National Institute of Corrections

Nebraska Department of Correctional Services
Tecumseh State Correctional Institution
Review Team Report

Incident Review of Disturbance and Death of Two TSCI Inmates
March 2, 2017

May 2, 2017

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DISCLAIMER

RE: NIC Technical Assistance No. 17P1021

This technical assistance activity was funded by the Prisons Division of the National Institute of Corrections. The Institute is a Federal agency established to provide assistance to strengthen state and local correctional agencies by creating more effective, humane, safe and just correctional services.

The resource person who provided the on-site technical assistance did so through a technical assistance agreement, at the request of the Nebraska Department of Corrections, and through the coordination of the National Institute of Corrections. The direct onsite assistance and the subsequent report are intended to assist the agency in addressing issues outlined in the original request and in efforts to enhance the effectiveness of the agency.

The contents of this document reflect the views of James Upchurch and Joan Palmateer. The contents do not necessarily reflect the official views or policies of the National Institute of Corrections.

Introduction

Scott Frakes, Director of the Nebraska Department of Correctional Services (NDCS) submitted a request for the National Institute of Corrections (NIC) to conduct an independent review of Tecumseh State Correctional Institution (TSCI) to assess pertinent systems and policies related to the disturbance incident occurring in Housing Unit 2A/B on March 2, 2017, wherein significant property damage was perpetrated and two inmates were murdered. The significance of this request was heightened further due to a previous larger scale disturbance occurring on May 10, 2015, wherein two inmate homicides also occurred. The review team assessment includes an evaluation of whether recurring contributing factors were implicated in both disturbances.

The review team consisted of NIC consultants Joan Palmateer and James Upchurch. NIC Correctional Program Specialist Wayne Hill and NIC Prisons Chief Ron Taylor were also present during the week long review. The Review Team was on site daily from March 20, 2017 through March 23, 2017 at the Tecumseh State Correctional Institution, Nebraska Department of Correctional Services. Final verbal exit briefing preparation and the actual verbal exit briefing to Director Frakes and designated members of his management team occurred on March 24, 2017.

This report identifies for discussion, assessment and, where indicated, recommended enhancements and other changes or additions to those systems, policies, practices, protocols, and technologies existing within the TSCI which could reasonably have been implicated as contributing factors impacting safety and security of staff, inmates and others prior to, during and following the disturbance occurring on March 2, 2017.

Staff at all levels with whom the reviewers interacted, while understandably somewhat guarded initially, were cooperative and generally forthcoming and very interested in sharing their concerns and providing constructive input about possible improvements at TSCI. Each individual that the reviewers encountered was hospitable, helpful and professional.

It is important to note that the review team had limited time to review the incident related documents or policies prior to our arrival on site to begin the review. We were, however, expeditiously provided with documents including incident timelines and needed additional supporting documentation throughout the week. We were also provided unfettered access to all areas of the facility as well as access to any and all inmates and staff that the review team believed to be necessary and consistent with the somewhat abbreviated time period available for this review.

In our opinion as corrections professionals with combined experience totaling some seventy plus years, this report resulting from our research, review of documents, interviews, on site observations and work formulating our conclusions and recommendations can provide opportunities to mitigate safety and security vulnerabilities at TSCI. Additionally, these recommendations may not only prove beneficial at TSCI, but also to other institutions within the Nebraska Department of Correctional Services'.

Entrance Briefing

Monday, 8:00 AM, March 20, 2017
Attendees:

Scott Frakes, Director, Nebraska Department of Correctional Services
Ron Taylor, NIC Prisons Chief
Wayne Hill, NIC Specialist
James Upchurch, Consultant
Joan Palmateer, Consultant
Debra Sabatka-Rine, Deputy Director, Operations
Brad Hansen, Warden
Scott Busboom, Deputy Warden
April Bulling-June, Associate Warden
James Jensen, Major
Shawn Sherman, Unit Administrator
Christopher Connelly, Investigative Captain
Luke Morris, Administrative Captain
Tony Simon, Operations Captain
Boris Ilic, Public Information Officer
Dawn-Renee Smith, Communications Director
Susan Tallant, Unit 2AB Unit Manager
Kevin Klippert, Unit 2CD Unit Manager

The Entrance Briefing was held in Warden Hansen's conference room at TSCI and began by providing an opportunity for all of those present to introduce themselves and describe their positions. The NIC representatives explained briefly the purpose of this Technical Assistance Project in terms of providing an after incident assessment of the March 2, 2017 disturbance that occurred at TSCI and that this assessment is being provided at the request of Director Frakes. The review team, Joan Palmateer and James Upchurch, discussed some broad, general areas of review about which questions will likely be posed and documentation requested for review. The team explained that additional issues will likely be included in the review as the assessment progresses.

