TEXAS DEPARTMENT OF CRIMINAL JUSTICE

Correctional Institutions Division

SERIOUS INCIDENT REVIEW
Telford Unit

Incident Date: July 15, 2015
On-Site Visit Date: July 21, 2015
Distribution Date: January 25, 2016

TEXAS DEPARTMENT OF CRIMINAL JUSTICE

Serious Incident Review

TO:	William Stephens Director Correctional Institutions Division	**INITIAL SITE VISIT DATE:** July 21, 2015
THRU:	Robert Eason Deputy Director Prison and Jail Operations	1-20-2016
FROM:	Cody Ginsel Deputy Director Management Operations	1/20/2016
		RE: Serious Incident Review Telford Unit – Employee Death July 15, 2015

BACKGROUND

On July 15, 2015, at approximately 9:00 a.m., Timothy Davison, Correctional Officer II, and Shanica Young, Correctional Officer III, removed Offender Billy Tracy, TDCJ #834031, from the 12 building, E Pod, 4 section day room. Officer Davison proceeded to escort Offender Tracy on his own to his housing assignment in the adjacent section. As Officer Davison was opening the cell door, Offender Tracy slipped his left hand out of the restraints and struck Officer Davison with his closed fists. Offender Tracy gained control of Officer Davison's tray slot tool and struck him in the head with the tool multiple times. Offender Tracy then threw Officer Davison down the stairs to the first floor and retreated to his cell. Security staff began life saving measures while unit medical staff and Emergency Medical Services (EMS) were called. Unit medical staff arrived and life saving measures continued. Upon their arrival, EMS staff determined Officer Davison should be transported by Life Flight. Officer Davison was taken by Life Flight to the St. Michaels Medical Center in Texarkana, Texas, arriving at approximately 10:31 a.m. At approximately 11:31 a.m., Officer Davison was pronounced deceased. A final autopsy revealed Officer Davison's death was due to blunt force trauma and the manner of death was listed as homicide.

An incident review team was formed at the request of William Stephens, Correctional Institutions Division Director. The review team was comprised of the following members:

Cody Ginsel, Director, Correctional Training and Staff Development
Tracy Bailey, Warden, Estelle Unit
Richard Wathen, Warden, Allred Unit
James Jones, Warden, Huntsville Unit
Christopher Carter, Warden, Stiles Unit
Travis Turner, Program Specialist V, Classification and Records
Tara Burson, Program Specialist III, Classification and Records
Cassandra McGilbra, Program Supervisor V, Safe Prisons/PREA Program

Dr. Linda Knight, Director V, Health Services
Sandra Jones, RN, Nurse IV, Health Services
Kevin Vonrosenberg, Assistant Director, Manufacturing and Logistics Division
Robert Cousins, Program Specialist III, Manufacturing and Logistics Division
Al Courtney, Program Supervisor V, Security Operations
Debbie Van Dyke, Program Specialist I, Security Operations
Frank Anizan, Program Supervisor V, Security Operations

The review team made an onsite visit to the Telford Unit on July 21, 2015. Team members have communicated with the Telford Unit staff since the initial site visit to finalize information in this report.

SCOPE AND OBJECTIVES

The scope of the review team was to examine unit staffing, correctional officer training, security procedures, emergency response, classification, safe prisons, physical plant, and health services. The objective of the team was to identify procedures that may prevent similar incidents in the future. The team utilized interviews with staff and offenders, inspection of training records, visual inspections of the area where the incident occurred, and reviewed all of the applicable documents and procedures pertinent to the incident.

INCIDENT REVIEW

Participant Summary

Security Staff
Timothy Davison, Correctional Officer II, 47 year old white male, victim (deceased)
Officer Davison had been employed with the TDCJ since December 18, 2014.

Offender
Billy Tracy, TDCJ #834031, W/M/37/Level 1A, assailant
Offender Tracy is a 37 year old, white male, 5'9", weighing 173 pounds from Rockwall County. He is serving two concurrent Life sentences for Burglary of a Habitation and Aggravated Assault with a Deadly Weapon.

