REPORT BY THE

Comptroller General

OF THE UNITED STATES

The Danbury Prison Fire-- What Happened? What Has Been Done To Prevent Recurrence?

GAO reconstructs the events of the morning of July 7, 1977, when a fire at the Danbury Federal Correctional Institution in Connecticut took the lives of five inmates and injured many others. The report discusses the fire's origin, the activities of correctional staff and inmates, the factors contributing to the tragedy, and the actions taken by the Bureau of Prisons to investigate the fire and make improvements.

GGD-78-82
AUGUST 4, 1978

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-133223

The Honorable Abraham Ribicoff
The Honorable Lowell Weicker, Jr.
United States Senate

This report examines the conditions at the Federal Correctional Institution at Danbury, Connecticut, before and after the fire of July 7, 1977, the events of the fire, and the subsequent Bureau of Prisons investigation and report. We made our review in response to your joint request letter of November 17, 1977.

As arranged with your offices, the report is available for general distribution.

Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT
TO THE HONORABLE ABRAHAM
RIBICOFF AND THE HONORABLE
LOWELL WEICKER, JR.
UNITED STATES SENATE

THE DANBURY PRISON FIRE--WHAT HAPPENED? WHAT HAS BEEN DONE TO PREVENT RECURRENCE?

D I G E S T

GAO was asked by Senators Ribicoff and Weicker to investigate the objectivity, accuracy, and completeness of the Bureau of Prisons investigation and report on the July 7, 1977, fire at the Federal Correctional Institution in Danbury, Connecticut. The fire killed five inmates and injured many others.

The Bureau of Prisons had convened a Board of Inquiry composed of Bureau personnel, none of whom were experts in fire safety investigations. This raised questions regarding the Bureau's objectivity and ability to effectively investigate the Danbury fire. Subsequently, the Connecticut chapter of the National Association for the Advancement of Colored People reported that institutional staff members did not adhere to established policies and procedures during the fire. (See chs. 1 and 5.)

GAO found no evidence that the Board of Inquiry was not objective in its investigation of the fire. The Board's report and supporting documents were not always clear, but they were basically accurate and in accordance with the evidence GAO gathered. Nevertheless, the fact that all members were Bureau personnel was perceived by some as reflecting on the Board's credibility and its ability to draw objective conclusions. (See ch. 5.)

To determine what happened during and after the fire, GAO

--interviewed 57 inmates, 16 prison staff members, the Board of Inquiry members and other Bureau officials, and officials from the responding fire department and the Danbury hospital;

--spoke with experts who investigated the fire, including investigators from the Connecticut Fire Marshal's office and the Federal Bureau of Investigation; and

--conferred with representatives of the National Fire Protection Association regarding fire safety in correctional institutions. (See ch. 2.)

GAO's review was hindered by several factors--physical evidence was no longer available, several inmates had been transferred or released, there was conflicting testimony, and confusion was caused by the frantic events at the time of the fire.

GAO, in its investigation,

--reviewed the policies and standards on fire safety established by the Bureau;

--evaluated conditions at Danbury both before and after the fire; and

--concluded that the building material used in remodeling the area which caught fire was, at the time of its installation, in accordance with the National Fire Protection Association Life Safety 101 Code.

However, the institution did not fully comply with existing fire safety training and preparedness guidelines. This aggravated the fire situation, hindering fire suppression and inmate evacuation. Weaknesses in the institution's fire safety program included

--inadequate and infrequent fire safety inspections,

--an inadequate fire plan,

--absence of reliable exits, and

--inadequate lighting. (See ch. 3.)

In the wake of the Danbury fire, the Bureau has taken action to improve fire safety at

Danbury and other Federal correctional institutions. Most of the Danbury deficiencies have been corrected. Moreover, agency-wide action has begun to bring all institutions into compliance with the Life Safety 101 Code by improving housing unit fire hose cabinets, emergency lighting, locks on emergency doors, fire plans, and inspections. Building materials and furnishings in housing units are to comply with the code by October 1, 1979. All living areas are to be equipped with smoke detection systems.

Significant fire safety improvements have been made at Danbury and are planned at other Bureau institutions. However, to further improve the situation, GAO recommends that the Attorney General require the Director, Bureau of Prisons, to:

--Provide correctional staff with increased fire safety training, emphasizing applicable Bureau policies and procedures and use of fire-fighting equipment.

--Include non-Bureau personnel, preferably with expertise in fire investigations, on future Boards of Inquiry.

--Keep abreast of significant changes in fire safety standards so that alterations in existing institutions can be considered. (See ch. 6.)

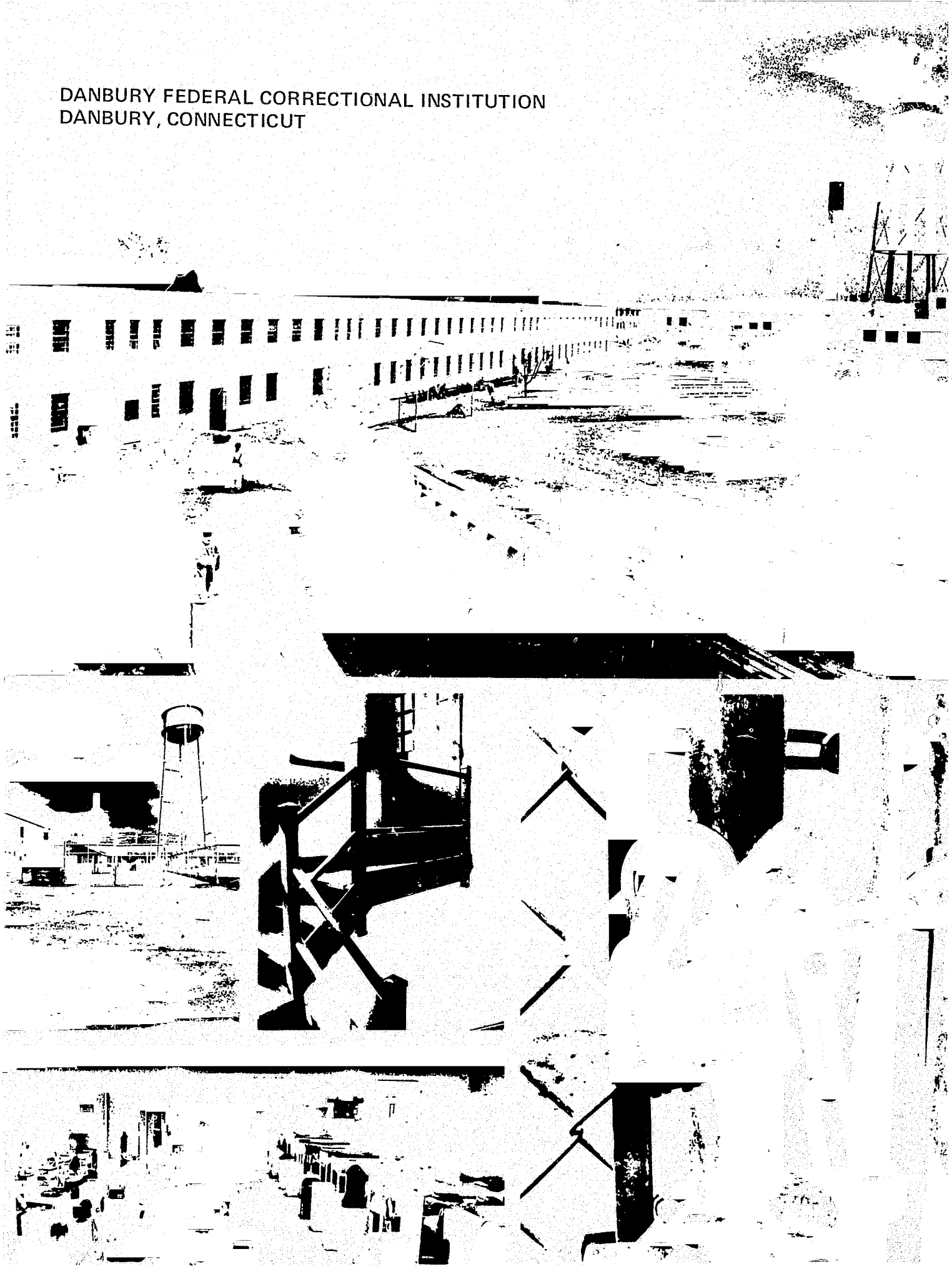
The Department of Justice concurred in these recommendations but believed that decisions to include outside personnel on future Boards of Inquiry ought to be made on a case-by-case basis. (See app. II.)

Contents

ABBREVIATIONS

FBI	Federal Bureau of Investigation
FCI	Federal Correctional Institution
GAO	General Accounting Office
NAACP	National Association for the Advancement of Colored People
NFPA	National Fire Protection Association
OSHA	Occupational Safety and Health Administration

DANBURY FEDERAL CORRECTIONAL INSTITUTION
DANBURY, CONNECTICUT



CHAPTER 1

INTRODUCTION

On July 7, 1977, a fire occurred at the Federal Correctional Institution (FCI) in Danbury, Connecticut. During the blaze, five inmates died and many people were injured. About 70 people were hospitalized as a result of their injuries.

The day after the fire, the Federal Bureau of Prisons convened a Board of Inquiry to investigate what happened, and in August 1977 the board issued its report. Subsequently, the National Association for the Advancement of Colored People (NAACP) questioned the completeness and objectivity of that document and initiated its own investigation.

Because of the concerns of the NAACP and others regarding certain aspects of the fire, Senators Abraham Ribicoff and Lowell Weicker, Jr., requested by letter dated November 17, 1977 (see app. I), that we investigate the objectivity, accuracy, and completeness of the Bureau's investigation and report on the Danbury fire.

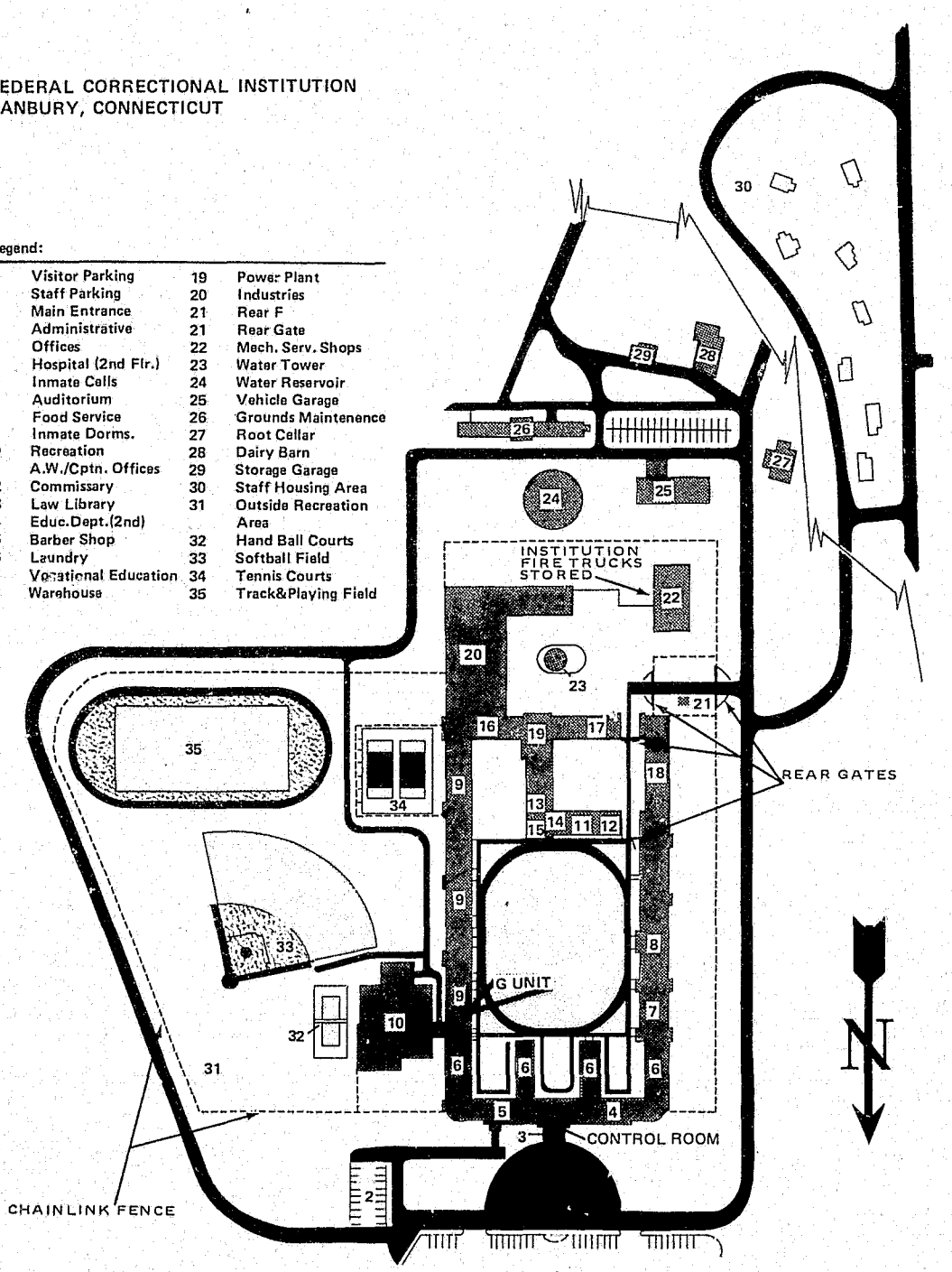
BACKGROUND ON THE SCENE OF THE FIRE

The Danbury FCI is a medium-security facility, and at the time of the fire housed 839 male inmates. The institution's 14 housing units contained either large open sleeping areas or groups of private rooms or cells. These housing units and several other buildings are joined together to form a rectangle with a center courtyard. (See diagram on p. 2.) The facility has two primary entrances: a front walk-in gate and a series of rear gates large enough to admit vehicles. The housing unit buildings are made of reinforced poured concrete, with case-hardened bars on the windows.

