### MAINE STATE LEGISLATURE

The following document is provided by the

LAW AND LEGISLATIVE DIGITAL LIBRARY

at the Maine State Law and Legislative Reference Library

http://legislature.maine.gov/lawlib



Reproduced from scanned originals with text recognition applied (searchable text may contain some errors and/or omissions)

# REPORT TO THE ATTORNEY GENERAL

Relating to
the Death of Inmate
Larry Richardson
at the
Maine State Prison
in March 1990

#### Introduction

A few minutes after midnight on March 6, 1990, Larry Richardson, Jr., a 31-year-old inmate at the Maine State Prison in Thomaston, was found dead. He was hanging from the bars of his cell door in the segregation unit, a bed sheet knotted around his neck. While his death was the result of asphyxiation, an autopsy the next day revealed fresh injuries consistent with beatings. Dominant among these was a ruptured testis with significant attendant internal bleeding and swelling, and the recent traumatic loss of an upper front tooth.

Subsequent investigation and the testimony of other inmates revealed that Richardson had in effect been sentenced to death by certain inmates in the segregation unit of the prison.

These inmates, in the mentality of a lynch mob, held a mock trial and convicted Richardson for the offense of being a "skinner." According to inmates, the mock trial included a

<sup>1/</sup>Although the term "skinner" is sometimes used as an all purpose term of abuse in the prison, a "skinner", strictly speaking, is the term used in the crude lingo of prison inmates to denote someone incarcerated for sexual crimes against female children. In the hierarchy of prison inmates, a skinner is one of the most despicable. Richardson was in the fourth month of an eight-year sentence for molesting a young girl. According to guards and inmates, "rippers" (those incarcerated for sexual crimes against male children), and "rats" (those who snitch on other inmates) were as low as skinners in the pecking order. Murderers and others incarcerated for particularly violent crimes, they said, were "heroes" among other inmates.

judge, jury, and prosecutor consisting of other inmates in the section of the segregation unit where Richardson was housed.

Richardson's executioner, selected by virtue of being the only one in a position to carry out the sentence, was his 22-year-old cellmate, Roger Smith, who was serving time for having sadistically assaulted his girlfriend. A State Police investigation disclosed that Richardson was brutally beaten by Smith for several nights in the 6x8-foot cell they shared before his death. Eventually, Richardson placed a noose around his neck and was hung to death.

A State Police investigation of the death was started within a couple of hours of the discovery of Richardson's body. It culminated three months later in murder indictments against Smith and against Randy Tenggren, an inmate in one of the other segregation cells. Tenggren, it was alleged, helped to cause or contributed to the death of Richardson by ordering or instructing Smith to beat and eventually murder Richardson.

Roger Smith originally told a State Police detective that Richardson had been instructed to hang himself by other inmates and that he (Smith) had tried to save Richardson twice, but failed on the second attempt. He later admitted, however, that he had kicked Richardson's feet out from under him after Richardson, presumably with Smith's help, had fashioned a noose around his neck. At Smith's trial, there was also testimony

that Smith had told another inmate that he had strung a noose from a bedsheet and ordered Richardson to put on the noose and jump down. According to this testimony, when Richardson refused to jump, Smith grabbed Richardson by the ankles and pulled him toward the floor, thereby killing him.

Smith, who was tried separately from Tenggren, was convicted of Richardson's murder by a Knox County jury on September 20, 1991. He was sentenced to a term of 70 years in the State Prison. The jury's verdict reflected a finding that Smith had directly murdered Richardson and not merely caused him to commit suicide. Smith's conviction has recently been affirmed by the Law Court. Tenggren's trial in April 1992 ended in acquittal.

#### Purpose and Scope of Investigation

As directed by you, we undertook an investigation in October 1991 for the express purpose of determining whether correctional officers or other officials of the Maine State Prison or the Department of Corrections engaged in wrongdoing, criminal or otherwise, with respect to the circumstances leading up to and surrounding Richardson's death.

The crucial question involves the relevant actions of correctional employees during the nights leading to

Richardson's death and the issue of whether guards or other state employees knew what was transpiring in Richardson's cell but did nothing to prevent it. As many guards and prison officials themselves wondered in our interviews, how could Richardson have been physically abused and beaten so severely over a period of several days — in a controlled environment such as the segregation unit and under conditions which involved verbal participation and instigation by other inmates — without the guards having known that something was going on?

Also at your direction, a separate aspect of our investigation concentrated on determining the nature and scope of the advice apparently given to correctional officials by the Criminal Division of the Attorney General's Office concerning the issue of disciplinary proceedings involving personnel at the State Prison.

Our investigation spanned a number of months and included personal interviews with over a hundred people. The interview portion of the investigation was primarily carried out in late 1991 and early 1992. The bulk of these interviews were with correctional officers. We also talked with inmates who were housed in the north wing of the prison's segregation unit at the time of Richardson's death in 1990.

While we also closely examined the results of the State Police homicide investigation, we discovered early on a need for detailed interviews of all the correctional officers engaged in segregation unit duties during the time period leading up to Richardson's death. Although these guards had been instructed by the prison administration after Richardson's death to prepare statements of their contacts with Richardson, none of the guards appear to have been separately questioned as part of the State Police investigation of the death.

We also examined and analyzed voluminous documentation at the State Prison with respect to the death of Larry Richardson. Also included in this phase was the review of records and procedures as they related to the general operation of the prison and, in particular, the segregation unit during the general time period in which Richardson died. Part of our efforts in this regard dealt with the investigation of an alleged "disappearance" of records believed to have been in Richardson's inmate file at the prison.

We also reviewed the testimony of guards and inmates from certain evidentiary hearings and from the trial of <u>State v.</u>

Roger Smith. Finally, we followed the numerous leads suggested by our interviews and other investigative activity. All of this required at times the resources of six investigators assigned for significant periods of time exclusively to the investigation.

#### **Findings**

#### The Imprisonment of Larry Richardson

Larry Richardson, Jr., arrived at the State Prison in Thomaston on November 20, 1989. Earlier in the day in York County Superior Court, Richardson had been sentenced to 20 years with all but eight years suspended to be followed by six years probation. Richardson's sentence was imposed after he pleaded guilty to a Class A criminal offense of gross sexual misconduct brought against him in 1988.

The original indictment against Richardson alleged that he sexually assaulted his five-year-old niece during the summer of 1988. The indictment charged Richardson with five counts of gross sexual misconduct and one count of unlawful sexual contact. All counts but one were dismissed by the State in exchange for Richardson's guilty plea to a single count of gross sexual misconduct. The District Attorney told the Court at the sentencing hearing that primary in the State's decision to forego a trial was to avoid subjecting the five-year-old victim to having to testify.

The District Attorney pointed out during the sentencing hearing on November 20 that Richardson had demonstrated a history of sexual assaults and that his prior criminal record was replete with unlawful conduct of a sexual nature. In 1983,

Richardson was convicted of rape and sentenced to four years incarceration with all but two years suspended. According to the District Attorney, Richardson's release from prison was followed shortly after by new sexual assaults and the revocation of his probation which resulted in his serving the remaining two years of his first sentence.

At the sentencing hearing on November 20, the District
Attorney noted that Richardson was "out of control" with an
"overwhelming" sexual drive for young girls. The District
Attorney noted that counseling had been ineffective and that
Richardson needed to be "warehoused to protect anybody that
would come near him."

Richardson's lawyer at the sentencing hearing pointed out that Richardson was sexually abused as a child, that he lost his father at an early age, and that he was emotionally and physically disabled from the effects of a severe automobile accident at the age of eight. A married couple who had been looking after Richardson and had become close to him addressed the Court at the hearing, noting that while testing had not determined Richardson to be mentally retarded, he was a "simple man" who did not understand what others took naturally. The wife told the court, "I know he's not retarded, but he is simple. He does not understand everything. I have seen it.

We tried to emulate my husband, the way he would act and everything, so he could be accepted."

Justice G. Arthur Brennan's imposition of sentence was preceded by his comments about the absence of treatment programs in correctional facilities for persons like Larry Richardson. While noting the overcrowding and other problems facing the correctional system, Justice Brennan expressed the frustration of having to function in a system where the near absence of meaningful treatment programs in correctional institutions amounted to nothing more than "locking him up and throwing away the key." While noting a need for citizens to speak up and demand a more rational corrections policy, Justice Brennan told Richardson that, although the type of therapy and treatment he required would not be readily available, he needed to take advantage of what little might be available to him.