CHRONOLOGY OF EVENTS

At approximately 9:01 a.m., Timothy Davison, Correctional Officer II, and Shanica Young, Correctional Officer III, were both present when Offender Billy Tracy, TDCJ #834031, was removed from the 12 Building, E pod, 4 section day room. Officer Davison then escorted Offender Tracy on his own to the offender's cell (#66) in the adjacent section. As they approached the cell, Officer Davison reached to open the cell door while Offender Tracy slipped his left hand from the restraints. The offender then struck the officer with his fists on the side of his face causing Officer Davison to fall to the ground. Offender Tracy then gained control of Officer Davison's tray slot bar and began striking him with the tool. Officer Davison was able to stand and began defending himself from the assault; however, fell again to the ground with the offender. Offender Tracy regained his footing, stood over Officer Davison, and continued striking him in the head and upper body with the tray slot bar, as the officer was attempting to block them with his hands. One of the strikes appeared to

cause Officer Davison to lose consciousness. Offender Tracy then struck Officer Davison multiple times in the head and face with the tray slot bar. Offender Tracy took control of the Carry on Person (COP) Chemical Agents issued to Officer Davison. He then picked up Officer Davison and threw him down the stairs. Offender Tracy sprayed the COP toward the entrance of the section.

Marty Bradford, Correctional Officer IV, assigned to 12 building E picket, witnessed the assault in progress and requested assistance via hand held radio.

At approximately 9:03 a.m., James Culverhouse, Correctional Officer II, Justina Henry, Correctional Officer II, Bryan Schuster, Correctional Officer II, Elizabeth Caraway, Correctional Officer II, Andrew Sanchez, Correctional Officer II, and Nina Andrews, Correctional Officer IV arrived at E pod. As they entered, Officer Young was standing at the entrance of the wing.

Offender Tracy threw the tray slot bar towards the officers hitting the top of the 5 section doorway. He then returned to his cell and shut the door.

Jacob Harrison, Captain, and Kevin Squibb, Correctional Officer II, arrived to the scene and determined that Officer Davison should be removed from the section and into the main hallway of 12 building. George Snodgrass, Correctional Officer IV, and Majken R. Raines, Correctional Officer II assisted Captain Harrison and Officer Squibb in moving Officer Davison.

At approximately 9:05 a.m., Unit Medical staff Gwen King, Licensed Vocational Nurse, and Melody Hill, Licensed Vocational Nurse, arrived on scene. The medical staff noted that Officer Davison was breathing on his own. Pressure dressings were immediately applied to the back of the head and the face of Officer Davison due to extent of injuries and blood loss. Upon arrival of the gurney, a C-Collar was applied. Officer Davison was transported to the Unit Medical Emergency Room arriving at approximately 9:06 a.m., where Tamar Merchant, Medical Doctor, and Jamie Barker, Advanced Practice Registered Nurse, assumed care.

At approximately 9:13 a.m., Jeff Butler, Office of Inspector General Investigator, was notified.

At approximately 9:14 a.m., Emergency Medical Services arrived and assumed care. It was determined that a life flight was needed due to the extent of the wounds. Officer Davison was placed onto the Emergency Medical Services gurney and taken to the ambulance. Dr. Merchant and LVN King traveled with Officer Davison in the back of the ambulance to the landing zone. Once the Life Flight arrived, Officer Davison was moved from the ambulance to the helicopter. The Life Flight departed the landing zone at approximately 10:08 a.m. and arrived at the St. Michaels Medical Center in Texarkana, Texas at approximately 10:31 a.m.

At approximately 11:31 a.m., Officer Davison was pronounced deceased by the attending physician. Offender Tracy was administratively charged with committing a felony while incarcerated and transferred to the Coffield Unit.

UNIT STAFFING

The Telford Unit is staffed according to the Texas Department of Criminal Justice Security Staffing Plan dated April 1, 2015. Security staff members work twelve hour shifts. The twelve hour shift schedule follows a cycle of four days on duty followed by four days off duty.

Findings

- The Telford Unit was authorized 527 correctional officers positions. On July 15, 2015, 430 correctional officers were assigned. The unit staffing strength was 81.6%. The housing area was appropriately staffed with one correctional officer assigned to the housing control picket and two correctional officers assigned as Administrative Segregation housing rovers.