FEDERAL CORRECTIONAL INSTITUTION
DANBURY, CONNECTICUT

Legend:

1	Visitor Parking	19	Power Plant
2	Staff Parking	20	Industries
3	Main Entrance	21	Rear F
4	Administrative Offices	21	Rear Gate
		22	Mech. Serv. Shops
5	Hospital (2nd Flr.)	23	Water Tower
6	Inmate Cells	24	Water Reservoir
7	Auditorium	25	Vehicle Garage
8	Food Service	26	Grounds Maintenence
9	Inmate Dorms.	27	Root Cellar
10	Recreation	28	Dairy Barn
11	A.W./Cptn. Offices	29	Storage Garage
12	Commissary	30	Staff Housing Area
13	Law Library	31	Outside Recreation Area
14	Educ.Dept.(2nd)		
15	Barber Shop	32	Hand Ball Courts
16	Laundry	33	Softball Field
17	Vocational Education	34	Tennis Courts
18	Warehouse	35	Track&Playing Field



APPOINTMENT OF THE BOARD OF INQUIRY AND ITS REPORT

On July 7, 1977, the Director of the Federal Bureau of Prisons appointed a Board of Inquiry to investigate the fire. The Board was composed of five Bureau of Prisons employees. It convened on July 8, 1977, in Danbury, and during its inquiry interviewed more than 100 inmates, 24 staff members, and various witnesses and investigators from other organizations. It also inspected the damaged unit several times and performed tests on material involved in the fire.

The Board's report, issued August 30, 1977, described the sequence of events during the fire and addressed several significant issues which are discussed in chapter 4.

THE NAACP INVOLVEMENT

Friends and families of some of those who were injured or perished in the fire asked the NAACP for help. They felt that the staff at Danbury had failed to take all necessary steps to protect the lives of the inmates. After reviewing the Board of Inquiry's report, the NAACP concluded that it was "vague, evasive, and failed to deal with the key questions that had been raised regarding the fire." The NAACP also questioned the Board's objectivity, and as a result began an independent investigation of the fire.

NAACP investigators interviewed 7 Danbury FCI staff members and 19 inmates, 7 of whom lived in G unit--the unit where the fire occurred. The NAACP report concluded that "established policies and procedures covering the prevailing situation of the morning of July 7, 1977, were not adhered to by the staff members nor were they enforced by the institution."

SCOPE OF THE REVIEW

We interviewed 57 inmates, 16 prison staff members, and officials from the responding fire departments and the Danbury hospital. We spoke with experts who investigated the fire, including an investigator from the Connecticut Fire Marshal's office and one from the Federal Bureau of Investigation (FBI). We also conferred with the National Fire Protection Association (NFPA) regarding fire safety in correctional institutions.

We reviewed Bureau of Prisons policies and standards on fire safety in effect both before and after the fire,

and identified and evaluated the pre- and post-fire conditions at Danbury FCI with Bureau of Prisons officials at the institutional, regional, and national level. We also reviewed the Board of Inquiry's report and supporting documentation in order to determine its accuracy, completeness, and objectivity. We discussed these matters with the members of the Board.

In addition, we reviewed and evaluated the reports of the FBI and the NAACP. The FBI used interviews and laboratory examinations to identify the cause of the fire and develop its findings. The NAACP based much of its report on its evaluation of the Board of Inquiry's report and interviews with several individuals.

Our review of the Danbury FCI fire was hindered by several factors. Much of the physical evidence was no longer available, and accordingly we were forced to rely on unverified information provided by other investigative organizations. Further, several inmates had been transferred or released, making some contacts difficult. In addition, one former correctional officer--on duty during the fire--did not reply to our inquiries.

Conflicting testimony also presented problems. During the long interval--about 9 months--between the occurrence of the fire and our investigation, many witnesses' recollections of the events became clouded. In addition, experts informed us that during the confusion of a fire, even trained observers often become confused regarding actual events. With these facts in mind, we carefully reviewed all our source material and attempted to reconcile differences. Chapter 2 of this report presents a chronology of the happenings of the early morning of July 7, 1977, as we have reconstructed them.

This report contains several sketches and illustrations of the location, activities, or people who witnessed, responded to, or were involved in the July 7, 1977, fire. The sketches do not represent an individual's actual physical characteristics or facial identity.

CHAPTER 2

THE FIRE--JULY 7, 1977

We have reconstructed the key events of the fire at the Danbury Federal Correctional Institution on July 7, 1977. Considering the chaos and confusion which invariably are associated with a tragedy of this nature, and recognizing that individual perceptions of any event frequently vary, the following represents our best judgment as to what happened.

WHERE THE FIRE OCCURRED

The Danbury FCI is a medium-security institution for men 24 years of age or older and with 5 years or less to serve. Individuals committed to Danbury are not considered to be either dangerous or significant escape risks. On July 7, 1977, 839 inmates were assigned to the 14 housing units.

The fire was restricted to G unit, where 80 inmates slept. G unit is located on the top floor of a two-story building. The inmates slept in 42 single bunks and 19 double bunks aligned in four parallel rows. (See diagram on p. 6.) The construction and materials of G unit were similar to other housing units at the institution.

The majority of the inmates in G unit were former drug addicts participating in a rehabilitation program. G unit was one of two such units at Danbury.

CORRECTIONAL PERSONNEL ON DUTY

Normally, nine staff members were on duty at the institution from midnight to 8:00 a.m. They included a correctional supervisor, a medical technical assistant assigned to the prison hospital, and seven correctional officers assigned as follows:

--Three on roving dormitory patrol.

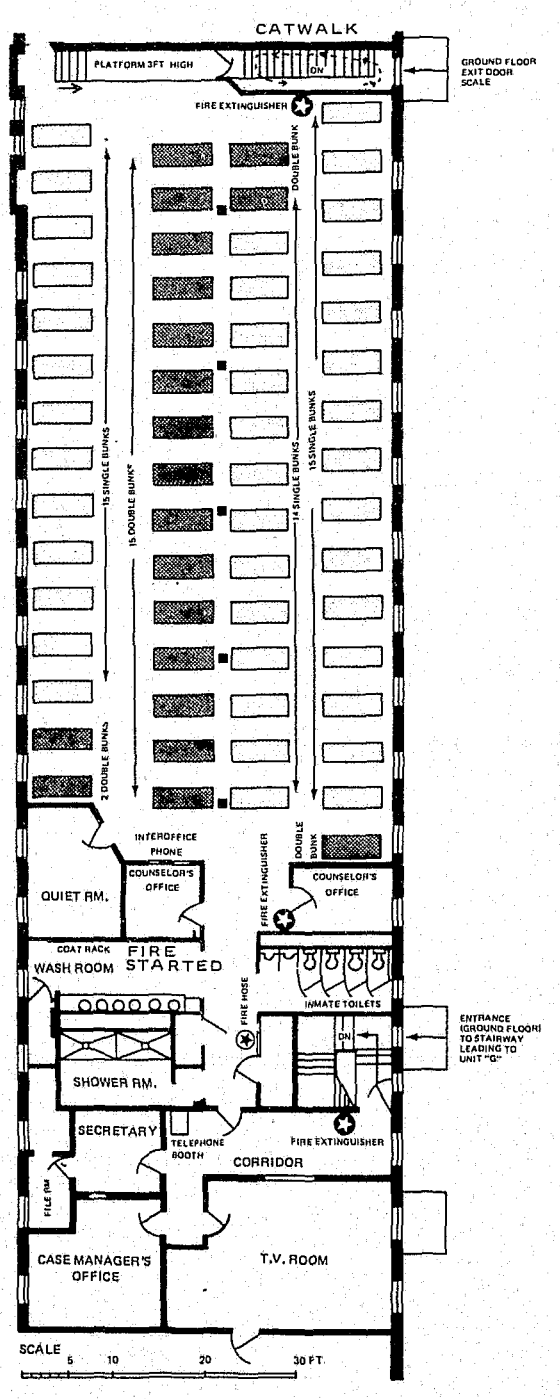
--One in the administrative detention unit.

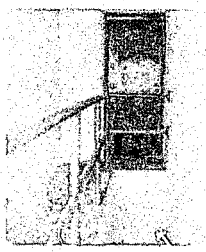
--One in the institution control room.

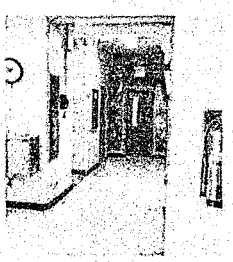
--One patrolling the courtyard.

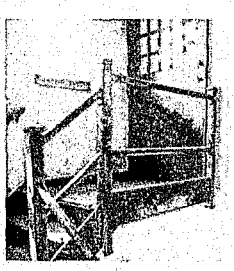
--One patrolling the institution's perimeter.

UNIT "G" SECOND FLOOR
FEDERAL CORRECTIONAL INSTITUTION
DANBURY, CONNECTICUT









On the morning of July 7, 1977, a tenth staff member was present, the correctional supervisor from the preceding watch.

REPORT OF FIRE

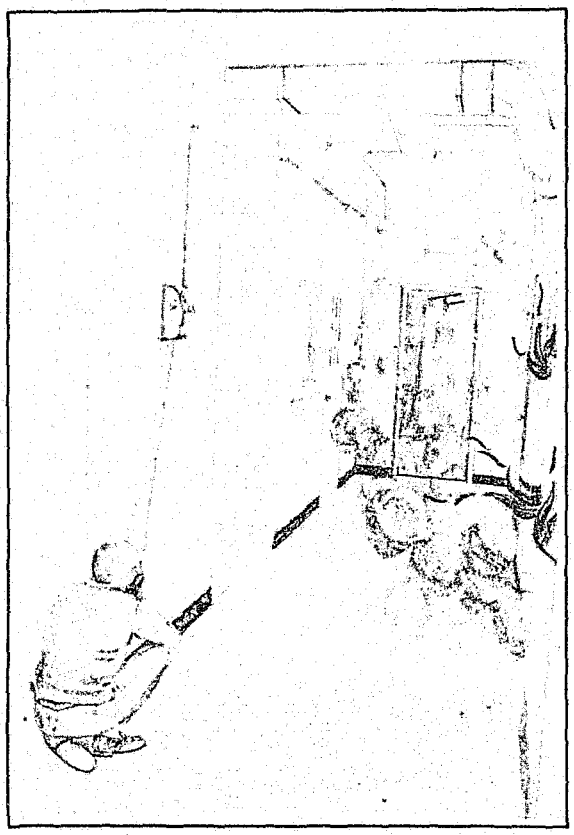
The morning watch began normally and the correctional officers went about their usual duties, including a count of all inmates which was completed by 1:00 a.m.

