional staff, including IPS and the disciplinary section. The DOS reports to the Deputy Superintendent of Operations.

investigates matters concerning inmate behavior, however, they can also investigate matters concerning staff members.

- **SUPERINTENDENT SPECIAL INVESTIGATORS (SSI)**

Superintendent Special Investigators are facility-based investigators who work directly for the Superintendent. SSI's conduct investigations as assigned by the Superintendent. Most commonly, an SSI conducts investigations concerning complaints against staff; however, it is permissible for SSI's to conduct investigations into inmate complaints. The Superintendent then may take whatever action(s) he/she deems appropriate.

- **OFFICE OF INVESTIGATIVE SERVICES (OIS)**

The Office of Investigative Services (OIS) is the Department's investigative unit assigned to the Commissioner's Office and is based in Milford, Massachusetts at the Department's Central Office. The person in charge of the unit reports directly to the Commissioner and the unit conducts investigations, as assigned by the Commissioner. OIS also renders assistance to various local, state and federal law enforcement agencies involved in investigations that relate to the Department. The OIS is further divided into three units. They are:

- **FUGITIVE APPREHENSION UNIT**

This unit concentrates on investigating Department of Correction escapees. They work in conjunction with the Massachusetts State Police Violent Fugitive Apprehension Squad, as well as the FBI Fugitive Task Force.

- **INVESTIGATION UNIT**

This unit conducts investigations that involve departmental matters, both criminal and non-criminal.

- **INTELLIGENCE UNIT**

This unit collects, analyzes, and disseminates Security Threat Group (STG) intelligence for the department, as well as other appropriate law enforcement agencies. Additionally, this unit maintains a central intelligence database.

## **PHYSICAL ABUSE OF INMATE GEOGHAN ON MARCH 19, 2002:**

One of the primary goals of the Panel's investigation was to uncover the facts about the treatment of Inmate Geoghan during his eighteen (18) month incarceration within the Massachusetts Department of Correction. During the initial stages of the Panel's investigation, the question arose of whether or not Inmate Geoghan had been physically assaulted, either by other inmates or correction officers.

As part of the Panel's investigation, Inmate Geoghan's sister, Ms. Catherine Geoghan was interviewed. Ms. Geoghan expressed several concerns regarding the treatment of her brother, during his 18-month incarceration. Specifically, Ms. Geoghan stated she believed that Correction Officer [REDACTED] had slapped her brother, and his tooth had been loosened as a result of the blow.

In addition, the Investigative Team interviewed numerous line and supervisory staff, and all thirty-eight (38) inmates housed in the MCI Concord SHU. The inmates were questioned specifically about their knowledge regarding the treatment of Inmate Geoghan while he was held in the SHU, as well as the overall treatment of inmates within the unit. These interviews yielded a variety of complaints about the treatment of Inmate Geoghan at the hands of a few correction officers, as well as a fair amount of positive comment for the administration and staff within the SHU.

On September 15, 2003, an inmate whose identity is known to the Panel, but who is not identified by name in this report was interviewed. The Cooperating Inmate, whose identity for the purposes of this report will be reflected as CI, expressed a fear of reprisal from Department of Correction officers for cooperating with this investigation. CI stated that he was housed in the SHU J-4 for several years. He recalls that when Inmate Geoghan arrived in the SHU he and Inmate Geoghan became friends. During CI's interview, CI stated that in March 2002, following a visit with a family member, he was in the visiting room strip-search area along with Inmate Geoghan.<sup>25</sup> CI stated that he was standing in the back room area, which is located off of the main visiting room, waiting to

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<sup>25</sup> Per DOC Search Policy # 103 DOC 506, all inmates are strip-searched upon conclusion of a visit.

be strip-searched. CI stated that he observed Inmate Geoghan being strip-searched by Correction Officer [REDACTED]. CI stated that he heard Officer [REDACTED] make a comment to Inmate Geoghan about "little boys" and that he saw Officer [REDACTED] strike Inmate Geoghan in the face. The Panel asked CI if he ever reported this incident to anyone within the Department of Correction administration. CI stated that he did not. CI stated that his fear of being singled out by correction officers had prevented him from officially speaking out about the incident until this time. The Panel explained to CI that these allegations would have to be followed up on. CI initial response was, "I'll say I never saw it, I really don't want to go forward with this."

Over a period of several weeks, the Investigative Team continued to interview the inmates assigned to the SHU (J-4). The Investigative Team specifically asked each inmate if they knew of an incident involving Inmate Geoghan and a correction officer following a visit. As a result of these interviews, five inmates came forward and stated that they either personally observed that Inmate Geoghan had a red mark on his face following a visit, or that Inmate Geoghan specifically told them that he was struck in the face by a correction officer following a visit.

Throughout the course of this investigation, the Department of Correction provided the Panel with hundreds of documents, files, reports and logs which detail inmate activities, as well as contact with Department of Correction staff. Of particular note was a report authored by [REDACTED] of the Department of Correction. In his report, dated March 25, 2002, [REDACTED] wrote that he met with Inmate John Geoghan on 3/25/02 at 1805 hours. [REDACTED] reports that he was directed to speak with Inmate Geoghan at the request of [REDACTED]. In his report, [REDACTED] wrote, "...following an anonymous report that (1) Inmate had been struck by a CO and that (2) he [REDACTED]. [REDACTED]'s report reflects that during his conversation with Inmate Geoghan, he (Geoghan) explains,

“...He gets along with all SHU inmates and most officers. Reported that two officers (whom he named) have come into his cell to make threatening statements to him. Reported that another officer (whose name he knows) punched him in the face in visiting area last Tuesday and on three prior occasions verbally assaulted him.” (Note: March 25, 2002, the date of [REDACTED] conversation with Inmate Geoghan, was a Monday. Therefore “last Tuesday” would be Tuesday, March 19, 2002.)

In an effort to follow up on [REDACTED] report, the Investigative Team began a review of investigations that were handled by the Superintendent's Investigator at MCI Concord, Sergeant [REDACTED]. The Investigative Team found that on or about March 29, 2002, Sergeant [REDACTED] initiated an investigation (# C-2002-S-0022) into several complaints filed by Inmate John Geoghan regarding his treatment by correction officers. In an undated report filed by Sergeant [REDACTED] he stated that on April 1, 2002, he conducted an interview of Inmate John Geoghan. Inmate Geoghan stated that on or about March 23, 2002, he believed that a Correction Officer, identified as [REDACTED] had defecated and urinated in his cell. Sergeant [REDACTED] further reported that during this same interview, Inmate Geoghan told him that he had been assaulted by Correction Officer [REDACTED] following a visit with a priest. Sergeant [REDACTED] wrote that Inmate Geoghan advised him that he had received a visit on Saturday, April 14, 2002 (note: interview was conducted on April 1, 2002) from a priest, and following the visit Officer [REDACTED] was conducting a strip-search on Inmate Geoghan in the back room of the visiting area. In the report, Inmate Geoghan stated that Officer [REDACTED] was rushing him to remove his clothes. Inmate Geoghan tells Sergeant [REDACTED] that as he was handing Officer [REDACTED] his underwear, Officer [REDACTED] “slugged” him with a clenched fist on the right side of his face. Inmate Geoghan stated that he twice yelled out, “I’ve been hit.” Sergeant [REDACTED] wrote that Inmate Geoghan told him that he did not report this assault because he is terrified of the staff. Inmate Geoghan also claims that his face was red until the next day, and that he did not seek medical attention.

Sergeant [REDACTED] reports that on April 4, 2002, he interviewed Correction Officer [REDACTED] regarding the accusation made by Inmate John Geoghan. Officer [REDACTED] stated to Sergeant [REDACTED] that he has never assaulted Inmate Geoghan during a visit. Sergeant [REDACTED] further reported that Officer [REDACTED] tells him that he has never had any problems or incidents involving Inmate Geoghan, and that he can only remember strip-searching Inmate Geoghan a couple of times over the past several months without incident.

Sergeant [REDACTED] further reports that the date of the alleged assault (which according to Sergeant [REDACTED] was March 14, 2002) was Officer [REDACTED] day off, (note: Officer [REDACTED] tells Sergeant [REDACTED] that his regular scheduled days off are Friday and Saturday).

Sergeant [REDACTED] reports that on April 4, 2002, he interviewed Correction Officer Brian Chin regarding Inmate Geoghan's claim he was assaulted by Officer [REDACTED]. Officer Chin stated to Sergeant [REDACTED] that he was on duty in the visiting room on March 14, 2002, but that he does not exactly remember the date that inmate Geoghan had a visit. Sergeant [REDACTED] writes that Officer Chin further stated that he never observed any officer assault Inmate Geoghan while Officer Chin was on duty in the visiting room.

Sergeant [REDACTED] reports that on April 4, 2002, he interviewed Correction Officer [REDACTED] regarding Inmate Geoghan's claim he was assaulted by Officer [REDACTED] following a visit. Officer [REDACTED] stated to Sergeant [REDACTED] that he was working in the visiting room on the day in question, which Sergeant [REDACTED] reports is March 14, 2002, but that he never observed anyone assault any inmate in his presence.

Sergeant [REDACTED] reports that on April 4, 2002, he interviewed Correction Officer Edwin Silva regarding Inmate Geoghan's claim that he was assaulted by Officer [REDACTED] following a visit. Inmate Silva stated to Sergeant [REDACTED] that he was on duty in the visit room on March 14, 2002, and that he recalls Inmate Geoghan received a visit from his (Geoghan's) sister and a priest. Sergeant [REDACTED] reports that Officer Silva told him that he recalls the priest left before Inmate Geoghan's sister, and that he did not witness any officer or inmate assault Inmate Geoghan on this date.

In concluding his investigative report, Sergeant [REDACTED] offered the following findings regarding his investigation into Inmate John Geoghan's claim that Officer [REDACTED] physically assaulted him.

A. Inmate John Geoghan did make the accusation that he had been assaulted by Correction Officer [REDACTED] in the visiting room on April 14, 2002 (emphasis added).

B. Inmate Geoghan's accusation of being assaulted by Officer [REDACTED] have been deemed unfounded due to Officer [REDACTED] not being on duty the specific day in question coupled with inmate Geoghan's testimony of the date the incident took place.

In an effort to decipher the many conflicting dates supplied by Sergeant [REDACTED] in his report, the Investigative Team reviewed the visiting records of both Inmate Geoghan and the Cooperating Inmate (CI) to determine the date of the alleged assault. Additionally, the Investigative Team reviewed the attendance records of CO [REDACTED] as well as those of the other correction officers working in the visit room area. The Investigative Team, with the assistance of the Department of Correction, who since the murder of Inmate Geoghan have been reviewing all his recorded telephone conversations in hopes of capturing any conversations which would shed light on the incident, or further assist in determining the exact date in question.

After reviewing all of the above, the Investigative Team quickly determined that March 14, 2002, which Sergeant [REDACTED] stated to be a Saturday (which would have been a scheduled day off for CO [REDACTED] was actually a Thursday. In light of the report filed by [REDACTED] the Investigative Team focused in on Tuesday, March 19, 2002 as the most likely date of occurrence. The attendance records reflect that CO [REDACTED] was in fact working in the visiting room area on Tuesday, March 19, 2002. The visiting records reflect that on Tuesday, March 19, 2002, Inmate Geoghan received a visit at 1800 hours from a priest, later identified as [REDACTED]. Likewise, the visiting records show that (CI) also received a visit at 1800 hours from his mother, which

places him in the visiting room with Inmate Geoghan as he previously stated. A review of Inmate Geoghan's recorded telephone conversations following this visit (3/19/02) revealed that Inmate Geoghan was involved in a confrontation with CO [REDACTED] during a strip-search following his visit.

*The following is a portion of a transcript of a telephone conversation between Inmate Geoghan and his sister, Catherine Geoghan, which occurred on March 19, 2002 at 2031 hours (note: per DOC Inmate Telephone Access and Use Policy 103 CMR 482, all telephone calls are monitored/recorded, except pre-approved attorney and clergy calls).*

**Inmate Geoghan (IG):** "[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

**Catherine Geoghan (CG):** [REDACTED]

**IG:** [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

**CG:** [REDACTED]

**IG:** [REDACTED]

A review of the recorded telephone conversations of Inmate Geoghan on Wednesday, March 20, 2002 reveals that Inmate Geoghan spoke with his sister Catherine at approximately 0902 hours. In this conversation, Inmate Geoghan expounds on his altercation with CO [REDACTED] following his visit the previous evening.

*The following is a portion of a transcript of Inmate Geoghan's telephone conversation with his sister, Catherine, on March 20, 2002 at 0902 hours:*



IG: [REDACTED]

A further review of Inmate Geoghan's visiting records shows that on Thursday, March 21, 2002 at approximately 1300 hours, Inmate Geoghan received a visit from his sister, Catherine Geoghan. Following this visit, at approximately 1815 hours, Inmate Geoghan calls his sister at her home. In this conversation, Inmate Geoghan attempts to comfort her regarding his disclosure to Ms. Geoghan that he had been struck by [REDACTED] in the face immediately following his visit with [REDACTED]

*The following is a portion of a transcript of Inmate Geoghan's telephone conversation with his sister, Catherine, on March 21, 2002, at 1816 hours.*

IG: [REDACTED]

CG: [REDACTED]

IG: [REDACTED]

CG: [REDACTED]

IG: [REDACTED]

CG: [REDACTED]

IG: [REDACTED]

CG: [REDACTED]

IG: [REDACTED]

*(Operator comes on line advises one minute left to talk)*

IG: [REDACTED]

*(Inmate Geoghan call his sister back at 1831 hours.)*

IG: [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

CG: [REDACTED]

IG: [REDACTED]

CG: [REDACTED]

IG: [REDACTED]

CG: [REDACTED]

IG: [REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED] Note: a  
review of [REDACTED] attendance records reflects that he went on time off from  
March 21, 2002 until April 1, 2002.)

CG: [REDACTED]

IG: [REDACTED]

CG: [REDACTED]

IG: [REDACTED]  
[REDACTED]

CG: [REDACTED]

IG: [REDACTED]  
[REDACTED]

CG: [REDACTED]

IG: [REDACTED]

CG: [REDACTED]

IG: [REDACTED]

*The following is a portion of a transcript of a telephone call between Inmate Geoghan and his sister, Catherine. This conversation occurred on March 21, 2002 at 1919 hours.*

IG: [REDACTED]  
[REDACTED]

CG: [REDACTED]

IG: [REDACTED]  
[REDACTED]

CG: [REDACTED]

In light of this information, the Investigative Team again contacted Catherine Geoghan via her attorney Charles Houlihan. Ms. Geoghan stated that it was in fact during her visit

with her brother John on Thursday, March 21, 2002 that she learned that he had been struck by CO [REDACTED] following his (Inmate Geoghan's) visit with [REDACTED] on Tuesday, March 19, 2002.

The check of the roster at MCI Concord for Tuesday, March 19, 2002 revealed that along with CO [REDACTED] CO [REDACTED] was also working in the visiting room area at approximately 1800 hours.

On January 15, 2004, at approximately 1150 hours, the Investigative Team interviewed CO [REDACTED] in the IPS office at MCI Concord. Throughout the interview, Officer [REDACTED] was accompanied by his union representative, Lt. Jaworski. Officer [REDACTED] was asked if he had any interaction with Inmate Geoghan. He replied that he once wrote Inmate Geoghan a disciplinary report for calling him [REDACTED] a clown in the visiting room. Officer [REDACTED] also stated that he recalls being in the visiting room area and that he witnessed Inmate Geoghan and Officer [REDACTED] bump into each other near the visiting room desk. At the time of this reported incident, the Department of Correction conducted a separate investigation.