General areas of review by the review team that were described and discussed for input with the NDCS and TSCI staff present to formulate a status baseline included:

- Review of lessons learned and improvements made since the 2015 disturbance;
- Assessment of contributing factors for either/or both events;
- Nature of homicides; targeted; Security Threat Group(STG)/Gang related;
- Management instituted changes/improvements;

- Emergency Management including Incident Command System (ICS) and its implementation;
- Emergency Plans, training/simulations, quality and frequency;
- Communications including availability of radios, personal body alarms, telephone off-hook alarms, and intercoms;
- Staff accountability system;
- Staff personnel protection equipment, i.e., chemical agents;
- Condition, ready availability and adequacy of emergency response equipment;
- Immediate emergency response options including tactical capabilities;
- Staffing issues and concerns including vacancies, demographics, turnover rate, experience levels, and overtime use;
- Frequency/type of employee grievances, staff morale;
- Training sufficiency – entry level and annual;
- Management reports potentially indicating unrest, identifying potential problem areas;
- Inmate Grievances – totals/patterns by institution over time, by category, i.e., staff, food, conditions, discipline, health care, and other programs;
- Inmate misconduct reports, total numbers, major, serious, minor over time for comparison, sanctions utilized, guilty/not guilty determinations frequency, charge offenses frequency over time comparisons, especially assaults (staff/inmate), refusing lawful orders, staff disrespect, etc.;
- Contraband discoveries, types and quantities over time, including weapons, drugs, cell phones, and alcoholic beverages;
- Operational status of various core security areas including those such as tool control, hazardous materials control, including flammable, incendiary materials, searches of inmates and living areas, etc.;
- Use of Force, frequency over time, types;

- Classification process, comparative characteristics of inmates involved in both disturbances, Restrictive Housing utilization, STG/gang management concerns, number of protective management cases, etc.;

- Inmate inactivity level, available programs, other activities, recreation, jobs, and industry; and

- Staff inmate interaction, direct - indirect supervision, level/character of communication; staff encouraged to interact, manage or to just watch and intervene when necessary.

All of these areas, as well as several others, were considered and evaluated to various degrees during the review team's assessment. It is important to note that an in-depth assessment of all areas in a week's review period was not feasible. The review team was able to utilize the responses by TSCI management and supervisory staff to questions in these areas; interviews with both staff and inmates; and review of various documents, and/or our observations while on site that indicated further in depth review in some areas was not necessary and therefore not a priority for the time available. The review team has not included comments about areas that did not appear to be significant contributing factors in relation to the March 2, 2017 disturbance.

Facility Tour

At the conclusion of the entrance briefing and subsequent discussions with NDCS and TSCI management staff, the review team was accompanied on a comprehensive tour of the TSCI facility with an emphasis on housing unit 2A/B where the disturbance occurred on March 2, 2017.

The TSCI is a relatively modern (opened 2001), campus style designed facility with a reported total inmate population of 1,050 at the time of our visit.

The review team toured all support and program areas within the facility including the chapel; kitchen/dining; inmate clothing issue; medical; industries areas (Cornhuskers State Industry (CSI) laundry and wood shop); maintenance; gymnasium; library; and education. We were able to observe both staff and inmates in each area and talk with some of each as the tour progressed.

Two of the three primary inmate housing areas, Housing Units (HU) 1 and 2 generally consist of one hundred twenty-eight (128) double bunked cells allowing for a total of two hundred fifty-six (256) inmates in each area. These housing units were further divided into four wings of thirty-two (32) cells each, housing sixty-four (64) double bunked inmates. Both the A/B and C/D sides of HUs 2 and 3 have secure officer stations/control areas for observation of the galleries/common areas and some limited locking control of cell doors. HU 1 has a different configuration including additional beds located in three housing sections and a correspondingly larger inmate population capacity. HU 1 houses three hundred forty-five (345) protective management inmates

and is the primary protective management unit for all of the NDCS. It also houses a sixty-four (64) bed substance abuse program.

Housing Unit 2 houses maximum custody inmates and Housing Unit 3 houses Medium Custody inmates including the majority of those inmates assigned to the industries areas and other facility work assignments. There is also a Special Management Unit (SMU) for Restrictive Housing that is divided into six wings; some limited number of which are double bunked with the remainder being single occupant cells. This unit can house one hundred ninety-seven (197) inmates. There are ten death sentenced inmates housed in this area as well.

The grounds outside the housing units were well maintained and are monitored from an armed tower position that generally has a good view of most of the fenced grounds with some notable exceptions, particularly in areas near the housing units. The perimeter security features include a double chain linked fence with affixed razor wire, electronic perimeter detection system mounted on the interior fence, and two armed officers in roving patrol vehicles.

There is a fenced sports-related courts area and large recreation field area located in relatively close proximity to the tower position. A small outdoor religious area is located adjacent to the recreation field. Inmates recreate by schedule in either one of these areas and, more frequently, in the mini-recreation yards attached to each of the housing units. Inmates are not allowed to recreate or otherwise congregate on the large yard area located between the housing units and the support building(s).

Of significant interest was the tour of HU 2 A and B wherein damage to the physical plant resulting from the disturbance of March 2, 2017 remained visible. Damage appeared to be significant with clear evidence of fires and destruction to housing unit walls, doors and ceilings. There were several areas that appear to have withstood serious damage by inmates during their efforts to overcome physical security enhancements made to the building subsequent to the May 10, 2015 disturbance. At the time of the review team's tour, the unit was being operated in a restricted/controlled manner with several custody staff present and limited inmate movement as well as individual time outside their cells. Noticeably absent, was the presence of gas ports for chemical/OC spray deployment into the area which were reportedly requested after the 2015 incident but not approved (justification for non-approval was not provided to the review team.) We also noted that there were no cuff ports in the cell doors and the lavatory/toilet fixtures were porcelain as opposed to the more damage resistant stainless steel type generally found in Maximum Security housing units (these deficiencies will be discussed later in this report.)

Throughout this extensive tour, the review team had an opportunity to observe the inmate population and their interactions with staff. The team did note a significantly greater number of inmates wanted to talk with the review team and expressed interest in what the team was were doing (e.g., questioning what organization the team was associated with as well as wanting to voice complaints). The number of inmates who

attempted to engage with the team was significantly more than the team is accustomed to during similar institutional reviews or assessments.