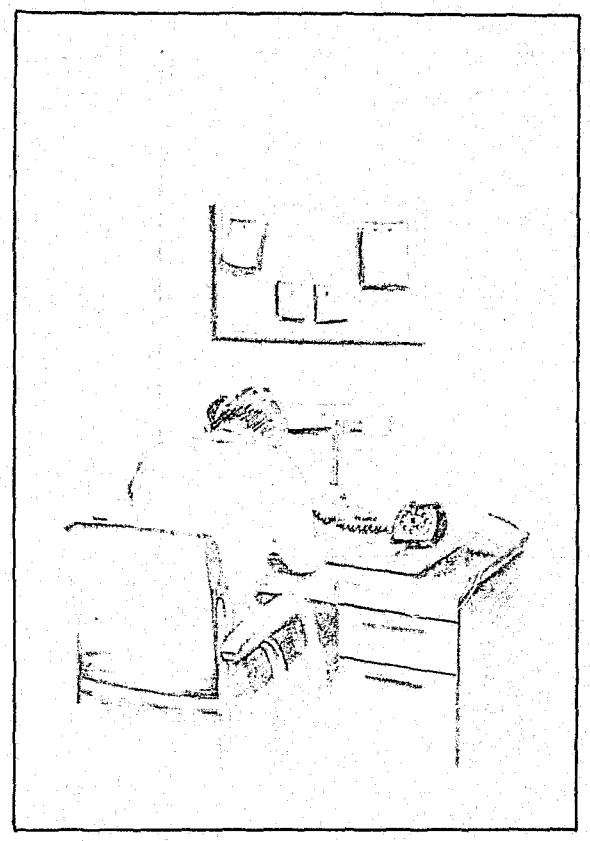
Between 1:00 and 1:15 a.m., the institution's internal emergency telephone rang. The exact time of the call is unknown, because the institution did not record such calls. There was a wide disparity in estimates of the time by various individuals involved, ranging between 12:45 a.m. and 1:22 a.m. However, based on our interviews and analysis of the actions of individuals involved, it appears that the call was made no later than 1:15 a.m., and probably between 1:05 and 1:10 a.m.

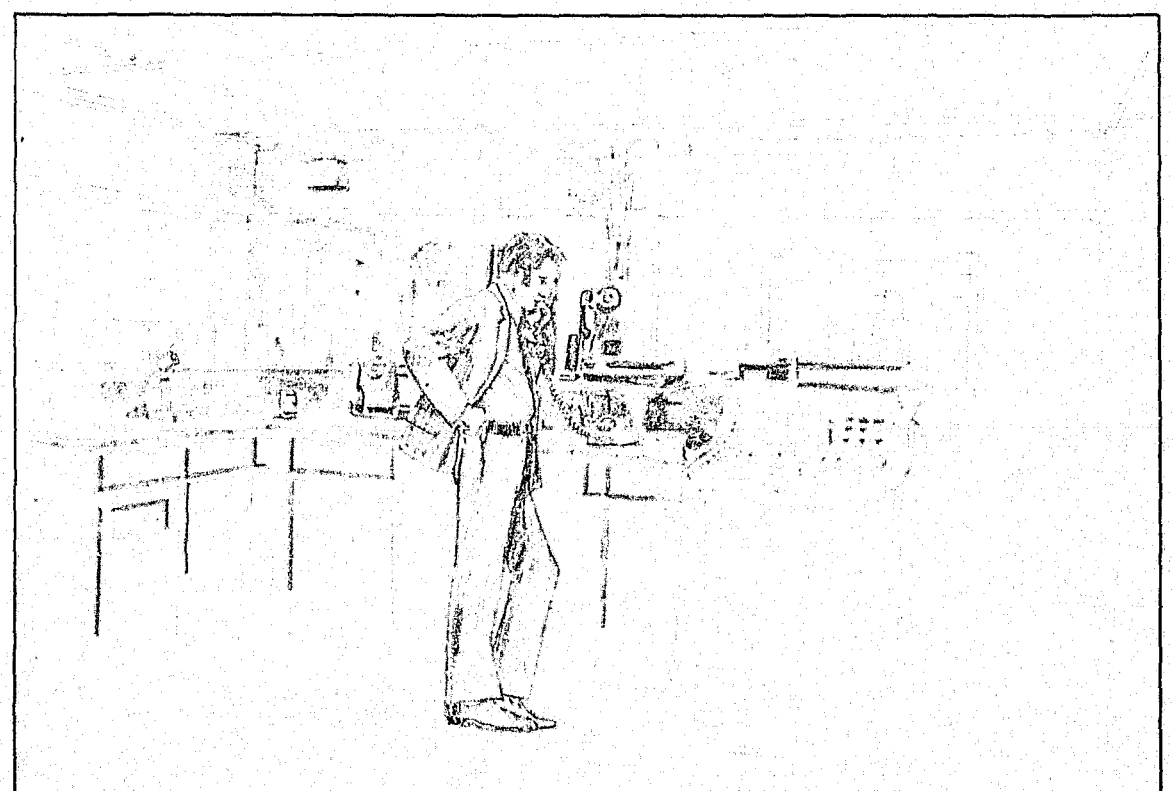
The call was answered simultaneously by the control room officer and the prior watch supervisor, who along with the other supervisor was in a building across the courtyard from the control room. (See diagram on p. 2.) The inmate caller reported a fire in G unit and requested assistance.

It has been reported that the control room officer made certain comments which indicated that he failed to take the call seriously and hung up. He denies this. In this regard, the supervisor who simultaneously answered the call stated that he hung up immediately after receiving the message and could not comment on how the control officer responded. We were unable to identify the inmate who made the initial call. At least three calls came from G unit at the alleged time the fire was reported, and the officer's comments could have been made to any one of the callers.

Despite this unresolved issue, response to the emergency call was prompt; both supervisors immediately headed for G unit to investigate the report.

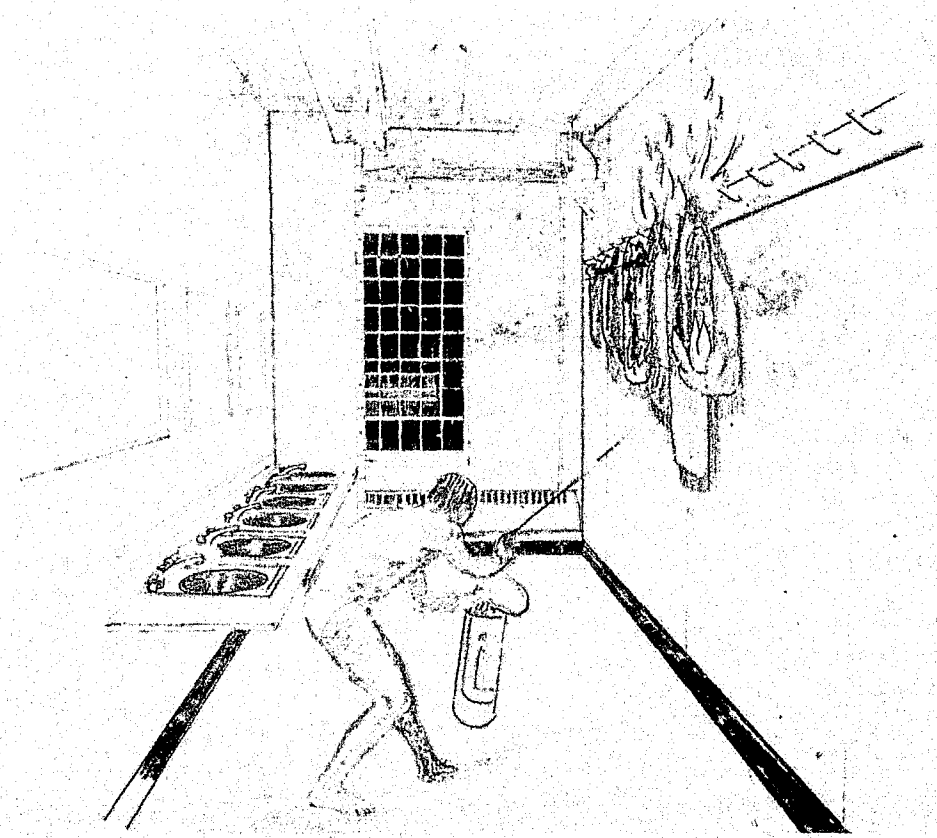






ACTIONS OF INMATES PRIOR TO
ARRIVAL OF CORRECTIONAL SUPERVISORS

Several G unit inmates discovered a small smouldering fire in some jackets hanging on the washroom wall. As inmates gathered, they collected the three unit fire extinguishers (see diagram on p. 6 for locations) and attempted to extinguish the fire. However, the flames were fanned by an updraft from an open window and were propelled in a swirling motion along the wall and ceiling--igniting both surfaces.



When the inmates failed to suppress the fire with the extinguishers, 1/ they attempted to apply more water to the expanding fire. Mop buckets were used to collect water from their only other readily available source--the shower heads. The unit's standpipe fire hose was in a locked metal cabinet and inaccessible to inmates.

1/One of the compressed air type extinguishers was improperly used--inverted instead of held upright--and released air.

LOCATION AND REACTION OF STAFF WHEN THE FIRE WAS REPORTED

As the first report of the G unit fire was received, the on-duty staff was in various locations.

The control room officer

Post-of-duty orders require the control room officer to maintain his position in the control room until relieved. The control room is located in the center of the administration building, on the northern perimeter of the institution. When the fire was reported, the control officer was alone in the room. From his vantage point, he had a very limited view of the courtyard and was unable to see G unit. (See diagram on p. 2.)

The medical technical assistant

The institution hospital is located on the second floor of the administration building near the northeast corner of the institution. The medical technical assistant was locked inside the hospital. 1/ He was in the hospital pharmacy when he heard frantic conversations referring to G unit on his radio. From the pharmacy window, he could see heavy smoke coming from G unit. At about 1:15 a.m., he telephoned the institution doctor and the supervising medical technical assistant and told them of the situation. The supervisor then called all other hospital staff. After making his call, the assistant on duty immediately started breaking out the emergency equipment. He was subsequently called to the yard, but because he was busy with injured inmates, he was unable to leave the hospital.

1/Standard morning shift security procedures require that inside personnel not have keys to exterior doors. Indoor personnel have keys for inside doors only. The yard officer must release the inside officers from the units.

The administrative detention unit officer

The administrative detention unit is located in the northeast corner of the institution and is used as private preferred housing for some inmates and segregated detention cells for others. The officer in this unit was locked in and was never actively involved in the events surrounding the fire.

The courtyard officer

This officer was routinely searching the auditorium when called by the control room officer and advised that there was a fire in G unit. He looked out the window and observed heavy black smoke rising out a G unit window. He reported his observations and, as instructed, headed toward G unit to assist the two supervisors who were enroute.

The outside patrol officer

This officer patrols the institution's perimeter. The officer was driving an institution truck on the east side of the institution when the control room officer called by radio to advise him of the G unit fire. At approximately the same instant, the officer observed heavy smoke billowing out a second floor window. The officer reported the smoke and was ordered to the control room to pick up keys to release the west side dormitory officer.

Dormitory officers

There were three roving dormitory officers on duty on the morning of the fire, only one of whom had a radio. Two were assigned to the dormitories along the east wall--one to upper and the other to lower units. These units were all connected by locked interior doors. The third officer (the one with the radio) was assigned to the units along the north and west side. In order to travel between these units, this officer had to be released to the courtyard.

The lower dormitory officer

The lower dormitory officer, while in C unit below and north of G unit, was paged and called the control room. He was instructed to report to G unit. Shortly thereafter, he was released from C unit by the courtyard officer and was admitted to G unit.

The upper dormitory officer

When the fire was reported, the upper dormitory officer was in F unit--immediately north of G unit, on the same level. Although the control officer says differently, according to this officer he was never verbally informed of the fire. Instead, he said that while on normal patrol, he heard a disruption in G, looked out of the F windows, and saw smoke. He activated a body alarm 1/ and opened the door between F and G units, only to see smoke and fire. He then notified control of the situation by telephone. He subsequently returned to the door, saw it was fruitless to attempt entry to G unit, reclosed but did not relock the door, and instructed F unit inmates to pack linen around the door to block the smoke. He then reported to the yard.