Officer [REDACTED] was asked if he recalls any other time that Inmate Geoghan might have claimed he was assaulted in the visit room. Officer [REDACTED] stated, that although he can't recall the date, he does remember that Inmate Geoghan claimed to have been struck by Officer [REDACTED] in the strip-search area off of the visiting room. Officer [REDACTED] was asked to further explain the details surrounding this event. Officer [REDACTED] stated that he was working in the visiting room and he was assigned to the "stage desk" position. Officer [REDACTED] was asked if he was the supervisor for the area at that time. He replied that because there was no Sergeant on duty in the area, he would have been the acting supervisor. Officer [REDACTED] stated that at the conclusion of Inmate Geoghan's visit, he (Geoghan) was brought into the back room to be strip-searched. Officer [REDACTED] stated that he was seated at the visiting room desk and that he heard Inmate Geoghan yell out, "He hit me, he hit me." Officer [REDACTED] added that he heard Officer [REDACTED] respond to Inmate Geoghan, telling him to be quite. Officer [REDACTED] was asked what, if anything, he did when he heard this

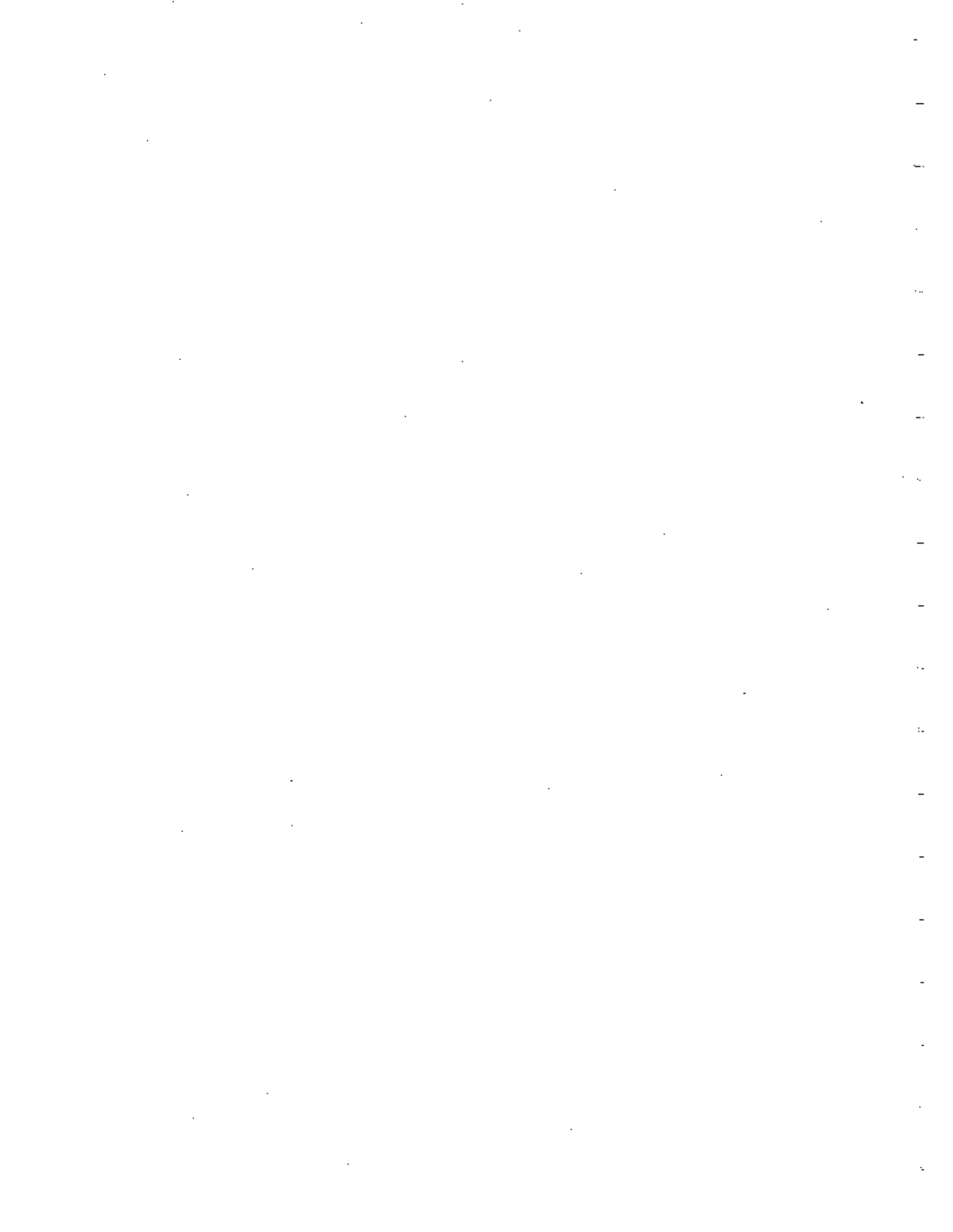
exchange. He replied that he didn't do anything. Officer [REDACTED] was asked if he went into the back room area to observe what was going on. He stated that he did not. Officer [REDACTED] was asked if he had further conversation with Officer [REDACTED] regarding Inmate Geoghan's claim he was being struck in the back room area of the visiting room. Officer [REDACTED] stated that he did speak with Officer [REDACTED] sometime later and that Officer [REDACTED] told Officer [REDACTED] that he didn't know what Geoghan was talking about. Officer [REDACTED] was asked if he told this information to Sergeant [REDACTED] when [REDACTED] interviewed him on April 4, 2002. Officer [REDACTED] replied that he did not tell Sergeant [REDACTED] that he heard this exchange between Inmate Geoghan and Officer [REDACTED]. Officer [REDACTED] added, "He asked me if I witnessed Geoghan get assaulted. I told him no. He never asked me anything else."

On January 11, 2004, at approximately 1220 hours, the Investigative Team returned to MCI Concord and re-interviewed the inmate previously referred to as CI. CI now expressed his willingness to speak with the Investigative Team, and following a brief conversation, was asked to accompany the Investigative Team to the visiting room area. Once in the visiting room area, CI was asked to show the Investigative Team where he was positioned, as well as where both Officer [REDACTED] and Inmate Geoghan were standing on the evening of the assault. CI gave a detailed description of these locations which enabled the Investigative Team to make a drawing of the area.

On January 16, 2004, at approximately 1140 hours, the Investigative Team interviewed Sergeant Harold [REDACTED] at the Department of Correction Central Office in Milford, Massachusetts. Sergeant [REDACTED] was previously interviewed on October 7, 2003 by the Investigative Team, regarding his duties and responsibilities as the Superintendent's Investigator at MCI Concord. Conversely, the Investigative Team now wished to speak with Sergeant [REDACTED] specifically regarding his investigation surrounding Inmate Geoghan's allegation that he was struck by Officer [REDACTED] following a visit.

In the interview, Sergeant [REDACTED] stated that he was advised at some point that Inmate Geoghan was alleging that Officer [REDACTED] had defecated in his cell, as well as alleging that Officer [REDACTED] had struck him following a visit. The Investigative Team explained to Sergeant [REDACTED] the discrepancies they uncovered in his investigation, as well as the calendar errors which led to a great deal of confusion. Sergeant [REDACTED] expressed remorse in failing to thoroughly investigate the matter, and stated that he relied solely on the date supplied by Inmate Geoghan. He further stated that, beyond asking Officer [REDACTED] if he had personally witnessed an assault on Inmate Geoghan, he does not recall asking him any additional questions regarding Inmate Geoghan's claim he was struck by Officer [REDACTED]

During this investigation, the Investigative Team was notified that on September 10, 2003, Correction Officer [REDACTED] telephoned MCI Concord and resigned effective immediately. Upon also learning that [REDACTED] was now represented by Attorney [REDACTED] the Investigative Team contacted Attorney [REDACTED] to arrange an interview of [REDACTED]. On November 5, 2003, after repeated failed attempts to schedule an interview, [REDACTED] ultimately declined to be interviewed by the Investigative Team. A subsequent attempt to interview [REDACTED] was made through his attorney on January 16, 2004. Attorney [REDACTED] declined to have his client be interviewed.



# **SECTION D**

## **FINDINGS AND CONCLUSIONS**



## INVESTIGATION FINDINGS AND CONCLUSIONS

### Investigation Finding No. 1:

Mark Reilly stated that there was no central control of investigations. Investigations occurring at the facility level would not necessarily be brought to the attention of the central office. Further, there was no central repository for department investigations and no process for centralized tracking of investigations nor procedures for quality control.

### Investigation Conclusion No. 1:

The system of investigations within the Department of Correction is sporadic and cavalier. The lack of central control and supervisory oversight makes it impossible for top administrators to be informed of ongoing pertinent investigations. This deprivation of knowledge prohibits executive management from being aware of deficiencies and taking appropriate corrective action.

### Investigation Finding No. 2:

Each Superintendent had wide discretion in determining the duties of their investigator, as well as the level and depth of the investigations. They also maintained discretion in the manner in which the findings were reported. The investigations conducted by the Special Investigators (that came to our attention) were, for the most part, initiated by complaints by inmates against facility employees. The findings of the Special Investigator were turned over to the Superintendent for review and appropriate actions. These reports remained in the sole custody of the institution and were not forwarded up the chain-of-command to a central repository for review and any possible action.

### Investigation Conclusion No. 2:

Unless there were informal conversations between Superintendents, there was no mechanism to share information about inmates and correctional employees when they were transferred to other institutions. Similarly, if a Superintendent was transferred or retired there was no policy in place dictating that these reports are turned over to his or her successor. The Department's Central Office was unaware of the information

developed in these investigations and even more importantly was in the dark about what, if any, action was taken by the Superintendent and its appropriateness.

Investigation Finding No. 3:

The Special Investigator at MCI Concord conducted three investigations that involved Inmate John Geoghan and Department of Correction employees. In the first instance, Inmate Geoghan made an allegation that Correction Officer [REDACTED] had defecated in his cell.

Investigation Conclusion No. 3:

The Panel found there were feces in Inmate Geoghan's cell area on March 23, 2002. The Panel concluded, based upon the investigation that this incident was most likely committed by an inmate(s). Interviews of several inmates revealed that there was a widely held belief that another inmate had placed the feces in Inmate Geoghan's cell. Additionally, a review of Inmate Geoghan's recorded telephone conversations revealed that it was always Inmate Geoghan's belief that the feces was placed in his cell area by another inmate and not a correction officer.

An interview of the investigator (Sergeant [REDACTED]) showed while he believed that Inmate Geoghan was sincere in his thinking that Officer [REDACTED] was responsible for the action, he could not support his allegation with facts. Sergeant [REDACTED] stated he did not write a disciplinary report on Inmate Geoghan because he did not consider the complaint a lie.

On April 4, 2002, Officer [REDACTED] confronted Inmate Geoghan and accused him of making false statements against him with regard to the feces that had been found in his cell on March 23, 2002. Inmate Geoghan reportedly denied that he had. Officer [REDACTED] then advised Inmate Geoghan he would receive a "disciplinary report for lying." Coincidentally on the same day that Officer [REDACTED] writes this disciplinary report - Sergeant [REDACTED] interviewed Officer's Harris, Chin, [REDACTED] and Silva regarding the allegation that Officer [REDACTED] had struck Inmate Geoghan.

The Panel also concludes that Officer ██████ did admit that he had seen the feces. However, Officer ██████ did not immediately submit an incident report regarding his observations. He did submit an incident report some three weeks later, but only after advised to do so by Investigator ██████. The failure to immediately report the incident was a violation of departmental policy, but Officer ██████ was never reprimanded or disciplined for his failure to adhere to the policy.

Investigation Finding No. 4:

Inmate Geoghan made a second allegation, that he had been "slugged" on the side of his head by Correction Officer ██████ after a visit in the strip-search area of MCI Concord. Special Investigator ██████ investigated this claim and after interviewing Geoghan ██████ and other corrections officers he determined the complaint was "unfounded".

Investigation Conclusion No. 4:

The Panel concluded that in fact Inmate Geoghan was physically assaulted by Officer ██████ in the strip-search area of the visiting room in MCI Concord. The results of the Panel's investigation into this allegation are included in the background section of this report.

Investigation Finding No. 5:

Inmate Geoghan made a third allegation that he was assaulted by Correction Officer ██████ in the form of a shoulder check in the MCI Concord visiting room on September 5, 2002 while visiting with his sister Catherine Geoghan.

Superintendent Investigator Sergeant ██████ conducted an investigation into this allegation. Sergeant ██████ concluded this allegation was "unfounded" and issued Inmate Geoghan a disciplinary report for lying.

Investigation Conclusion No. 5:

The Panel concluded that Sergeant ██████ investigation into this allegation was incomplete at best. Sergeant ██████ failed to determine if any video cameras within the visiting room were working and might have captured the incident on tape. Further,

Sergeant [REDACTED] failed to interview any non-Department of Correction staff, including inmates, other visitors and Catherine Geoghan, who stated she witnessed the incident.

The Panel concluded that the issuance of a disciplinary report to Inmate Geoghan for this allegation to be completely inappropriate. Unquestionably, by all accounts Inmate Geoghan and Officer [REDACTED] came into contact with one another. Inmate Geoghan opined that Officer [REDACTED] deliberately struck him. Officer [REDACTED] stated it was an "accidental bump". Sergeant [REDACTED] concluded that Inmate Geoghan was lying. The difference is clearly a matter of perception and not a lie. Given the lack of any corroborating evidence, this Panel cannot make a final determination as to the intentionality of contact by Officer [REDACTED]. Had the incident been investigated thoroughly at the time of the complaint, perhaps a definitive conclusion could have been reached.

Investigation Finding No. 6:

On May 13, 1999, inmate Smiledge/Druce, while at MCI Cedar Junction and being held in the West Wing Segregation Unit (WWSU) wrote [REDACTED]. He was subsequently issued a Disciplinary Report for his actions.

At approximately 12:00 PM on [REDACTED] 1999, inmate Smiledge/Druce was escorted from his cell and interviewed by Captain [REDACTED] the shift commander. The interview was held in a private office and no one else was present. In separate interviews both parties agreed that the reason for the meeting was to discuss inmate Smiledge/Druce behavior. After the interview, Inmate Smiledge/Druce was escorted back to his cell. Inmate Smiledge/Druce refused his afternoon meal and remained in his cell with the outer door closed so he could not be observed. Later in the day he refused his evening meal telling a corrections officer that he was not hungry. At approximately 5:30 PM, inmate Smiledge/Druce advised the same officer that he [REDACTED]. At the time, the officer noted that inmate Smiledge/Druce had some facial injuries. He made arrangements for inmate Smiledge/Druce to be interviewed by a member of [REDACTED]. Following a screening, inmate Smiledge/Druce was escorted to the Health Service Unit where he was held and [REDACTED].

A review of the medical notes regarding inmate Smiledge/Druce showed that the observer noted [REDACTED]

Additionally, a second health worker spoke with inmate Smiledge/Druce and noted that [REDACTED] During his intake interview inmate Smiledge/Druce reported that he wanted "out of 10B or [REDACTED]" he added that was "beaten down" and feared for his safety.

Superintendent John Marshall ordered his Special Investigator, Sergeant [REDACTED] to look into the allegations made by inmate Smiledge/Druce that Captain [REDACTED] assaulted him on [REDACTED] 1999. We were provided a copy of the investigative report.

The Special Investigator interviewed Captain [REDACTED] but not inmate Smiledge/Druce. Later, Inmate Smiledge/Druce was interviewed twice. A Sergeant from the IPS team conducted the first interview on [REDACTED] 1999, after inmate Smiledge/Druce made allegations that Captain [REDACTED] assaulted him. Another Sergeant assigned to the IPS team held the second interview the following day. In addition the Special Investigator collected reports that were written by other corrections officers and health service personnel regarding events surrounding the meeting and contacts with inmate Smiledge/Druce.

In brief, Captain [REDACTED] stated in his interview that he conducted the meeting alone with inmate Smiledge/Druce, because he didn't want him "putting on a show". He said the meeting lasted approximately two minutes and he told inmate Smiledge/Druce to stop his racist activities and to "relax for awhile because he was going to DDU." Captain [REDACTED] stated that he yelled at inmate Smiledge/Druce during the meeting, but, "never once laid a hand on him, "That's the God's honest truth."

Inmate Smiledge/Druce gave two statements that were slightly varied. In the first interview he stated he was kicked and punched by Captain [REDACTED] during their meeting. When he was asked why he waited several hours to report his injuries, he replied that the staff had ignored an earlier request to be seen by the medical staff and it wasn't until he [REDACTED]. In the second interview, inmate Smiledge/Druce was asked how he sustained his injuries. He replied that he fell while trying to rip electrical wires from the wall and that he had a seizure and fell from the bed. The investigator said the swelling around his eyes did not appear consistent with a fall, adding that he was aware that inmate Smiledge/Druce had complained on the evening of May 14 that he had been assaulted by Captain [REDACTED]. Inmate Smiledge/Druce was asked once again if he was assaulted and he answered, "not really". When asked if his wounds were self-inflicted he shrugged his shoulders.

Special Investigator Sergeant [REDACTED] wrote a report to the Superintendent. In his "executive summary" he concluded that:

"based on all facts, physical evidence, and the interview process, the following has been concluded: Inmate Smiledge was interviewed numerous times, and each time his statements were inconsistent with that of previous statements he had given. Staff interviews were consistent with the facts obtained throughout this investigation. Although inmate Smiledge had multiple injuries about his face and body, it could not be determined if these injuries were self-inflicted or a result of a physical assault by Captain [REDACTED]. Therefore, these allegations were determined to be inconclusive.

Within days of the incident, inmate Smiledge/Druce was finally transferred to the DDU and he remained there for slightly over four years. When it was time for him to be released he sent letters to the Superintendent asking that he be sent to the SBCC SHU as soon as possible and not back to the West Wing Segregation Unit because he feared for his safety.

Investigation Conclusion No. 6:

The Panel finds that this investigation, like the ones cited from MCI Concord reaches a conclusion that is flawed because it is based on an incomplete investigation. The Superintendent's Investigator interviewed one of the principles and then relied on interviews conducted by others to draw the conclusion that there were inconsistencies in the statements. Furthermore, the Special Investigator never spoke to medical personnel regarding inmate Smiledge/Druce's injuries. He didn't ask to see if they were consistent with a beating, nor did he inquire about the possibility of inmate Smiledge/Druce having a seizure resulting in a fall. He didn't interview the person(s) who escorted inmate Smiledge/Druce to and from the interview with [REDACTED] so he didn't know if injuries were incurred prior to when they were first reported several hours after he returned to the Unit. He didn't interview corrections officials who may have been in the area when inmate Smiledge/Druce met with [REDACTED] nor did he speak with corrections officials who came in personal contact with inmate Smiledge/Druce to determine when the injuries may have first been noticed.

