INVESTIGATION REPORT
OF THE
DEATHS OF JOHN LOVE AND THOMAS DURHAM
(Inmates at the Minnesota State Prison)

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INTRODUCTION

Within a period of less than one month, five people died as reported suicides in Minnesota prisons and jails. These deaths are a grim reminder of how the frustrations of life in a prison community are too frequently manifest in acts of violence. At the extreme, as with these cases, such acts result tragically in death. I wonder why? Shouldn't all of us wonder why?

Violent acts whether directed at another or at oneself are shocking as well as perplexing. If five people had been murdered within a period of one month in any community, there would have been grave concern and preventive measures taken if at all possible. Should this not also be the case when five die by their own hands? I hope that we do not view suicide in prison as a form of poetic justice since capital punishment has been banned. I wonder if that was the case in the Torgersen death. I should hope not.

Three of the people who died did so at the Minnesota State Prison. The Ombudsman office was involved in investigating the deaths of two of those persons, John Love who died on October 28, 1973 and Thomas (Bo) Durham who died on October 30, 1973. A brief reference will be made in this report to the death of Wayne Baker which occured on November 19, 1973 and was reported as suicide.

The Ombudsman office initiated an investigation into the reported suicide deaths of John Love and Thomas Durham upon the request of Warden Bruce McManus and on its own initiative.

The method of inquiry chosen was that of a hearing panel consisting of the Ombudsman and his staff. Both staff and inmates were called to testify.

In connection with the John Love inquiry, we interviewed 28 people totaling 28 hours. In the case of Thomas Durham, we saw 15 people over a period of 13 hours. In addition to testimony, we examined the cells of both inmates and the evidence that was made available to us. In the case of John Love, we studied the autopsy report prior to writing this report.

This report will attempt to recount what happened in the cases of John Love and Thomas Durham. We will describe how each man was discovered in his cell and what action was taken by staff. The report will indicate whether the Ombudsman felt that death was due to suicide and will make specific recommendations concerning corrective measures that ought to be taken. The report deals with John Love and Thomas Durham separately.

In the case of John Love, we began our inquiry without any preconceived notions as to how he died. The investigation was aimed at discovering all of the facts pertaining to his death. The questions to be answered were: When did he die? How did he die? Where did he die? Why did he die? Who was responsible for his death?

With Tom Durham, we had talked with him shortly before he died. Our inquiry into his death was an attempt to verify what he said on his deathbed that his wounds were self-inflicted. In addition, we wanted to determine the appropriateness of staff response to his situation (the rescue effort from his burning cell). The report comments briefly on the Why? When? and How? of Tom Durham's death.

JOHN LOVE

At approximately 9:00 A.M. on Monday morning, October 29, 1973, we were notified of John Love's death. It was reported to us as a death of suicide by hanging. Prior to visiting the prison on the same day, the Ombudsman and two members of his staff visited the Hennepin County morgue and viewed John Love's body. We visited the prison and met with a group of black inmates who were disturbed about John Love's death and were making accusations about John having been killed. After assuring the group that the Ombudsman would thoroughly investigate John Love's death, we examined and photographed the cell in which John Love died. By this time (approximately 1:30 P.M.) the cell had been thoroughly cleaned and all items had been removed.

When and Where did John Love Die?

At approximately 9:00 P.M. on Sunday, October 28, 1973, John Love was found dead in his cell in a seated position in a corner near the bars and cell door. According to the officer who found him, John had a prison issued bath towel, radio earphones and cord, and an approximately 18" torn and rolled strip of bedsheet around his neck. The towel was draped around his neck with the ends hanging down front on his chest. The earphone and cord were wrapped in the towel. The bedsheet was wrapped around John's neck. In addition, a 12" to 15" strip of bedsheet was tied to the top of the cell bars about five bars in from the North wall on the same side of the cell where John's body was found. This may have been the mate of the torn sheet found around John's neck.

John was found in his C-Detention cell by the Custody sergeant. C-Detention is located immediately behind the Custody Office in an area consisting of ten cells and a shower area. The cells face several windows which open into a courtyard. In order to reach the C-Detention cells from the main corridor outside the Custody office, one must pass through four locked steel bar doors. The first door is controlled from within by an electric switch. The last two doors that must be unlocked before entering the C-Detention area

are keyed differently and require two different keys to open them. The doors to the cells are locked requiring still another key to open them.