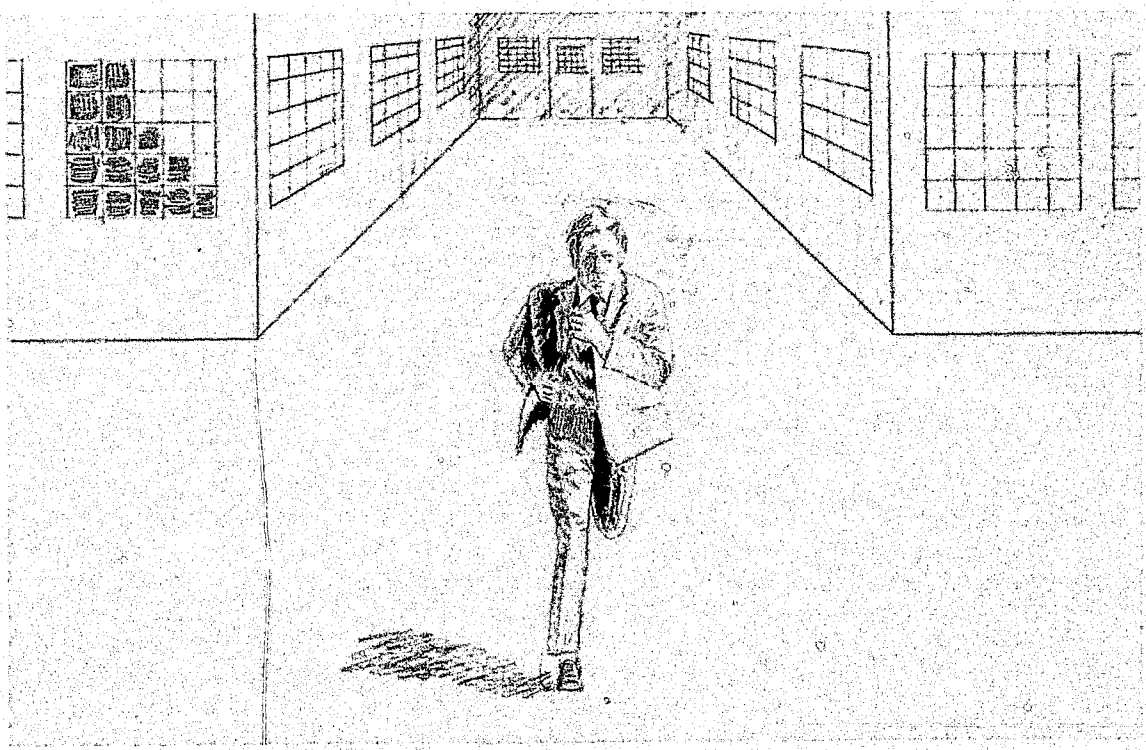
1/An electronic device similar to a pager which is used by officers to advise control of an emergency.

The west side dormitory officer

While in a unit across from G unit, the west side dormitory officer was contacted by radio and was informed of the fire. The patrol officer subsequently released him and he headed to G unit.

The two correctional supervisors

Upon receiving the emergency call, the two officers left their office and headed toward G unit, where they saw smoke rising out of the windows. They quickened their pace and within a few moments met the courtyard officer at the unit door.



RESPONSE BY CORRECTIONAL SUPERVISORS

When the two correctional supervisors arrived at the entrance to G unit, the prior watch supervisor surrendered his keys 1/ to the yard officer who met them at the door. The

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1/During the midnight to 8:00 a.m. shift, it is standard practice to relinquish outside door keys upon entering any of the housing units.

morning watch supervisor informed us that he had no keys since he had not yet taken equipment from the off-duty supervisor--as is normal practice.

The supervisors then entered G unit, and, according to procedure, the door was locked behind them. They proceeded upstairs to G unit to evaluate the situation. One supervisor estimated that about 4 minutes had elapsed since the time of the original emergency call.

Conditions in G unit

When the supervisors arrived at the scene, the fire had spread to the washroom ceiling. Dense, black smoke was billowing from the washroom and spreading into the hallway and dormitory area. Although descriptions of the location and severity of the fire at this time varied considerably depending on individual vantage points, we believe that the fire along the upper half of the wall was fanned by an open washroom window. The flames were fed by the air currents and pushed in a swirling motion up and along the ceiling and back down toward the floor. The expanding flames were rapidly involving larger areas and increasing the intensity of the fire. Burning ceiling panels began to fall to the floor.

Initial actions of correctional supervisors

The supervisors, who by this time had been joined by the lower dormitory officer, determined that they could not immediately extinguish the fire and that it was necessary to evacuate the inmates and obtain assistance in fighting the flames and heavy smoke. There was no attempt to use the standpipe fire hose on the wall opposite the washroom. (See diagram on p. 6.) The morning watch supervisor and the lower dormitory officer had forgotten that a standpipe was located in the area. Although the prior watch supervisor was aware of the standpipe, he did not have a key to the cabinet and did not think to ask the dormitory officer if he had the key--which he did.

The morning watch supervisor decided to personally notify the control room officer that an emergency existed and proceeded to the control room. He cannot explain why he did not instead use the other supervisor's radio for notification.

The prior watch supervisor, meanwhile, decided that the evacuation of inmates down the hall near the washroom was impractical. He also decided it was too dark to cross the

dormitory to open the door at the opposite end from the inside. The lower dormitory officer disagreed with the supervisor's assessment and was inclined to cross directly to the door. However, before he could take any action, the supervisor directed him back.

As the three correctional officers turned to leave, a section of the washroom ceiling collapsed, putting out the only lights that were on in G unit--in the bathroom. Flames and smoke billowed across the hallway--effectively blocking it.

The three staff members along with six inmates who had been fighting the fire then exited G unit through the main entrance, which was then relocked by the courtyard officer. Shortly thereafter, another inmate ran through the flames and smoke to the main entrance and was released by the inside yard officer. The inmate suffered burns during this escape from G unit. The door was again relocked.

Once outside G unit, the morning supervisor ran to the control room to report the seriousness of the fire and to call for additional help. The prior watch supervisor went with the lower dormitory officer to E-P unit, which adjoined G unit on the south side, in order to open the door at that end of G unit.

CALL TO DANBURY CITY FIRE DEPARTMENT

The morning watch supervisor ran to the control room, less than 100 yards away from the main entrance to G unit, ordered the officer to call other institution personnel, and then left. The control room officer had already started to call additional institution personnel as stated in the institution's fire plan. Moments later the supervisor returned and told the control room officer to also call the city of Danbury's fire department. The institution fire plan authorized the control room officer to call the city fire department only on the instructions of a senior officer. It received the call from the control room officer at 1:30 a.m.--about 15 to 20 minutes after the first emergency call.

Inmate fire brigade

The morning watch supervisor decided not to call up the institution's inmate fire brigade. He believed the city fire department would respond more quickly than the inmate brigade. Additionally, he believed he had insufficient correctional officers to release the inmates and escort them to their engine, which was housed outside the main perimeter. (See diagram on p. 2.) Further, he had little confidence in the brigade.

EFFORTS TO RELEASE INMATES

The evening watch supervisor and the lower dormitory officer went to the door in E-P unit that led to G unit. By this time, many G unit inmates had gotten out of bed and were shouting and pushing against the locked door trying to get out. Both officers tried unsuccessfully to unlock the door. The lower dormitory officer broke the key off in the lock cylinder during his efforts. The west dormitory officer subsequently attempted to open the door, also without success.

The door had a history of broken keys and had given many officers trouble. Officers had to play with the key and door to unlock it. It was a metal salvage door taken from another part of the the institution. Use of salvage doors is a common practice. It was warped and had to be installed upside down

to fit the door jam, and contrary to most other doors in the institution its knob was above the lock cylinder and was unlocked in the reverse manner from most doors. In addition to these difficulties, in the emergency inmates battered the door with a large floor fan and were pressing against it. Subsequent Bureau of Prisons tests on other heavy-duty doors and locks indicated that such pressure would be sufficient to prohibit unlocking them.

The only remaining usable exit from G unit was a narrow catwalk stairwell which ran up to it from the courtyard. (See diagram on p. 2.) Many correctional officers did not even know of its existence since it had not been used since 1974. Several inmates who had been released from other units informed the yard officer of the existence of this exit.

PLATFORM LEADING TO CATWALK

CATWALK STAIRWELL

The lower dormitory officer unlocked the courtyard door leading to the stairwell and accompanied several inmates up the narrow stairs to the G unit doorway. At the top of the stairs, they found the door secured by several wooden braces

and a plywood sheet. 1/ They removed the shoring and forced the wooden door that led directly into the G unit dormitory. During this effort the lower dormitory officer was injured and evacuated. Several correctional officers and a large number of inmates then arrived to assist in the G unit evacuation.

Shortly after this evacuation began, other inmates had broken through the metal door between G and E-P units using tools obtained from a shed outside the south courtyard gate. Inmates and staff then began to evacuate G unit inmates through this exit.

We were unable to determine the exact time either of the exit doors was opened. However, according to the captain of the Danbury City Fire Department, inmates were being evacuated from G unit, apparently through the catwalk door, when he entered the inside courtyard.

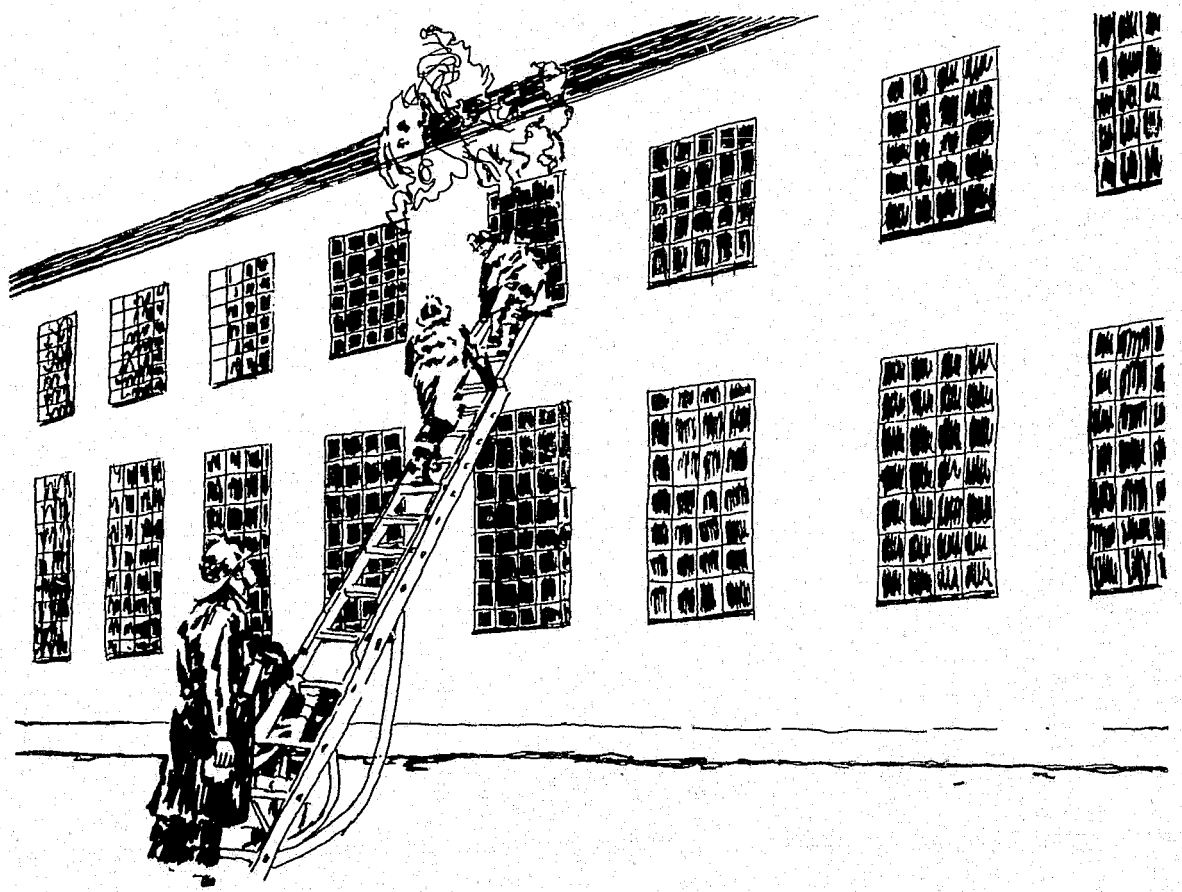
ARRIVAL, DEPLOYMENT, AND UTILIZATION OF THE DANBURY CITY FIRE DEPARTMENT

The fire department captain arrived at the institution at about 1:35 a.m., just prior to the arrival of the first fire engines and about 5 minutes after the emergency call was received. He reported to the control room and was directed to the rear of the institution. He reported to the west gate--which he felt was the logical entrance--and found the gate locked and unmanned. He continued on behind the institution toward the east side where he saw an institution truck leading two fire engines into the recreation area outside of the facility. (See diagram on p. 2.)