- A and B responders were noted on the turnout roster.

- Staffing levels do not appear to be a factor in this incident.

Recommendations

- None

TRAINING

The team reviewed training records for unit staff pertinent to the incident. Beginning October 2014, the Correctional Training and Staff Development provided direction that all security staff newly assigned to administrative segregation should receive specialized training prior to shift assignment as well as continued reinforcement of this training during shift briefing.

Findings

- Officer Davison was current on all training, including the 16-hour Administrative Segregation training upon completion of Phase II of the On-the-Job training (OJT) program and training on all Administrative Segregation training topics during shift briefings.

- Officer Young administratively transferred from the Coffield Unit to the Telford Unit on May 1, 2015. While at Coffield, Officer Young worked in administrative segregation. Upon her assignment to the Telford Unit administrative segregation, she did not complete the 16 hour OJT portion for administrative segregation operations. However, she had received training on all the topics during shift briefings.

- Officer Bradford was current on all training. She had practical experience working in the Telford Unit administrative segregation area and she had received training on all Administrative Segregation training topics during shift briefings.

Recommendations

- Update SM 02.25, On-the-Job Training (OJT) Program, to require that security staff who are to be newly assigned or transferred to work in administrative segregation should receive the 16 hour Administrative Segregation On-the-Job Training block prior to shift assignment.

SECURITY PROCEDURES AND EMERGENCY RESPONSE

The team reviewed unit security procedures and emergency response pertinent to the incident.

Findings

- Incident Command System drills were conducted in accordance with agency policy.
- The Incident Command System was initiated in a timely manner.
- All hand held radios were functioning properly.
- Post Orders were signed and up to date.
- Life Saving Response kits were stocked and readily available.
- Crisis Response Intervention Support Program was offered to all staff involved in the incident.
- Security staff did not follow Post Order 07.006, "Administrative Segregation Officer":
  - Officer Young remained in 4 section and was not in close proximity to respond in the event of an emergency while Officer Davison was escorting Offender Tracy back to his assigned cell.
  - During the escort of Offender Tracy, the 4 section door was not secured prior to the opening of the 5 section door.
  - The hand restraints were not properly applied to Offender Tracy prior to removing him from the day room. Specifically, the hand restraints were not double locked.
  - Offender Tracy was not strip searched prior to being removed from the day room.
- Cell inspections were not conducted and documented on the Administrative Segregation Confinement Record at least once every 72 hours in accordance with Security Memorandum 03.02, "Security Searches." A review of the Administrative Segregation Confinement Record for Offender Tracy, identified the last cell inspection conducted was on June 29, 2015.
- Comprehensive searches of the Telford Unit were being conducted in accordance with Security Memorandum 03.01, "Comprehensive Unit Searches."

Recommendations

- Security staff assigned to administrative segregation housing should follow Post Order 07.006, "Administrative Segregation Officer":
  - During the escort of an offender, the second rover should remain in close proximity to the escorting officer in order to respond in the event of an emergency.
  - Security staff should ensure the section doors are secured after entering or exiting a section.
  - Security staff should ensure the proper application of hand restraints to include double locking.
  - Security staff should ensure offenders are properly strip searched prior to exiting the day room area.

- Post Order 07.006, "Administrative Segregation Officer" should be reviewed and updated to reflect that two correctional officers shall be present at all times during the escort of an Administrative Segregation offender with a Security Precaution Designator.

- Cell inspections should be conducted at least every 72-hours and be documented on the offenders Administrative Segregation Confinement Record, I-201 in accordance with Security Memorandum 03.02, "Security Searches."

- Officer Shanica Young, assigned as a 12 Building, E-Pod rover at the time of the incident, was charged in accordance with Personnel Directive 22, General Rules of Conduct and Disciplinary Action Guidelines for Employees, for failing to ensure an offender was strip searched prior to removal from the dayroom to be escorted to his assigned cell. She was also charged with failing to secure the section doors after passing through them and for failing to respond when another officer was attacked by an offender. However, she resigned in lieu of disciplinary.