Larry Richardson by any measure was a vulnerable man. He was described in prison files as meek and unable to adapt in any fashion to life in prison. His waking hours were consumed by fright and apprehension. He told prison staff that on some occasions he was afraid to go to sleep because he was afraid that he would be attacked by fellow inmates. Prison records reflect that Richardson may have been retarded and his emotional makeup was that of a child. The records also reflect history of mental illness and treatment and past suicide

attempts. Richardson's institutional history was significant when he arrived at the Maine State Prison in late November 1989.

On December 4, 1989, Richardson was sent to the segregation unit after refusing transfer to general population, where he did not feel he would be safe given the nature of his crime. At an administrative hearing the same day, Richardson asked to be placed in a protective custody setting, saying that he feared being beaten or stabbed by other inmates in general population. Richardson was transferred to a protective custody dormitory the next day.

Two days later, however, Richardson was back in segregation after reporting that he was scared and being threatened in the protective custody dorm. Due to an apparent administrative oversight, a hearing had not been conducted for his transfer back to segregation. Consequently, Richardson was placed back in the protective custody dorm four days later.

On that same day, though, December 11, 1989, Richardson was returned to segregation "for losing control of himself" in the protective custody dorm. According to reports, Richardson was found smashing a chair against a wall and "was in an out-of-control state of mind." Richardson told a guard that other inmates in the unit were going to kill him and he needed protection. A prison psychologist concluded that Richardson was extremely unlikely to make a satisfactory adjustment to

prison life. The psychologist noted that Richardson's interactions with staff were likely to be subdued, and he was "quite unlikely to be able to negotiate interactions with other inmates." The psychologist speculated that Richardson was "at risk for abuse and exploitation and for self-injurious behavior."

In an administrative hearing held in connection with his transfer to the segregation unit from the protective custody dorm on December 11, Richardson told a panel of prison personnel that other inmates wanted to kill him because of the nature of his crime. Richardson said, "I'm afraid they'll beat the hell out of me . . . stab me." He told the panel he could not "handle it."

On December 12, 1989, the day after Richardson was returned to the segregation unit, a guard noticed that a shoelace had been tied to the vent in the ceiling of Richardson's cell and observed that Richardson was attempting to tie a knot in the shoelace. When the guard asked Richardson what he was doing, Richardson said he was going to hang himself. As a result of this incident, Richardson was placed on a suicide watch in the segregation unit which required that he be checked every 15 minutes. He was placed a cell with another inmate. He later told a second prison psychologist that he was experiencing no problems in segregation or with his cellmate.

As a second result of his tentative suicide attempt on December 12 -- an action which was against the rules of the prison -- Richardson was sentenced to 20 days of punitive segregation. 2/ This sentence did not commence immediately because, by the time it was imposed, Richardson had been transferred to another correctional institution. Specifically, because he was thought to be unable to adjust to life at the State Prison in Thomaston, Richardson was transferred on January 5, 1990, to the Downeast Correctional Facility in Bucks Harbor.

At Bucks Harbor he was initially placed in an administrative segregation unit. A week later, he moved to a dormitory. In another 10 days, however, Richardson was placed back in administrative segregation at the Downeast facility because he was "depressed and not able to communicate" and was possibly suicidal. It was reported that Richardson was refusing to eat. He would not communicate with the staff and he needed "very close supervision and support because of what appears to be complete withdrawal." Because the Buck's Harbor facility was not equipped to handle these problems, a decision was made to transfer Richardson back to the State Prison on February 9.

<sup>2</sup>/Treating suicide attempts as disciplinary infractions is apparently not uncommon in U.S. prisons because in the vast majority of cases, such attempts are not intended to be successful and are seen as efforts to manipulate the system.

Back at the State Prison, Richardson was evaluated by yet a third prison psychologist who, although he did not view Richardson as suicidal, took the precaution of placing him on a 15-minute watch in the prison's segregation unit. evaluated a couple of days later by another psychologist who also concluded that he was not suicidal. Richardson, however, remained in segregation on the 15-minute watch. The same psychologist talked with Richardson the next day. As a result, the watch on Richardson was reduced to 30 minutes on February 13, and the psychologist suggested that Richardson "having a cell mate may increase his socialization and decrease his isolation." It was noted by the psychologist that Richardson had demonstrated improvement during previous episodes "once he interacted with other inmates." The psychologist said that he discussed with the staff in the segregation unit the possibility of housing Richardson with another inmate.

In matching Richardson with a cell mate, the sergeant in charge of the day shift at the segregation unit consulted with prison psychologists and considered the various other inmates who were currently in the segregation unit. The sergeant stated that the decision was based upon the conduct and demeanor exhibited by the individuals in question while in the correctional system, rather than upon the crimes they had committed outside. It was decided that the best available

alternative for Richardson's cell mate was an immate named Roger Smith who had also experienced difficulties getting along with other inmates while in general population.3/

It bears emphasis that, at the time in question, inmates were not double celled unless they consented. Richardson's file thus contains a signed consent form, dated February 13, 1990, in which he voluntarily agreed to share a cell with Roger Smith. He became Smith's cellmate in the south wing of the segregation unit on February 14, 1990. Shortly thereafter, Richardson was removed from the 30-minute watch.

#### The Segregation Unit, circa March 1990

The segregation unit at the Maine State Prison consists of four corridors of cells designed to hold 31 prisoners. In early 1990, however, the unit held an average of 50. The two major corridors in the unit, consisting of 11 cells each, are known as north wing and south wing. The other two corridors contain a total of nine cells between them -- three on what is known as the Restraint Corridor and six on what is called the Plank Corridor. As shown on the accompanying floor plan (see

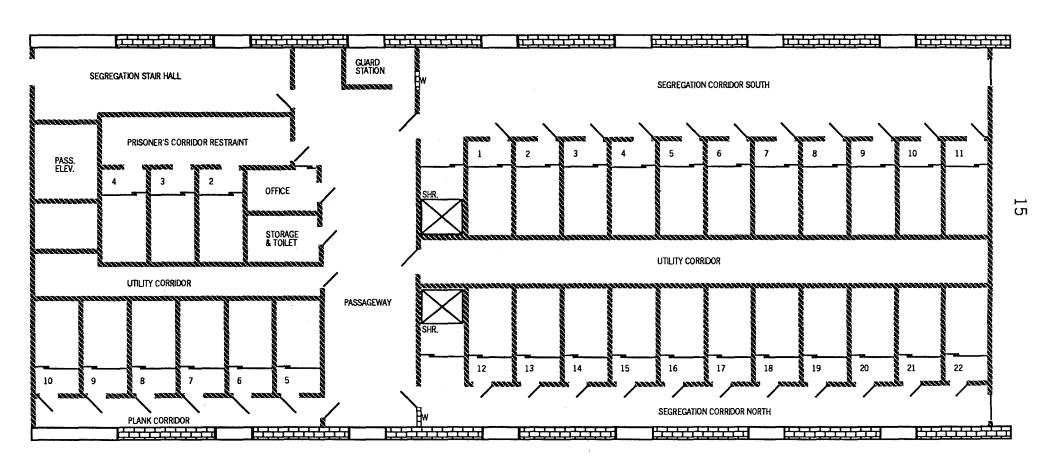
<sup>3/</sup>Roger Smith had arrived at the prison to serve a sentence for aggravated assault on December 28, 1989. After an initial period in the segregation unit on reception status, Smith had been placed in Dormitory Three but had then been transferred to Dormitory Four after some other prisoners in Dormitory Three had apparently tried to assault him. On February 6, 1990, he was found to have inflicted bodily injury upon himself by cutting his arm with a razor blade. At that point, he was placed in the segregation unit on protective custody status and written up for a disciplinary infraction.

following page), the segregation unit is entered through a locked door that leads from a hallway connecting to the rest of the prison and opens into a large central room that is approximately 12 feet in width and 45 feet in length. Along the narrow back wall of this central room is the guard station, which consists of a partially enclosed office area. Along the west wall of the central room are doors leading to the corridors of the south wing and the north wing. The door to the north wing is located along the west wall and is approximately 40 feet from the guard station.

The south wing housed several different categories of inmates: (1) "reception status" inmates who were quarantined for a period of several days upon entering the prison, (2) inmates waiting for a bed in other areas of the prison, (3) certain "protective custody" inmates — either inmates on suicide watch or inmates who were separated from the general population because they needed to be protected from other inmates; 4/ and (4) inmates on administrative segregation because they presented security risks or risks to other inmates. When Larry Richardson was first placed with Roger Smith on the south wing in mid-February of 1990, he and Smith were both on protective custody status.

 $<sup>\</sup>frac{4}{\text{These}}$  inmates needed protection above and beyond that available in the protective custody dormitory referred to earlier.