The west dormitory officer who was driving this truck had been directed by the morning watch supervisor to open the gate leading into the recreation area so that the arriving fire equipment could enter. The morning watch supervisor had decided to send the fire engines to the east side because he knew they would need access to the three fire hydrants there, none being in the inside courtyard. Additionally, he felt the first priority would be flame suppression, and the fire could be readily reached through a second floor washroom window.

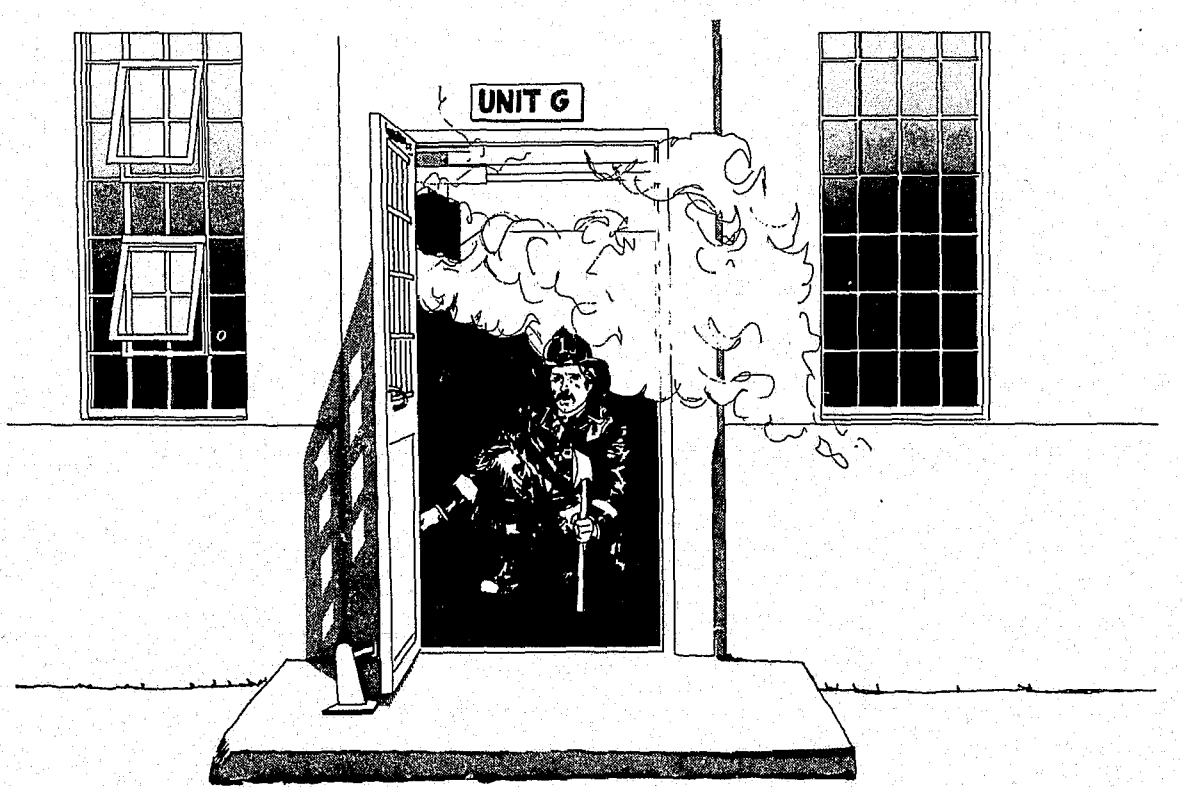
1/The door had been recently shored up to close a potential escape route created by trenching at the base of the courtyard door. Plumbing was being repaired in the trench.

The west dormitory officer had been given an incorrect set of keys and had to ram the gate. The fire Department captain followed the west dormitory officer into the recreation yard and saw dense, black smoke coming out the G unit windows and screaming inmates at broken windows trying to get air. He immediately realized that because there was no entrance to G unit from this area, the fire could not be adequately fought. Suppression from outside would force flame and smoke to the interior of the unit. He decided, however, to keep his men there. He knew additional equipment was enroute and felt that the inmates would become more desperate at the sight of the fire department leaving. He

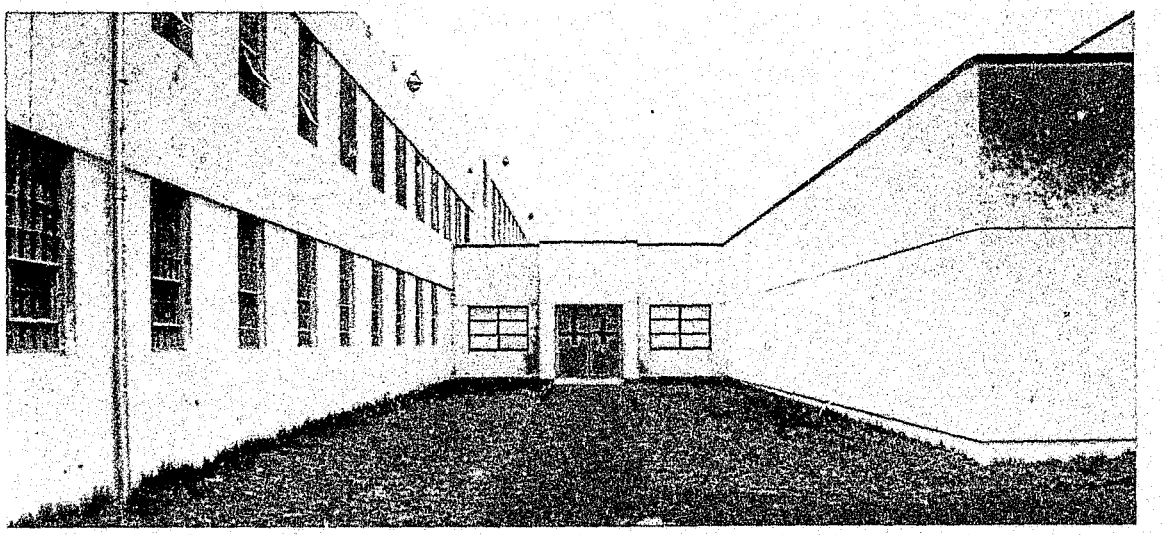


ordered the bars on the windows cut and a hole chopped in the roof. Both of these actions turned out to be useless because of the building construction--case-hardened steel bars and reinforced concrete.

The fire department captain called in a second alarm at 1:38 a.m. and drove to the front of the institution. He entered the inside courtyard after telling the control room officer to open the west side vehicle gates so additional men and engines could have access to the fire from the inside. It was at this time that he witnessed G unit inmates being evacuated, apparently through the catwalk door.



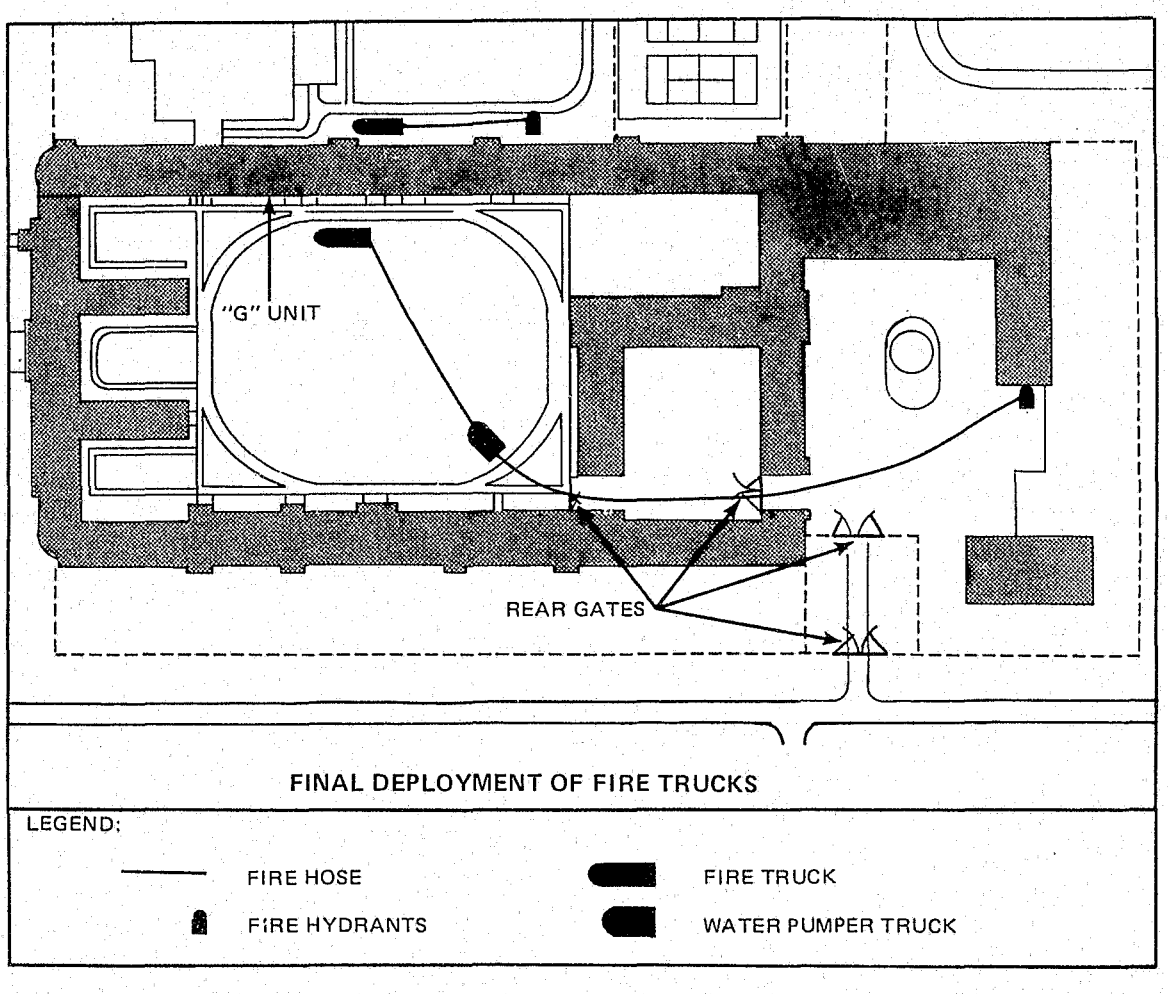
The fire department captain then entered the main entrance of G unit, found extremely heavy black smoke and extreme heat in the stairwell, and had to retreat. He returned to his car to get his airpack, and upon returning met two other firefighters with air packs who had forced their way into the institution through the double doors in the recreation building. (See photo below.) These three then entered G unit and assisted in the evacuation and fire suppression.



DOUBLE DOORS LEADING INTO RECREATION BUILDING

It was learned later that the control room officer had ordered two other officers to unlock the recreation building doors for the firemen outside. They were unable to do so, however, because they were given an incomplete set of keys.

Additional fire engines were directed to the west side, where one was admitted to the inside courtyard through a series of four gates. The first three gates were opened by correctional officers, who did not have a key for the fourth gate. The lock bolt for the fourth gate was cut by a firefighter after a delay of about a minute. Tools, previously taken from the shed, were cleared from the roadway, and about 1,100 feet of hose was laid to G unit from the most convenient outside hydrant. The firefighters encountered little difficulty in reaching the fire or hooking up to institution hydrants. They assisted in evacuations and fought the fire for about 30 minutes until it was completely extinguished.



OTHER ACTIONS BY INSTITUTION STAFF DURING THE EMERGENCY

During the fire, there was little direction by those in authority, and on-duty staff for the most part reacted to individual situations as they arose, without any coordination. A number of these activities, not previously discussed, are presented below.