The team also noted that the inmate population had access to a significant number of privileges, not commonly found at similar security levels in other state prison locations, including personal televisions (if purchased themselves); microwave ovens and ice machines in common areas of galleries; and Kiosks for e-mailing messages to friends and family, entering canteen orders, and personal MP-4 players for downloading purchased music as well as E-mail communication to the outside.

Chronology of Incident Events

- March 1, 2017; staff discovers inmate(s) living in Unit 2/A/B intoxicated;
- March 2, 2017; staff searches inmates' cells for homemade hooch (slang for inmate-made alcoholic beverage) in 2 A/B;
- Inmates returning from lunch discover cells being searched, large quantity of hooch found;
- A staff member accidently bumps into inmate while trying to exit cell, inmate states that he pushed him (video review does not support allegation);
- Staff continues to collect homemade hooch to place in unit conference room;
- Unit 2 A/B Inmates start breaking off into small groupings;
- Some inmates go outside; two staff leaves Unit 2 A/B day room area;
- One staff goes to mini-yard to take the inmate who accused staff of bumping him to holding cell for a prior issue in Unit 2 lobby area;
- Inmates tie mini-yard doors from A/B together to prevent them from closing, tell staff that they will not let staff take inmate to holding;
- Staff member perceives danger and leaves Unit 2 A/B housing area;
- Unit 2 A/B control staff informs other staff that inmates are covering their faces;
- Staff initiate emergency procedures and open command in master control;

- Inmates start to destroy the housing unit; try to gain access above control center; break through and destroy rooms above on right side of control; cannot gain access to rooms on left side;

- Inmates use unknown accelerant to start fires in area; try to burn through control window;

- One inmate is being beaten by other inmates in mini yard; staff calls it in to control; tower cannot see this area as much of mini yard is blind to tower;

- A second inmate is being assaulted inside Unit 2 A/B;

- Destruction, fires and inmate assaults continue until tactical team regains control of Unit 2A/B some four and one-half (4 ½) hours after incident began and three and one-half (3 ½) hours after tactical teams activated;

- Two inmates found deceased; and

- Institution locked down, count completed and planning for emergency follow-up continues.

Documents Reviewed

- Legislative Bill 598, Approved by the Governor of Nebraska on May 27, 2015;

- NDCS/TSCI provided manual with all documentation of the incident emergency on March 2, 2017 to include staff reports; memorandums; chronological events by ICS reporter(s); command structure; and some limited amount of after action planning documents;

- Reports of various types illustrating in particular inmate threats and staff assaults since the disturbance;

- TITLE 72, Nebraska Administrative Code, Chapter 1, Restrictive Housing;

- Sample Restrictive Housing Unit (RHU) release decision documents;

- Misconduct Report documentation;

- Canteen product inventory;

- Step 1 Inmate Grievance logs and sampling of Inmate Grievances submitted with responses;

- Inmate Job Assignments;

- TSCI Security Audit reports for 2016;
- TSCI Security Control, Searches for Contraband Operational Memorandum;
- Agency Security and Control Administrative Regulation;
- Photos of weapons found in immediate area of disturbance;
- Staffing Rosters and shift deployment documents;
- Diagram of Housing Unit 2;
- Incident reports from March 2,2017 of intoxicated inmate;
- AR 201.15 Inmate Classification and Assignment;
- AR Inmate Grievance Procedures;
- TSCI Operational Procedure 217.02, Inmate Grievance Procedure;
- Industries Chemical/Caustic Control Inventories and documents;
- Industries Tool Control Inventories and documents;
- Search logs with accompanying contraband receipt documents; and
- NDCS Administrative Regulation 116.02, Use of Force.

Consultants Primary Areas of Critical Review

James Upchurch:

- Post Disturbance Assessment of Institutional Status;
- Emergency Management;
- Inmate Classification including Restrictive Housing;
- Inmate Disciplinary (Misconduct) System;
- General Staffing Issues;
- Employee Grievance/Morale;
- Training Sufficiency;
- Use of Force; and
- Lessons Learned - May 10, 2015 Incident.

Joan Palmateer:

- Inmate Activity;
- Inmate Interviews (those uninvolved in ongoing criminal investigation);
- Staff Interviews;
- Management Reports;
- Inmate Grievances;
- Review Wood Shop Tool Control;
- Review Laundry Tool Control;
- Review Chemical Accountability in Laundry and Wood Shop;
- Review Cell Search Documents (past six months);
- Review/Observe Wood Shop/Laundry Inmate Entry/Exit Search Process; and
- Physical Plant.

It should be noted that due to the number and volume of documents reviewed and the limited time available to the review team to research and consider all aspects of each of the documents, the review team expects that there will be some additional follow-up in some of these areas by the Agency. These areas will be addressed in a limited manner in this report.

Issues Discussion and Recommendations

Post Disturbance Institution Status Assessment

Discussion:

TSCI is a facility bordering on a crisis condition. At various times, staff and inmates alike expressed to the review team their concerns, or at a minimum uneasiness, about their safety and the current level of order and control within the institution. Based on the review team's observations, interviews, and review of various documents, these fears appear to be valid - both perceptually and, in some cases, factually. There have been several occurrences over the past couple of years as well as other critical factors that appear to have contributed to staffs' concerns as verbalized to the review team. Some of these are discussed in the following paragraphs.