- Officer Marti Bradford, assigned as the 12 Building E-Pod Picket Control Officer at the time of the incident, was disciplined in accordance with Personnel Directive 22, General Rules of Conduct and Disciplinary Action Guidelines for Employees, for not ensuring that 12 Building, E-Pod, 4 Section entry door was secured prior to opening 12 Building, E-Pod, 5 Section entry door and for opening the day room door to 4 section for the escort of Offender Tracy without a strip search being conducted.

- Major Jerry Toft, who was assigned to the Telford Unit on November 15, 2014, as the Major over Administrative Segregation, until he was administratively transferred to the Roach Unit on July 1, 2015, was disciplined in accordance with Personnel Directive 22, General Rules of Conduct and Disciplinary Action Guidelines for Employees, for violation of Post Order 07.002, Major of Correctional Officers. Specifically, Major Toft failed to document his security rounds in administrative segregation and ensure that newly assigned staff to the Telford Unit administrative segregation area received the 16-hour Administrative Segregation Training.

CLASSIFICATION

Custody, housing assignments, and Unit Classification Committee (UCC) hearings pertaining to Offender Billy Tracy, TDCJ #834031 were reviewed.

Findings

Billy Tracy, TDCJ #834031, W/M/37/1A
Offender Tracy was received by TDCJ on August 3, 1998. He was assigned to the Allred Unit on August 20, 1998, for his initial unit of assignment. On April 23, 2014, he was assigned to the Telford Unit. At the time of the incident, the offender's housing assignment was 12 Building, E Pod, 5 section, cell 66, and had been so since October 21, 2014.

Offender Tracy had 49 major disciplinary convictions on file to include attempted escape, possession of contraband, possession of a weapon (multiple), staff assault with a weapon (multiple), offender assault with a weapon (multiple), tampering with a locking mechanism, refusing to obey orders, and creating a disturbance. His last major disciplinary was on April 22, 2014 for attempted escape.

- Offender Tracy's housing assignment and custody were appropriate as outlined in the Classification Plan.

- Offender Tracy's Security Precaution Designator codes were notated on the unit Administrative Segregation recreation/shower log. However, the codes were not highlighted on the upper right corner of the Administrative Segregation Confinement Record.

Recommendations

- Security Precaution Designators should be documented and highlighted in the Security Precaution Designator's section of the Administrative Segregation Confinement Record, I-201, in accordance with Administrative Directive 04.11, "Security Precaution Designators."

- Revise the Security Review Checklist to require that the unit warden has established the use of additional methods to notify staff, including rosters or the standardized cell door markers, to ensure staff is notified and aware of offenders with Security Precaution Designators.

SAFE PRISONS

An interview with security staff was conducted. Classification folders and the Safe Prisons database were reviewed for Offender Billy Tracy, TDCJ #834031.

Findings

- The Zero Tolerance Policy awareness posters were posted as required.

- Offender Tracy had not filed an Offender Protection Investigation, nor was one filed on his behalf.

Recommendations

- None

PHYSICAL PLANT

The area where the incident took place was observed.

Findings

- The comprehensive video surveillance system provided complete coverage of the incident.

- The tool utilized to open and close the food tray slot locking mechanism was used as a weapon to assault Officer Davison.

Recommendations

- Correctional Institutions Division, Business and Finance, Manufacturing and Logistics, and Facilities Maintenance should establish a working group to review and evaluate alternatives to the current method used to open and close the food tray slot.

HEALTH SERVICES

The medical records pertaining to Offender Billy Tracy, TDCJ #834031, are under review by the Texas Department of Criminal Justice, Health Services Division.

CONCLUSION

The team reviewed all available evidence regarding the incident and identified findings in the areas of unit staffing, training, security procedures, emergency response, classification, safe prisons, and physical plant.

Following the incident, the Telford Unit administration immediately initiated an investigation.

Interviews conducted with security staff by the Serious Incident Review Team indicated Offender Tracy's behavior over the last year had been non-disruptive and that he was consistently compliant with orders, as well as respectful to staff. Offender Tracy's last disciplinary on record was April 22, 2014. On the date of the incident, Officer Young removed Offender Tracy from his assigned cell and escorted him to the 4 section day room. Offender Tracy was compliant with all orders during that time. However, Officer Young did not recognize Offender Tracy had packed his personal property in his cell prior to being removed. There were no other indicators Offender Tracy was planning to assault staff, as his behavior was compliant up until the point of the assault of Officer Davison.