## **SEGREGATION UNIT**



The north wing housed the same categories of inmates but also housed "isolation status" inmates -- inmates who were serving disciplinary time for bad behavior in the prison, such as fighting or attempting suicide. Whether an inmate on the north wing was there for disciplinary or other reasons, the conditions of his confinement on the north wing were nearly identical. Inmates were generally denied the same privileges and expected to comply with the same rules. There was no TV. Inmates were locked in their cells 23 hours a day, allowed out daily in small groups for a one hour exercise period to mingle in the hallway outside their cells or to use the single shower within the north wing complex. Unlike general population inmates in the prison, inmates who lived in the segregation unit were served their meals and other essentials, including medications, in their cells. The only appreciable difference in terms of living conditions between inmates on disciplinary status in the north wing and the other inmates on that corridor were that inmates on disciplinary status were skipped over when guards distributed hot water a few times a day for beverages such as coffee. Disciplinary inmates were also denied the one hour exercise period on weekends.

Typically in early 1990, a minimum of two correctional officers were assigned to work the segregation unit at all times. One of the officers, usually the senior of the two, was

responsible for log entries and other record keeping. The actual number of guards working in the segregation unit depended on the time of day which dictated the duties of the officers. An evening or day shift, for example, involving the delivery of meals and medications and supervision of the one hour exercise period, required a larger contingent of personnel than a late night shift.

The first shift began at 6:28 a.m. and ended at 3:00 p.m. On this shift, a sergeant and three correctional officers were generally assigned to the segregation unit. The second shift began at 1:00 p.m. and ended at 9:30 p.m. On this shift, three correctional officers were generally assigned to the segregation unit from 1:00 p.m. to 5:30 p.m. and two officers from 5:30 p.m. to 9:30 p.m. The third shift began at 8:20 p.m. and ended at 7:00 a.m. Two guards were assigned to the segregation unit on the third shift.

At the time of a shift change, information was passed to the incoming shift by means of a briefing sheet and by verbal briefings in which the departing guards advised their arriving counterparts of matters requiring continuing attention. Guards could also consult the segregation unit log, which was intended to record all pertinent information and incidents within the unit, in order to bring themselves up-to-date on what had occurred before their shift.

During the overlap between the last hour of the second shift and the first hour of the third shift (at approximately 9:00 p.m.) the evening count was conducted. The evening count was one for four formal counts conducted throughout a 24-hour period. 5/ In addition to these counts, guards in the segregation unit were supposed to check every cell every hour during the hours from 6:00 a.m. to 8:00 p.m. and every half hour during the hours from 8:00 p.m. to 6:00 a.m. In the evening, this meant walking down the corridor and looking in each cell, using a flashlight if the lights in the cells were off. 6/

<sup>5/</sup>A "count," at least in segregation, was exactly what the word implied: counting the number of inmates to determine that none were missing. Nothing more than visual contact was required. An inmate, for example, was not required to verbally announce his presence or to present himself in any fashion. As long as the guard taking the count made sufficient visual contact to determine a specific inmate was physically present in the cell, the count was satisfied.

<sup>6/</sup>Although such checks were supposed to be performed every half hour at night and entered in the log at the guard station, these checks did not always take place as scheduled. While no correctional officer admitted to specific acts, a few guards stated that guards who were required to make 30-minute checks would actually conduct less frequent checks, but make entries on the log to show that 30-minute checks had occurred. guards stated that they always made the half-hour checks when they could but that these checks were sometimes made late or missed unintentionally, e.g., when guards were otherwise occupied in the block extinguishing a smoldering fire in a cell or attending to a new transfer. These occasions of late or missed cell checks, however, were routinely logged as being made on time because, according to these guards, the management of the institution insisted upon the practice of logging such checks for "accountability".

The correctional officers assigned to the segregation unit on the second and third shifts were supervised by a sergeant and a lieutenant, both of whom also had other responsibilities in the prison. These supervisors typically visited the unit several times during the shift and were otherwise accessible by telephone. In this connection, it is significant that for security reasons, guards on the segregation unit were not authorized to open the cell doors and remove inmates to interview them or to examine them for injuries but were required to report any concerns to their supervisors, who would then decide what action, if any, to take.

#### Transfer to North Wing

Larry Richardson and Roger Smith were moved to the north wing on February 28, 1990, five days before Richardson's death. This move was the result of the administrative discipline that had previously been assessed against both Richardson and Smith. As noted above, Richardson had been sentenced to 20 days of punitive segregation as a result of his suicide attempt on December 12, 1989 but had not served that time because he was sent to Buck's Harbor. On February 20, 1990, while he was housed with Richardson on the south corridor, Smith received a total of 25 days of punitive segregation for having cut his arm with a razor blade on

 $<sup>\</sup>frac{7}{\text{During}}$  the first shift, there was a sergeant assigned solely to the segregation unit.

February 6. On February 21, 1990, Smith received an additional five days in punitive segregation for possession of unauthorized property while in the segregation unit. As a result, since both Richardson and Smith were scheduled to serve disciplinary time, they were transferred together to the north wing on February 28, 1990. Since the pair had shared a similar cell in the south wing for two weeks without incident, it was not anticipated that any problem would emerge when they were housed together in the north wing. Indeed, as noted above, the placing of Richardson with a cellmate had been a conscious decision on the part of prison officials who had determined that Richardson's history with the institution indicated that he fared much better in the company of another.

A total of eleven 6x8-foot cells comprise the north wing of the segregation unit. All the cells are situated on one side of a common corridor in such a manner that an inmate in one cell cannot observe an inmate in another. (See floor plan on page 15). While each cell was originally designed to house a single inmate, seven cells in the north wing housed two inmates in early March 1990. As a result, while the north wing had been designed to house no more than 11 inmates, the situation of overcrowding in March 1990 had swelled the population to 18.

Double celling in the segregation unit had been necessary since the mid-1980's and resulted from the overcrowded

condition of the prison generally. The warden and other prison administrators had recognized that such double celling created both significant security concerns and the potential for other problems such as sexual and physical assaults between inmates. Nevertheless, given the overcrowded conditions at the prison, they had concluded that they simply had no other option. As of 1990, all of the State's correctional facilities were overcrowded. The State correctional system as a whole contained approximately 400 more prisoners than it was designed to house and approximately 80 of those extra prisoners were at the State Prison.

In May of 1989, construction was completed for a new multipurpose unit at the Maine Correctional Center in Windham. At that time, the possibility of eliminating double celling in the segregation unit at Thomaston by utilizing the new space at Windham was discussed. The administrators of the Windham facility, however, strongly objected to this proposal. They pointed out that the Windham facility was at least as overcrowded as Thomaston and that the staff at the Windham facility was already under great pressure. Nevertheless, later in 1989, the Department decided to send enough prisoners to Windham to create the space necessary to be able to eliminate double celling in Thomaston's segregation unit. This meant that prisoners in the new multipurpose unit at Windham would

have to be double celled and that new beds would have to be constructed in those cells. As a result, and in deference to the concerns of the staff at Windham, it was decided that the elimination of double celling in the segregation unit at Thomaston and the corresponding utilization of double celling in the multipurpose unit at Windham would be phased in gradually. This process had apparently begun by March of 1990 but had not yet had any appreciable effect on double celling in the segregation unit at Thomaston.

As of March 1990, therefore, the north corridor housed 18 prisoners in 11 cells. Separating that corridor from the central area where the guard station was located was a solid door, which is located approxmately 40 feet from the guard station and which is always kept locked except when guards are entering or leaving the wing. When guards enter the corridor for such purposes as delivering meals or checking on inmates, the door is locked behind them during the time they are in the corridor. Next to this door, on the side away from the guard station, is a glass window protected by metal bars. This window, which provides a view of the north wing corridor but not of any of the cells or inmates, was generally kept open to allow the guards to monitor the conduct of the inmates on the

<sup>8</sup>/The cells in the multipurpose unit at Windham, however, were approximately 70 square feet in size, as opposed to 48 square feet in the segregation unit at Thomaston.

corridor but could also be closed, particularly when the inmates were making a lot of noise.

Upon entering the north wing corridor, the first space on the left is a shower stall that is used by the occupants of the wing during the exercise period. The ll cells, which are all located on the south side of the corridor, begin immediately after the shower stall, and cell 12 is the first of these cells, located closest to the door.

When Larry Richardson and Roger Smith were moved to the north wing on February 28, 1990, they were placed in cell 12. Eight cells down the common corridor in Cell 20 lived Randy Tenggren and another inmate.

The inmates slept on thin mattresses on beds constructed of metal and attached to a wall of the cell in bunkbed fashion.

On another wall was attached a toilet and small lavatory.

Access to each cell from the corridor was through two doors.