The Panel found it impossible to determine exactly how Inmate Smiledge/Druce came about his injuries. In fact we were left with more questions than answers.

This case once again highlights the need for investigators to be more experienced, better trained, and more closely supervised so they can conduct thorough, well-developed investigations. It also shows a lack of understanding by supervisory staff who accept reports that contain conclusions that are not supported by facts.

## DISCIPLINARY REPORT FINDINGS AND CONCLUSIONS

### Disciplinary Report Finding No. 1:

The issuance of Discipline reports and the reliance upon them for punitive and corrective measures is a necessary function of Corrections. Discipline reports document violations of prison rules by inmates. The subsequent hearings conducted by the Discipline Board, will decide culpability and issue sanctions necessary to modify behavior and correct any non-compliance with acceptable prison decorum.

### Disciplinary Report Conclusion No. 1:

It is imperative that disciplinary reports be issued in compliance with Department Policy and Procedures. Discipline reports, when prudently issued and fairly and objectively adjudicated, can achieve positive behavior modification. However, when disciplinary reports are excessive or issued for relatively minor offenses on a continuous basis, the exact opposite results can occur.

### Disciplinary Report Finding No. 2:

The MCI Concord General Post Orders concerning disciplinary reports state, in part:

*"All inmates incarcerated by the Department of Correction are governed by rules and regulations dealing with minor infractions.. When inmates break these rules they are subject to disciplinary action. **Informal Resolutions between the officer and the inmate are the preferred method of dealing with minor infractions. When informal resolutions are impractical, or in cases of serious infractions, it will be necessary to write a disciplinary report.**"*

*"...The Disciplinary Report form will be written using IMS and immediately forwarded to the shift commander for investigation. The staff member writing the Disciplinary Report should first notify the Area Lieutenant that a Disciplinary Report is being written...."*



Inmate John Geoghan received a total of 15 disciplinary reports during his incarceration at the J-4 SHU at MCI Concord. Inmate John Geoghan received more disciplinary reports than any other inmate in the SHU. Eight (52%) of Geoghan's disciplinary reports were written by Officer Cosmo Bisazza from January 1, 2002 to April 1, 2003. It is also interesting to note that Inmate Geoghan received 40 percent of all disciplinary reports issued by ██████████ to SHU inmates within this same time period. There is no indication that the area Lieutenant was consulted before the issuance of any disciplinary reports, as required per General Post Orders.

Sergeant Sheridan, the MCI Concord Disciplinary Hearing Officer, told investigators that he had taken notice of the disciplinary reports issued to inmate Geoghan, due to both their number and nature. Sergeant Sheridan stated that he had spoken to Officer ██████████ about the disciplinary reports he had written against Inmate Geoghan.<sup>26</sup> Sergeant Sheridan stated that he told Officer ██████████ to "Take care of your own business." – meaning manage your housing unit on your own without having to write an excessive number of disciplinary reports. Sergeant Sheridan informed the Investigative Team that he thought the disciplinary reports written against Inmate Geoghan were either minor in nature, bad reports, or just "flat cr\_\_." Sergeant Sheridan was of the opinion that the behavior/attitude/demeanor of Inmate Geoghan and the expectations of correction officers clashed. Sergeant Sheridan described Inmate Geoghan as a little old man who didn't bother anyone. Sergeant Sheridan went on to say that Inmate Geoghan exhibited no repetitive bad behavior, was no danger to staff or inmates, and was not engaged in fighting. When the disciplinary board learned that Inmate Geoghan was being transferred, Officer Steve Lacrosse (MCI Concord Hearing Officer) telephoned the Director of Classification, Karen DiNardo, and said "Don't blame the D-Board, you do it on your own, but don't blame it on Inmate Geoghan being a discipline problem." Officer Larosse also stated that Inmate Geoghan received too many disciplinary reports as compared with the vast majority of inmates in the SHU, and that most were for petty offenses.

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<sup>26</sup> In an interview with the Investigative Team, Officer ██████████ stated he did not recall this conversation.

Members of the Investigative Team interviewed retired MCI Concord Superintendent William Coalter. Relative to disciplinary reports, Coalter stated, "There seemed to be an unusual number of disciplinary reports for someone that did not seem to be part of convict culture. I had suspicions that officers were enforcing rules a bit too stringently." He opined that the publicity surrounding Inmate Geoghan and the crime that he was convicted of might have been a causative factor in the excessive writing of disciplinary reports.

Deputy Superintendent of Classification at SBCC, Lois Russo, reviewed Inmate Geoghan's disciplinary reports and stated, "When you have sh\_\_ tickets (disciplinary reports) written by the same officer again and again... you have a problem. Instead of pulling out the officer, they give in and send out the inmate."

Acting Commissioner of Correction, Kathleen Dennehy, relative to disciplinary reports written against Inmate Geoghan stated, in hindsight, "I am troubled," by staff versus inmate interaction. She went on to say, "I question the quality of those disciplinary reports written against Inmate Geoghan, the Superintendent (Grant) should have also."

During an interview with MCI Concord Deputy Superintendent of Classification, Scott Anderson he stated that he overturned the Classification Board's recommendation based in part on two disciplinary reports Geoghan received immediately following his appearance before the Classification Board.

#### Disciplinary Report Conclusion No. 2:

The issuances of disciplinary reports to Inmate Geoghan were seldom in compliance with the MCI Concord post orders. Certain correction officers were quick to issue a formal disciplinary report, when less formal alternatives would have sufficed. These questionable disciplinary reports would later serve as the stated rationale for transferring Inmate Geoghan to SBCC.

Inmate Geoghan received a disproportional number of disciplinary reports, as compared to other inmates at MCI Concord, and in particular the SHU. The reports were not viewed as being as serious to the reviewers as they were to the writers, and as a result the staff responsible for conducting disciplinary hearings at MCI Concord consistently reduced the charges against Inmate Geoghan and either imposed a very minimal sanction or none at all. Moreover, it appears that a number of staff who were familiar with Inmate Geoghan concluded at the time that he was being unfairly singled out for discipline by some of the officers in the unit.

Some staff at MCI Concord were aware of it and reported their findings and concerns. Supervisory and management staff at MCI Concord were aware, or should have been aware, that Inmate Geoghan was being unfairly singled out and did nothing to correct the situation.

Inmate Geoghan was 68-years old and physically not a threat or danger to either correction officers or other inmates. The Discipline Hearing Officer's recognized the number and triviality of disciplinary reports issued to Inmate Geoghan and expressed their concerns to Officer [REDACTED] and others. Their expressed concerns evidently had no impact.

Disciplinary Report Finding No. 3:

Relevant information is not always shared or readily available to the staff who are making decisions about an inmate. For example, when Deputy Superintendent St. Amand reviewed Inmate Geoghan's disciplinary reports just after February 24, 2003, he was unaware that Inmate Geoghan was being considered for transfer to SBCC, in large measure as a result of those two disciplinary reports, which he determined to be less than consequential in terms of impacting Inmate Geoghan's future. In fact, St. Amand indicated that he learned that Inmate Geoghan was transferred one month after the fact. Similarly, when the Commissioner's designee, Lori Cresey was making the decision to transfer Inmate Geoghan from MCI Concord to SBCC, she was unaware of most, if not all, of the important events in Inmate Geoghan's stay at MCI Concord. For example, she was unaware of the "feces incident" and neither she nor any one else in Central Office

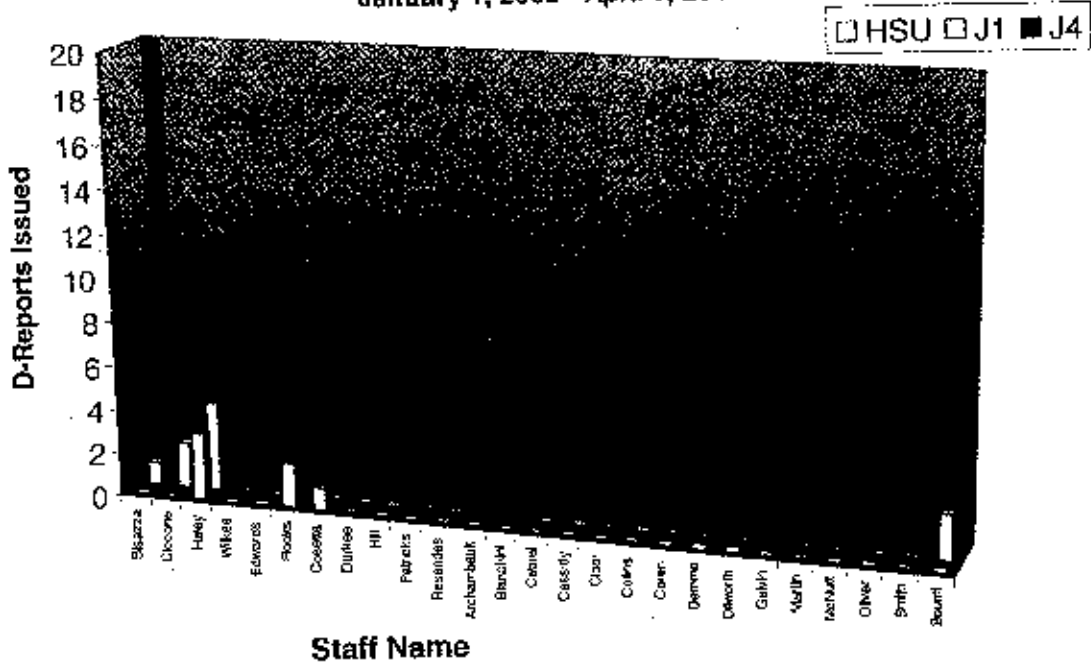
were aware that months earlier an investigation report had been written by MCI Concord Superintendent's Investigator [REDACTED] and submitted to the Superintendent.

Disciplinary Report Conclusion No. 3:

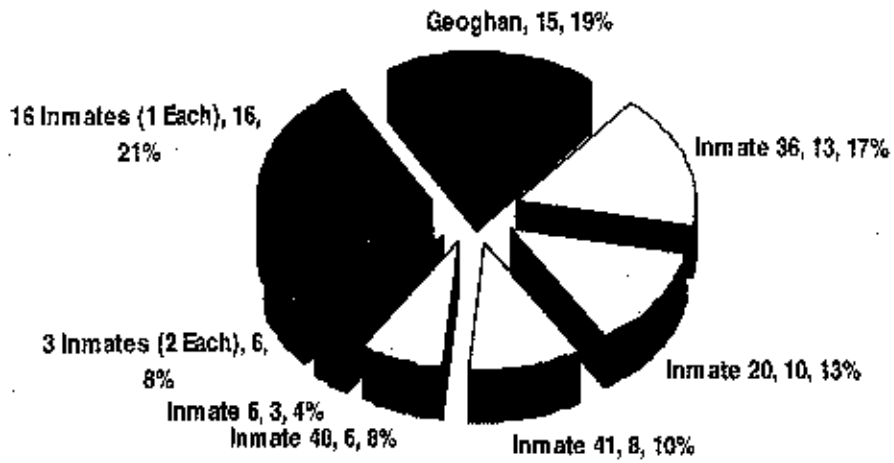
Absent complete, current, and accurate information about inmates, staff are in an impossible position to make informed recommendations and decisions. While much information is being gathered and stored both electronically in the automated inmate management system (IMS) and manually in the inmate's six-part file, that information appears to be difficult to access and apply as fully as it might. As a result, less than informed decisions may be made about inmates other than Inmate Geoghan.

# D-Reports Issued at MCI Concord

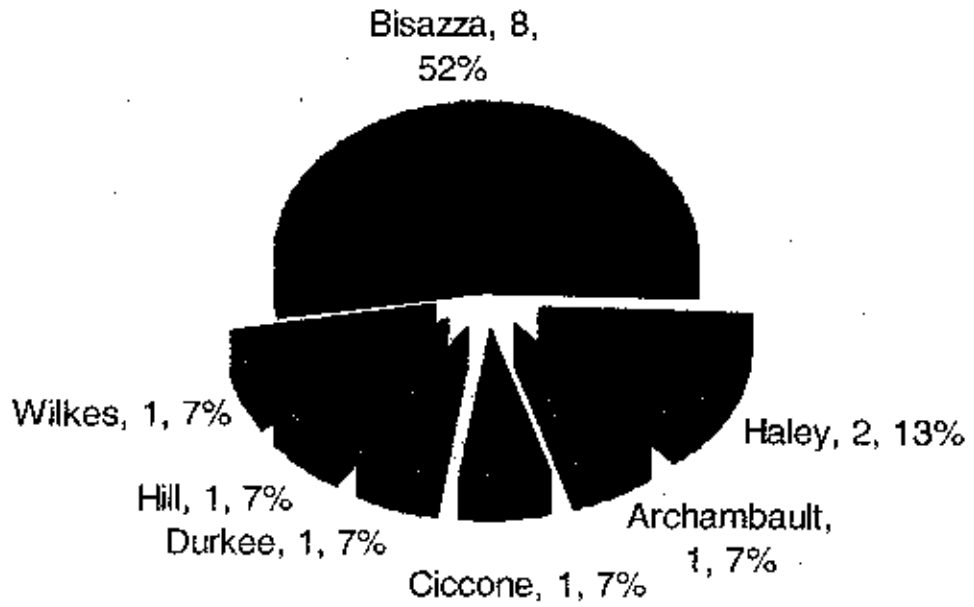
January 1, 2002 - April 1, 2003



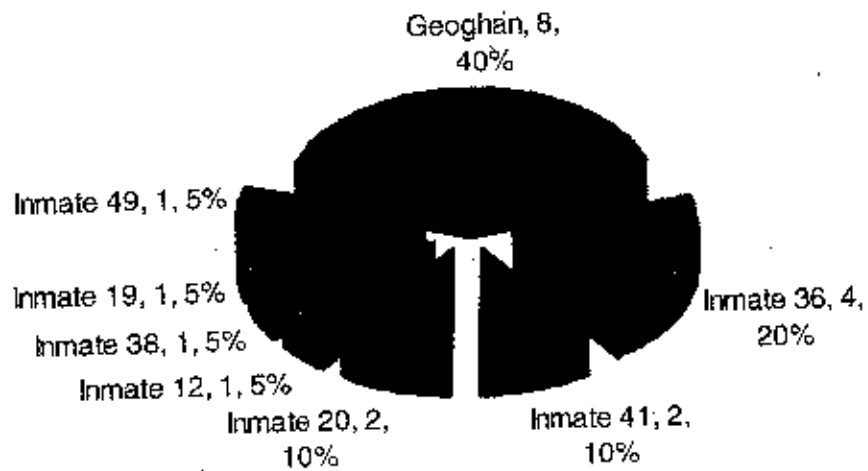
## D-Reports Issued to Inmates in J4 Between January 1, 2002 to April 1, 2003



**D-Reports Issued to John Geoghan  
(Between January 1, 2002 to April 1, 2003)**



**D-Reports Issued by Bisazza**  
**Between January 1, 2002 and April 1, 2003**





## CLASSIFICATION FINDINGS AND CONCLUSIONS

### Classification Finding No. 1:

Inmate Geoghan arrived at MCI Concord on February 21, 2002, to begin serving a ten-year sentence for Indecent Assault on a Child Under 14.<sup>27</sup> After an initial day or two in the Health Services Unit (HSU), he was placed in the SHU at MCI Concord. Inmate Geoghan remained here until April 1, 2003, when his transfer to the SHU at SBCC occurred, with the exception of three days in September of 2002, when he was placed in the Special Management Unit (SMU) as a result of a rule infraction.<sup>28</sup>

On February 20, 2003, in keeping with the department's policy, Inmate Geoghan appeared before a Classification Board at MCI Concord for his regular four-month review. Citing the "notoriety of [his] case and continued adjustment," the three-member board unanimously voted to recommend Inmate Geoghan remain in the SHU at MCI Concord.

On February 21, 2003, Inmate Geoghan received a disciplinary report for possessing a "tampered hot pot." On the next day, February 22, 2003, he received a second disciplinary report for disobeying an order, lying and insolence, when he questioned an officer in the SHU about the previous day's disciplinary report. A hearing was held for both disciplinary reports on February 24th at 1000 hours by the Disciplinary Hearing Officer who, following Inmate Geoghan's guilty plea, reduced both reports to minor infractions and imposed a sanction of four weeks loss of canteen privileges.

Between February 20-24, 2003, several two-party conversations about Inmate Geoghan's status occurred between three senior officials at MCI Concord. These senior officials were Superintendent Michael Grant, Deputy Superintendent of Classification Scott Anderson, and Director of Classification Karen DiNardo. During these conversations:

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<sup>27</sup> Inmate Geoghan received a 9-10 year sentence, with 6-years to be served. The Board of Probation indicated his Parole Eligibility date and wrap up date were both 1/16/2008.