Staff at many different levels within the facility readily express their serious concerns that they are no longer permitted to utilize the tools necessary to manage and adequately control a violent, "gangland"' type environment, predominantly, but not exclusively, in the maximum security areas of the facility. These concerns reportedly exist, at least in significant part; because of relatively recent statutory changes that significantly limiting the use of Restrictive Housing (RH). Additionally, NDCS executive direction further limiting the use of RH has been issued eliminating the use of disciplinary segregation (punitive RH) as a sanction for inmate misconduct violations. Instead, privilege loss sanctions are utilized, which most staff with whom the review team spoke regarded as minimally effective in controlling this difficult population.

According to numerous staff interviewed, inmates respond indignantly with such statements as "you can't do anything to me" when staff attempt to hold them accountable for compliance with the necessary rules and regulations to ensure an orderly and safe institutional environment. One staff member described sanctions being imposed for serious violations such as the possession and/or use of inmate manufactured alcoholic beverages as amounting to nothing more than a "slap on the wrist." It was evident to the review team during tours and inspection that inmates frequently do not follow existing rules and regulations and there appears, to some extent, to be an acceptance by line staff and some administrators that these violations cannot be effectively controlled. This was especially true regarding the relatively minor, but still important, rules and regulations such as those addressing inmate uniform/dress and housing.

Although the review team does not believe that the intent of the RH operating procedures is intended to reward inmates who do meet the limited criteria for placement in RH (either immediate or long term as it is being applied in the NDCS), once placed in the Restrictive Housing Unit (RHU), the inmates are being housed in a single cell (no cellmate) and are provided a television in their individual cell by the facility. This is to be distinguished from general population housing where they live in double bunked cells with other inmates not generally of their choosing, and, unless the inmate can afford to purchase a television, he does not have one. The concern expressed by staff who described this practice to us is that the inmates frequently view placement in the RHU as a relatively brief respite from general population life with little, if any, misconduct deterrence value.

From March 23, 2016 through March 22, 2017, data provided by TSCI staff describes the following misconduct report information for the TSCI inmate population:

- Twenty percent (20%) increase in reported assaults;
- Three hundred percent (300%) increase in reported drug or intoxicant abuse;
- Forty percent (40%) increase in the overall frequency of Class I (most serious) conduct offenses;
- Thirty-three percent (33%) increase in incidents of inmates refusing to obey direct orders from staff;
- Two hundred seventy-five percent (275%) increase in reports of inmates being in unauthorized areas despite instruction to the contrary;
- Fifty-five (55%) percent increase in tattooing activities (frequently gang associated activity);

- Fifty percent (50%) increase in the overall frequency of Class II (second level of seriousness) conduct offenses; and

- Two hundred percent (200%) increase in inmates violating the sanctions applied in response to conduct violations overall (important in that privilege restriction sanctions are the only disciplinary type actions available to staff for all but the most egregious conduct violations.)

These numbers certainly appear to be indicative of inmate management and control problems that would easily support the staffs' perception concerns. However, the fact staff has continued to issue misconduct reports for such violations does indicate that they have not given up on the management tools that are available to them and continue in their efforts to address inmate misconduct despite their concerns about the effectiveness of the process. Should staffs' concerns regarding effective sanctions not be addressed, they may begin to back away from utilizing the system to address misconduct, if not, in some cases, stop using it all together.

Additionally, many staff and inmates were aware that twenty-five (25) of the inmates identified as participants in the May 10, 2015 disturbance were also identified as participants in the March 2, 2017 disturbance which resulted in inmate deaths and significant damage to the facility's physical plant.

A review of the classification documents provided by TSCI staff describing the consideration process for five (5) of these twenty-five (25) inmates released from the RHU, while limited and certainly not conclusive, does raise some concerns about the documented basis for release decisions from RHU status. The primary considerations for release appear, from the documentation provided, to be the inmate's behavior while in the RHU and his participation in the Transformation Project Program.

The documentation does not appear to support that a thorough assessment of the inmate's history of violence and related occurrences, such as possession of weapons and documented participation/leadership in gang activities, was fully considered as part of the review process. If accurate, this would appear to be inconsistent with the fact that the most reliable predictor of future violent acts is a history of such acts in the past. The more frequent acts of violence have been perpetrated by an individual in the past and the more serious these acts are, the more likely such acts will be perpetrated again in the future. The most serious issue for consideration in such RHU release determinations should be the likelihood of recurrence of violent disturbance participation and the perpetration of violence upon staff and other inmates.

The concern with this release process is even more significant when inmates are being assessed for release directly from the RHU to a general population status in an open housing setting where continued violent acts can be perpetrated with relative ease due to increased freedom of movement. This appears to be what occurred with a significant number of the RHU inmates released between the May 10, 2015 disturbance at TSCI and the subsequent disturbance involving a significant number of the same inmates occurring on March 2, 2017. This concern appears to be further supported by the

number of TSCI inmates noted on a list of inmates (March, 2014 – March, 2017) provided by TSCI staff, who, over the last three years, have been assigned to the RHU and subsequently released on multiple occasions over this time period.

The situation described thus far is further exacerbated by the staffing issues facing the facility. According to TSCI personnel staff there were a total of sixty (60) vacant custody and unit management positions of the total three hundred fifty (350) such positions allocated to TSCI (an approximate 18% vacancy rate). These are the staff who manage the inmate population on a day-to-day basis. Management indicated to the review team that placing many of the custody staff on a four (4) day, twelve (12) hour shift per week schedule has mitigated the impact of staff shortages by generating an additional eight (8) hours per week of staff coverage per employee.