At approximately 9:00 P.M. the Custody sergeant responded to a call from one of the two inmates who were housed in the C-Detention area with John Love. Prior to calling, they reportedly heard a snap and a loud thud sound coming from John Love's cell. After calling to him several times and receiving no answer, one of the inmates called for the Custody sergeant. He responded and found John in the previously described slumped position. The sergeant reportedly reached through the bars and shook John by the shoulder and got no response. He then returned to the Custody office to secure the key to unlock the cell. Another officer accompanied him back to John's cell. They unlocked the cell and removed the towel, radio and earphone cord, and rolled strip of bedsheet from around his neck. They began to apply artificial respiration. They were unsuccessful in their attempt to revive John Love. Shortly thereafter, two other officers and the hospital nurse arrived on the scene to assist. A few moments later at least two other officers arrived. The coroner was called and arrived on the scene at approximately 9:30 P.M. A few moments later John Love was pronounced dead. At approximately 10:00 P.M. the physician on call to the prison arrived and confirmed John Love's death. Shortly thereafter, the body was removed to the University of Minnesota. The following morning it was transferred to the Hennepin County morgue.

The exact time of death has not been established. He probably died some time between 8:30 and 9:00 P.M. He was last seen alive at 8:30 P.M. when the officer made his rounds.

How did John Love Die?

The autopsy report was inconclusive as to a definite cause of death but "the marks on the neck would be consistent with a broad, soft cincture and the small amount of hemorrahage in the connective tissue of the neck as well as pulmonary findings would be consistent with asphyxia." The broad, soft cincture to which the autopsy report refers is the torn and rolled bedsheet referred to earlier in this report. The autopsy report, along with the testimony of the officer who found the body, would tend to eliminate the towel and the radio earphone and cord as the instruments of death.

In attempting to restructure how John may have died, we concluded that the sheet was the probable instrument of death. He probably attached it to the top of his cell and tied it around his neck with the towel and earphone cords covering it and sat down. In doing so, the sheet tore apart thus accounting for the strip of sheet shown hanging from the top of the cell bars in the pictures taken shortly after his death. It would also account for the piece of sheet reportedly found around John's neck.

Because of the way the prison officials handled the situation, it makes it difficult to be any more conclusive about how John may have died. The cell was cleaned the following morning before anyone other than prison officials had an opportunity to inspect it. Either in the process or prior to cleaning the cell, certain evidence disappeared never to be found again. The most crucial of which was the torn bedsheet found around John's neck and the piece tied to the top of his cell.

There was a suicide note found with John Love's name signed to it. We have been unable to verify who found the note; therefore, we are not sure when and where it was found in his cell. The writing on the note is of a style that is somewhat different from John's traditional style of writing which is rather meticulous. However, he has occasionally deviated from the meticulous style. It is probable that the note was written by John, but we have requested that it be authenticated.

We found no evidence during our inquiry to indicate that foul play was involved in John Love's death.

From the time that John Love was found dead in his cell and until the body was removed from the C-Detention area there were several staff people (at least six) and inmates (at least two) in and out of the area. No special effort was made to secure the area and control the flow of traffic in and out.

Who was Responsible for John Love's Death and Why did He Die?

The effort to establish responsibility and determine why John Love died is based upon testimony from inmates, staff, friends, and relatives. In addition, we reviewed the prison files on John along with several other documents

and information including photographs of the body and the cell.

John Love was transferred from the State Reformatory for Men to the Minnesota State Prison on July 14, 1972. In less than six months after his arrival, he was involved in a variety of situations that resulted in his confinement to segregation or detention. He had five different periods of confinement beginning with December 5, 1972 and ending with October 7, 1973. There were only brief periods in between when he was a resident in the general population of the prison.

On October 7, 1973, he was confined in the detention area of the prison as a suspect in the stabbing of an officer. John was found dead in his locked cell at approximately 9:00 P.M. on October 28, 1973. He had not been arraigned in Washington County court nor had he had a hearing in the prison disciplinary court. A hearing had been scheduled for October 30, 1973.

On October 25, 1973, John made a written request for a special visit from his girlfriend. That request was denied by the captain. We were unable to verify whether John was notified of the denial. On the morning of October 28 John telephoned a friend who has been a frequent visitor to see if she could visit him. She was out and did not get the message until it was too late to visit. This same person had previously responded to requests from John to visit. During those visits, John was always pleased to see her. He invariably did most of the talking in a compulsive way. He was constantly trying to be impressive.

We learned that the girlfriend apparently visited the prison on October 28 and was denied a visit with John. He later learned that she had been to the prison. According to one of the inmates housed in the detention area with John, he was very upset when he learned about the visit.

Several letters from John Love written to different people made mention of his frustrations over prolonged lockup in segregation and detention. He felt he was being unduly harassed and that he was not guilty of the offense for which he was currently locked up. John wrote a letter to the Governor dated October 18 and received in his office on October 26, 1973. In that letter he spoke of his frustration with what was happening to him.

According to the two inmates in detention with John Love, he had talked about killing himself. They told him not to do it but did not take him seriously and made no effort to summon any staff at the time.