<sup>28</sup> The SMU is any unit set apart from the rest of the institution, which is used primarily for the housing of inmates, who are under Administrative Segregation, Protective Custody or Disciplinary Detention.

- Superintendent Grant inquired of Director of Classification DiNardo if she had acted on the Classification Board's recommendation per her role as the Superintendent's Designee in reviewing the Classification Board's recommendation.
- Superintendent Grant expressed to Deputy Superintendent for Classification Anderson, his desire to transfer Inmate Geoghan to the SHU at SBCC.
- Director of Classification DiNardo told Deputy Superintendent for Classification Anderson, that she would not reverse the recommendation of the Classification Board and that Deputy Superintendent Anderson would have to reverse it if it were to be reversed, to which Deputy Superintendent Anderson replied that he had already assumed the role of "Superintendent's Designee" and reversed the Board's recommendation.

On February 24, 2003, having reviewed the two recent disciplinary reports, Deputy Superintendent for Classification Anderson, citing Inmate Geoghan's "overall poor adjustment in Level 4 security, [and] receipt of two additional disciplinary reports since [his] review [by the Board]" reversed the Board's recommendation for Inmate Geoghan to remain in the SHU at MCI Concord and recommended to Commissioner's designee Cresey that Inmate Geoghan be designated Level 6 and transferred to the SHU at SBCC. In reversing the Classification Board's recommendation, Deputy Superintendent Anderson did not seek out or consult with any members of the Classification Board.

On or about February 28, 2003, Inmate Geoghan appealed Superintendent Designee Anderson's recommendation to transfer him to the SHU at SBCC noting in his appeal "no penalties [were] imposed with [the two recent] disciplinary reports [and that he was a] model prisoner and [had] problems with only C.O. Bisazza and associates." On March 24, 2003, Inmate Geoghan sent a letter to the Commissioner asking for the Commissioner's help in overturning the Deputy Superintendent's recommendation to transfer him to the SHU at SBCC.

On March 28, 2003, Deputy Superintendent for Classification Anderson denied, without explanation, Inmate Geoghan's appeal to remain in the SHU at MCI Concord. On that same day, as the Commissioner's designee, Acting Deputy Director of Classification Cresey approved the transfer of Inmate Geoghan from MCI Concord to the SHU at SBCC as a Level 6 inmate.

On April 1, 2003, Inmate Geoghan was transferred from the SHU at MCI Concord to the SHU at SBCC. On April 3, 2003, Inmate Geoghan's letter to the Commissioner dated March 24, 2003, arrived in the Commissioner's office. On June 16, 2003, Acting Deputy Director of Classification Cresey, in the capacity of the Commissioner's designee denied, without comment, Inmate Geoghan's appeal of the recommendation to transfer him to SBCC.

Classification Conclusion No. 1:

Based on extensive interviews with staff involved in the process that led to Inmate Geoghan's transfer, study of relevant documents and reports, and analysis of the events, several conclusions are reached. They are:

1. Having a staff member, who makes either a classification recommendation or a classification decision and then reviews the appeal of that recommendation or decision, negates the legitimacy and credibility of the appeals process. The appellate process has no merit if inmates are transferred while awaiting the outcome of an appeal.
2. The Classification Board's recommendation for Inmate Geoghan to remain in the SHU at MCI Concord should have been affirmed by both the Superintendent's Designee and by the Commissioner's Designee. The relatively minor nature of the two intervening disciplinary reports did not rise to a level to warrant increasing Inmate Geoghan's custody level and placing him in a SHU with inmates of a higher custody level.

3. Although some of the staff that were interviewed, concluded that Inmate Geoghan's receipt of two additional disciplinary reports immediately after the Classification Board recommended he remain at MCI Concord was other than coincidental and that it was purposeful behavior aimed at getting him transferred, it is difficult to concur with that conclusion. It could have been coincidental in that the interactions between Inmate Geoghan and the two officers in the SHU were consistent with their behaviors on several earlier occasions.
4. The Superintendent's interjection of himself into the recommendation and review process appears to be unusually intrusive and out of the ordinary; given what appears to be the normal hands-off role of the Superintendent in these processes. While some might conclude that he was merely exercising the professional prerogative of the Superintendent with regard to a high profile inmate, others allude to the influence of forces outside the normal process [DOC employees and/or MCOFU representatives] that resulted in the Superintendent pushing for a recommendation to transfer Inmate Geoghan. There is, however, no evidence that anyone exerted pressure on the Superintendent to intercede directly in the process, and therefore it was concluded that based on what he knew of Inmate Geoghan's behavior at MCI Concord, he interjected himself because he thought the new SHU at SBCC was the more appropriate placement for Inmate Geoghan.
5. On the other hand, we do conclude that Superintendent Grant should not have directed the Deputy Superintendent Anderson to reverse the Classification Board's recommendation and that the Deputy Superintendent should only have passed on the Superintendent's direction to the Director of Classification DiNardo and not have designated himself as the Superintendent's Designee, even though he had served in this capacity on a periodic basis. Rather, Superintendent Grant and Deputy Superintendent Anderson should have permitted the review process to proceed normally according to MCI Concord procedures and Department policy. In this instance it would have meant that MCI Concord's Director of Classification DiNardo would have conducted the review of the Classification Board's recommendation, and given that contemporaneously she expressed strong support for the Classification

Board's recommendation she would have concurred with it and that might have been the end of the matter. This is because it would not have gone on to the Commissioner's Designee since no change in status was being recommended. At that point, the Superintendent could have either expressed his concerns and thoughts directly to the Director of Classification, or to the Commissioner's Designee, or to both of them. In any event, it is difficult to determine what impact any of those events might have had. However, it is likely that had the Superintendent expressed his concerns about Inmate Geoghan's continued presence in the SHU at MCI Concord directly to the Commissioner's Designee Cresey, that those concerns would have been given considerable weight.

6. The review process that is followed by the Department in making classification and re-classification decisions does not provide opportunity for staff to learn from the process to the extent to which they might. Absent formal feedback from the reviewer, the Board members are left to guess at why their recommendation was reversed. As a consequence, they learn little from the experience, and are more likely to repeat a pattern of thought that runs counter to policy or expectation.
7. Members of Classification Boards do not receive specific and sufficient formal training in how to perform their roles and carry out their responsibilities. While the person who Chairs the Board does receive formal training and is certified to perform this role, there is no similar requirement for the two other members of the Board. The lack of formal training puts them at a disadvantage and is more likely to result in less appropriate classification recommendations.
8. The selection of a correction officer to participate as a member of a Classification Board is done in different ways at different times in different facilities. In some cases, they work in the housing unit in which the inmate resides, while in other cases they have no prior knowledge of the inmate or his particular issues and situation. It is difficult to see how this latter type of person, through no fault of his/her own, can contribute meaningfully to the recommendation of the Board.

### Classification Finding No. 2:

The process used to make determinations regarding the classification of any inmate is found in the general policies and procedures of the Department of Correction. These guidelines are the same regardless of the inmate's situation or their special needs. While this type of classification process may work well in assessing and making decisions about inmates in the general population, they are not as appropriate when addressing the needs and concerns of inmates in categories, such as those with mental health issues or in protective custody, and administration segregation.

### Classification Conclusion No. 2:

Due to the unique and often complex nature of the situations surrounding inmates with protective custody needs, assessment and placement decisions need to be made based on a much broader range of inmate specific information.

For example, in this case, Inmate Druce was well known by Department of Correction authorities as a troubled, violent inmate with a documented hate for minorities, Jews and homosexuals. He was in prison for killing a person who was alleged to have made homosexual overtures to him. He was placed in a Special Housing Unit in a cell next to Inmate Geoghan, a man recognized by virtually everyone in the correctional system because of his conviction for the indecent sexual assault of a young boy and the constant media reports of the allegations that he abused many other young men.

During our interviews, virtually everyone we spoke to, who had anything to do with the classification of inmates, said they were surprised when they first heard that Druce and Geoghan were housed in the same unit. In non-segregation classifications an inmate is assigned to a facility and the personnel who direct that institution place him in a unit that they deem appropriate based on many factors including the individuals safety. In the case of inmates transferred to SHU's, they are sent there without sufficient regard or understanding of the impact their presence may have on other inmates within the unit.

Classification Finding No. 3:

One of the options available to the Department of Correction when deciding on where a high profile inmate should be confined is transfer to a federal, other state, or local jail. In the case of Inmate Druce, such consideration was done, and in fact, the decision was made to try and place him in a prison outside of Massachusetts. As a result, he was transferred early in his confinement first, to the Rhode Island Department of Corrections and then to the New Mexico Corrections Department. While neither placement was entirely successful, they were considered and accomplished. In Inmate Geoghan's case, however, it appears as though an out-of-state transfer was not considered. It might not have been considered because of the possibility that he might have to return to Massachusetts frequently to appear in court to face additional charges.

Classification Conclusion No. 3:

While the final determination might have been not to pursue an out-of-state placement for Inmate Geoghan, the acknowledged high profile nature of his sensational case warranted, at a minimum, serious consideration of this option. The fact that there is no evidence or documentation that such a placement was considered leads to the conclusion that all reasonable and appropriate placement alternatives were not thoroughly or thoughtfully explored. It is not inconceivable, that Inmate Geoghan could have been safely confined in another prison system.

Classification Finding No. 4:

Inmate Druce was serving a life sentence for murder. In his twelve years of incarceration he had proven to be an extremely difficult inmate to manage. Many corrections officials referred to him as a "system failure." Finding proper housing was extremely difficult because he had shown time and again that because of his racist, anti-Semitic, anti-gay beliefs he would be disruptive to other inmates and was likely to be assaultive. In addition he had a history of s [REDACTED] requiring hospitalization.

Classification Conclusion No. 4:

Inmate Druce would seem to be the type of inmate for whom the SHU at SBCC was created. He was properly classified as a Level 6 inmate and was in need of protection because he had a lengthy list of documented inmate enemies in the general population at the Commonwealth's two Level 6 facilities, Cedar Junction and the SBCC.

Inmate Druce created enemies wherever he went because of his personality and actions. The same held true when he was placed in the SBCC SHU population. He was involved in a fight with another inmate in the SHU and was sentenced to fifteen days in isolation. He was released and returned to the SHU on the day before he killed Inmate Geoghan.

The options available to the Department were very limited. While Inmate Druce might have remained at MCI Cedar Junction for a few weeks after his release from the DDU in order to decompress from four years in the DDU, where he had been confined to his cell for 23 hours a day, he would have had to been held in some sort of a restricted housing unit in order to keep him separated from his inmate enemies. That type of housing was not available at MCI Cedar Junction for other than a very short duration, which meant that had he not been transferred to SBCC when he was, he certainly would have been transferred there shortly thereafter. Given the options available to the Department, the SHU at SBCC was the preferred alternative.

Classification Finding No. 5:

Inmate Druce never had any contact with Inmate Geoghan until they he was transferred to SBCC on May 30, 2003, and based on Druce's telephone conversations, there is also no reason to think that he knew Inmate Geoghan was at SBCC prior to his arrival on the SHU on that same day.

Neither interviews with inmates in the SBCC SHU, nor study of records and reports, nor information from any person interviewed produced any evidence that Inmate Druce talked with anyone about his intentions to kill Inmate Geoghan. Further, statements made by Inmate Druce to law enforcement officers conducting the murder investigation indicated that he acted solely on his own.



Classification Conclusion No. 5:

Inmate Druce acted on his own and there is no reason to conclude that anyone knew of his plans to kill Inmate Geoghan until after the fact. Inmate Geoghan died as the result of a lone individual's actions.

Classification Finding No. 6:

While confined in the DDU, statements made by Inmate Druce about his hatred of homosexuals were documented by the MCI Cedar Junction Chaplain in a memo he wrote on October 19, 2001, which was placed in Inmate Druce's six-part file. Such statements appear to be consistent with many other statements he made about harming other individuals, including other inmates, and even the President of the United States. He was certainly viewed as a person capable of hurting and murdering others, and in fact was in prison as a result of a homicide.

Classification Conclusion No. 6:

Clearly at the time the decision was made, everyone involved in the process thought it was the best option of all options available to them. After the fact, most Department officials believed that it was the proper decision. Had we been involved in the decision-making process at the time it was being discussed, we would have concurred with the Department's decision to transfer Inmate Druce to the SHU at SBCC.

Classification Finding No. 7:

In 1999, while confined to the DDU at MCI Cedar Junction, Inmate Darrin Smiledge petitioned the Norfolk Probate Court to have his name legally changed to Joseph Lee Druce. He gave as a rationale that there were safety issues that necessitated him adopting a new name. The request for a name change went uncontested. After the Court granted the request, Inmate Smiledge notified Correction Administrators and he was thereafter known in the correctional system as Joseph Druce.

Classification Conclusion No. 7:

The Panel found that while an inmate has the constitutional right to change his name, the Department of Correction has to devise a way to make their personnel aware that the change has taken place. Furthermore, this information must be highlighted and made prominent in all Department of Correction files from that day forward, so that months or years later the information is still known.

In this case, when Correction Employees were interviewed about the murder of Inmate Geoghan, the great majority of them said that when they were told that the assailant was Inmate Druce that the name meant nothing to them, but when they learned that it was really Inmate Smiledge they immediately recognized the name and knew of his reputation as a management problem within the Department. They added that when they learned it was Darrin Smiledge they were not surprised at all because he was so well known throughout the system for his violent and aberrant behavior.

## **STAFFING AND OPERATIONS FINDINGS AND CONCLUSIONS**

### **Staffing and Operations Finding No. 1:**

The daily activities of the SHU's are based in large measure on the provisions contained in the court's order in *Blaney*. Department policy and institutional procedures and post orders for the operation of the SHU's at both MCI Concord and SBCC liberally incorporated the language contained in the court's order.

### **Staffing and Operations Conclusion No. 1:**

While well intended in its aim to correct past practices, the overly broad provisions of the order placed the Department in the unenviable position of having to run the SHU as if it were a general population housing unit. The very real reality is that the SHU is not just another general population housing unit. It is a very special housing unit, designated for the confinement of inmates who are at far greater risk of harm than any other group of inmates. As such, the Department needs to be able to implement procedures that take into account the need to keep prisoner safe within the unit itself. Specifically, group activities and group movement of prisoners should be limited to times when there is both an appropriate level of supervision and a legitimate correctional purpose for providing the group activity.

### **Staffing and Operations Finding No. 2:**

Although it does not appear as though any of the officers assigned to work in the SBCC SHU received any special orientation or training for their new assignments, at least two correction officers were specifically selected to work in the SHU because they had worked together in SBCC's Admission Unit, L2.

### **Staffing and Operations Conclusion No. 2:**

Because J-1 became SBCC's SHU, specifically designated for the confinement of inmates in protective custody status, it required skilled and experienced staff to operate it effectively. It was not just another housing unit. In many respects, it was more like the Special Management Unit (SMU) than any other unit at SBCC. As a consequence, its operation warranted special attention from supervisors and managers, and its staff

required orientation to the type of inmates to be confined in the unit and training in how and why the unit was to be run. The same holds true for the SHU at MCI Concord.

Staffing and Operations Finding No. 3:

Moreover, a few officers worked in the SBCC SHU, particularly on weekends, although J-1 was not their regularly assigned post. This was the case on the day [Saturday, August 23, 2003] that Inmate Druce murdered Inmate Geoghan. On the 7:00 a.m. – 3:00 p.m. shift that day, both officers working in J-1 were in that unit because they had “swapped” assignments with the two officers who were assigned to work J-1 on the shift that day. In fact, they had regularly “swapped” assignments, resulting in them having worked many weekends in J-1 since it opened on February 10, 2003. The practice of “swapping” assignments is a regular practice both at SBCC and other Department of Correction institutions and is authorized and regulated in accordance with a memorandum of understanding between the Department of Correction and MCOFU that was ratified on January 1, 2001.

Staffing and Operations Conclusion No. 3:

One of the major benefits of “swapping” for the officers is that it provides an officer with four days off per week, because they can work two shifts on two days, and one shift on the third day. On the other hand, it could also work to the detriment of the institution, if the officer who replaces the regularly assigned officer is not as skilled or well trained as the person being replaced. This situation is of particular concern if the post in question provides coverage in a sensitive area. In this instance, however, because both officers had worked J-1 on regular “swap” basis, it would seem as though the two officers on duty at the time of Inmate Geoghan’s death should have acquired sufficient experience and knowledge in how to run the unit properly.

Staffing and Operations Finding No. 4:

Protective Custody Units within the Department of Correction are designated as Special Housing Units (SHU's). For a number of years the Department operated a single protective custody unit at MCI Concord, a security level 4 facility. In early 2003, the Department opened a second protective custody unit (SHU) at SBCC, a security level 6 facility.

The inmates in these units require protection from harm to a degree far greater than inmates within the general population of prisoners. The reasons they require such additional protection may vary among them, but in all instances the Department has concluded that there are valid reasons for providing additional measures to ensure their safety.