More significant and problematic is the staff turnover in these positions, resulting in 20% of the filled positions having less than one year of experience and one 56% having between one and five years of experience.

Although the review team does not believe the positions allocated for TSCI in these categories to be inadequate (absent consideration of at least one of our recommendations provided later in this report), vacancies do contribute to the successful operations of a correctional facility. Even though the vast majority of all positions allocated are filled, the review team is concerned with the turnover rate resulting in low experience levels among those staff charged with managing the inmate population at the line level on a day-to-day basis in the current environment at TSCI.

The racial demographic disparity between the staff at TSCI wherein whites/Caucasians make up ninety plus percent (90%+) of the custody and case worker staffing complements, while the inmate population has much larger numbers/percentages of both African Americans and Hispanics. This disparity is especially significant in light of the gang issues that have been indicated in many of the disruptive and violent issues at TSCI, and the fact that such gangs in a prison setting frequently align themselves along racial lines. This alignment appears to be true at TSCI as well. High levels of racial tension are frequently seen in such prison environments and not only contribute to tension, and frequently violence, among members of the inmate population itself, but also carry over to staff and inmate interaction when the racial demographic disparity between inmates and staff found at TSCI is present.

Also, reportedly very significant in the eyes of TSCI staff, was the assault on four staff members in HU 2/B on March 15, 2017. Several inmates assigned to HU 2/B attacked four staff members resulting in injuries that required two of the staff receive outside medical attention. This incident combined with threats and innuendos of threats by the members of these violent and disruptive inmate groups have further increased staff concerns, indicating a the need to manage this difficult population in a safer more structured manner (reportedly the facility was locked down for an unspecified time period in September, 2016, based on the gravity associated with such threats against staff members).

Based on the review team's findings in regards to the issues discussed in this section of the report - as reported by TSCI staff and/or supported by documents they provided to the review team -TSCI is an institution "on edge" with a significant number of violent, gang affiliated and disruptive inmates who have attained a sense of violent empowerment. The inmates' behavior at TSCI is not dissimilar in character from the violent and intimidating dominance applied by gangs on city streets in control of their claimed territory. Up against this force is an inexperienced staff that is uncomfortable, if not fearful, to approach members of this inmate population. This staff indicated that they do not feel supported by management in addressing the violent, aggressive and intimidating behavior of these inmates with the available disciplinary tools at their disposal. The review team does not wish to be alarmist; however it is important to clearly state the necessity of corrective action in an expedited manner to resolve this situation.

Restrictive Housing Step Down Levels

Recommendations:

Step Down Units

Implement the establishment of "Step Down Units" in HU 2A/B wherein inmates from Restrictive Housing may be assigned to receive additional time out of their cells (no less than twenty-four (24) hours per week) for organized and structured activities in numbers commensurate with the assigned custody/case management staffing complement's ability to safely and securely manage them.

As is currently in place in the RHU, all appropriate and required medical/mental health treatment should be provided, as well as programs that address behavior and cognitive changes. Positive behavior should be rewarded with progressive privilege increase to television viewing, MP-4 player use, etc. Assigned inmates should be reviewed at a minimum of every six months for consideration to either (1) move from Step Down Level II (HU 2B) to Step Down Level III (HU 2A – increased out of cell time within that which can be safely managed), (2) be released to general population or (3) if necessary, returned to the RHU.

The assessment by the multi-disciplinary review team that is conducted to review these inmates for step level changes should not only consider the inmate's behavior while at the current level as well as his program and treatment achievements, but also the frequency and degree of his violent acts in his past, both in and out of prison. This comprehensive review should be the basis for the ultimate final decision, providing and ensuring, as best possible, an environment safe from predatory harm for staff and other inmates alike.

It is certainly possible and appropriate that some inmates at various Step Down levels may remain in that status for an extended period of time. It is important to remember that the conditions in either Step Down Level and/or in the RHU as it is currently managed, do not approach the conditions of austerity, deprivation and/or isolation

determined in some jurisdictions to be unconstitutionally damaging to inmates in the segregation units of the past. There is significantly less risk of harm involved with the assignment decision to extend a chronically violent inmate's stay in such Restrictive Housing settings as are proposed here and that currently exist at TSCI, when compared to releasing him to an open population housing setting. The "rush to release" movement in some corrections' jurisdictions today – recognizing the many positive changes to the Restrictive Housing environment in many jurisdictions -may perpetuate the acceptance of an unnecessary dangerous risk and put the lives and well-being of others in jeopardy .

Included in this recommendation are physical plant changes to HU 2 A/B to add "cuff/meal ports" to all of the cell doors and to replace all porcelain laboratory/toilet fixtures with stainless steel fixtures. When necessary, these "ports" allow for passing meals and other items to and from inmates within the cells without the significant risk of assault associated with accomplishing these functions by opening the cell door. Additionally, disorderly and threatening inmates can be handcuffed through such a port, again with much less assault risk to staff and/or force required potentially resulting in injury to staff and inmates alike. To reduce cost, this may be initially completed in HU 2 B and completed in HU 2 A at some point in the future. Porcelain fixtures should be replaced because they are relatively easily destroyed by inmates as was evidenced in the previous disturbances. The pieces of porcelain resulting from its destruction can readily be used to fashion weapons, etc.

Additionally, while better control practices associated with use as a Step Down area should reduce the need; "gas ports" should be added to these areas as well as possibly to 2 C/D. Tactically, this is an essential feature to manage a disturbance within the housing unit by introducing chemical agents into the area through the "port" and directing the inmates subsequently forced from inside the housing unit into an open but contained area such as the mini-recreation yards where they can be supervised from several open vantage points and subsequently individually restrained and controlled.