The correctional supervisors

After advising the control room officer of the situation in G unit and who to contact, the morning watch supervisor returned to the courtyard. He first unlocked the institution auditorium so that it would be available to house evacuated inmates. He then returned to the G unit main entrance and entered. He hoped to assist anyone he could find upstairs; however, like the fire department captain, he was forced out by floor-to-ceiling smoke and intense heat. After being

frustrated in his attempt to enter G unit, he proceeded south to the catwalk and E-P unit entrances where he assisted in helping the injured to the hospital. During one of his trips to the hospital he was asked to obtain fresh oxygen tanks from the storage areas in the extreme southern portion of the institution. He was assisted by two others. Subsequently, he was stricken by a heart-attack-like seizure and was evacuated to the Danbury hospital.

The prior shift supervisor, after leaving the disabled E-P door, returned to the main G unit entrance. He now had a key to the cabinet housing the standpipe firehose which he hoped to use to clear the hallway into G unit's dormitory. As he reached the hallway, however, the heat and smoke became intolerable, and he, like the others who tried, had to retreat. He moved back toward the E-P unit but was intercepted by an agitated previously evacuated G unit inmate. The supervisor spent a great deal of time calming the inmate. He suggested to the courtyard officer that the inmates be ushered to the auditorium so they would not interfere with rescue efforts--he thought the fire engines would be entering the courtyard shortly. The prior watch supervisor spent the rest of his time during the upcoming hectic moments helping to carry inmates to the institution hospital, releasing inmates from other units, and assisting in moving oxygen tanks to the hospital. He felt the chief correctional supervisor, who arrived shortly after the alert was called, would take control of the situation. (The chief supervisor was new to the institution and did not feel competent to take control--he instead went to the control room area to monitor the transfer of inmates to the Danbury hospital.) The chief correctional supervisor instructed him to move the uncontrolled inmates--now in the hundreds--to the auditorium. The prior shift supervisor made no effort to do so--he was too busy with other things and felt it was, under the circumstances, an impossible task.

The control room officer

After being notified of the fire by the emergency telephone caller, the control room officer reviewed the institution's fireplan. He began calling the institution's staff and received authorization to call the city fire department--the plan specifies that only the correctional officer in charge can authorize a call for city fire department assistance. The control room officer implemented the plan as written--calling those listed in order. The city fire department was the twelfth item on the list.

During the emergency the control room officer was inundated with work. He had to telephone large numbers of off-duty staff to order them to the institution. He answered a large number of incoming calls. He had to respond to radio calls from other officers, direct officers to tasks, and dispense keys and other equipment. He also had to operate the institution's detailed front gate system.

The courtyard officer

After a brief period in the courtyard monitoring the movement of previously released G unit inmates, the courtyard officer assisted in the early phases of evacuating inmates through the catwalk entrance. He then obtained an emergency airpack from the administration building and, despite putting it on incorrectly, entered G unit through E-P unit and carried injured down the stairs to the courtyard.

The outside and west dormitory officers

The outside and west dormitory officers assisted in the courtyard--opening doors, releasing inmates from dormitories, controlling inmates in the courtyard, and assisting in carrying the injured to the hospital.

The upper and lower dormitory officers

Subsequent to being injured on the catwalk stairwell, the lower dormitory officer was taken to the courtyard. He then proceeded to try to further assist in the rescue--obtaining airpacks from a storage area and tools from the shed. He was later overcome by exhaustion and took no further active role in the events of the evening.

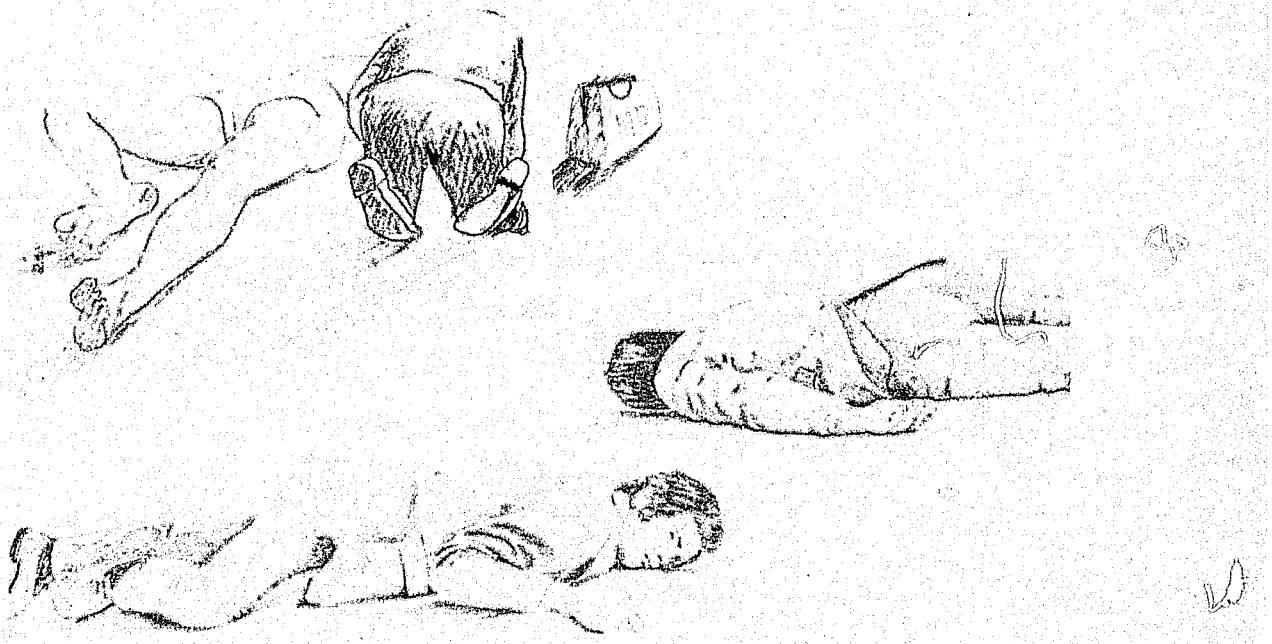
After the lower dormitory officer was removed from the catwalk stairwell, the upper dormitory officer replaced him. The upper dormitory officer then entered the smoke-filled G unit dormitory and along with some inmates evacuated those trapped in the room.

Off-duty staff

As the off-duty staff reported to the institution, they assisted in operating the control room, opening gates and dormitory units, and moving injured inmates to the hospital area. The institution's acting safety officer entered G unit during the fire and evacuated several injured inmates.

MEDICAL CARE

The medical technical assistant on duty was alerted to the fire by conversations on his radio. Once the hospital door was unlocked by a correctional officer, the assistant was overwhelmed by injured inmates. The hospital's 15 beds filled quickly, and the injured were placed on floors and on the ground outside the hospital. As medical staff arrived, they, as well as knowledgeable inmates, administered first aid--primarily resuscitation and oxygen.



Upon arrival, the doctor established an emergency diagnostic system, identifying the most seriously injured for immediate attention and priority evacuation to the Danbury city hospital. Ambulance crews from surrounding communities assisted in the evacuation and helped in the delivery of emergency first aid.

Although ill-equipped for such an emergency situation, the hospital implemented an emergency plan and handled all injuries in a timely manner. The Danbury fire department captain and a representative of the Connecticut Fire Prevention and Control Commission, who is a licensed emergency technical assistant, commented favorably on the efficiency of this aspect of the activities at Danbury.

THE INJURIES AND DEATHS

During the fire, more than 70 persons were injured and 5 inmates died. While there were a variety of injuries incurred--including cuts, scrapes and bruises--the majority and the most serious were caused by smoke inhalation.

Four of the individuals carried from the G unit dormitory to the courtyard were subsequently pronounced dead. It is unclear, however, whether they died in the dormitory or courtyard. The body of the fifth dead inmate was found on the G unit washroom floor. He was the only one of the dead to sustain burns--over about 50 percent of his body. Some controversy has surrounded the death of this inmate, and it is discussed in more detail in appendix III.

CHAPTER 3

CONDITIONS CONTRIBUTING TO THE SEVERITY OF THE FIRE

The fire at the Danbury FCI began in the washroom of G unit and is suspected to be a case of arson. The fire spread from a number of coats to the wall, and then to the ceiling. Although the materials used in the washroom construction conformed to fire safety standards at the time they were installed, they helped generate a large amount of heavy black smoke which was primarily responsible for the injuries and deaths. In addition, the institution did not comply with existing fire safety training and preparedness requirements, which made it harder to suppress the blaze and evacuate inmates.

Although there were allegations that the fire began in the washroom ceiling and was electrical in nature, the FBI and State Fire Marshal's Office found otherwise. In investigating the fire, they determined that it began in a group of coats hanging on the washroom wall. The fire ignited the wall and ceiling materials and spread to other portions of the predominantly concrete structure. Despite the absence of accelerants, such as gasoline, the investigators concluded the fire was deliberately set. (The FBI's investigation was still ongoing at the time we completed our work.)

APPLICABLE FIRE SAFETY REQUIREMENTS

Bureau of Prisons policy is to adhere to the Occupational Safety and Health Administration's (OSHA's) regulations and the National Fire Protection Association's Life Safety Code 101 as guides for its fire safety program. OSHA fire safety regulations are primarily a reprint of NFPA's code. The Bureau of Prisons had developed certain fire safety guides for its institutions, which are responsible for implementing the guidance and code in a manner most appropriate to individual circumstances.

Materials in compliance with standard when installed

NFPA informed us that its code does not require modification of existing construction to comply with the most recent code, and accordingly many materials currently considered hazardous remain in use. Such was the case at

Danbury. When installed in 1974, the fiberglass paneling used on the washroom walls and ceiling of the FCI was in compliance with the 1973 edition of the NFPA code, which contained no smoke spread standard. However, the code was revised in 1976 and prohibited the use of materials with high smoke spread potential in penal occupancies. The fiberglass paneling generated far more smoke than the 1976 standard allowed.

EXAMPLE OF WASHROOM WALL PRIOR TO FIRE

Failure to comply with other fire safety requirements and guidance

The fire at Danbury showed a number of weaknesses in the institution's fire safety program, including

--inadequate and infrequent fire safety inspections,

--an inadequate fire plan,

--absence of reliable exits, and

--inadequate lighting.

Inadequate and infrequent fire safety inspections

The Bureau of Prisons requires that its institutions be inspected for safety and sanitation hazards. Further, it encourages visits and inspections by outside fire safety specialists, such as local fire departments and fire marshals. Resident safety officers are required to conduct inspections of their institutions to identify hazards having

the capacity to cause personal injury, death, property damage, or health problems. The reports of sanitation and safety inspections conducted by the resident safety officer at Danbury prior to the fire identified no significant fire safety problems.

Biennially, selected safety officers are instructed by Bureau regional offices to inspect other institutions for sanitation and safety problems. In this regard, a safety officer from another Bureau institution inspected Danbury in 1975 and 1977 (prior to the fire). However, the Bureau provided the inspector with no guidance as to what to look for during fire safety inspections. The inspections were primarily concerned with mechanical and sanitary services. Only the barest essentials of fire safety were included--for example, the conditions of fire extinguishers and fire engine hoses. No significant fire safety problems were identified.

Within a few days after the fire, this safety officer was requested to perform a detailed review of the institution's fire safety program. At this time, he identified a significant number of deficiencies, including inadequate protective gear for the inmate fire brigade, the lack of a portable smoke ejector fan, the lack of hydrants in the institution's courtyard, and the lack of staff training in fundamental firefighting.

Bureau of Prisons policy encourages the central office safety administrator to inspect institutions for compliance with applicable policies and codes. The administrator had not visited Danbury for 3 years prior to the fire, but it should be recognized that Danbury is only one of 37 institutions he is required to inspect. Also, although Bureau policy encourages inspections by outside specialists, no such inspections were conducted at Danbury for several years prior to the fire.

Inadequate fire plan

Although the Bureau of Prisons recommends an annual review and revision of each institution's fire plan, the Danbury plan in effect during the night of the fire had not been revised since 1973. The plan was, however, being rewritten at the time of the fire.

The plan was insufficient in several areas; it did not provide for notification of the local fire department in a timely manner, and the plan did not include housing

unit evacuation procedures, specific roles and duties for correctional personnel, and the location of fire safety equipment.

The NFPA code recommends that in the event of fire the local fire department be immediately notified. The Danbury fire plan, however, provided that 11 personnel outside the institution be called prior to calling the fire department, and the latter could only be called upon the authorization of the officer in charge. Both NFPA and the Danbury fire captain who responded to the fire said they believed the fire department should have been alerted sooner.