The reasons they require protection may be because of threats that can be attributed to specific prisoners, or staff may have concluded that there is a significant general dislike of an inmate that could result in harm coming to him, that cannot be attributed to any specific prisoner, to warrant placement in the SHU. Inmate Druce exemplifies the first type of prisoner, while Inmate Geoghan falls into the latter category.

The type of inmate in protective custody status can be further characterized by custody level. There are high custody levels (Level 6) and lower custody levels (Level 4). Inmate Druce was a Level 6 inmate, and Inmate Geoghan was a Level 4 inmate.

Applying each of these two dimensions – custody level (high or lower) and threat (known or unknown) – produces four types of proactive custody inmates. They are: (1) Inmates, like Druce, who are in the high custody classification status and who have known enemies; (2) there are inmates in lower custody status, with unknown enemies; (3) there are inmates in high custody status with unknown enemies; and (4) there are inmates, like Inmate Geoghan, in lower custody status with unknown enemies.

Staffing and Operations Conclusion No. 4:

While all four types of prisoners require separation from the general population of prisoners, care must also be given in their housing assignments to ensure that a prisoner within an SHU is not likely to harm another prisoner in the same SHU. One way to do this is by separating prisoners with different custody levels. In general, the higher the classification level the more dangerous and disruptive the prisoner is. When the Department created the second SHU at SBCC, a level 6 facility, it did so because it recognized that not all inmates in need of protection were the same and that some were very disruptive and dangerous, even though they also required protection from other inmates. Thus, the Department created the second SHU for the confinement of level 6 inmates, while retaining the level 4 SHU at MCI Concord.

In the case of Inmate Geoghan, just prior to his transfer to SBCC, he was "labeled" a level 6 inmate by Deputy Superintendent Anderson, at MCI Concord even though the Classification Board recommended he remain a level 4 inmate. It is the Panel's opinion that he should have remained as a level 4 inmate, and as such should not have been assigned to a level 6 SHU, where he would come in contact with level 6 inmates.

Indeed, these protective custody housing units are "special" units. They are "special" because of the unique nature and circumstances of the inmates assigned to them. Just as Special Management Units (SMU's) in which the more difficult to manage inmates are confined because of their disruptive behavior demand special and uniquely tailored procedures, so do the inmates assigned to the SHU's. They must be protected not only from harm from prisoners outside the SHU, they must also be protected from harm from other inmates within the SHU. This important second objective is more easily met when level 6 inmates are not mixed with level 4 inmates in a SHU.

Staffing and Operations Finding No. 5:

Post Order 13 for Post Assignment J-1 Housing Unit Officer does not specify the number of inmates that the housing unit officer should let out of their cells at one time to pick up their food trays before returning to their cells to eat their meals. Neither do the Post Orders specify how many inmates should be let out of their cells to return their food trays to the food cart.

Staffing and Operations Conclusion No. 5:

The lack of specificity permits more inmates to be released at one time than a single officer can effectively observe and supervise. As a consequence, inmates may take advantage of this weakness to conduct rule-breaking activities undetected. Inmates in Protective Custody status warrant constant supervision when not confined to their cells.

Staffing and Operations Finding No. 6:

Two officers are assigned to J-1 the Special Housing Unit (SHU) that confines inmates in Protective Custody status. While the Daily Shift Roster lists and assigns officers to both a "primary" and a "secondary" post, no distinction is made in their duties and responsibilities. One set of post orders is written for any officer assigned to J-1.

Staffing and Operations Conclusion No. 6:

The lack of specific and distinct post orders for each of the two posts results in a lack of clarity of duty for each, leaving it up to the individual officers to determine who is to perform what function. Similarly, it results in unclear lines of authority within the unit with regard to who is in charge.

Staffing and Operations Finding No. 7:

At the noon meal on August 23, 2003, in J-1, one inmate told investigators that he had another inmate return his lunch tray from his cell to the food cart.

Staffing and Operations Conclusion No. 7:

This practice is in violation of unit rules and is expressly prohibited in the J-1 officer's Post Orders – Special Instructions. With just one officer in J-1 at that time, it is easy to see how this type of inmate behavior could easily go undetected by the single officer remaining in the unit.

Staffing and Operations Finding No. 8:

On August 23, 2003, after Correction Officer [REDACTED] directed the inmates to return to their cells to be locked in after they returned their noon meal food trays, he did not, "physically check each cell door to ensure the cell door is secured and the locking mechanism engaged," as prescribed in the J-1 officer's Post Orders – Special Instructions. Similarly, the officer(s) failed to check the cell doors after the inmates were locked in their cells to eat their noon meal. The Special Instruction Post Orders contains a second directive, reinforcing the importance of this practice. It prescribes that, "You shall make a security round of the unit to observe each inmate within the unit after inmates are secured at the completion of any movement period." Rather than conducting rounds to check on the security of the cell doors, and the well-being of the inmates, the officer went into a room behind the unit officer's station, making it impossible to observe the unit itself, and difficult if not impossible to hear sounds coming from within the cells.

Staffing and Operations Conclusion No. 8:

This element of the post order is important not only for the reason stated in the post order, but also because it provides an important way to check on the safety and well being of each inmate in the housing unit. This is particularly important in a housing unit in which inmates in protective custody status are assigned. Had rounds been made immediately following lock-in, shortly after 1152 hours, the officer would have quickly discovered that Inmate Druce was in Inmate Geoghan's cell, rather than having it called to his attention at 1157 hours by the two inmates who were out of their cells, unsupervised, cleaning up the unit after the noon meal.



Staffing and Operations Finding No. 9:

One of the two correction officers assigned to the SBCC SHU on both the 7:00 a.m. – 3:00 p.m. shift and on the 3:00 p.m. – 11:00 p.m. shift, are regularly and frequently “pulled” from the SHU to assist other staff in supervising the movement of general population inmates, as they move along the corridors and stairwells to and from their housing units to participate in activities, including meals and recreation within the prison. [According to SBCC’s administrators the practice of “pulling” officers from their assigned posts has to be done because there are not enough staff available to assign officers on a “normal” basis to these areas.] Neither the general post orders for J-1 nor the J-1 Special Instructions Post Orders provide for this task to be carried out by J-1 officers.

The practice of pulling officers from housing units for this purpose is a longstanding and ongoing practice at SBCC. One officer who regularly worked in J-1 estimated that the second officer could be gone from the unit for as long as three hours per eight-hour shift. On August 23, 2003, the second officer left J-1 at approximately 1140 hours, leaving the one officer in the unit with 24 inmates locked in their cells and two outside their cells. [See J-1 Operator Action History Log.] While the second officer was still absent from the unit, the remaining officer let the 24 inmates out of their cells so that they could return their food trays to the food cart, and sign up for afternoon activities. The second officer did not return to J-1 until just after the lone officer in J-1 gave the call for assistance at 1157 hours.

Staffing and Operations Conclusion No. 9:

Two officers should always be on duty within J-1 when one or more inmates are out of their cells. The inmates in J-1 have been designated as requiring special attention by virtue of their protective custody status. That includes enhanced supervision and observation, greater than provided for inmates within the general population. The size and physical layout of the housing unit reinforces the need for two officers to be on duty when the inmates are out of their cells. Should all of the inmates be confined in their cells, one of the officers may be temporarily and briefly detailed to assist other staff

elsewhere in the prison. During the time that one officer is away from the unit, the remaining officer should constantly patrol the unit.

Staffing and Operations Finding No. 10:

On August 23, 2003, 26 inmates lived in the Special Housing Unit (J-1) at SBCC. Before being assigned to J-1, they were residing several different prisons, including SBCC, where nine of the inmates were assigned to one or more of several other housing units within SBCC. Those nine inmates had arrived from five different Massachusetts Department of Correction facilities, including MCI Concord (3), MCI Cedar Junction (2), OCCC (1), MCI Norfolk (1), and MCI Shirley (2). They had spent anywhere from several weeks to several years at SBCC before being assigned to J-1 after it opened on February 10, 2003, as the SHU for Protective Custody inmates. From a review of their records, it was not entirely clear as to when seven of the nine inmates were actually placed in J-1. The two inmates for whom it could be ascertained when they were placed in J-1 records indicated that they were assigned on May 18, 2003, and July 23, 2003.

Of the remaining 17 inmates, seven were transferred from MCI Cedar Junction, three from OCCC, two from BSH, three from MCI Concord, one from MCI Shirley, and one from a facility other than operated by the Massachusetts Department of Correction. The first of the 17 inmates was assigned to J-1 on February 12, 2003 and the last on August 19, 2003.

Of the three direct placement inmates who arrived from MCI Concord, Inmate Geoghan was the second. He was assigned to J-1 on April 1, 2003. The first inmate from MCI Concord arrived on February 27, 2003. He had been residing in MCI Concord's SHU in Protective Custody status. The third inmate also had been residing in MCI Concord's SHU prior to arriving at SBCC on April 28, 2003.

Inmate Druce arrived on May 27, 2003, the fourth of the seven direct placement inmates from MCI Cedar Junction. The first of these seven inmates arrived on February 14, 2003, and the last on August 19, 2003.

Staffing and Operations Conclusion No. 10:

The inmates assigned to the SHU at SBCC included many who came from institutions other than MCI Cedar Junction. It provided a placement option for inmates throughout the Department, most of whom, but not all of whom were Level 6 inmates. While the SHU had a maximum capacity of 64 inmates, its population never exceeded 30 inmates leading to a conclusion that the need for this type of a unit was either over estimated, or under utilized.

Staffing and Operations Finding No. 11:

Department of Correction staff provided a range of explanations as to how, for whom, and why a second Special Housing Unit for inmates in Protective Custody status was established at SBCC. The Department's intent was aimed at addressing concerns at MCI Cedar Junction where a number of Level 6 inmates could no longer be legitimately confined in segregation or disciplinary status, but at the same time because they had inmate enemies and could not be placed in the general population of a Level 6 facility. Based on the *Blaney* decision and the more recently decided *Haverty* case, the Department was obligated to provide inmates in protective custody status with programming similar to inmates in the general population of that same security level. In early November of 2002, Commissioner Michael Maloney directed the establishment of a Special Housing Unit at SBCC for Level 6 protective custody inmates. A memorandum from Deputy Commissioner Kathleen Dennehy dated November 4, 2002, memorializes the task that had been assigned to an Assistant Deputy Commissioner and a small team of Central Office staff who were to be responsible for developing a plan to establish a protective custody unit at SBCC. No memoranda or report was prepared that described the plan or the planning process that was employed.

Subsequently, to guide the operation of the SHU, staff at SBCC prepared written procedures, based on the Department policy, which, in turn, had been based on the requirements prescribed in *Blaney*. SBCC Superintendent Ficco completed that procedural document on January 29, 2003, and submitted it to the Central Office for review and approval. On March 13, 2003, the Director of the Department's Policy

Development and Compliance Unit (PDCU) approved the previously submitted procedures.

A fourteen-page set of specific instruction post orders for correction officers working in J-1 were approved by SBCC Director of Security Ed Williams on February 14, 2003, along with a four-page schedule of J-1 activities and the tasks to be performed by correction officers with regard to them. These post orders were placed in J-1 for correction officers to read and acknowledge that they had read them each time they were assigned to the unit.

Staffing and Operations Conclusion No. 11:

The role of the SHU at SBCC was to provide secure confinement and appropriate programming for Level 6 inmates. The availability of the SHU at SBCC would permit the Department to transfer from MCI Cedar Junction Level 6 inmates who had completed their disciplinary or administrative segregation, restrictive confinement periods, but who could not be placed in a general population to participate in available programming opportunities. As a result, the Department would be able to provide programming for those inmates in a secure setting, while also complying with the law as prescribed in both *Blaney* and *Haverty*.

Subsequently, several inmates were transferred from MCI Cedar Junction to the SHU at SBCC, others, including Inmate Geoghan, arrived from other prisons. While the rationale behind the establishment of the SHU at SBCC was clear to those who were directly involved in its creation, it was not as clear to other staff, in particular many individuals at MCI Concord. MCI Concord is a Level 4 facility and the SHU within it is therefore a Level 4 SHU – that is, the protective custody inmates confined in it should not and are not to be classified at a level higher than Level 4. Once the Level 6 SHU at SBCC was opened, some staff viewed it as just another SHU, identical to the SHU at MCI Concord into which any inmate in need of protective custody might be placed. Following this line of reasoning, the population of the SHU at MCI Concord might be reduced in number by transferring inmates laterally to the SHU at SBCC.

Other staff thought the SHU at SBCC was intended solely for Level 6 inmates and therefore, quite different from the Level 4 SHU at MCI Concord. No one we interviewed thought it was created exclusively for addressing the needs and requirements of Level 6 inmates solely from MCI Cedar Junction. However, it was clear that every inmate who was to be placed in the SHU at SBCC had to be classified or re-classified as a Level 6 inmate prior to their transfer/placement. Other than the requirement that an inmate be a Level 6 inmate, and required protection from another inmate(s), identifiable or unknown, there did not appear to be any other transfer/placement criteria to apply in the recommendation and decision making process.

Staffing and Operations Finding No. 12:

The ability of staff to open any of the cell doors in the SBCC SHU can be easily compromised by an inmate inside a cell by an inserting object(s) in the door jam, to prevent the door from sliding to the open position when activated electronically by the officer via the touch-screen monitor. This structural flaw, in the ability to jam the cell door was known by the inmates and correctional staff. It was the Panel's opinion that Inmate Druce knew he could thwart the staff's ability to open Inmate Geoghan's cell door, should he be discovered in Inmate Geoghan's cell before he had the opportunity to kill Inmate Geoghan and thus, planned his murder of Inmate Geoghan accordingly.

Staffing and Operations Conclusion No. 12:

SBCC staff were aware that inmates could prevent the cell doors from opening at SBCC by jamming them. The Department had taken steps to reduce the risk of adverse consequences to such situations by fabricating a tool, which was used in the past to remove objects inserted by inmates. Since the Inmate Geoghan homicide, the Department of Correction has triaged this problem in an effort to find a solution to prevent or limit the ability of inmates to jam the cell doors. Specifically, the SBCC Locksmith has welded a plate on the upper track portion of a test cell door, within the SBCC SMU and it appears likely to prevent the jamming of this area of the cells doors in the future. However, no remedy or fix has been identified for the lower track.

The Investigative Team contacted Detection Devise Systems (DDS), the manufacturer of the cell doors at SBCC. DDS stated, that although they were aware of the jamming of the cell door at SBCC relative to the Inmate Geoghan homicide, they described this incident as isolated, noting they had no knowledge of similar incidents nationwide. DDS stated there are currently no recalls or recommended retrofits to the cell doors at SBCC, nor does it appear likely for any such plans.

Normally, when an inmate locks himself in his cell, it does not create a serious security problem or a safety issue. The inmate is not going to go anywhere, and therefore, staff normally have time to plan and implement an appropriate course of corrective action. It only becomes an urgent matter if the inmate in the cell is trying to harm himself or if, as in the case of Inmates Druce and Geoghan, an inmate other than the one who resides in the cell, is also in the cell to harm or kill the resident inmate. In this instance, it took slightly more than six minutes to open Inmate Geoghan's cell door, using a Halligan tool, after he had been in Inmate Geoghan's cell unnoticed by staff for approximately five and a half minutes.

Staffing and Operations Finding No. 13:

The Department of Correction requires that correction officers in uniform properly display their nametags.

Staffing and Operations Conclusion No. 13:

During the course of this investigation, the Panel observed that correction officers at the Souza Baranowski Correction Center consistently were in compliance with this directive. Conversely, nametags of correction officers at MCI Concord were conspicuously absent.

Staffing and Operations Finding No. 14:

During the course of this investigation, Department of Correction Staff cooperated with the Investigative Team complying with interview requests, except for Correction Officer Charles Haley, who refused to be interviewed.



# **SECTION E**

## **RECOMMENDATIONS**



## RECOMMENDATIONS

### Discipline Reports:

- It is recommended that the Department of Correction provide specific training and guidelines for the manner that Disciplinary reports are to be issued. The post order already requires that a Lieutenant be notified when a Disciplinary report is to be issued. However, we did not see this requirement in practice. This oversight should be made mandatory, and a necessary inclusion before the Captain signs off.
- All supervisory personnel- should critically review – disciplinary reports for compliance with post orders and make a qualitative assessment.
- There should be a central repository for disciplinary reports so that management can monitor any patterns that may be emerging.
- The correction officer who issued the Disciplinary reports should be informed of the outcome, so that he/she can benefit and learn from this feedback.
- The Department of Correction should evaluate the role of the Disciplinary Officer, specific to their rank, assignment and chain of command. Consideration should be given to have centralized oversight of the disciplinary function.

### Special Housing Unit: Assignment of Staff:

- The Department of Correction should consider uniformity in the assignment of personnel to the SHU blocks. At the Concord SHU J-4, the assignment is a biddable job, while at SBCC SHU J-1, officers are assigned on the basis of administrative selection. A Special Housing Unit by its own descriptive title suggests special requirements. The SHU inmates in fact do have special needs, often accompanied by mental health issues. It stands to reason that Correction Officers chosen to manage these inmates be specially selected, and receive specialized training.