Staffing levels should be increased, both in the custody and case worker ranks to accommodate the safe and secure operation of the Step Down units. There should be a sufficient number of properly equipped and trained custody staff assigned to these units to ensure they can manage the required number of assigned inmates while out of cell at any one time, to ensure that all inmates meet the minimum out of cell time required each week. Case Worker and Case Management staff should be sufficient to monitor in detail the behavior and program/treatment achievements by the assigned inmates and communicate/counsel with them regularly. There are fairly significant costs associated with this recommendation; however they are minimal when taking into consideration the cost of the past two recent disturbances - both in terms of human life and property damage.

Restrictive Housing (Immediate and as a Misconduct Sanction)

It is recommended that the use of disciplinary segregation be permitted at TSCI in accordance with Legislative Bill 598, which left intact section 83-4,114.01,

paragraph (2). This section of the policy states in part that "In cases of flagrant or serious misconduct, the chief executive officer may order that an inmate's reduction of term as provided in section 83-1,107 be forfeited or withheld and also that the inmate be confined in disciplinary segregation." Further, in paragraph (5), "The department shall adopt and promulgate rules and regulations to define the term flagrant or serious misconduct."

The review team was provided a copy of the NDCS IDC Hearing Officer Meeting Minutes dated January 26, 2017, which include a reference at paragraph k), to a new definition for "flagrant or serious misconduct" stating that it is "to include: causes major disruption to the operation of the institution; creates danger for the public, staff and/or inmates; violence; substantial destruction of property; risk of escape or repeated violations of the same offense in the past 12 months." The review team could not determine the rule adoption status of this definition that we assume would be used to initiate disciplinary segregation implementation in accordance with the statute. The review team encourages this definition be adopted formally and that this option be made available to Misconduct Hearing Officers, particularly as it applies to its use for repeated misconduct violations where assessed privilege loss sanctions have not proven effective in deterring such misconduct.

The review team further recommends that the allowable use of Immediate Restrictive Housing be reviewed with consideration under Nebraska Administrative Code, Restrictive Housing, Paragraph 003.02(F). This code states that "...Inmates whose presence in the general population would create a significant risk of physical harm to staff, themselves and/or other inmates", for its use in those cases where inmates are reasonably believed to be sufficiently under the influence of alcoholic beverages, other intoxicants or drugs that the concern expressed in 003.02(F) is implicated. This determination can be made by the shift commander or other experienced supervisor in concert with medical staff and should only extend for the short period necessary to allow the substance(s) to no longer be physically present in the subject's body in an amount sufficient to significantly impact his behavior.

This process, as the review team has described it, may be specified differently as long as the intent of pre-empting the potential violent acts that history has shown us to be associated with such intoxicants in a prison setting is met. According to staff reports, the use of synthetic drugs such as K-2 has increased significantly at TSCI. Experience in prisons across the country with these substances has served to demonstrate the potentially dangerous effects associated with them that can often result in violent acting out and injury to staff and others. Direct knowledge or well supported suspicion of the use of such substances should likewise implicate the use of Immediate Restrictive Housing in a similar manner to that of alcohol and other intoxicants. The review team shares the concerns expressed by staff who reported that the utilization of Immediate Restrictive Housing in such cases is currently not allowable.

Emergency Plan Implementation – Preparedness

Recommendations:

Incident Command System Full Implementation and Immediate Armed Response Capability

It is recommended that ICS be fully implemented as it is taught in the training program offered by NIC, *Incident Command System for Corrections*. This includes the frequent utilization of the ICS process in order to ensure the internalized familiarity with it that is required when it must be implemented in response to emergency situations where stress and pressure frequently make well organized thinking difficult.

Frequent (weekly) simulation training for shift staff as well as scenario training for supervisors and managers is of critical importance. An essential part of scenario training is the assessment of various areas of the facility where inmates are housed and/or are frequently present, in terms of vulnerability(s) to assault, hostage situations and/or take over by the population. These should be carefully evaluated as to physical security changes that may be needed to prevent such acts by inmates. Each scenario should be assessed in terms of tactical problems presented and tactical options/solutions developed that offer the best likelihood of successful resolution. These tactical options should be carefully catalogued for review and immediate consideration should a situation(s) arise where application may be appropriate. Again, organized consideration and option evaluation are made much more difficult in the face of a significant disruptive occurrence.

Additionally, it is recommended that TSCI create armed emergency response teams that are similar but more advanced in training and capability than the "Response and Movement Team(s)" previously initiated at TSCI but reportedly disbanded. These teams should be comprised of designated on-duty staff who are trained and proficient in the use of a select number of less lethal and lethal options as well as tactical formations and strategies. Such a capability, quickly available to contain and isolate incidents where such force is needed, and to protect, defend and rescue those whose lives are in danger, is clearly needed due to the remoteness of TSCI and the subsequent delay experienced in mustering a response force to violent incidents where this type of intervention is needed.

These teams, as utilized in other jurisdictions, are not intended to be an offensive force, but rather primarily used in defense of life and to contain violence. There are existing procedural and training documents available in other state jurisdictions which can provide much more detail as to how these teams are trained, organized and utilized (Review Team members will be glad to assist with contacts in this area if requested by TSCI). It is important to note that these teams are comprised of on duty staff who are assigned to posts that can be either quickly vacated or relieved should the need arise. A quick inspection of the TSCI armory by a member of the review team would appear to support the determination that much of the weaponry, etc. needed may already be

available. The review team does encourage expansion of the existing armory regardless of any increase of weapon, equipment options.