The NFPA code also recommends that penal institutions prepare evacuation plans for housing units, since these areas house large numbers of people and are locked during the evening. Danbury did not have evacuation plans for its housing units.

Inadequate fire safety training

NFPA recommends that correctional staff and inmates be provided fire safety training. The training should include fire drills--simulating actual emergency conditions. Such training can serve to prepare individuals to respond instinctively to fire emergencies and is particularly important at institutions using a manual fire detection and suppression system--which was the case at Danbury.

The correctional staff at Danbury received minimal training in fire safety and none in firefighting. Upon assignment to Danbury the correctional officers only read the institution's fire plan and annually received a 1-hour lecture on the capability of the institution's fire engine. The general inmate population similarly received little fire safety training, and the institution did not conduct periodic fire drills.

Although Danbury, in accordance with Bureau policy, had established an inmate fire brigade, it received little training, had not drilled since late 1976, and its role was not well defined. In this regard, the morning watch supervisor, as indicated in chapter 2, had little confidence in the inmate brigade, and this lack of confidence was one reason why the brigade was not activated during the fire.

During our review, we also noted that there was confusion on the part of correctional staff as to whether safety considerations took precedence over security in

emergency situations. Although the Director of the Bureau of Prisons told us that safety is the primary consideration, there is no written policy dealing with this matter.

Absence of reliable exits

The NFPA code advocates that dormitories with four or more occupants have access to two separate and distinct exits. G unit complied with this requirement. (See diagram on p. 6.)

The NFPA code also recommends that exits be readily accessible and operate properly. In the case of G unit, the fire blocked the hallway leading to the main entrance and F unit, effectively closing off this escape route. Evacuation, accordingly, was restricted to the exit leading to E-P unit. (Another exit--the catwalk door discussed in chapter 2--was barricaded and unusable to those inside G unit.) The door to the available E-P exit was unreliable--it was warped, did not fit properly, and had been difficult to open. A number of keys had broken in the lock. During the fire this door once again became inoperative when a key broke off in the lock.

Inadequate lighting

The NFPA code recommends that exits be illuminated and that emergency lighting provide sufficient illumination for egress. The exit doors at Danbury were not illuminated. Additionally, it was alleged that the emergency lighting did not work since the unit was in total darkness during the fire.

Evidence indicates that the emergency lights were not connected to the circuit containing the night light--the only light that was on when the fire began. That circuit was tripped early in the fire, but since the emergency lights were not connected to it, they could not come on until the fire became serious enough to trip the other circuits. At that time the heavy smoke would have rendered them useless.

CHAPTER 4

ACTIONS TAKEN TO IMPROVE FIRE SAFETY AT DANBURY AND OTHER FEDERAL INSTITUTIONS

In the wake of the Danbury fire, the Bureau of Prisons has acted to improve fire safety at Federal correctional institutions. The Danbury FCI has taken steps to eliminate many of the deficiencies that became apparent during and after the fire. The lessons learned at Danbury have also been communicated to other Federal correctional institutions, and Bureau personnel have informed us that they will be used as a basis for improvements in fire safety programs.

A NUMBER OF DEFICIENCIES HAVE BEEN CORRECTED AT DANBURY

The Danbury FCI has taken steps to minimize the potential for recurrence of a fatal fire. Most of the deficiencies noted during the Bureau's investigation have been corrected, and accordingly the institution is better prepared to cope with future fire emergencies. Specifically, Danbury has

--called on outside fire safety experts for inspections and advice;

--removed non-standard building materials;

--improved the fire plan;

--increased the training of both the general inmate population and the inmate fire brigade;

--replaced the defective door and installed a second exit in a unit not previously having one;

--increased the number of staff on duty during the morning shift; and

--improved the institution's fire detection system.

Danbury is also reviewing its lighting system.

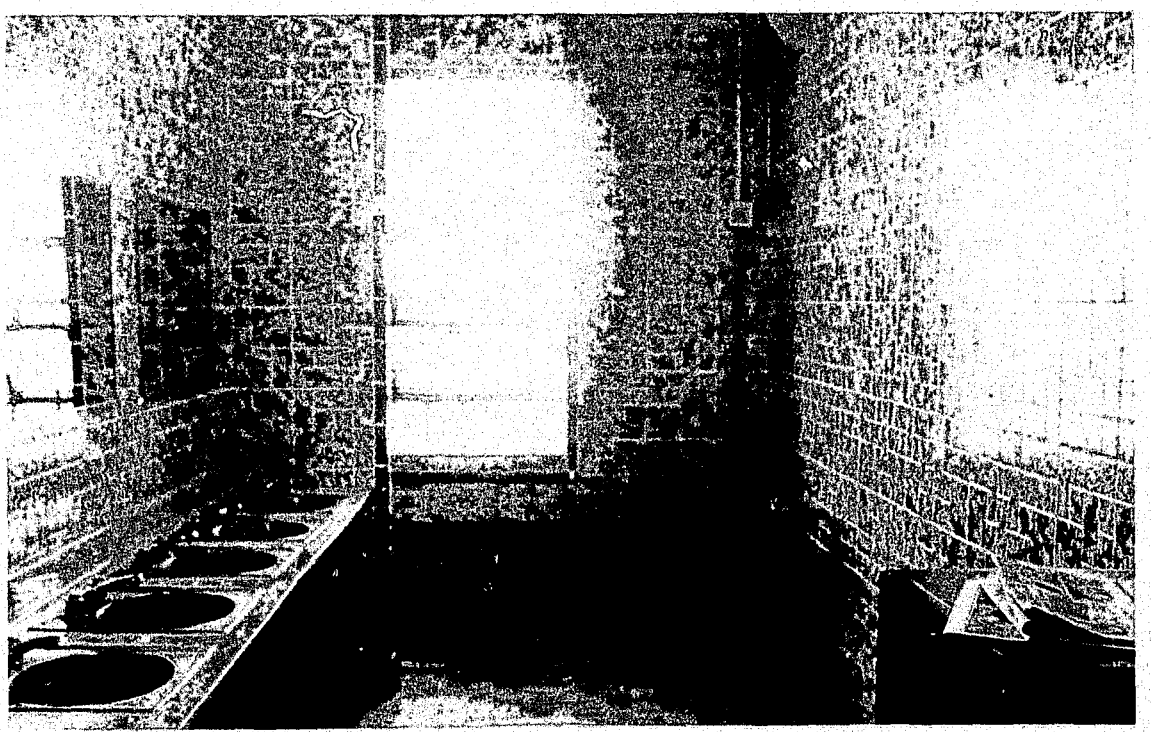
Improved inspections

Since the fire, the institution safety officer weekly inspects each housing unit, with some emphasis on fire safety. The condition of fire extinguishers is checked monthly. In addition, the Bureau has reemphasized its program of having safety officers from other institutions conduct safety and mechanical inspections to include fire equipment and exit locations.

Institution officials have also solicited the assistance of the Danbury fire department in identifying and solving fire safety problems. Department personnel have frequently visited the institution since the fire and advised institution officials of necessary changes. Many have been implemented, including the installation of hydrants in the institution's courtyard.

Nonstandard materials replaced

Those building materials which contributed to the spread of the fire and generation of heavy black smoke have been removed from all the institution's housing units. These materials are being replaced with others complying with the 1976 NFPA code for penal occupancies.



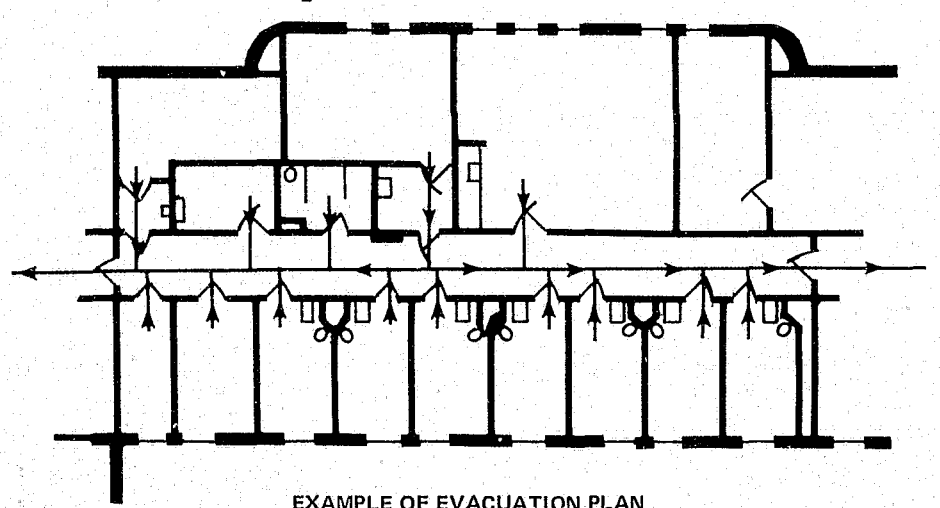
G UNIT WASHROOM AFTER RENOVATION

Improved fire plan

Danbury has condensed its fire plan and distributed it to all staff. The plan is now a brief summary of the important things to do in case of a fire. The plan includes evacuation instructions for the housing units. Diagrams of evacuation routes are posted in each housing unit. The plan now instructs the control room officer to notify the Danbury fire department whenever a fire is reported by an inmate or staff member. The fire department will again be called when it is determined it will be needed to suppress a fire.

Inmates better trained and prepared for fire emergency

The safety officer at Danbury currently requires each housing unit to conduct monthly fire drills. The staff and inmates are notified in advance when drills are to be conducted and are told which exits are to be used. For security reasons, drills are normally conducted in the early evening hours--around dinner time. Institution officials are concerned that drills later in the evening would encourage escape attempts. They told us that since safety precedes security in the case of fire, it was not necessary to test institution security under less controlled circumstances.



EXAMPLE OF EVACUATION PLAN

The inmate fire brigade is also receiving more training. Weekly, the brigade receives training from the institution's safety officer, and monthly from the Danbury fire Department. This training includes the use of firefighting equipment and fire suppression tactics. The institution is still attempting to resolve some of the problems involved with activation of the brigade, including access to firefighting equipment and

use of the fire truck in the institution's courtyard. For example, the Danbury fire department has not yet determined the best location for the fire truck. Additionally, the institution believes that during sleeping hours, the fire brigade would be used to support the fire department, which could probably reach the institution before the brigade could activate its equipment--no matter where it was located.

It should also be noted that the safety officer is training selected housing unit inmates in the use of firefighting equipment. When the training is completed, each unit will have a resident three-to-five-man firefighting unit.

Housing unit exits upgraded

After the fire, the Danbury FCI reevaluated the housing unit exits. In accordance with the NFPA code, the institution verified the reliability of housing unit doors, placed illuminated exit signs over the doors, installed a second exit in a unit not previously having one, and replaced the damaged door between G and E-P units.

CORRIDOR IN G UNIT WITH NEW EXIT SIGNS

The number of correctional officers on the morning watch has been increased

The morning watch (midnight to 8 a.m.) staff has been increased to 15 from the pre-fire level of 9. In addition to the correctional supervisor and a medical technical assistant, eight correctional officers are assigned to dormitories, and one officer to each of the following positions: outside patrol, the courtyard, the control room, unassigned patrol, and the administrative detention unit.

Improved fire detection systems

The Danbury FCI has installed an extensive smoke detection system throughout the institution's housing units. When a detector is activated, the system will sound an alarm in both the affected housing unit and the control room. Additionally, the system includes a recording mechanism in the control room which will indicate the time and location of the alarm and the time the alarm was acknowledged by the control room officer. Officers will be dispatched to verify the existence of a fire.

G UNIT WITH SMOKE DETECTORS

Review of emergency lighting system

As a result of our discussions with Danbury FCI officials concerning the problems with the emergency lights, they are reviewing the electrical system in all housing units.

BUREAU OF PRISONS HAS DIRECTED AGENCYWIDE IMPROVEMENTS IN FIRE SAFETY

In April 1978, the Bureau issued a memorandum regarding fire safety in institutional housing units. The Bureau has recommended that its institutions immediately take all possible actions to come into compliance with the NFPA code. The Bureau has established target dates for satisfying certain aspects of the code which will require increased funding. However, actual completion is contingent on the availability of funds.

The memorandum requires that

--By June 1, 1978, all existing housing unit standpipe hose cabinets be fitted with breakglass fronts, lined hoses, and adjustable nozzles. Additionally, emergency lighting must be installed in housing units to provide sufficient illumination to egress areas and stairwells during emergencies.