### Staff Briefing / New Inmates on Housing Unit:

- From interviews it was learned that Correction Officers are not made aware of the past history of inmates who arrive on their housing unit. There is a definite benefit in staff having knowledge of an inmate's history in the Department of Correction. Supervisory correction officers should review an inmate's six-part folder and brief the

Housing Unit Officers as to any special needs, requirements, or causes necessitating extra vigilance or care.

Investigations:

- There should be more supervisory oversight and guidance in the area of investigations. More training should be provided to all entities whose function is to perform investigations. Best practices should be employed. Complete and impartial investigations are necessary for meaningful results. All available evidence should be examined and preserved and all potential witnesses should be interviewed. Attempts should be made to corroborate all statements. When these ideals are accomplished, then correction officers, inmates, and administrators can accept investigative conclusions with confidence, and remedial action will be more precise and meaningful.
- All inmate complaints should be documented and reported to an Internal Affairs Unit (IAU). This unit should be a centralized unit within the Office of Investigative Services (OIS). OIS should have functional control and oversight of all investigations throughout the Department of Correction. OIS will make a determination as to who will conduct specific investigations. A tracking number will be assigned by OIS and all investigations will be returned to OIS upon completion for final disposition. All complaints and investigations must be tracked and directly supervised by OIS. OIS must also be responsible for maintaining a database on all inmate complaints. The database must be analyzed for any patterns or trends.
- Each investigation needs to be complete and thorough, to include a supervisory review and authority before conclusion. All completed investigations must be filed in a central location maintained by OIS, with a copy to be kept locally. OIS should be responsible for any dissemination of investigative files and/or information regarding investigative files. The Department of Correction should look for best practices when developing policy, procedures and operational manuals for all its investigative units and entities.

- The Panel recommends that the Department of Correction re-open the investigation into the injuries sustained by Inmate Smiledge/Druce, while at MCI Cedar Junction on May 14, 1999.

#### Cell Door at SBCC SHU:

- The Department of Correction should correct the deficiency in the design of the cell doors in the SHU at SBCC. It is common knowledge amongst correction officers and inmates that the tracks can be jammed to prevent the door from opening. This is evidenced by the fact that the SBCC locksmith created specialized tools to clear the tracks when they are intentionally blocked. The manufacturer of the door should be compelled to fix this design flaw or, in the alternative, the Department of Correction must seek some failsafe means to prevent the jamming of this track at a minimum in the SHU and the SMU.
- The Department of Correction should explore equipment and technology that would enhance their ability to access cells in an expedient manner during various emergencies.

#### Classification:

- The people involved in the Classification process need more guidance and specialized training. The Department of Correction has to define the mission and goals of the classification process and those involved in the process must have a clear and complete understanding of the system and the role they play within it. For example, everyone involved in the classifying of inmates needs to be uniform in their understanding of the difference between the level 4 and level 6 SHU's. It is crucial that the Department of Correction is consistent with their classification of all inmates.
- The classifications' appeal process needs to be more objective. The same person who made the original decision should not hear an appeal. An individual with a fresh outlook and without prejudice should conduct the review. To have the same person, who made the decision hear the appeal, runs contrary to the reason for an appeal.
- The classification process should have input from mental health.

#### MCI Concord SHU:

- The location of the MCI Concord SHU (J-4) within the facility is not conducive to segregating protective custody inmates from the general population. The inmates at the MCI Concord SHU are exposed to general population inmates as they proceed to the dining hall, library, visiting room, gymnasium, and other activities. Presently, they share the same visiting room with the general population. They literally sit within several feet of these general population inmates. These practices are inconsistent with the purpose and definition of protective custody. Due to the limitations of the physical structure of the MCI Concord SHU, the Department of Correction might consider moving the level 4 SHU to a facility, which can afford the protective custody inmates with the security they need. If the decision is not to move the MCI Concord SHU, the Department of Correction should consider feeding the protective custody inmates within their block, similar to the method used at the SBCC SHU.

#### Inmates Legally Changing Names:

- The Investigation discovered confusion with regards to Inmate Druce/Smiledge name change. It is recommended that all records of inmates whose name is legally changed, have some form of an alert, highlight, alarm, or other means to flag the attention of Department of Correction staff as to the original identity and history of the inmate.
- The Department of Correction should file legislation regarding inmates changing their names while incarcerated. The legislation should prohibit inmates from legally changing their names, except for religious reasons.

#### SBCC Special Housing Unit: Limitations on Inmate Interaction:

- There should be a standing order in the Special Housing Unit at SBCC that limits the movement of inmates during mealtime. Allowing the inmates the freedom to mill around for a few minutes before returning to their cells would appear to be a slight courtesy that would engender good will between corrections staff and the inmates. Unfortunately, the benefit was abused and the consequences cost Inmate Geoghan his life. It is recommended that for the safety of the inmates and the protection of the

correction officers, that no more than five (5) inmates, at a time be allowed outside of their cells to pick-up or return their meal trays.

- The Department of Correction Administrator's should carefully consider the number of inmates within the SHU's, that are allowed out of their cells at one time. The Department should adopt and follow an acceptable staff to inmate ratio, which allows for the proper management, care, custody and control of Protective Custody inmates.

Special Housing Units: Department Oversight:

- There should be one individual in the Department of Correction Central Office tasked with the oversight of assigning inmates to both Special Housing Units. This person should have the right to veto transfer assignments if it appears that a move could endanger the health and safety of the inmate being transferred or one or more of the inmates currently housed in the unit. Currently, the Superintendents of both MCI Concord and the SBCC receive inmates to their Special Housing Units without benefit of official input. It is doubtful that if one person were responsible for all the Special Housing assignments they would have placed a known member of the Aryan Brotherhood and outspoken enemy to minorities, Jews and homosexuals, in the same unit as a person acknowledged by the Department to be a "high profile" inmate because of his conviction for the sexual abuse of young males.

Correction Officer Nametags:

- The Massachusetts Department of Correction Uniform Policy (103 DOC 224) specifically addresses the procedures for the wearing of regulation uniforms for the ranks of Correction Officer I, II, III, and Captain. In particular, section 224.01, Part I, Letter G, requires the officer's wear a "cloth embroidered Velcro nametag". It is recommended that the Department of Correction insure that all employees in these ranks are aware of this policy and conform to all of its sections. In particular, all officers must adhere to the segment regarding the wearing of nametags.

Blaney:

- The Department, through its legal counsel, should seek judicial review to the provisions of *Blaney*. In the interim to the extent possible, it should modify its SHU operational procedures to reduce the amount of contact that inmates in the SHU have with one another. This Panel recognizes the importance of inmates' rights as described in the *Blaney* decision; however the inmates' right to be safe and secure should prevail over all other rights.

Placement of Protective Custody Inmates:

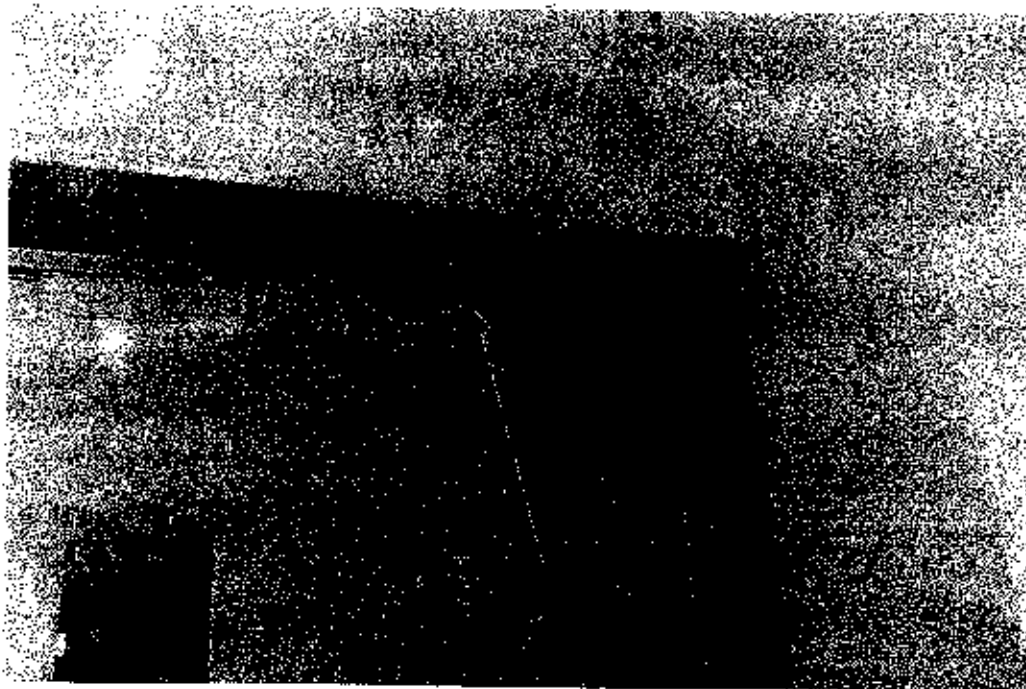
- The Department should ensure that only Level 6 inmates are assigned to the SHU at SBCC and that no Level 6 inmates are assigned to the SHU at MCI Concord.

Monitoring Facility Operations:

- The Department should re-assess the manner in which it determines that individual facilities are in compliance with policy, procedures, and post orders.

# **SECTION F**

## **PHOTOGRAPHS**

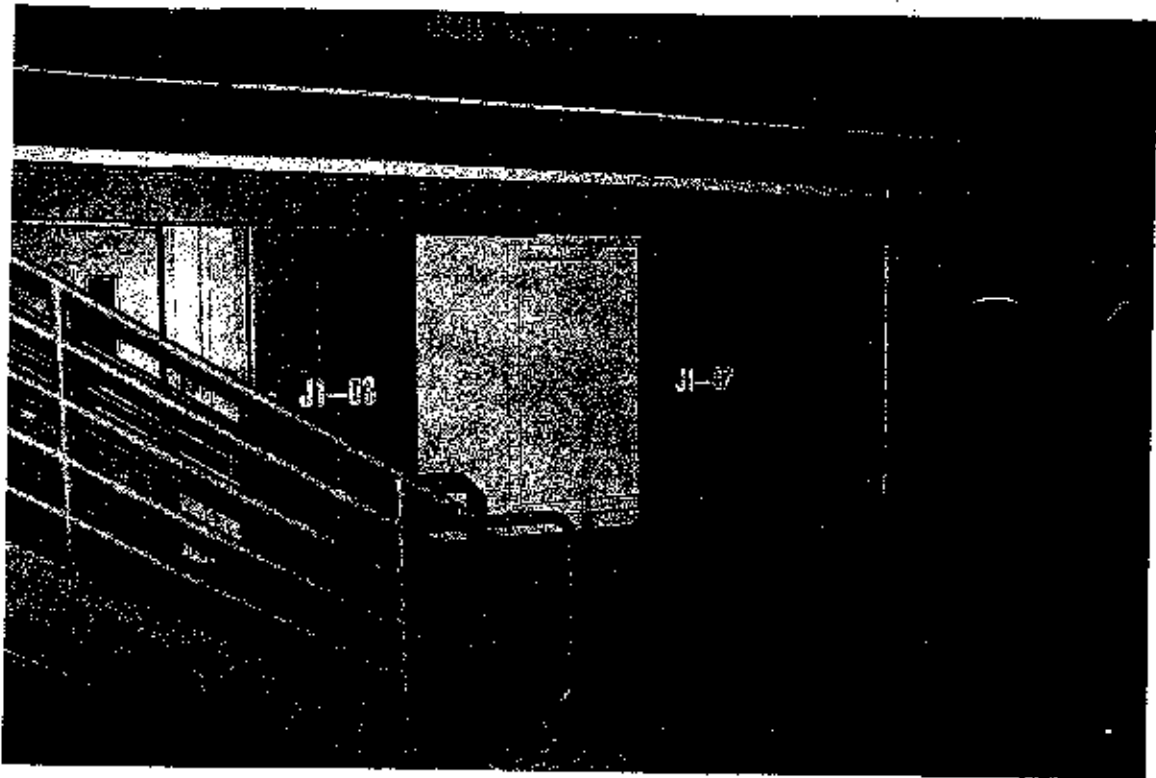


SBCC J-1 Interior of Cell 2 depicting upper track, which was jammed by Inmate Druce. Cell 2 was the cell occupied by Inmate John Geoghan.

{

SBCC J-1 Interior of Cell 2 depicting lower track which was jammed by Inmate Druce. Cell 2 was the cell occupied by Inmate John Geoghan.







SBCC J-1 Exterior view of Cell 2, the assigned cell of Inmate John Geoghan.



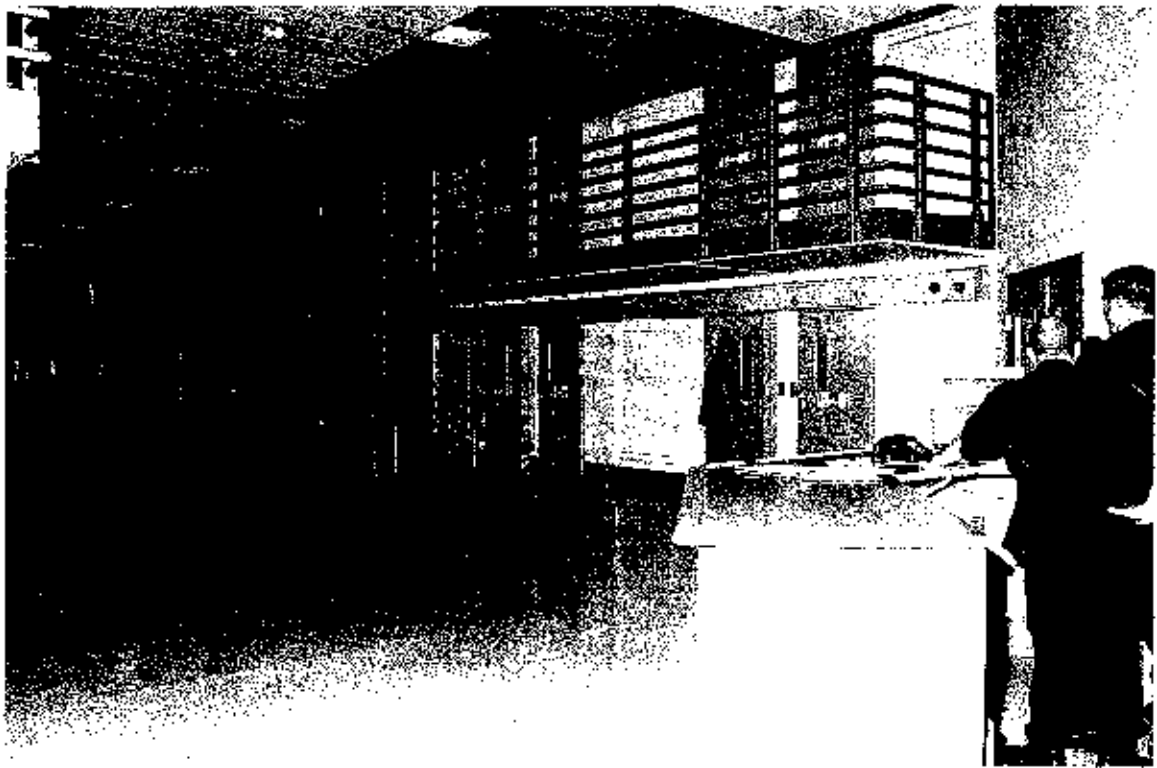
SBCC J-1 Special Housing Unit. Note the blue phones used by inmates.



The Halligan tool used to open the Cell 2 door.