The review team cannot leave this area of discussion and recommendation without briefly addressing comments that were shared with us by TSCI management level staff concerning the consideration of use of force, up to and including deadly force, to stop further inmate assaults and loss of life in HU 2A/B while waiting for the full emergency teams to get to TSCI and assemble on March 2nd. These comments included a belief that if lethal force was used by staff - whether it was the last resort to stop serious assaults and deaths in accordance with the agency Use of Force Regulation or not - they would not be supported for their actions and that they would have lost their jobs. Such a belief by managers that the last resort and appropriate use of lethal force would have such consequences is of great concern to the review team, especially when it is and was a significant part of the strategy and tactical discussions/considerations being evaluated in response to ongoing violent/homicidal actions by inmate perpetrators.

The review team recommends that this mindset be addressed with all TSCI staff and managers assuring them that when they act within the lawful parameters and the NSDC regulations, that they will be supported fully.

Discussion:

The review team carefully assessed the hundreds of documents related to the March 2, 2017 disturbance, and concluded that the documentation supports a generally appropriate implementation of the Incident Command System (ICS) as it is being applied/implemented at TSCI.

The appropriate response teams appear to have been progressively activated consistent with the levels of activation for a disturbance of this type and size. While the review team did not have the time available to read line by line the TSCI Emergency Plan, the team was able to determine from the chronology of events provided by the assigned recording staff for the incident and the documents illustrative of the appropriate response organization to the disturbance, that it was managed consistently with emergency plan requirements commonly found in such plans in the corrections field today.

The organization of the documents presented to the team could have been have been improved and reported in a manner more consistently adhering to the ICS processes. Based on the documents provided, the review team could not determine the existence of a master, descriptive report prepared at the management level, summarizing the event in detail.

The review team did note that there was some deviation at TSCI from the instruction provided in the NIC curriculum for implementing ICS in a correctional setting. The review team was told by TSCI managers that ICS is only used for significant "emergency" situations such as the disturbance on March 2, 2017. In fact, one of the strengths of ICS is achieved when the system is activated regularly in response to all

incidents – including those that are relatively minor such as a one-on-one inmate fight on the recreation yard. ICS can also be utilized to plan and manage institutional events of various sizes including area searches, religious/volunteer events, etc. The ICS system lends itself to responding to, and/or, organizing such events in a consistent manner wherein staff practice utilizing the system and subsequently internalize its principles. ICS utilized in this manner makes managing all incidents a way of "doing business" and avoids the situation where emergency plans sit on shelf until something happens, spurring everyone to pull out the limited copies and begin to furiously attempt to implement its content.

Frequent simulations at the shift level as well as working through scenarios in "table top" exercises are critical areas of ICS training after the initial training on its procedures has been provided to all staff. While the review team was advised that "table top" exercises were occurring on a quarterly basis, there did not appear to be a significant part of the training, simulation and/or planning beyond that.

One of the most critical outcomes of a properly implemented ICS response is that the response to the incident stays ahead of the incident's growth (size and/or severity). Experience and evidence has shown that the most serious riots/disturbances began as relatively small scale incidents/events that escalated ahead of the facility's response capability and overwhelmed the resources initially committed. This means that at each ICS response level (A though E), there occurs the activation of response resources at that level while the additional resources associated with the next level prepare for response and are simultaneously staged in preparation for immediate use if needed.

While the March 2, 2017 incident was contained to HU 2A/B by the housing unit's physical security, the efforts of staff, and the indication that other inmates in the institution did not wish to participate, the resource/response growth of resources to manage it was stymied by the approximately three and one-half (3½) hours required to assemble the appropriately trained and equipped/armed emergency response team to enter HU 2 A/B and regain control. It was during this time period that two homicides occurred and extensive property damage was perpetrated by the inmates involved in the disturbance.

Emergency Plan Implementation – Preparedness

Staff Interviews

Recommendations: (in addition to those provided previously in this report)

Increased Contraband Control Efforts are recommended. It is unusual in corrections to have large and frequent discoveries of homemade alcohol. The dangerousness of alcoholic beverages in a prison environment urgently requires that this problem be addressed at TSCI. Specific recommendations in this area include:

- Review kitchen security practices and controls and institute stricter accountability of fruits, sugar, potatoes, bread, etc.;

- Implement more thorough searches of all inmate kitchen workers assigning supervisory staff to supervise and carefully monitor these searches for thoroughness;

- Limit and restrict the movement of assigned kitchen workers to and from the kitchen during work hours;

- Ensure staff directly supervise HU 1 food carts at all times and that each cart is locked until it is in the unit and directly supervised by HU 1 staff during the feeding process;

- Ensure that more frequent and consistent frisk searches of inmates upon exiting the dining halls are conducted and these careful searches are directly monitored by a TSCI supervisor to ensure that they are conducted properly;

- Identify nutritionally equivalent substitutes for fresh fruit, especially in HU 1 where food is served in the housing unit. Different bread type options may also be considered;

- Review canteen listing carefully for any items sold there that can be used to make hooch; and

- Review search policy and procedure with consideration for developing a search team for frequent cell and area searches to have contraband such as hooch, K-2 and weapons under control.

To reiterate, this is a very serious issue about which TSCI managers and supervisors must take a more active and direct role than that apparent to the review team during our on-site review.