The psychological tests (MMPI) administered to John on February 8, 1971 revealed, among other things, that he"may express suicidal fears or thoughts." The hearing officer at the prison indicated that prolonged segregation or detention for John Love would be counterproductive and probably injurious to his mental health.

CONCLUSION AND FINDINGS

The evidence for suicide is considerable. The question of responsibility has to be considered in the light of how different people may react to external forces. John Love was under considerable pressure. He felt harassed and unable to control what was going on around him.

1. The autopsy report supports death by asphyxiation which is consistent with hanging.

2. Although the autopsy report revealed the presence of Butabarbital in the blood specimen in the concentration of 1.15 mg. percent and .82 mg. percent concentration in the liver specimen, that was not a sufficient quantity to have had an adverse effect upon John Love. It most certainly would not have rendered him unconscious or unable to defend himself.

3. The autopsy report did not reveal any evidence of a struggle. There were no bruises on the body.

4. John Love was 5'9" tall and weighed approximately 175 pounds. He was strong and muscularly well developed. It is unlikely that he could have been easily subdued.

5. On October 25, 1973, John Love requested a special visit with his girlfriend. The request was denied, but he may not have been told of the denial.

6. On October 28, 1973, during the morning, John Love telephoned a friend who had been a regular visitor to request her to visit him. He felt it urgent. She did not receive the message until it was too late to arrange a visit.

7. The girlfriend appeared at the prison on October 28 and was denied a visit with John. He learned about this and was obviously upset.

8. He discussed committing suicide with two inmates in detention with him. They discounted it and did not call for help.

9. The detention area was visited at 8:30 P.M. by an officer on a routine check. John was still alive and in his cell at that time.

10. The officers' check sheet-Cell Hall C is supposed to show the name and time of every visit to the segregation, isolation and detention area of the prison. On October 28, 1973, the only listing shown was the routine checks which occurred on a 45 minutes to one hour basis. The last entry was 9:30 P.M.

11. There were considerably more people who entered the C-Detention area than the entries on the check sheet show.

12. The two inmates reported that they heard a snap-like sound and a thud from John's cell shortly before 9:00 P.M. They called to John and got no response and then called for the sergeant.

13. The response was immediate and efforts were made to revive John.

14. The coroner was called and he arrived at approximately 9:30 P.M. and pronounced John dead.

15. The sheriff was not called. No consideration was given to calling the sheriff or any other law enforcement official, but the staff assumed it was suicide and there would be no further need to defend that assumption.

16. The traffic in and out of the area where John died was heavy and basically uncontrolled. At least two or more inmates were allowed in the area prior to the removal of the body.

17. No special effort was made to seal off the area before or after the removal of the body. The cell and doors leading to detention were locked after the body was removed, but at least one inmate was allowed back in the area after the body had been removed and the two inmates confined back there were transferred to the quiet cells in the hospital.

18. Evidence in the cell was not protected. The staff did not feel the need to take precautions to protect evidence that might clearly establish what happened.

19. The cell was cleaned the following morning without any precautions being given about protecting evidence. As a result, key evidence is missing, e.g. the two parts of torn bedsheet that allegedly was used as the instrument of death.

20. A suicide note was found, but no one will admit to finding it. This could raise a question as to whether the note dated October 27, 1973 was found prior to John's death and there was a failure to act on it.

21. The note is in a style of writing somewhat different from John's traditional style. He has upon occasion written in a similar style. Because of the question of authenticity, the note is being submitted to the F.B.I. for analysis.

22. John Love's MMPI report indicated, among other things, that he may express suicidal thoughts or fears.

23. No real effort had been made to develop a treatment program for John Love based upon his needs or what was already known about him.

24. John Love had not been granted parole.

RECOMMENDATIONS

1. Death procedure now in use at the prison should be revised to include the calling of the appropriate law enforcement officials in the case of deaths that are not due to obviously natural causes. Until such officials appear on the scene,things should remain undisturbed. This does not mean that a person should not attempt to give first aid where there might be an opportunity for survival.

2. Because the prison is a part of the criminal justice system, staff should be trained in the protection of evidence for further investigation.

3. The professional staff must become increasingly more aware of the needs of the inmates and begin to work with them toward meeting those needs. The psychological test on John Love was quite revealing, but it seems obvious that the staff had not attempted to make use of that information in a constructive way.

4. If psychological tests and psychiatric evaluations are important, then the results should be used constructively.

5. The prison should explore the creation of a crisis intervention team that would be on call on a 24 hour basis. This team could consist of both staff and inmates and they would be available to talk with an inmate who is undergoing a crisis that might lead to suicide or some other form of destructive behavior. Members of such a team should be trained. Assistance in establishing such a program could probably be obtained through the Crisis Intervention Center at Hennepin County General Hospital.

6. The officers' check sheet for Cell Hall C should fully reflect the traffic in and out of the area. In addition, records should be kept in the Custody office area that would tell why an individual is confined and whether there are any

special problems that the staff should know about.