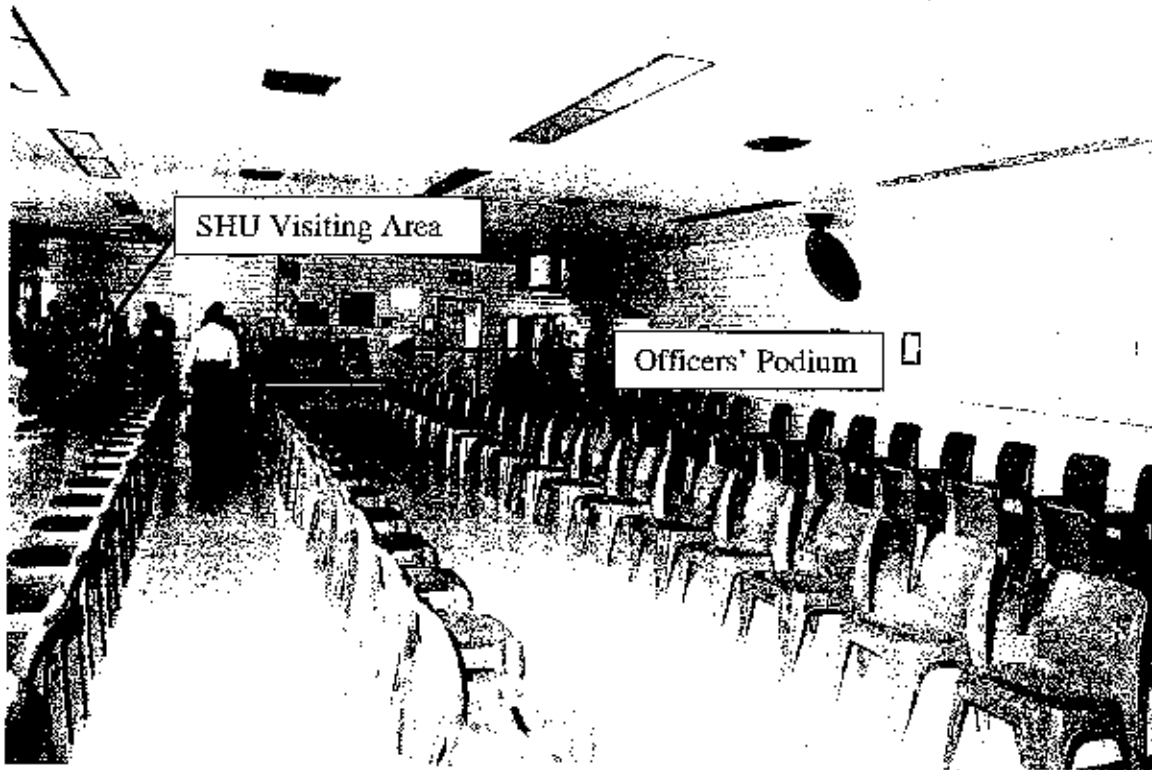
Assorted tools used to clear the tracks of jammed cell doors.



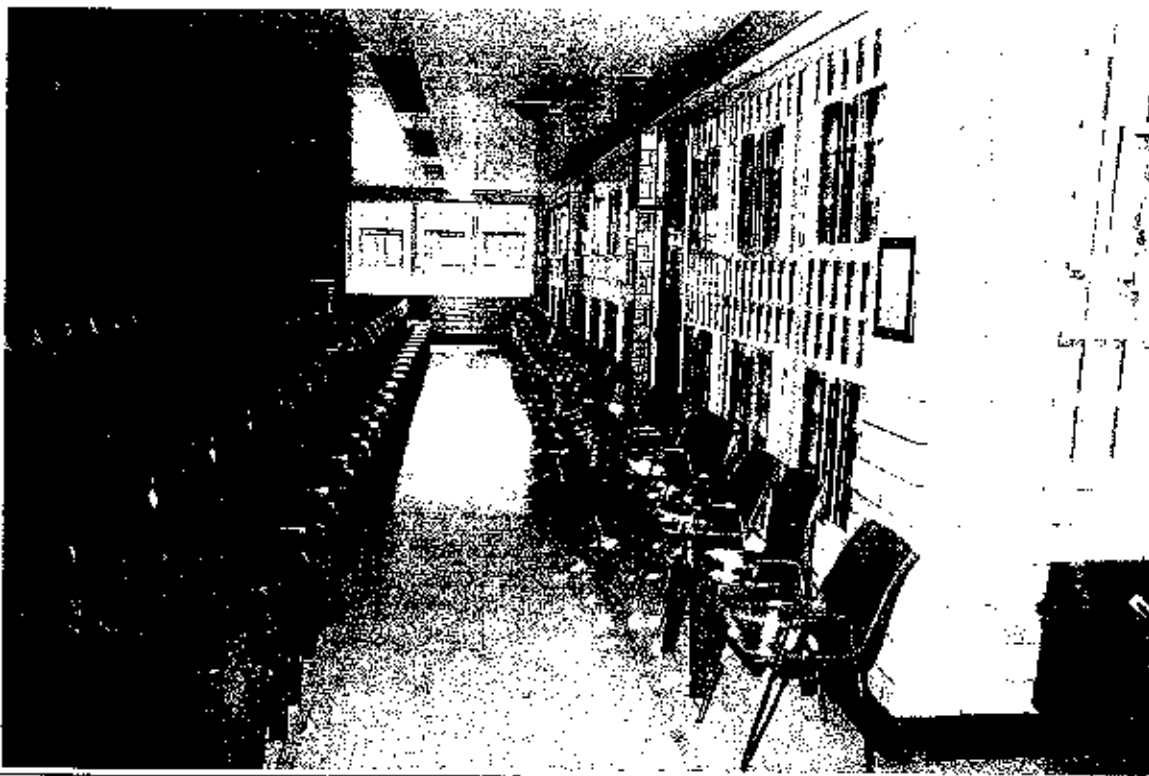
The Correction Officers' Podium at SBCC J-1.



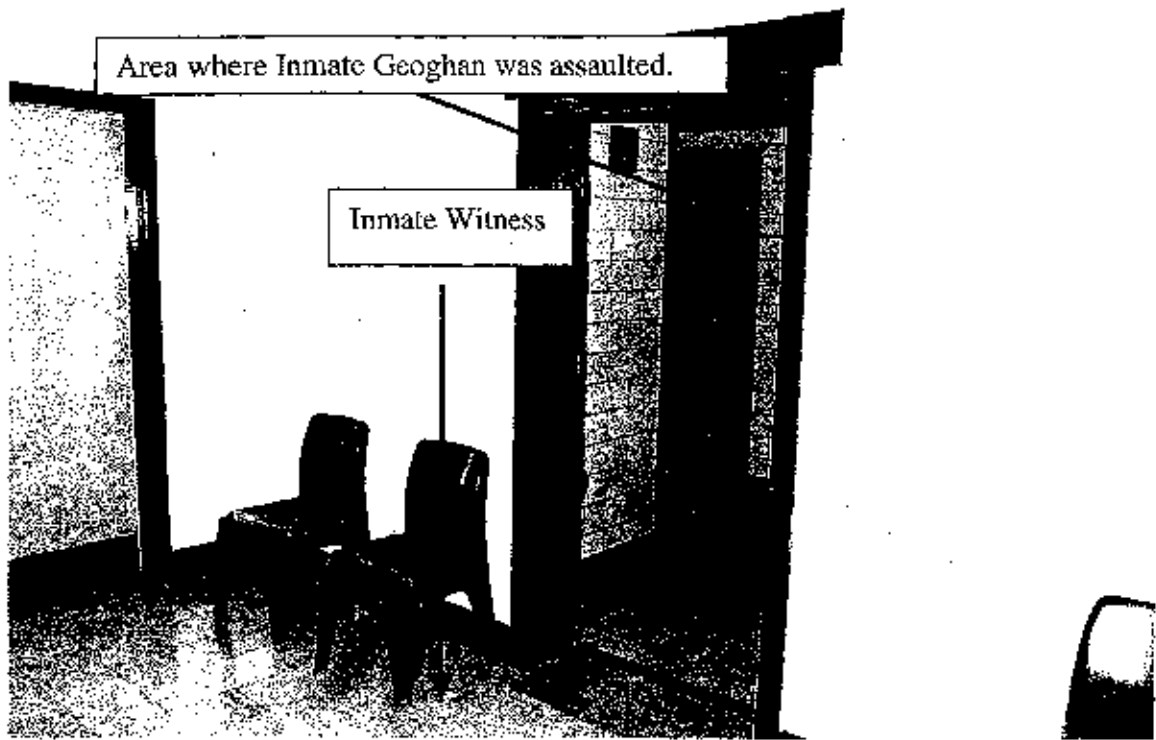
SBCC J-1 Correction Officers' Podium. Note the room Correction Officer Lonergan was located during the assault.



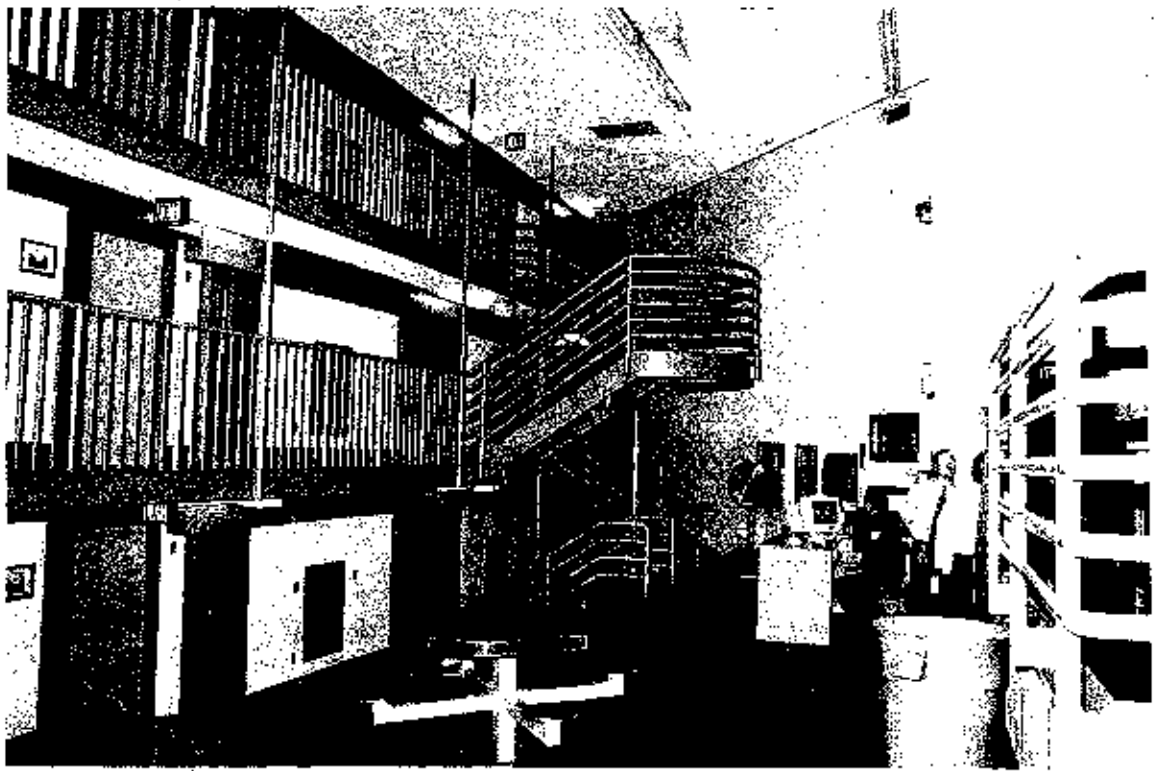
MCI Concord Visiting Room. Note Officers' Podium in the background. Note the SHU Inmate Visiting Area in the top left corner of the picture.



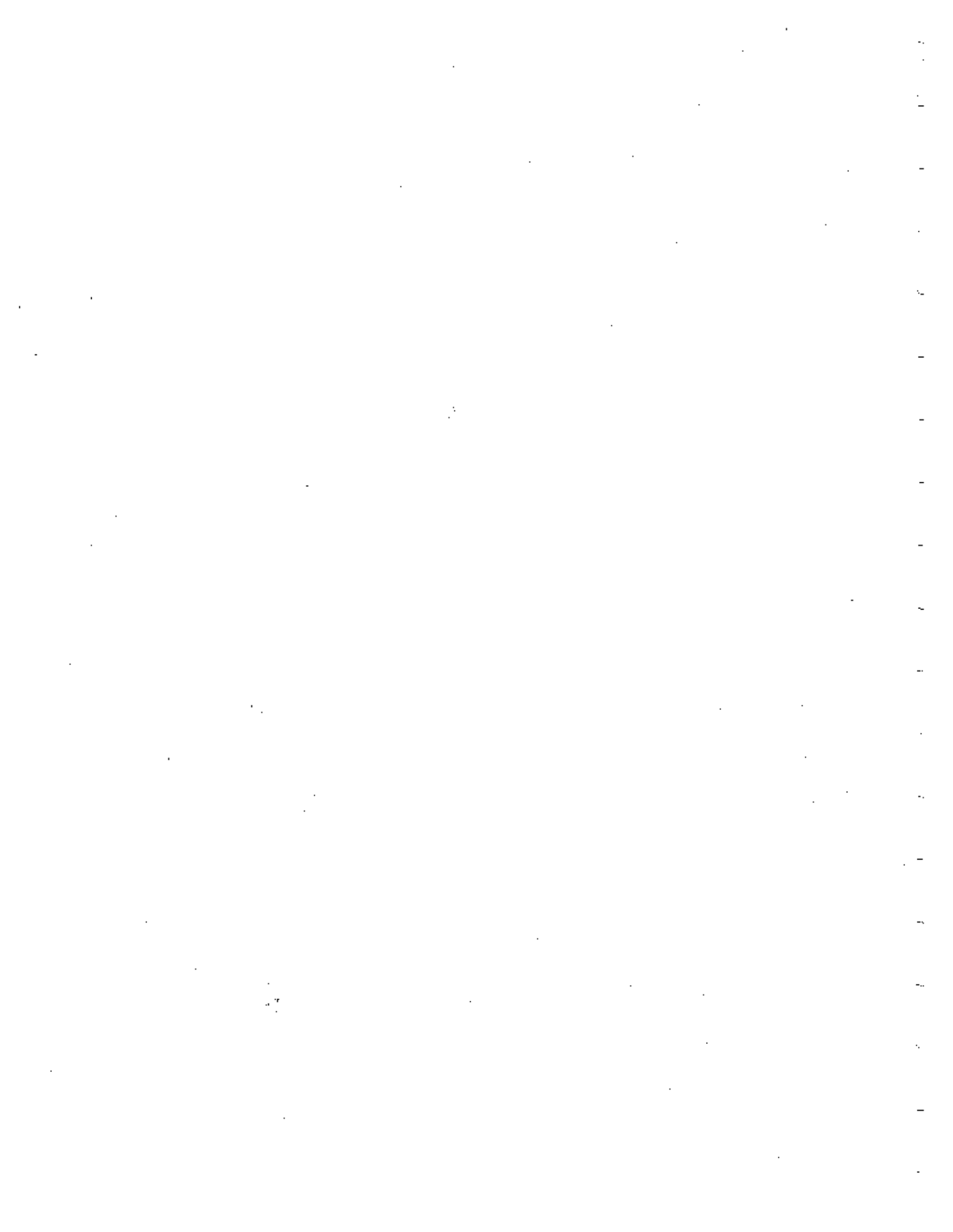
MCI Concord Visiting Room. This row, located in front of the Officers' Podium, depicts where SHU inmates sit when receiving visitors.



MCI Concord Visiting Room Inmate Strip Search Area. Inmate Witness observed assault in foreground. Inmate Geoghan assaulted in room in background.



MCI Concord SHU J-4 Unit.



## DOCUMENTS REVIEWED BY GEOGHAN PANEL

1. DOC INCIDENT REPORTS REGARDING INMATE GEOGHAN HOMICIDE.
2. PHOTOGRAPH OF TOOLS USED TO OPEN CELL DOOR.
3. INMATE GEOGHAN HOMICIDE REPORT AND INTERVIEWS CONDUCTED BY STATE POLICE ASSIGNED TO WORCESTER COUNTY DISTRICT ATTORNEY CONTE'S OFFICE.
4. REPORT OF CELL CONTENTS - DRUCE - GEOGHAN (WORCESTER EVIDENCE).
5. INMATE GEOGHAN TIMELINE.
6. INMATE DRUCE TIMELINE.
7. MA DEPARTMENT OF CORRECTION ORGCHART.
8. PERSONNEL FILES OF DOC STAFF.
9. JANUARY 1, 2002 INMATE STATISTICS MASSACHUSETTS DEPARTMENT OF CORRECTION
10. GUIDELINES FOR PLACEMENT IN LEVEL 6 FACILITIES AND PROTECTIVE CUSTODY UNITS
11. INVESTIGATIONS NEW DATABASE PRINTOUT REPORT STATISTICS REPORT GENERATED ON 12/04/2003
12. SIX PART FOLDER: INMATE DRUCE, JOSEPH [REDACTED] Section I & II AKA: SMILEEDGE, Darrin VOL. I of V
13. SIX-PART FOLDER - INMATE JOHN J. GEOGHAN W70597
14. 08/01/03 INCIDENT REGARDING INMATE JOSEPH L. DRUCE [REDACTED]
15. AGREEMENT BETWEEN MCOFU AND DOC SWAP AGREEMENT
16. AMERICAN CORRECTIONAL ASSOCIATION REPORT SOUZA BARANOWSKI CORRECTIONAL CENTER SEPTEMBER 18, 2003

17. ANNUAL AUDIT SOUZA BARANOWSKI CORRECTIONAL CENTER OCTOBER 10, 11, AND 12, 2001
18. AMERICAN CORRECTIONAL ASSOCIATION REPORT SOUZA BARANOWSKI CORRECTIONAL CENTER FEBRUARY 23, 2001
19. INMATE FINANCIAL TRANSACTION DRUCE, JOSEPH L W47601
20. INMATE DRUCE, JOSEPH L [REDACTED] MAIL CORRESPONDENCE AFTER 08/23/03.
21. INMATE GEOGHAN'S TELEPHONE CALL DETAIL REPORT.
22. INMATE DRUCE'S TELEPHONE CALL DETAIL REPORT.
23. CLASSIFICATION REPORT INMATE GEOGHAN, JOHN J W70597.
24. CLASSIFICATION REPORT INMATE JOSEPH L. DRUCE [REDACTED]
25. NIC COOPERATIVE AGREEMENT REQUEST RE:  
REVIEW/EVALUATION OF CLASSIFICATION PROCESS FOR FEMALE OFFENDERS
26. 103 CMR 491 INMATE GRIEVANCE POLICY.
27. BLANEY DECISION.
28. HAVERTY DECISION.
29. OVERVIEW OF THE CLASSIFICATION PROCESS AND DOC POLICY.
30. BARGAINING UNIT RECORDS FOR PC UNIT STAFF.
31. RULES AND REGULATIONS FOR DOC EMPLOYEES (BLUE BOOK).
32. MEDIA FILE.
33. VARIOUS INMATE VISITING RECORDS.
34. INMATE JOSEPH DRUCE INTEL FILE.
35. AUDIO TAPES OF INNATE GEOGHAN'S TELEPHONE CALLS.
36. AUDIO TAPES OF INMATE DRUCE'S TELEPHONE CALLS.