The first was a solid door with a small window off the common corridor. This door led into a small foyer adjoining the cell. Between this foyer and the cell itself were the cell bars, which ran the width of the cell and which included a sliding door that allowed access to the interior of the cell. This door was always kept locked except during the one hour exercise period when the inmates in that cell were allowed out on the corridor. The outer corridor door, at least in early

1990, was typically kept open for the convenience of guards checking the cells or delivering essentials to the inmates, and so that inmates could freely converse with one another. At times, through, this outer door was closed by guards attempting to quiet an individual in a cell or at night when many of the inmates were sleeping. Whether an outer door was open or closed often depended on the wishes of the cell occupants.

Each cell was dimly illuminated by a single ceiling bulb and whether the light remained on or off was generally the election of the cell occupants. Some of the lights could not be controlled by switches outside the cells. Indeed, several of the guards to whom we spoke expressed difficulty with this practice given that completely darkened cells at night afforded little opportunity to observe inmates. While the guards acknowledged that the accepted procedure was to shine a flashlight into a darkened cell during the course of checking the cells every half hour, several said they did not do this because of the turmoil that it would often cause when an inmate was awakened or annoyed by the interruption. These guards told us that their outlook simply became one of keeping the peace; quards were hesitant to annoy any inmate because it would often result in the entire wing or unit becoming agitated and uncontrollable. When this happened, according to the guards,

there were no effective means available to stop it and the situation could carry on for hours on end.

Indeed, there is ample evidence that the inmates on the north wing were capable, upon occasion, of making a considerable commotion. One guard said that it was sometimes possible to hear noise from the north wing from the parking lot in front of the prison. Other guards noted that nothing more than friendly persuasion was available to them to quiet a large group of inmates intent on creating a high level of noise and general chaos. When a particular inmate could be singled out as the instigator, an arrangement might be made to relocate the inmate. This, according to the guards, however, was infrequent given the inability of guards to determine the source of recurring bedlam.

These guards said it sometimes became a game for the inmates in which one of them would do enough to call the attention of a guard and then cease the activity as soon as a guard appeared. Some of the guards told us of trying to sneak down a closed maintenance corridor that runs behind the cells between the north and south wings in order to more accurately pinpoint the source of troublemaking in the wing. Almost always, they said, their attempts would be discovered by an inmate who would yell out a code warning to the other inmates of the presence or approach of a guard.

Several of the guards we interviewed expressed a deep sense of frustration over the limited means available to control unruly inmates in the segregation unit. These quards complained that they had few options to deal with these situations and were therefore left with no option other than simply trying to block out a constant level of noise and disruption. 9 As described above, they said it was often times difficult, if not impossible, to determine which inmate was the source of verbal assaults that often resulted in all the inmates in the segregation unit shouting and becoming unruly. While at least one guard expressed the sentiment of many others in describing the segregation unit as one of "constant pandemonium," other guards said they became conditioned over time to a constancy of a high level of noise from the inmates and had developed an ability to ignore all but the extraordinary.

One guard told us the poor lighting in the segregation block was a longstanding problem and a common source of irritation to guards working in the block. This guard noted that the lighting had been a problem for 15 years. The same guard said the effects of overcrowding in 1990 brought about

The noise reached the guards through the walls and through the window that looks from the central passageway down the north wing corridor. As noted above, this window was closed some of the time. When it is closed, sounds from the north wing were still audible but were muffled to some extent. There is evidence that the window was probably closed for some or all of the time during the evenings leading to Richardson's death.

other deficiencies, not the least of which was a relaxing of rules. For example, he said, a prohibition on inmates placing items between or over the bars of the cell doors was loosely enforced. This, he indicated, resulted in greater visual obstruction for guards checking the cells. The guard also said the cells were unkempt and the general behavior of inmates was worse during the time of double celling. This guard described the segregation unit during this time as a "dirty, filthy and nasty ground."

#### A Note About Credibility

Before discussing the actions of others during the crucial timeframe, the issue of credibility must be addressed.

In focusing on the issue of whether guards know or had reason to know of Richardson's ordeal, there is a threshold issue of credibility. In several cases there are direct contradictions between the versions of events offered by inmates and guards and in some cases between the versions offered by different prison employees. In evaluating these different versions of events, one can begin with the general rule that the prison inmates do not like their jailers and frequently seize any opportunity they can, truthfully or otherwise, to discredit them. It is therefore not surprising that several inmates on the north wing gave a version of events which indicated that the guards must have known what was going

These statements cannot necessarily be taken at face on. Indeed, a lot of the most vocal proponents of this value. theory were inmates who were identified by others as being the most active participants in the mock trial and the most forceful in urging Roger Smith to greater heights of depravity. 10/ These inmates obviously have both a general interest in discrediting the prison and a specific interest in evading responsibility for their participation in the events leading to Larry Richardson's death by claiming that the guards or the administration were really responsible. Similarly, specific prison employees whose own conduct may be subject to question may have an interest in minimizing their own role and in pointing the finger elsewhere -- at other prison employees or back at the inmates.

As an example of an issue where the accounts given by guards and inmates directly conflict, one inmate who was on the north wing when Richardson was first moved there but who was transferred out on March 2 later testified under oath that he knew Richardson from a previous sentence at the York County Jail and spoke to Richardson during Richardson's exercise period on March 1, a day after Richardson and Smith were transferred to cell 12. That inmate stated that even on

<sup>10/</sup>Virtually without exception, the inmates identified as active participants in the mock trial said that there had been such a trial but asserted that they themselves had not been involved or claimed that they had vocally objected to the abuse of Richardson.

March 1, Richardson expressed great fear for his safety. As a result, according to the inmate, he went to the day shift sergeant and suggested that Richardson be moved. According to the inmate, the sergeant rejected the suggested and rudely told him to mind his own business. The sergeant, however, squarely denied under oath that any such conversation ever took place, and it should be noted that when initially interviewed, this inmate did not mention that he had ever spoken with the day shift sergeant.

#### Events of March 1 through March 4

North wing was home to some of the prison's toughest and most unruly inmates. The combination of pathological personalities and the close conditions of confinement for 23 hours-a-day brought about an environment some guards referred to as a "zoo". These guards stated that fundamental human traits of decency and compassion were often replaced by vile bravado and depravity. For their part, some inmates referred to the north wing as the "hell hole".

The prison logs indicate that on March 1 (the day after Smith and Richardson were transferred to the north wing), Richardson was out of his cell for a 20-minute exercise period, that he refused a shower, and that he visited the prison hospital. During the day on March 2, according to the logs, both Smith and Richardson showered and exercised. Sometime

thereafter, according to other inmates on the north corridor, Smith apparently saw an opportunity to ingratiate himself with the population on the north wing by announcing, "Hey, I've got a skinner in here with me." Smith, they said, had been in the system long enough to learn how an inmate became accepted by other inmates. They said to beat up on a "skinner" was to secure a respectable position in the pecking order of the prison population.

It is not entirely clear whether Smith began physically abusing Richardson on his own initiative or upon the instructions of other inmates. There is evidence that Smith first beat Richardson when he awoke on March 1 or 2 to find Richardson masturbating three or four feet away from his head. Smith, however, later told the State Police that the other inmates instigated the more serious abuse that followed; that they had held a "kangaroo court" and directed that Richardson be punished for being a "skinner". He stated that Richardson had been instructed by other inmates to recite the sexual acts he had committed with young children and that Richardson had been ordered by other inmates to beg Smith to physically strike Richardson. According to Smith, Richardson did beg Smith to strike him and Smith obliged. On the other hand, another inmate testified at Smith's criminal trial that Smith told him that he and Tenggren had planned the beating and murder from

the outset because they disliked "skinners" and wanted to make an example of one. $\frac{11}{}$ 

At any rate, whether Smith began physically abusing Richardson on his own initiative or at the request of other inmates, his statements and those of the inmates suggest that the ordeal of Richardson began on either Friday night, March 2, or Saturday night, March 3, and continued until Richardson's death on March 5. Smith stated that during this period he struck Richardson with his fist in the face and in the kidneys and that his knuckles became black and blue from striking Richardson. He stated that he had kicked Richardson in the groin at least three times while wearing boots on the evening of March 3 and that he observed huge bruises and severe swelling in Richardson's groin area as a result. The State's medical examiner later confirmed that the bruises around Richardson's left eye and the injury to his groin area appeared to have occurred at least a day or two before his death.

The statements of several other inmates on the north wing suggest that although Smith may have initiated the abuse of Richardson and was anxious at first to demonstrate his willingness to punish Richardson for being a "skinner", he was not prepared for what would follow. These inmates said Smith became less eager as the beatings became more severe and deprayed. While Smith, coaxed and coerced by others, dutifully carried out Richardson's "sentence", his motivation, according to these inmates, changed from seeking stature to responding to threats that Smith himself would be subject to severe physical harm if he let up on Richardson. On the other hand, some other inmates said that it appeared to them that Smith was excited by and was enjoying his sadistic activities.