--By October 1, 1978, all locked emergency doors be modified to function with pressure applied to the inside of the door. All exits must also be designated with illuminated signs.

--By November 1, 1978, all living areas shall be equipped with smoke detection systems including control room and local alarms.

--By October 1, 1979, building materials and furnishings and all stairwells in housing units must comply with the NFPA code. Those living areas not having fire hose stations or second exits will have them installed by this date.

--Automatic sprinklers shall be installed where required to meet the NFPA code, for example, in two-story wood frame dormitories with open stairwells. No date has been established for meeting this requirement.

In addition to these requirements, Bureau personnel responsible for reviewing new construction or rehabilitation projects--institution safety officers and regional facilities personnel--are to assure that the projects conform to the NFPA code whenever possible. Additionally, architects working on Bureau projects are to consider the NFPA code while designing institutions and making security decisions.

CHAPTER 5

THE BUREAU OF PRISONS BOARD OF INQUIRY AND REPORT

All the members of the Danbury fire Board of Inquiry were Bureau personnel, and none were experts in fire investigations. This has given rise to questions regarding the Board's objectivity and ability to effectively investigate the fire. However, we concluded that the Board's report was basically accurate and in accordance with the evidence we gathered.

THE BOARD OF INQUIRY

Who was on the Board and why

On July 7, 1977, the Bureau Director appointed a Board of Inquiry with responsibility to investigate the Danbury FCI fire. The Board was to determine "what happened, why it happended, and what could be done to prevent a tragedy such as this from happening again."

The Board was composed of the following Bureau personnel, none of whom had experience in fire investigations:

The northeast regional director

The northeast regional director was appointed chairman of the Board of Inquiry. Although the Danbury FCI was under the administrative control of this individual, the Bureau Director stated the regional director had only taken over the position a few months previously and had no longstanding ties with the Danbury FCI. The Bureau Director also stated he had a great deal of confidence in the regional director and felt he could more than adequately handle the inquiry.

The northeast region's counsel

The Bureau Director said it was necessary to have an attorney on the Board to handle the technical legal issues that might arise. Additionally, the Director told us he felt an attorney by training would be well suited to a board of inquiry.

An assistant prison camp superintendent

The assistant superintendent of a Federal prison camp was appointed to the Board. The Bureau Director stated that while not directly associated with the Danbury FCI, this individual had previously served at Danbury and was knowledgeable of the institution's construction, procedures, and organization.

The central office safety administrator

According to the Bureau Director, the central office safety administrator was appointed to the Board because of his general knowledge of safety as well as knowledge of the Bureau's safety procedures and policies.

The central office chief of facilities development

The Bureau Director selected the central office chief of facilities development for the Board because of his knowledge of construction and Bureau material procurement and construction policies and procedures. Additionally, since the chief had never worked in a prison, the Director felt he could offer a fresh view.

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Additionally, the Board enlisted the help of a safety officer at another Bureau institution--the agency's expert in fire safety--to explain the standards of NFPA's Life

Safety Code 101 as they related to the pre-fire conditions in G unit.

The Bureau Director advised us that he did not select any outside parties for the board because (1) he believed immediate action was necessary and he did not feel he had the time to recruit outside members to join the Board when it convened on July 8, 1977, and (2) he was aware that other groups would be reviewing the conditions surrounding the fire, including the FBI, State and local fire marshals, and NFPA. The latter organization--a nongovernment entity--was granted approval to investigate the fire by the Director.

The Board did not fully understand the NFPA code

As part of its investigation, the Board evaluated the Danbury FCI's compliance with the NFPA Life Safety Code. We found, however, that the Board had problems understanding the highly technical standards within the code. Board member notes indicated this lack of understanding, and errors in the Board's report further reflect a degree of confusion. For example, the Board, when evaluating the adequacy of the G unit exits, considered only the number of exits and not the guaranteed egress recommended by the code. (See chapter 3 for further comments on this topic.)

The makeup of the Board did not lend an image of credibility

Although there is no evidence that the Board was not objective in its work, the fact that all the members were Bureau personnel was perceived by some as reflecting on the Board's credibility and its ability to draw objective conclusions. In this regard, we and the FBI spoke with many inmates who did not speak to the Board, some of whom indicated they refused to talk to an internal Board of Inquiry because they feared inaction, retaliation for honesty, or even a "whitewash."

THE ACCURACY OF THE REPORT

Although the report and supporting documentation were not always clear, it was basically accurate and in accordance with evidence we gathered. Not all the facts of the report were supported by the documentation maintained by the Board of Inquiry, but we were able to obtain satisfactory explanations from Board members. We also reviewed the FBI's documentation, especially interviews with the same inmates as the Board interviewed. We found much greater clarity, detail,

and meaning in the FBI documents than in the Board's documentation. However, the higher quality of the FBI's documents should be expected because of the training and experience of its investigators. The members of the Board did not possess such expertise. We believe the lack of investigative experience of Board members may have hindered the effectiveness of the Board's report.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

In any fire emergency, a degree of confusion on the part of participants can be expected; however, in the situation at Danbury, weaknesses in the institution's fire safety program aggravated the situation. Safety inspections had been infrequent and inadequate. The fire plan did not provide for timely notification of the Danbury fire department and did not include housing unit evacuation procedures. Correctional staff and inmates did not receive adequate fire safety training, which led to confusion concerning the role of each staff member and the inmate fire brigade in a fire emergency and concerning the extent to which inmate safety takes precedence over security.

The Bureau of Prisons has taken steps to improve fire safety programs at Danbury and at its other institutions. However, we believe that further steps could be taken. First, more fire safety training for correctional staff would help. Also, while there were good reasons for selecting the people who served on the Board of Inquiry and there are no indications that it failed to objectively investigate and report on the Danbury fire, its credibility could have been improved. The fact that the Board was composed entirely of Bureau personnel, none of whom were expert in fire investigations, heightened concern about the objectivity of its study. In addition, we believe that the Bureau should more alertly monitor how changing fire safety standards affect its installations.

RECOMMENDATIONS TO THE ATTORNEY GENERAL

We recommend that the Attorney General require the Director, Bureau of Prisons, to:

--Provide correctional staff with increased fire safety training during their initial orientation and periodically thereafter. Such training should emphasize applicable Bureau policies and procedures and use of firefighting equipment. To alleviate confusion concerning safety versus security, the Bureau's policies should specify that each institution's fire plan incorporate inmate evacuation procedures which will highlight safety while maintaining institutional security.

--Include outside personnel, preferably with expertise in fire investigations, on Boards of Inquiry in the future. The Bureau should take action now to assure the availability of such people on an as-needed basis.

--Keep abreast of significant changes in fire safety standards so that alterations to existing institutions can be considered.

The Department of Justice commented on a draft of this report by letter dated July 21, 1978. The Department concurred in our recommendations, but believed that decisions to include outside personnel on future Boards of Inquiry ought to be done on a case-by-case basis. The Department's comments are included in appendix II to this report.

APPENDIX I

United States Senate

COMMITTEE ON
GOVERNMENTAL AFFAIRS
WASHINGTON, D.C. 20510

November 17, 1977

Honorable Elmer B. Staats
Comptroller General
General Accounting Office
441 G Street, NW
Washington, D.C. 20548

Dear Mr. Staats:

We request that the General Accounting Office investigate the objectivity, accuracy and completeness of an investigation and report done by the Federal Bureau of Prisons with respect to the fire incident at the Federal Corrections Institute at Danbury, Connecticut on July 7, 1977.

Enclosed for your information is a letter from the Connecticut Chapter of the National Association for the Advancement of Colored People questioning the objectivity, motives, accuracy and completeness of that report. We would appreciate your evaluating the investigation done by the Bureau of Prisons and the report they filed, and reporting back to us on your conclusions as soon as possible.

Sincerely,

Lowell Weicker, Jr.

Abe Ribicoff

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20530

Address Reply to the
Division Indicated
and Refer to Initials and Number

JUL 21 1978

Mr. Victor L. Lowe
Director
General Government Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Lowe:

This letter is in response to your request for comments on the draft report entitled "The Fire at Danbury Prison--What Happened and What Steps Have Been Taken to Prevent Recurrence."

The draft report confirms the findings and conclusions of the Bureau of Prisons' Board of Inquiry in all significant respects, and makes three recommendations which we support. All but one of the recommendations are similar to the recommendations made by the Board of Inquiry.

As noted in the draft report, the Bureau of Prisons (BOP) has taken steps to improve fire safety conditions at Danbury and at all other institutions in the Federal Prison System. These steps include the installation of automatic sprinklers in all new and existing institutions when required by National Fire Protection Association Life Safety Code, and the placing of smoke detectors in all inmate housing areas at all institutions.

In addition, BOP has directed that all institutions, with the aid of local fire safety experts, review and update their fire evacuation plans. Employees at each institution are being educated in effective evacuation procedures and are conducting fire drills routinely. The lessons learned during the fire at Danbury are being emphasized, and correctional personnel are being trained to realize that adequate fire safety demands cessation of security procedures when human life is being jeopardized.

The draft report implies that the failure to assign a non-Bureau fire safety expert to the Board of Inquiry may have raised questions regarding the Board's objectivity and ability to investigate the Danbury fire. We would like to point out that those who served on the Board of Inquiry were specifically appointed because they represented a variety of professional disciplines. Among them was a person with a fire safety background and knowledge of the Life Safety Code of the National Fire Protection Association. BOP did not feel it was necessary to appoint an outside fire expert to the Board because of the number of investigations already being conducted, namely, by the State and local fire departments, the Federal Bureau of Investigation, and the National Fire Protection Association. Since GAO has confirmed the objectivity of the Board's report, we doubt whether the presence of an outside expert in fire safety would have significantly added to the objectivity or accuracy of the Board's report. We do, however, agree with GAO's recommendation that outside experts should be named to future boards of inquiry, but this should be done only on a case-by-case basis as the need arises.

We appreciate the opportunity given us to comment on the report. If you have any additional questions, please feel free to contact us.

Sincerely,

Kevin D. Rooney
Assistant Attorney General
for Administration

QUESTIONS ABOUT THE DEATH OF ONE INMATE

The body of one of the inmates killed in the Danbury Prison fire was found in the G unit washroom. Controversy has developed concerning the circumstances of the death of this inmate.

Like the other four who died, this inmate was a victim of smoke inhalation. However, unlike the others, he suffered multiple burns over more than 50 percent of his body. He also suffered a hemotoma 1/ to the side of his head. The Connecticut State chief medical examiner indicated that, while the wound could have resulted from a blow, it is not an uncommon injury for someone who has been subjected to extreme heat. (The fire captain who first arrived at the fire estimated the temperature in areas of the washroom reached 2,000 degrees Fahrenheit.)

Although we were told that this inmate had another head injury as well, the medical examiner reported no traumatic injuries or external abnormalities.

Since the dead inmate had not been seen in the washroom prior to the washroom ceiling collapse, some people have asked how he got there--especially with the flames and heat. While we are unable to conclusively say, he may have wandered into the washroom while attempting to escape the fire.

A number of inmates indicated that this inmate was in the rear of the dormitory, assisting in moving other inmates to the E-P door, immediately after the washroom ceiling collapsed. However, inmates stated that after realizing the rear doors could not be opened, this inmate decided to run through the flames and attempt to exit through the main G unit entrance. Shortly after disappearing through the flames, this inmate could be heard calling out that the main entrance was locked and exit not possible. This was the last known communication between this inmate and other trapped G unit inmates.

An inmate we interviewed said that he saw an unrecognized inmate standing inside the locked main entrance of G unit during the fire. The inmate outside sought out a correctional officer to unlock the door. By the time the correctional officer arrived, the inmate at the door was gone. The officer left the door unlocked. We could not confirm this account

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1/A tumor or swelling containing blood.

with the correctional officer, who did not respond to our inquiries and no longer works for the Bureau.

Recent studies of the National Bureau of Standards have indicated that a variety of behaviors are common in a fire. They indicate it is not unusual for an individual to successively demonstrate different behaviors during the same fire--from courage and leadership in helping others to panic and fear, especially when faced with unexpected adversity such as a blocked exit.

We were also informed by representatives of NFPA and the Danbury fire department that an individual can become disorientated during a fire, and even go toward the fire. The dead inmate may have suffered this unfortunate fate.

(18254)

GPO 931-626

END