37. IPS FILES ON GEOGHAN AND DRUCE.
38. DOC INMATE MANAGEMENT SYSTEM FILES ON INMATES GEOGHAN AND DRUCE.
39. DIANE MCGLAUGHLIN-MCLS REPORT WRITTEN 2002.
40. VARIOUS INMATE LETTERS OF COMPLAINT (NOT SPECIFIC TO GEOGHAN INVESTIGATION).
41. PROTECTIVE CUSTODY PLACEMENT POLICY AND SCREENING STATEMENT.
42. MA DOC INTERNAL AFFAIRS POLICY (DEVELOPED AFTER INMATE GEOGHAN HOMICIDE).
43. INMATE GRIEVANCES – UNIT SBCC SHU.
44. SOUZA BARANOWSKI CORRECTIONAL CENTER 08/23/2003 SHIFT ROSTER
45. SOUZA BARANOWSKI CORRECTIONAL CENTER 08/15/03 – 08/23/03 - SHU UNIT VISITOR LOG
46. SOUZA BARANOWSKI CORRECTIONAL CENTER 08/15/03 – 08/23/03 – SHU UNIT ACTIVITY LOG
47. SOUZA BARANOWSKI CORRECTIONAL CENTER 08/15/03 – 08/23/03 – SHU – INMATE ROSTER
48. SOUZA BARANOWSKI CORRECTIONAL CENTER QUARTERLY REPORT – 10/02 – 12/02
49. SOUZA BARANOWSKI CORRECTIONAL CENTER QUARTERLY REPORT – 01/03 – 03/03
50. SOUZA BARANOWSKI CORRECTIONAL CENTER ANNUAL REPORT – FISCAL YEAR 2003
51. SOUZA BARANOWSKI CORRECTIONAL CENTER QUARTERLY REPORT – 07/03 – 09/03
52. 103.CMR 403, INMATE PROPERTY POLICY SOUZA BARANOWSKI CORRECTIONAL CENTER

53. SBCC SHU STAFFING FEBRUARY 10 – AUGUST 23, 2003
54. SBCC LABOR MANAGEMENT MEETINGS MINUTES FOR 2003.
55. EMPLOYEE RELATIONS CORRESPONDENCE RE: SBCC PROTECTIVE CUSTODY UNITS
56. SBCC AND MCI-C DISCIPLINARY REPORT INFORMATION
57. SBCC CLASSIFICATION PROCEDURES.
58. DOC POLICY AND SBCC PROCEDURE ON PROTECTIVE CUSTODY UNITS.
59. CORRESPONDENCE TO SUPERINTENDENT FICCO FROM PC UNIT INMATES.
60. SOUZA BARANOWSKI CORRECTIONAL CENTER POST ORDERS.
61. SBCC SHU UNIT FLOOR PLAN.
62. SBCC SHU DOOR OPERATION PRINTOUT.
63. PHOTOGRAPHS OF SBCC SHU AND CONCORD SHU.
64. MONTHLY CLIMATE REPORTS OF SBCC AND MCI-CONCORD.
65. MCI-CONCORD - INVESTIGATION #2002-S-022
66. MCI-CONCORD INVESTIGATION #2002-S-075
67. INMATE GRIEVANCE LOG MCI-CONCORD
68. MCI-CONCORD SHU UNIT LOGBOOK FOR 3/19/02.
69. MCI-CONCORD POST ORDERS.
70. CORRESPONDENCES FROM INMATE JOHN GEOGHAN TO MCI-CONCORD STAFF.
71. INMATE JOHN GEOGHAN INCIDENT AND DISCIPLINARY REPORTS AT MCI-CONCORD.
72. MCI-CONCORD BOOKING AND ADMISSIONS POLICIES AND PROCEDURES.

73. 11/21/02 INMATE I-34 DISCIPLINARY REPORT AND USE OF FORCE.
74. MCI-CJ INVESTIGATION #99-030.
75. REVIEW OF INTERVIEWS CONDUCTED.
- 44 Department of Correction Administrators
  - 20 Department of Correction Uniform Staff
  - 46 Inmates
  - 7 Civilians

### VIDEOTAPES

1. 09/09/03 - 4:45 P.M. - INMATE JOSEPH DRUCE [REDACTED] BEING PLACED IN HSU CELL [REDACTED] (STRIP SEARCH) INMATE DRUCE SWALLOWING PENCILS, AND HSU OFFICERS' STATION. (3 COPIES OF TAPE).
2. 09/09/03 - 4:33 P.M. - 5:02 P.M. - INMATE JOSEPH DRUCE [REDACTED] BEING ESCORTED FROM K3-01 TO HSU CELL [REDACTED] AND STRIP SEARCH (2 COPIES OF TAPE).
3. 08/23/03 - 7:10 A.M. - 1:20 P.M. - SBCC UNIT SHU OFFICERS' STATION, [REDACTED] GEOGHAN, JOHN J W70597 HOMICIDE (COPY OF TIME LAPSE VIDEO).
4. 08/23/03 - 7:10 A.M. - 1:20 P.M. - SBCC SHU TIER CAMERA [REDACTED] GEOGHAN, JOHN J W70597 HOMICIDE (COPY OF TIME LAPSE).
5. 08/23/03 - 1:21 P.M. - 3:45 P.M. - SBCC SHU UNIT [REDACTED] [REDACTED] (COPY OF TIME LAPSE).
6. 08/23/03 - 1:21 P.M. - 3:00 P.M. - SBCC SHU UNIT [REDACTED] (COPY OF TIME LAPSE ).
7. 08/23/03 - 12:04 P.M. INMATE JOSEPH DRUCE [REDACTED] OUT OF CELL [REDACTED] ESCORT TO THE HSU (TIME LAPSE )
8. 08/23/03 - 12:00 - 1:03 P.M - SBCC SHU UNIT [REDACTED] [REDACTED] VIDEO (COPY).
9. 08/23/03 - 11:16 A.M. - 12:54 P.M. - SBCC SHU [REDACTED] GEOGHAN, JOHN J W70597 HOMICIDE.

10. 08/23/03 - 11:17 A.M. - 12:13 P.M. - SBCC SHU [REDACTED]  
GEOGHAN, JOHN J W70597 HOMICIDE.
11. 08/23/03 - 12:21 P.M. - 12:37 P.M. - [REDACTED] SBCC  
SHU VIDEO GEOGHAN, JOHN J W70597 HOMICIDE.
12. 03-016 - MCI-CEDAR JUNCTION DOWNEY.

# CHRONOLOGY

INMATE JOHN GEOGHAN

INMATE DARRIN SMILEDGE

AKA

JOSEPH L. DRUCE

## INMATE DARRIN SMILEDGE

**December 18, 1989**

Smiledge is convicted of First Degree Murder, Essex Superior Court - Sentenced to life in prison and sent to MCI-Cedar Junction.

**Jan. 8, 1990**

DOC Classification Board recommends moved out of state - modified and he remains in state.

**April 25, 1990**

Modification of above - stays at MCI-Cedar Junction.

During 5 month period, receives 13 D-reports for violent and non-violent infractions.

**May 3, 1990**

Transferred to MCI-Norfolk.

No D-reports; fair evaluations.

**July 30, 1990**

Transferred to MCI-Concord/SHU. Awaits out of state transfer.

Goes on hunger strike [REDACTED]

**Sept. 7, 1990**

Transferred to Bridgewater State Hospital (BSH) for observation.

DOC initiates process to move him to MCI-Concord/SHU. [REDACTED]

**Sept. 27, 1990**

Moved to MCI-Norfolk Hospital for treatment.

Following treatment, transferred to MCI-Concord and placed on Awaiting Assignment (AA) status. Disruptive behavior continues.

**Dec. 7, 1990**

Transferred to SECC to await out of state placement at ACI Cranston, RI.

Rationale for move is numerous enemies within Massachusetts' DOC system.

## INMATE JOHN GEOGHAN

**Nov. 1999**

Indicted on one count of Indecent A&B on Child Under 14.

**Jan 23, 2002**

Transferred to Bridgewater State Hospital (BSH) for 30-day observation.

**Jan. 2002**

Following four-day trial, convicted of charge and held at the Middlesex County Jail to await sentencing.

**Feb. 21, 2002**

Appears before Judge Hamlin, sentenced to 9-10 years in state prison. Six years to serve and the balance suspended for the remainder of his life.

**Feb. 22, 2002**

Sent to MCI-Concord to begin sentence. Ordered held in the SHU-J4.

**April 2, 2002**

Receives D-report #02-0350 issued by CO Bisazza for lying re: feces incident. Dismissed on 4/5/02 by Superintendent.

**June 11, 2002**

Receives D-report #02-0636 issued by CO Bisazza for expired meds. Found guilty. Issued a warning.

Receives D-report #02-0638 issued by CO Breneus for lying to a CO. Dismissed.

**July 30, 2002**

Receives D-report #02-0915 issued by CO Hill for making three-way phone calls (21 counts). Dismissed after investigation.

**Aug. 2, 2002**

Receives D-report #02-0935 issued CO Bisazza for insolence and lying. Found guilty at hearing. Given 15 days room detention and reprimand.

Receives D-report #02-0936 issued by CO Haley for insolence. Found guilty. Fifteen day room detention and reprimand.

# CHRONOLOGY

INMATE JOHN GEOGHAN

INMATE DARRIN SMILEDGE

AKA

JOSEPH L. DRUCE

## INMATE DARRIN SMILEDGE

**Aug. 11, 1992**

Returned from RI, deemed a management problem. Held in MCI-Cedar Junction on AA status. Awaits out of state transfer.

Decision made and sent to MCI-Concord/SHU.

**May 1993**

Transferred to Old Colony Correctional Center (OCCC) and later same day transferred to SBCC.

**July 6, 1994**

Reclassification Board recommends transfer back to OCCC. Recommendation modified because of enemies and remains at SBCC.

**Aug. 9, 1994**

Transferred to BSH due to [REDACTED]

**Sept. 6, 1994**

Returned to MCI-Cedar Junction. Placed in West Wing Segregation Unit (WWSU).

**Dec. 30, 1994**

Transferred to MODS - Phase III/SHU, due to enemies list.

**Oct. 15, 1995**

Transferred out of state to New Mexico. Adjustment is poor. Receives five D-reports for [REDACTED]

**Feb. 3, 1998**

Returned to Massachusetts' custody. Immediately [REDACTED]

Following treatment, transferred to MCI-Concord/SHU per orders of Commissioner.

## INMATE JOHN GEOGHAN

**Aug. 15, 2002**

Receives D-report #02-1005 issued by CO Archambault for insolence in visit room. Found guilty. Given six weeks loss of phone privileges, use of canteen and loss of visit rights.

**Aug. 24, 2002**

Receives D-report #02-1045 issued by CO Durkee for medications left unattended. Found guilty and reprimanded (no sanctions).

**Sept. 6, 2002**

Receives D-report #02-1110 issued by CO Wilkes for lying. Receives six weeks loss of canteen, phone privileges and visit rights.

**Sept. 13, 2002**

Receives D-report #02-1132 issued by CO Bisazza for disobeying an order. Found guilty. Given 14 days room detention and 14 days loss of TV/radio.

**Oct. 2, 2002**

Receives D-report #02-1226 issued by CO Ciccone for using phone during privilege restriction. Plead guilty. Received additional four weeks loss of phone, canteen and visit privileges.

**Oct. 15, 2002**

Undergoes a scheduled re-classification board. Remains at MCI-Concord/SHU and approved at all levels.

**Jan. 31, 2003**

Receives D-report #03-9938 issued by CO Bisazza for insolence and lying. Plead guilty to lesser offense. Given four weeks loss of canteen, suspended for 60 days.

Received D-report #03-9947 issued by Co Bisazza for lying. Plead to lesser offense. Received four weeks loss of canteen, suspended for 60 days.

**Feb. 20, 2003**

Undergoes re-classification hearing. Board votes to keep Inmate Geoghan at MCI-Concord/SHU.

# CHRONOLOGY

INMATE JOHN GEOGHAN

INMATE DARRIN SMILEDGE

AKA

JOSEPH L. DRUCE

## INMATE DARRIN SMILEDGE

**May 8, 1998**

Receives "major" D-report for [REDACTED]

Concord Superintendent recommends transfer to Baystate Correctional Center (BCC). While awaiting

**July 3, 1998**

Receives two "major" D-reports at MCI-Concord for [REDACTED]

**Jan. 1999**

[REDACTED] Superintendent

Admits to sending letters of this nature.

**March 25, 1999**

Transferred to BSH.

**April 6, 1999**

Returned to MCI-Cedar Junction.

**May 19, 1999**

As a result of the assault on 7/3/98 and activities in January 1999, committed to DDU at MCI-Cedar Junction for a period of 48 months. Projected release date is 4/27/03.

Shortly after DDU placement, Smiledge files paperwork to formally change his name to Joseph Lee Druce.

While in DDU, receives a number of D-reports.

Charges include [REDACTED]

**Oct. 2001**

[REDACTED]

## INMATE JOHN GEOGHAN

**Feb. 21, 2003**

Receives D-report #03-10940 issued by CO Haley for having contraband item and insolence. Plead guilty. Given four weeks loss of canteen.

**Feb. 22, 2003**

Receives D-report #03-10952 issued by CO Bisazza for lying, insolence, and violating Department rule. Plead guilty to lesser offense. Given four weeks loss of canteen, concurrent with previous D-report.

**Feb. 24, 2003**

Deputy Superintendent Scott Anderson overrules Geoghan's re-classification board decision of 2/20/03. Recommends transfer to SBCC, citing excessive D-reports and failure at Level 4.

**March 24, 2003**

Writes to Commissioner Maloney seeking assistance re: Deputy Superintendent Anderson's transfer recommendation.

**March 28, 2003**

Deputy Superintendent Anderson is assigned to review appeal. Does not overturn his own original decision.

Acting Deputy Director of Classification approves Deputy Anderson's recommendation to transfer.

Appeals transfer to the Commissioner or designee.

**April 1, 2003**

Transferred to SBCC/SHU.

**April 15, 2003**

Receives written response to letter sent to Commissioner dated March 24, 2003. No change in placement.

**June 16, 2003**

Acting Deputy Director of Classification, Lori Cressey, denies final appeal.

# CHRONOLOGY

INMATE JOHN GEOGHAN

INMATE DARRIN SMILEDGE

AKA

JOSEPH L. DRUCE

INMATE DARRIN SMILEDGE

INMATE JOHN GEOGHAN

**Feb. 2002**

DOC intercepts letter, which shows Inmate Smiledge/Druce is [REDACTED] [REDACTED] [REDACTED]

**May 28, 2003**

Transferred to SBCC/SHU.

**Aug. 1, 2003**

[REDACTED] and is placed in the SBCC-Special Management Unit (SMU).

**Aug. 22, 2003**

Removed from SMU and returned to the SHU, Cell No. [REDACTED]

**June 26, 2003**

Undergoes scheduled re-classification review at SBCC. Is adjusting well, has received no D-reports in the previous 12-week period, while incarcerated at SBCC. Board votes to remain at SBCC.

**Aug. 23, 2003**

Inmate Geoghan murdered in Cell No. [REDACTED] by Inmate Druce.



## **ACKNOWLEDGEMENTS**

The panel would like to thank the following for their contribution towards this investigation and the completion of this report.

- The Office of Worcester County District Attorney John J. Conte
- The State Police Detectives assigned to the Worcester District Attorney's Office
- The Massachusetts Department of Correction
- The Massachusetts State Police Crime Scene Services Section
- Sergeant Robert Sojka of the Massachusetts State Police – Criminal Information Section
- The Investigative Team of State Police Officers, who despite their busy schedules, conducted the majority of the interviews necessary to complete this investigation.
  - Detective Lieutenant William Powers
  - Detective Lieutenant John Tutungian
  - Lieutenant Francis Matthews
  - Sergeant Paul Petrino
- Ms Julie Tondera, Massachusetts State Police, Division of Investigations-Administrative Staff
- Mr. Dennis Lafauci – Massachusetts State Police Print Shop