Smith also stated that on two occasions during the period from March 3 through March 5, he forced Richardson to drink urine and that on one occasion he forced Richardson to insert a toothbrush into his rectum. Other inmates stated that when Richardson was being sodomized with the toothbrush, Smith taunted him by likening the experience to the pain Richardson had caused "the babies" he had sexually molested.

Smith later stated that at one point during the ordeal, probably on the night of Sunday, March 4, he had been instructed by other inmates to knock out one of Richardson's teeth. To achieve this result, he had smashed Richardson's face into the toilet bowl in order to dislodge a front tooth, which he delivered on an exercise break the next day to inmate Randy Tenggren. 12/

These events culminated in Richardson's death on the evening of Monday, March 5. According to the subsequent statements and testimony of Smith and other north wing inmates, Richardson probably did not receive any further beatings on March 5. Richardson was definitely seen alive at approximately 8:20 p.m. on the evening of March 5, when he was observed by a prison nurse and the guards who were accompanying her and

<sup>12/</sup>Tenggren placed the tooth in an envelope addressed to the warden with a note that said, "This is what happens to your baby fuckers", and delivered the envelope into the prison mail system, apparently on the evening of March 5. This envelope was delivered and opened on the following morning, March 6, approximately eight hours after Richardson's body had been found.

refused his prescribed medications. He was found dead, with his body partially hanging from a sheet tied to the bars, shortly after midnight.

The evidence indicates that the actual beatings took place only at night. Both Smith and the other inmates on the north wing consistently testified that the beatings of Richardson took place after 9:00 p.m. This is supported by the fact that there was considerably more activity on the north wing during the day than in the evening. Typically, during the period from 5:30 a.m. to 9:00 p.m., there is considerable activity on the corridors of even the segregation unit, including four formal counts of the inmates, four medical runs where nurses dispense medications and check on the medical condition of inmates, the delivery and pickup of meal trays three times during the day, two mail runs (one for delivery; one for pickup), and the opportunity for an hour's exercise where up to four inmates at a time are allowed out in the corridor. In the evening, after the final medical run around 8:00 p.m, and the last count of inmates for the day at approximately 9:00 p.m., the only activities are the half hour checks, often performed as unobtrusively as possible to avoid disturbing sleeping inmates, and hourly hot water runs (for those inmates not on disciplinary status) until 11:00 p.m.

A major area where there are dramatic contradictions relates to the amount of noise that was made during the beatings and trial of Larry Richardson during the nights leading to his death. Although some inmates later testified and were quoted in press reports as saying that Richardson's screams had echoed down the north wing, the statements of most inmates indicated instead that Richardson remained remarkably silent throughout the physical abuse perpetrated by Smith. their part, the guards on duty consistently denied that they ever heard the cries or screams of a man being tortured and There is considerable evidence, therefore, that throughout his ordeal, Richardson did not scream or cry out loudly enough to draw the attention of the guards. supported by Richardson's own behavior during his interactions with correctional staff during the period in question. Although he had numerous opportunities, he never reported that he had been beaten or that he was injured. Nor did he apparently ever try to call attention to his condition. inmates also stated that one reason Smith was instructed to dislodge one of Richardson's teeth and provide the tooth to

<sup>13/</sup>This is a different issue from whether any guard heard the inmates on the corridor verbally abusing Richardson during what we now know to have been the mock trial. As discussed below, it has recently come to light that at least one guard did hear yelling and dialogue among the residents on the north wing on Sunday, March 4, which appears, at least in retrospect, to have been part of the mock trial. This same guard may have heard the sound of Richardson being beaten later that evening.

inmate Tenggren was because some inmates believed that Smith was not, in fact, beating up on Richardson as he claimed to be doing -- another indication of Richardson's silence.

In any event, even though the beatings of Richardson appear to have begun on the night of Friday, March 2 or Saturday, March 3, the guards who served on the third shift on those nights said that while there was the usual amount of noise and talking, it was not especially noisy, and they heard nothing out of the ordinary on either of those nights. The prison logs indicate that Richardson received medication shortly after 10:00 p.m. on Saturday night 14/ but otherwise make no special mention of cell 12 or its occupants.

## Events of Sunday Night, March 4

In contrast, there is evidence of some unusual commotion on the north wing on the night of Sunday, March 4 -- commotion that appears in retrospect to have been related to the mock trial and beating of Richardson and that may also have been intended to mask the sound of Richardson's beatings from the guards.

Following Richardson's death, the two guards who were assigned to the third shift on March 4 reported that they had

<sup>14/</sup>The medication was provided approximately a hour after the general evening pill run. The nurse who delivered this medication did not specifically recall why this occurred but believed that it happened because the envelope containing Richardson's medication was left behind when the usual evening "pill run" was made.

not been aware that Richardson was being subjected to physical abuse. One of these guards reported that on one of his rounds Richardson had asked for and been given a new roll of toilet paper. Both guards also reported, however, that they had heard inmates yelling that there was a "skinner" on the corridor. The junior guard reported that he had heard shouts that the skinner "should choke himself" but could not tell who was yelling or to whom the yelling was directed. The senior guard reported that he heard inmates call out "skinner" on several occasions and believed that he then heard Richardson answer "yes, sir." He said he could not tell for sure because every time an officer went on the corridor, the inmates would immediately quiet down. 15/

Sometime after Roger Smith's trial in September of 1991, this same senior guard admitted to a fellow guard that in addition to shouts of "skinner", he had also heard some additional noise on the north wing on the evening of Sunday, March 4, 1990. This guard also acknowledged to an investigator from the Attorney General's Office in late 1991 that on the evening of March 4 he had observed that Richardson had lost one of his front teeth. This information first came to the

<sup>15/</sup>The Segregation Individual Behavior and Exercise Log for this shift contains a general notation that the unit was "quiet". When used in the log, this notation did not necessarily refer to the amount of noise but appears instead to have been used as a synonym for "uneventful".

attention of the prison administration in May of 1992<sup>16</sup> and resulted in disciplinary proceedings which have not yet been concluded. The guard in question has admitted that there had been considerable commotion on the corridor and that in addition to shouts of "skinner", he had heard a noise which he described as "like flesh hitting the toilet". He believed this noise had come from cell 12 but when he checked, the occupants of that cell appeared to be asleep. He stated that he thought that Smith (who was in the lower bunk) had perhaps been hitting the toilet with the flat of his hand. He stated, moreover, that he heard this noise some time after he had observed that

<sup>16/</sup>It is notable that this information did not surface until May of 1992. The guard in question apparently told a fellow guard sometime between September of 1991 and April of 1992 that he had heard indications of a beating. The recipient of this information in turn told a supervisor, who took no action because he stated that he believed the guard who had disclosed the information was not truthful. It was not until the recipient of the information told a second supervisor in May of 1992 that the prison administration was informed. Because of his failure to report the information, the first supervisor has been demoted.

 $<sup>\</sup>frac{17}{\text{The}}$  facts developed in the disciplinary investigation are currently confidential under 5 M.R.S.A. § 7070(2)(E). The facts recited above are based upon the independent investigation conducted by the Attorney General's Office.

<sup>18/</sup>The guard reported that the commotion ceased immediately if the officers went to the corridor and that he had attempted to investigate further by furtively walking down the utility corridor behind the cells but had been perceived by one of the inmates almost immediately, who then warned the other inmates of his presence.

Richardson's front tooth was missing. He added that he did not know that the loss of Richardson's tooth had occurred that same day.

This guard acknowledged that he had not reported any of this to his supervisors at the time. He stated that the reason he had not reported the information was because he was scared to report it to the supervisor unless he had more conclusive factual information. He also volunteered that after this information had come out, he had told prison officials that he had made some "very grave errors" on the night of March 4. However, he said that he had been referring only to his failure to tell a supervisor. He also said that it was possible that his description of a sound "like flesh hitting the toilet" was based on his subsequent knowledge of what had occurred. Finally, he also acknowledged that he had said at one point after Richardon's death that Richardson was a skinner and had gotten his just desserts, but these were not his true feelings and that he tried to treat "skinners" like any other inmate. 19/

The junior guard who was on the same shift acknowledged that there was an extreme amount of noise on the north wing that night and that he had heard shouts about "skinners" and "what should be done to skinners" but stated that he had heard

 $<sup>\</sup>frac{19}{\text{According}}$  to this guard, what he had meant by saying that Richardson had gotten his just desserts was that it appeared from his failure to call attention to himself that he must have wanted to die.

the same kind of statements on other occasions in the segregation unit. He said that he also had a recollection of hearing a noise at one point (although he was not certain it was on the night in question), and that the noise he had heard had sounded like a roll of wet toilet paper hitting the wall. This guard stated that he had not reported the information to a supervisor because it had been his experience that the supervisors would think he was wasting their time unless he had more concrete information. This guard also said he had not observed that Richardson was missing a tooth and would have entered that information in the log or reported it to a supervisor if he had seen it. This guard resigned his position at the prison after the disciplinary investigation began.