Interviews conducted with offenders by the Serious Incident Review Team revealed they were not aware Offender Tracy was going to assault Officer Davison. Multiple offenders stated Officer Davison was a good officer and had no negative interactions with Offender Tracy prior to the incident. After the incident, Offender Tracy made comments to staff "it was time" and "they didn't know how dangerous I am."

Offender Tracy was interviewed at the Coffield Unit by Senior Warden John Rupert. He stated Officer Davison was a good officer who did his job and was fair to the offender population. Offender Tracy further stated he had no problems with Officer Davison prior to the incident. However, he continued to justify his actions by indicating that the staff were complacent and "I had my reason".

Offender Tracy was not on the mental health caseload at the time of the incident. He was being monitored by mental health staff for regular 90 day administrative segregation assessments and his most recent contact, June 12, 2015, showed no signs or symptoms of mental illness. He had not made any request for any mental health services.

Since this incident, security practices in administrative segregation housing areas have been emphasized. In particular, escort procedures and training regarding employee safety have been reinforced at Pre-Service, In-Service, and at unit level staff meetings and shift briefings. Having a heightened level of situational awareness,

specifically, when becoming aware of unusual behaviors such as when an offender packs their personal property prior to being removed from a cell without prior notice of a housing change, has also been emphasized. The importance of reporting those situations to a shift supervisor has also been emphasized with security staff.

Offender Tracy was administratively charged with committing a felony while incarcerated and transferred to the Coffield Unit for assignment. On December 10, 2015, the Bowie County Grand Jury handed down an indictment against Offender Tracy for Capital Murder.

Attachment A – Unit Profile

ATTACHMENT A

Telford (TO)
Correctional Institutions Division - Prison
ACA Accredited Unit Since May 2006

Unit Full Name:	Barry B. Telford Unit
Unit Address and Phone Number:	3899 Hwy 98, New Boston, TX 75570 (903) 628-3171 (**067)
Unit Location:	Two miles south of IH-30 on Hwy 98 in Bowie County
Senior Warden:	Dawn Merchant
Regional Director:	Kelvin Scott, Region II
CI Division Deputy Director:	Robert "Jay" Eason
Date Unit Established or On Line:	July 1995
Total Employees *:	706
Security Employees *:	552
Non-Security Employees *:	94
Windham Education Employees *:	11
Contract Medical and Mental Health Employees *:	Medical = 44; Mental Health = 5
Offender Gender:	Male
Maximum Capacity *:	2,872
Custody Levels Housed:	G1-G5, Administrative Segregation, Safekeeping
Approximate Acreage:	1,206
Agricultural Operations:	Security Horses, Security Pack Canines, Unit Garden, Cow/Calf Operation, Field Crops, Unit Food Bank Garden Program
Manufacturing and Logistics Op.:	None
Facility Operations:	Unit Maintenance
Additional Operations:	Scent-Specific Canines
Medical Capabilities:	Ambulatory medical, dental, and mental health services. Medical care available 24 hours a day, seven days a week. Seventeen bed infirmary, including 13 assisted living beds, two respiratory isolation beds and two mental health observation rooms. Telemedicine Services available. All services on a single level, including CPAP accommodating housing. Managed by UTMB.
Educational Programs:	Literacy (Adult Basic Education/GED), CHANGES/Pre-Release, Cognitive Intervention Career and Technology Programs: Construction Carpentry; Electrical Trades; Small Engine Repair
Additional Programs/Services:	Adult Education Program (upon availability), Life Decisions Program, Peer Education, Reentry Planning, Chaplaincy Services, Crime Stoppers, GO KIDS Initiative
Community Work Projects:	Services provided to city and county agencies, area school districts, and the Texas Department of Transportation.
Volunteer Initiatives:	Employment/Job Skills, Substance Abuse Education, Life Skills, Parent Training, Support Groups, Victims Awareness, Religious/Faith Based Studies and Activities, Post-Release Housing

* Data as of August 31, 2013