The Ombudsman office feels that its inquiry has been as thorough as possible and that the findings and recommendations are supported by the testimony from witnesses and other documentation.

THOMAS DURHAM

At approximately 6:00 A.M. on October 30, 1973, staff members discovered that Thomas Durham's cell, #219 in A House, was ablaze. Upon extinguishing the fire, the staff with the assistance of the inmates removed Mr. Durham from his cell. He was taken by ambulance within an hour to the University of Minnesota Hospital from where he was transferred to the burn unit of the St. Paul Ramsey Hospital.

At 10:30 A.M. on October 30, Ombudsman Williams interviewed Mr. Durham at the St. Paul Ramsey Hospital. During this interview Mr. Durham admitted that he had set fire to his own cell. He also indicated that he had swallowed Sani-Flush, taken thorazine, and cut his wrists. On the evening of October 30, he died as a consequence of these actions.

Mr. Durham's death has prompted both inmates and staff members at the prison to ask two critical questions: Why did Thomas Durham Commit suicide? How adequate was the response of the staff to the emergency?

Why did Thomas Durham Commit Suicide?

During his interview with Mr. Williams, Mr. Durham said that he was "disgusted" with himself. He also felt that "everybody" was talking about him and that "someone" was going to get him because of "something" he had told a "snitch." These feelings of self-disgust and fear may have had a legitimate, factual basis. However, they were undoubtedly "aggravated" by the combination of drugs taken by Mr. Durham during the three days prior to his death. He had smoked at least one joint of marijuana and had taken an unknown quantity of valium and thorazine on October 29. He had also been on "speed" on at least two consecutive days--October 27 and October 28.

How did the Staff Respond?

Several factors hampered the immediate extinguishment of the fire and the rapid removal of Mr. Durham from his burning cell:

1. The fire was extremely intense! It was started by the use of lighter fluid and/or other "volatile components probably derived from a petroleum product." The State Fire Marshall's report stated that "enough combustibles were available to produce a very hot fire near 1200 to 1400 degrees. Based on the extent of the burning and the comsumption of combustible material within the cell...the fire burned about ten minutes but not more than 15 minutes."

2. Mr. Durham had placed a hasp and padlock on his cell door, thus locking himself inside. Officers responding to the fire had to secure a bolt cutter to remove the hasp.

3. Mr. Durham had stacked all his personal items in the front of his cell thus impeding rapid entrance from the outside.

4. The cell itself is 6'x12'. Three of the walls are concrete covered with rubber-base paint; the fourth side is constructed of iron bars set approximately four inches apart. One half of this barred section is a door which slides on tracks mounted at the top and bottom of the cell front. The flames and smoke from the fire could escape only through this front barred opening. As a consequence, the bars became extremely hot and the smoke poured out profusely.

Given these set of circumstances, it is evident that Mr. Durham was removed from his cell as rapidly as possible. At least two inmates were instrumental in extinguishing the fire and in removing Mr. Durham from his cell.

FINDINGS

1. Thomas Durham set his own cell ablaze. His death was a suicide.
2. Given the nature of the circumstances, the staff responded reasonably well.
3. At least two inmates were instrumental in extinguishing the fire and in removing Mr. Durham from his cell.

RECOMMENDATIONS

1. The Minnesota State Prison should develop a program to train its staff in firefighting, first aid, and rescue procedures. This would insure that at least some staff members on each shift would be able to respond to emergencies

quickly and effectively.

2. We strongly endorse the MSP Fire Marshall's request for three self-contained breathing devices. In addition, there are other firefighting tools that could be secured. These include smoke masks , more extinguishers capable of putting out chemical fires, portable exhaust fans capable of removing smoke from a cell house, asbestos gloves, and perhaps a full asbestos suit.

3. The fire evacuation plan now being formulated for the entire prison must be completed as soon as possible.

4. The inmates who were instrumental in extinguishing the fire must be given deserved recognition. At the very least, positive reports should be written describing their role. These reports should be placed in their base files.

5. A more accurate record must be kept of drug dispersal from the prison pharmacy to inmates.

WAYNE BAKER

Wayne Baker was found by a staff member hanging in his cell in B House at approximately 3:15 P.M. on November 19, 1973. During the afternoon of November 20, 1973, we discussed Mr. Baker's death with two staff members and with the inmate who lived two cells from Mr. Baker. These discussions revealed that Mr. Baker was upset by several personal problems. We also examined the contents of his cell and noted in particular that the end of the rope used by Mr. Baker to hang himself was still attached to the upper bars. A note, written by Mr. Baker, was discovered in his cell. It pointedly states his desire to end his life.

Based upon our discussion with staff and an inmate, the examination of his cell, and the contents of the note, we conclude that Mr. Baker committed suicide.