Both these guards insisted that they had not been aware that Richardson was being physically abused on the evening in question and that they would not have permitted that to happen if they had been aware of it. While they said that things might look different in hindsight, they stated that they did not have adequate reason to believe at that time that Richardson was being beaten on their shift and that they do not believe even now that any severe beatings occurred on their shift.

### Events of Monday, March 5

On Monday, March 5, the prison logs reflect that Richardson refused breakfast and was allowed out of his cell for an hour

of exercise. 20/ During that time he requested a towel so that he could take a shower. The guard who provided the towel to Richardson through the bars of the window at the end of the north wing corridor stated that he did not see any bruises or injuries and, in particular, did not notice bruises around Richardson's left eye; he also said that he did not observe Richardson in the shower. Although this was an instance in which a guard might have noticed that Richardson was injured, it was also one of the many instances in which Richardson could have called attention to his plight yet did not do so.

Indeed, the prison logs also reflect that Roger Smith saw the prison's substance abuse counselor on Monday, March 5. Prison staff have advised us that Smith left the cell for this meeting, leaving Richardson alone in cell 12. If Richardson had been afraid to bring his injuries to the attention of the guards while in Smith's presence, this occasion gave him an opportunity to speak to the guards or to pass a note without detection, yet he did not do so.

During the late afternoon medication run on Monday, Smith gave a note to the nurse, apparently written by Smith but

<sup>20/</sup> Because they were on disciplinary status, neither Richardson nor Smith had been eligible for exercise or a shower on Saturday and Sunday. As noted above, both had showered and exercised on the preceding Friday.

purportedly signed by Richardson, saying that Richardson did not want his medication. At this time Richardson was lying in his bunk with a blanket over his head. The note was disregarded because Richardson was not scheduled to receive any medication at that time.

On the evening "pill run", which occurred shortly after 8:00 p.m., both Smith and Richardson were scheduled to receive medications. According to the prison nurse, at that time Smith showed his hand to the nurse to reveal that he had bruises between his knuckles, which he said he had received while doing push-ups. He added that Richardson did not want his medication that evening because it made him dizzy. He also told the nurse that because Richardson had been dizzy, he had fallen from his bunk and hurt his eye and his groin area. The nurse, who was accompanied by two guards from the second shift, then asked Richardson, who was lying on a bunk with a blanket over his head, to get up. Although Richardson was initially hesitant, he got up when requested to so do by one of the guards, and, in the words of the nurse, "shuffled" forward. At that time, the nurse observed black and blue marks in the area of Richardson's left eye. She asked Richardson several questions and Smith answered for him, explaining again that Richardson had fallen and his medication made him dizzy. 21/ According to the nurse,

<sup>21</sup>/ The nurse, who had worked at the prison for 10 months at the time, later stated that she believed at the time that Smith was attempting to look out for his cellmate.

Richardson eventually assented to the nurse's questions as to whether he had fallen and whether his medication made him dizzy, although his part of the conversation at most consisted of his answering "yes" to two or three of the nurse's questions. The guards who accompanied the nurse did not recall that Richardson actually said anything; it was their recollection that Smith answered for Richardson and that Richardson did not speak up to the contradict his cellmate.

The nurse later stated that she knew that Richardson's medication could cause dizziness and that she did not believe that there was any kind of medical emergency in the cell. In addition, prison records confirm that Richardson had frequently refused his medication during his stay at the prison. The nurse instructed Richardson to obtain a medical pass and to see the prison doctor in the morning. She did not observe that Richardson was missing a tooth and did not check on the groin injury that Smith had mentioned.

Although he did not make any entry on the subject in the log, one of the guards accompanying the nurse was sufficiently concerned to notify his supervisor of his observations and the nurse's conversation with Smith. That supervisor, the second shift sergeant, stated that he immediately notified his lieutenant of all the relevant information and asked the lieutenant if he wanted the sergeant to check on Richardson.

There was some variance between the recollections of the second shift sergeant and the lieutenant on this issue. The lieutenant acknowledged that he was told that there was reason to believe that there had been an altercation between Smith and Richardson and that Richardson appeared to have "a red mark" on his cheek, but he did not recall being told that Richardson had suffered a groin injury or that Smith had been answering questions addressed to Richardson.

The lieutenant stated that although the sergeant had suggested moving Richardson, he decided this was not necessary because the information he had received suggested at most that there might have been a previous altercation but did not suggest an ongoing problem. The lieutenant also relied on the fact that the nurse, who had observed the same incident, had not felt the need to take any immediate action. Finally, he noted that there was only one cell available at that time to which Richardson could have been moved, and that cell would have been needed if anything else happened that night. The lieutenant did tell the sergeant that the information should be passed on the third shift, which had just come on duty.

The testimony as to exactly what information was passed on to the third shift is inconsistent. The second shift sergeant recalled that he spoke to both the third shift lieutenant and the third shift sergeant, gave them all the details that had been observed on the 8:30 p.m. pill run, and made a request that they keep an eye on cell 12. The second shift lieutenant said that he also briefed the two third shift supervisors with respect to the possible problem in cell 12.

The third shift lieutenant, however, said that he was briefed in only general terms that there might have been an altercation in cell 12 and was told that he might have to separate the inmates if any further trouble occurred that night and that consideration should also be given to separating the two inmates in the morning. 22/ The third shift lieutenant denied that he was informed that there had been any observation of Richardson's facial bruises or that there was any mention of a groin injury; he stated that if he had received such information, he would have taken measures to check out the situation.

Information relating to a possible problem in cell 12 was also transmitted to the third shift in two other ways: one of the officers who had accompanied the nurse stated that he told the two arriving third shift guards what he had observed on the pill run shortly after he had reported the matter to his second shift sergeant. For his part, the second shift sergeant said that after briefing the two third shift supervisors, he also

<sup>22/</sup>He recalled receiving this information from the second shift sergeant but not from the second shift lieutenant. Moreover, while both of the second shift supervisors recall that the third shift sergeant was also briefed about cell 12, the latter denies being present for any such briefing.

informed the two third shift guards just coming on duty in the segregation unit of his sense that "something strange was going on with the two inmates, possibly fighting or possibly forced sexual activity, as I knew that inmate Richardson had previously had problems [in the protective custody dormitory] and that he was a very scared and timid person" He said the senior of the two third shift guards promised to keep a watch on cell 12.

The senior third shift guard remembered, for his part, that he was told by both a guard from the second shift "pill run" and by the second shift sergeant that they thought there had been some kind of altercation in cell 12.23/ He firmly recalled, however, that no specific details were provided. Thereafter, when he checked cell 12 on one of his scheduled half hour rounds, he observed that both Smith and Richardson appeared to be sleeping in their bunks. This guard said he was later contacted by his own lieutenant who inquired about the information received from the second shift sergeant concerning cell 12. The guard said he informed the lieutenant of his own observations of cell 12, which had not disclosed any problem.

<sup>23/</sup>The other third shift guard, questioned later, said he could not recall any such briefing in this regard. The guard said that he recalled seeing the second shift supervisor in the segregation office at the start of the third shift that night but did not pay attention because he was the junior man and was otherwise occupied cleaning up a mess in the guard station left by the second shift.

A few hours later, shortly after midnight, this same guard found Richardson hanging from the bars of his cell during a routine half-hour check.  $\frac{24}{}$ 

Two other allegations came to light after Richardson's death. In a report prepared several days later, the nurse who had observed Richardson on the Monday evening pill run reported that at approximately 9:30 p.m. that evening, before she left the prison, she was in the nurse's station when she heard a guard say that he believed a rape might be occurring in the segregation unit. According to the nurse, she asked the guard why, if this were so, the inmates were not being separated. At

<sup>24/</sup>Smith subsequently stated the Richardson had hung himself (with Smith kicking his legs out from under him) shortly after the 10:30 p.m. check by the guards. This is supported by other inmates. If so, however, it is difficult to explain why Richardson was not found on the half-hour checks at 11:00 p.m. and 11:30 p.m. Both Smith and the guards testified that these checks were in fact made by the junior guard. According to Smith, however, the cell was entirely dark and the junior guard missed seeing Richardson when he briefly shined his flashlight into the cell. The junior guard, in contrast, says that he does not think he could have missed Richardson, and his partner says he immediately saw Richardson as soon as he opened the outer door of cell 12 shortly after midnight.

It is, of course, possible that, contrary to Smith's claims, Richardson's death did not occur until after the half hour check at 11:30 p.m. There is also a theory that an anxious Smith initially took measures to conceal Richardson's body by placing in on a bunk and covering it with a blanket during the 11:00 p.m. and 11:30 p.m. checks, then repositioned the body in a hanging position prior to midnight. In support of this theory, several persons at the prison suggested that the awkward position of Richardson's body when it was found at midnight was inconsistent with death by hanging and looked instead as if Smith had tried to rehang Richardson's body after the latter's death.

trial, she testified that in response the guard shrugged, perhaps because he was not sure if the report was true or not.

The guard who the nurse identified as having made this statement had worked in the segregation unit on the first shift and had provided Richardson with a towel for his shower; he had thereafter worked a second shift elsewhere in the prison. The guard, however, emphatically denied that any conversation such as the nurse described had ever occurred and added that he had been the same guard who had caught Richardson attempting suicide on December 12 and had immediately intervened at that time. As a result, the guard stated that he was not someone who would fail to take action if he knew something was occurring.

The other allegation that was made came from a north wing inmate who stated that the junior guard on the third shift, hours after Richardson's death, had advised him that he should keep quiet about whatever he knew. The guard in question denied this conversation, and it is notable that it was recounted by an inmate who other inmates depicted as one of the primary participants in the mock trial but who, according to his own version of events, had been the only person who had objected to the abuse of Richardson.

#### CONCLUSIONS

- We do not find evidence of criminal wrongdoing by any correctional employee. There is no evidence of any intent by correctional employees to harm Richardson or to facilitate the assaults and the homicide committed by Smith. See 17-A M.R.S.A.  $\S\S$  57(3)(A), 608. There is no evidence of any conduct by correctional employees that rose to the level of manifesting a deprayed indifference to the value of human life within the meaning of the Criminal Code. See 17-A M.R.S.A. § 201(1)(B). Indeed, there is a particular difficulty in this case because the independent actions of Smith were plainly the primary cause of Richardson's injuries and his death. While we would not rule out prosecution of prison guards in a circumstance where they had actual knowledge that a serious beating was in progress and unjustifiably failed to take any action to stop it, there is insufficient evidence of such actual knowledge in this case.
- 2. A unique feature of the circumstances surrounding Richardson's death was that Richardson never brought or attempted to bring his ordeal or his injuries to the attention of the guards. The corrections personnel with whom we spoke stated that it is not infrequent for inmates to engage in scuffles and it is also not infrequent for inmates to decline

to explain how they have received bruises. However, the corrections personnel can remember no comparable incident where a seriously injured prisoner did not call attention to his condition. They also have reported that in cases where prisoners have been harassed, other prisoners on the corridor have either said something or passed a note to the guards to alert them to the situation. This also did not happen with respect to the events on the north wing that culminated in Richardson's death.

We are convinced that had Richardson called attention to his injuries, he would have been promptly removed from his cell and that he had no reasonable basis for believing otherwise.

Why he did not seek such assistance remains a mystery.

3. Obviously one contributing factor to the events which led to Richardson's death was the existence of double celling in the segregation unit. Because of double celling, Richardson was vulnerable to the savagery of his cellmate. Indeed, while physical and sexual assaults can and do happen in prison even without double celling, the existence of double celling contributed to the particular horror of Richardson's death — that he was unspeakably tortured over a period of several nights interrupted by seemingly normal activities during the day. In part, this resulted from Richardson's failure to take any action to save himself. However, the existence of double

celling plainly gave rise to a potential for physical or sexual assaults between cellmates -- a potential that may have been heightened in the segregation unit because it contained some of the toughest and most vicious inmates in the prison.

Department of Corrections personnel recognized that double celling in the segregation unit had the potential for serious problems and had accordingly undertaken a plan to eliminate such double celling. Double celling in the segregation unit was in fact eliminated in May of 1990. Department officials stated that the Richardson incident accelerated their timetable but only by a little. As noted above, the price of eliminating double celling at the segregation unit in Thomaston was to increase double celling at the Maine Correctional Center in Windham.

4. Another decision that has been questioned is the choice of Smith as Richardson's cellmate. In hindsight, this may not have been the best choice. Given that a psychologist had recommended that Richardson be housed with another inmate and given the other prisoners from which to choose, however, this is a close question. Both Smith and Richardson were viewed as relatively weak, and both had had difficulty getting along in general population. Both had ended up in the segregation unit on protective custody status and both had attempted to harm themselves in one fashion or another. Other

inmates who were double celled in the segregation unit at the same time as Richardson and who had been convicted of the same crime as Richardson (gross sexual misconduct) were housed with prisoners convicted of murder, arson, rape, and burglary. The placement of Smith with Richardson does not look to be out of line with these other placements.

While Richardson's timidity was apparent, Smith's record in the prison to date did not suggest that he was a predator or sadist. Perhaps a detailed psychological workup of Smith and a detailed analysis of the crime that had sent him to prison would have revealed his potential for abusing Richardson, but the prison did not perform and had no resources to perform such an assessment. In the end, while the placement of a child molester with a person convicted of aggravated assault can be questioned, the real problem appears to be the inherent danger of assaults as a result of double celling.

5. Notwithstanding the above, there were also three occasions when action might have been taken which would have saved Richardson. The first occasion was Sunday night, when the third shift officers heard considerable commotion, taunts directed at skinners, verbal harassment of Richardson in particular, and one of the two guards later admitted hearing sounds like "flesh hitting the toilet". While it is possible that this guard described the sound he heard in light of his

subsequent knowledge as to what had happened, his version of events raises questions. At a minimum, he heard various noises which he says he attempted to check out without success but which he did not report to any supervisor. He also acknowledged observing that Richardson was missing a front tooth, which no one else at the prison appears to have observed. This guard also understood that Richardson was the target of verbal taunting for being a skinner. If all of the above facts had been reported to a supervisor, they very likely would have led to the immediate removal of Richardson from the cell for evaluation at that time.

taken to aid Richardson occurred during the second shift on Monday night, based on what happened during the evening "pill run." One of these two occasions was during the pill run itself. If the nurse had sought to have Richardson examined at that time in order to check the groin injury reported by Smith, his condition would have been discovered. This should have been done. However, this is not necessarily the same as saying that the nurse should have suspected the beating. She had been working at the prison only ten months, and Smith offered a plausible reason for Richardson's injuries — that his medication had made him dizzy.

One of the guards who accompanied the nurse was somewhat more suspicious and correctly reported what he had seen to his supervisor, who in turn reported the facts to the second shift lieutenant. If action had been taken at that point, Richardson's condition again would have been discovered. Whether this should have been done depends in part on what the second shift lieutenant was told — an issue on which recollections differ. What was done instead was that the information was reported to the third shift.

By passing the information on in this fashion (even if it was intended that the third shift should independently evaluate whether to take action), the second shift inevitably sent the message that the information did not warrant immediate action but that the situation should only be monitored. Passing the information on also led to the possibility that the information would be watered down as it was passed from shift to shift (which appears to have happened). It is human nature that the second shift, having worked its eight hours, wanted to go home. It appears, however, that if action should have been taken, it should have been taken by the second shift.

We would note in addition that if the events of March 5 are typical of the transmittal of information from guards to supervisors and from shift to shift, there appear to be some serious failings in this respect. In this connection it is

significant that none of the information was entered in the log, and it is therefore impossible to determine after the fact exactly what information was passed along.

It bears emphasis that we have been informed that the prison authorities have responded to these problems by instituting a formal policy that if any injury to an inmate is observed, it is now required that the inmate in question be given a complete medical examination and the circumstances of the injury be personally evaluated by a supervisor at that time. This policy was instituted in 1991. The warden has told us that he believes that the same procedure was usually followed even before there was such a policy but that the Richardson incident demonstrated the need for a formal policy to be instituted. We strongly agree with the implementation of this policy.

7. Lastly, one cannot escape the view that Richardson's death reflected some underlying problems at the Maine State Prison and particularly in the segregation unit during the time period in question. Some of this resulted from lack of resources -- for instance, the poor lighting and particularly the overcrowding -- and some of it resulted from the effect of these conditions on prison personnel. As the warden stated in an interview, "they were dealing with a nightmare up there for five years, at all shifts, they were worn out, they may have

got complacent, they may have got used to the noise, they may have got used to bruises, but they were dealing with a terrible situation that the State in total should have never let happen for five years."

# Allegedly Missing Records

At a suppression hearing held in connection with the criminal case against Roger Smith, an issue arose as to whether some of the relevant prison records relating to Larry Richardson were missing.

Guards in the segregation unit were required to keep a daily record of general inmate behavior on a form entitled "Segregation Individual Behavior and Exercise Log". The document, called the "white sheet", provided space to record specifics about each inmate's behavior and the time that they were afforded their one-hour cell break. Each white sheet represented a 24-hour period and also contained notes about inmate movements or transfers. For example, moving an inmate from one cell to another or one wing to another would be recorded on the white sheet. Also recorded was the transfer of an inmate in or out of the segregation unit.

A white sheet, in combination with the segregation unit log, provided a documented picture of the activity and events in the segregation unit for a 24-hour period. Another document, referred to as a "blue sheet", provided the same

information as the white sheet, but only as it applied to a particular inmate. Indeed, these blue sheets were generally prepared on the basis of the information contained on the white sheets. There was a blue sheet for each inmate in the segregation unit and, unlike the white sheet, it was a running log of individual inmate behavior and movements. As a new page of the blue sheet was completed, it was forwarded to the prison's Classification Department and filed in an inmate's jacket. A single page of the blue sheet typically contained information on an inmate for a two week period.

The blue sheets in Larry Richardson's jacket comprised four pages. Three pages covered his stay in the prison from November 20, 1989 through January 5, 1990. The fourth page represented his stay from February 10 through February 26, 1990. There was no blue sheet for the period February 27 through March 6, 1990.

While one can but surmise about the disposition of a fifth blue sheet in Larry Richardson's file, if indeed it ever existed, our investigation disclosed no evidence that the document was either purposely concealed or destroyed. Indeed, we learned that these blue sheets, periodically submitted to the Classification Department in bulk, were occasionally misfiled. An employee at the prison who assisted in our

<sup>25/</sup>Richardson was transferred to the Downeast Correctional Facility in Bucks Harbor on 1/5/90, and back to the State Prison in Thomaston on 2/9/90.

reconstruction of this situation told us that several misfiled blue sheets (but not Richardson's) were discovered in the course of our inquiries.

It is important to recognize that the blue sheets generally contained information duplicated from the white sheets.

Indeed, the white sheets more frequently than not contained more detailed information. None of the white sheets for the period February 27 through March 6, 1990, were missing or altered. During the period for which blue sheets on Richardson exist (11/20/89 through 2/26/90) there are only two dates where the blue sheets contain information not on the white sheets. The blue sheet entry for December 14, 1989, reads that Richardson took a shower in the north wing of segregation; another entry reads that he refused a shower the next day.

We conclude that there is no evidence to suggest that the missing blue sheet was intentionally destroyed or concealed.  $\frac{26}{}$ 

<sup>26/</sup>At Roger Smith's trial, the defense also raised an issue with respect to the absence of prison briefing sheets with respect to March 3 and 4 of 1990 (the Saturday and Sunday before Richardson's death). These briefing sheets, which cover the entire prison, list such items as the arrival of new inmates, releases or transfers of prisoners to other facilities, transfers of prisoners within the prison, and certain incidents such as assaults. Our review of prison records indicates that it was not at all unusual for such briefing sheets not to be prepared on a Saturday or Sunday. On four of the six weekends immediately preceding March 3 and 4, no briefing sheets were prepared for either Saturday or Sunday. On each of the remaining two weekends, briefing sheets were omitted for one of the two weekend days.

### Postponement of Disciplinary Investigation

Another issue which became a matter of controversy during the criminal case against Roger Smith related to a decision by the Department of Corrections to forego any internal disciplinary investigation until the completion of the criminal case. The facts relating to this issue are as follows:

On March 13, 1990, slightly more than a week after Richardson's death, officials from the Department of Corrections attended a meeting at the Attorney General's Office with several State Police investigators, two Assistant Attorneys General who were assigned to represent the Department of Corrections, and two members of the Attorney General's Criminal Division. During the course of the meeting, the Corrections Department representatives raised the issue of whether they should proceed to investigate the circumstances of Richardson's death with a view toward possible disciplinary These officials advised us that at the time, they had not reached the conclusion that any disciplinary action was warranted but they had not ruled it out. They were concerned, however, because the collective bargaining contract applicable to correctional officers provided that when there was a possibility that an employee might be disciplined, the Department was to notify the employee within 15 days of the incident giving rise to the possible discipline or within 15 days of when the State first had knowledge of the incident.

The Corrections Department representatives at the meeting remember that they raised the subject of a disciplinary investigation and pointed out there were time limits under the collective bargaining contract and requirements that employees be notified that disciplinary action was possible. One of the Corrections Department representatives believes that 15 days was specifically mentioned as the time limit, but the others did not recall that 15 days was specifically mentioned. They all agreed that the Attorney General's chief prosecutor expressed the view that any disciplinary investigation might interfere with the criminal case and asked them to hold off for this reason. In fact, while no one recalls the exact words that were used, all of the Corrections Department representatives and one of the lawyers from the Attorney General's office stated that they left the meeting with the understanding that a disciplinary investigation should not go forward until all criminal proceedings were concluded.

Others at the meeting stated that there was a misunderstanding on this latter point. The chief prosecutor recalled being told that the collective bargaining contract required notice of contemplated discipline and agreed that he had expressed the view that this might interfere with the investigation. $\frac{27}{}$  He was concerned, he recalled, that

<sup>27/</sup>Other participants in the meeting recall that concern was also expressed that any interviews of corrections personnel under the threat of disciplinary proceedings might not be (Footnote continued on next page.)

corrections employees who had been informed that they were facing possible disciplinary action would consult lawyers or union representatives and would be reluctant to cooperate with the criminal investigation.

He added, however, that this potential problem was only present during the investigative phase of the case and that once the State Police had conducted all necessary interviews, he did not see any problem with any disciplinary investigation that the Department of Corrections wanted to conduct. He did not recall mention of any contractual time limits. His understanding at the conclusion of the meeting was that the Corrections Department would be free to proceed with a disciplinary investigation as soon as the investigative phase of the criminal case had been concluded, which he believed would be in a matter of days or at most weeks. Two of the State Police representatives at the meeting agreed with the chief prosecutor's understanding of this issue.

It is undisputed that no one at the meeting suggested in any manner that any negligence or wrongdoing of prison guards be ignored and that no one suggested that the Department of Corrections forego disciplinary action for all time.  $\frac{28}{}$  Nor

<sup>(</sup>Footnote continued from previous page.) usable in a criminal case under the U. S. Supreme Court's decision in <u>Garrity v. New Jersey</u>, 385 U.S. 493 (1967).

<sup>28/</sup>In a memo to the file dated February 22, 1991 -- almost a year after the meeting at the Attorney General's Office -- one of the Corrections Department representatives stated that at the meeting the chief prosecutor had "advised against taking (Footnote continued on next page.)

did anyone state at the meeting that postponing a disciplinary investigation would effectively prevent any discipline from being imposed. One reason is that the Department of Corrections representatives did not believe that this was true. In fact, they consulted the Department personnel officer after the meeting and recalled that he advised them that they could wait to initiate discipline until they received the results of the investigation. 29/ This has since been borne out by the Department's actions in initiating discipline when information came to its attention with respect to the incidents which occurred on the third shift in the segregation unit on the night of Sunday, March 4.

<sup>(</sup>Footnote continued from previous page.)
any type of employee discipline due to the potential damage it
may cause to future criminal cases." When interviewed, this
representative stated that it was his understanding that
disciplinary action could nevertheless go forward once the
criminal cases were completed. This understanding was shared
by all the other attendees at the meeting who recalled any
discussion of the issue. Moreover, this is consistent with a
memo to file, dated three days after the meeting, that was
prepared by another Corrections Department representative.
That memo stated that the Attorney General's Office had said
that "disciplinary cases, if necessary, should be conducted
following the criminal proceedings."

<sup>29/</sup>This was based on the proposition that the time limit under the contract did not begin to run until the Department had knowledge of the incident giving rise to possible discipline. That incident, in turn, was not Richardson's death because the death, in and of itself, would not be the basis of discipline. Rather, discipline could only be based on specific incidents in which correctional employees had acted wrongfully or contrary to existing policy, and the Department did not have knowledge of such incidents.

The unfortunate result of the March 13 meeting was that the Corrections Department representatives left with the understanding that they should not proceed with a disciplinary investigation until the criminal cases were concluded, whereas the message the chief prosecutor intended to convey was that they should wait only until the investigatory phase was concluded. However, we found no evidence of any intent on the part of any attendees at the meeting to cover up negligence or other errors on the part of Corrections Department personnel. The Department of Attorney General and Office of Employee Relations have since met with Corrections officials and provided training on the distinction between criminal and personnel proceedings.