Improve communication strategies – including the quality of communication - between Administrative, Management and Line Staff throughout the institution. After such an incident as that occurring on March 2, 2017, an overall communication strategy to create a supportive culture for staff is critical at this point. This communication improvement must encompass the fears and concerns of line staff and address the very apparent concerns by TSCI managers and supervisors about the viability of the agency policy changes changing (partially statutorily driven) in terms of inmate management.

It is imperative that TSCI management and upper level supervisors buy into the changes and help to "sell" them to staff. For such significant changes to be effective, staff at all levels must understand the rational and be shown how it can work to ensure an orderly, secure institutional environment where everyone is safe. This is extremely

difficult when considered in the contextual face of the two relatively recent significant disturbances and other factors discussed earlier in this report.

The review team recommends first that the changes included in previous recommendations in this report be adopted and shared with staff at all levels and with the inmate population. Doing so should significantly allay the concerns of much of the TSCI staff and express to them the agency's ability to both hear and respond to their concerns. If this does not occur, in favor of a return to business as usual prior to the March 2, 2017 disturbance, constructive communication strategy options appear to the review team to be limited.

As stated above, in order to present the relatively recent changes in a positive way that staff can buy into and support their perceptions of what they see happening around them must be either explained or otherwise addressed in order to produce confidence that they are safe and can effectively manage the inmates under their supervision.

Additional staff training around safety and effective communication with inmates is recommended. This recommendation includes such things as training refreshers for staff on safety in the work place and situational awareness and communication tools for them to utilize to correct inmate behavior and redirect them that are less likely to prompt confrontation. A survey of staff may be of assistance to determine if there are safety suggestions or tools they believe would assist in better control of inmate population. Training in these areas can serve to increase staff confidence and improve morale.

Discussion:

While various concerns and issues described by staff to the Review Team have been referenced in this report, it is important to summarize and, in some cases, reiterate both these comments and others provided. It is also important to note that the team's time limitations for this review resulted in conducting fewer interviews than desired. The review team was able to glean information from staff during facility tours and other onsite activities, thus broadening the team's information base. The review team is confident that the comments from staff reflect and are indicative of general concerns and issues/opinions that are shared by a significant number of the staff at TSCI. A sampling of staff comments (summarized in some cases) include:

- Hooch (inmate made alcoholic beverage), approximately 150 pounds was discovered in search on the morning of incident;
- Finding hooch is not new, "we" find some almost every day and many times in large quantities;
- The hooch was definitely made from oranges, fruit and other things available to inmates on a routine basis and in the kitchen;
- Sanction for hooch is essentially a slap on the hands, no deterrent to inmates not to go immediately back to cell and make more;

- Fruit, bread, potatoes, etc. delivered to HU 1 for meals provided in the living area, no way to determine what is kept in cell to make hooch because it is always readily available and not monitored;

- No system planned or put in place to prevent and/or mitigate availability of hooch ingredients;

- Hooch is not abnormal here especially in Unit 2; it's nothing to find sixty to eighty (60-80) pounds of hooch;

- Inmate Travon Brown got bumped by staff while exiting cell, so not likely a planned disturbance, more likely due to hooch being removed from cells and conflict with Inmate Brown;

- Tried to send in a shotgun team with shield when knowledge of inmate down, but staff saw mop on fire in the hands of inmates waiting for them (indicates reluctance to use lethal force when it may have been lawfully justified and required to protect life and significant property damage during the disturbance);

- Gas ports in the unit control centers were requested after last disturbance, but rejected because not a budget priority;

- Staff are fearful of inmates and their ability to create a disturbance again, and the ability for inmates to do what they want in 2 A/B (if released from restrictions currently in place);

- Inmates have an entitlement belief regarding their stay in NDOC;

- Likely staff will be even more fearful after the March 2, 2017 disturbance;

- Staff says their hands are being tied because they are not allowed to have some of the tools in their tool box they used to have, such as Immediate Segregation when inmates are discovered to be drunk. Staff believes that intoxicated inmates could turn violent or hurt others, themselves and/or destroy property, yet the inmate is frequently sent back to his cell and suffers minimal consequences;

- Staff state that the staffing in 2AB is frequently less than needed/authorized because the area is not one where caseworkers want to bid because of the difficult, challenging inmates;

- Staff have stated that in fact they operate short-handed because there may be no one available or willing to send into 2AB to work when someone does not show up for work;

- The night before the March 2, 2017 disturbance, four (4) inmates were discovered drunk in 2AB, taken to medical, and then sent back to their HU 2A/B cells;

- The next morning unit staff conducted hooch search, the presence of hooch was clearly evident from its odor in the housing unit and was a precipitating factor in the disturbance;

- Routine security protocols for cell searches were followed as noted in search logs but rarely much found, except alcohol, manufactured weapons and (not noted in every case when compared to rule violations logs;)

- Cells searched once a month in some cases, some cells not searched for some months;

- Staff are starting to believe that the presence, use and discovery of hooch is the new routine at Tecumseh;

- Immediate Segregation would have typically been used for inmates who represent a risk to others, themselves, or property if they are drunk or impaired from a drug or alcohol;

- "One of the inmates in HU 2 came to me the day prior to the disturbance and said he had packed things up and wrote a letter to his daughter for staff to mail giving indication in staff's opinion that the disturbance may have been planned based on this inmate possibly being fearful for his life, etc.;"

- SB 598 ties "our hands" and there is no respect for staff from the inmates;

- Some staff are not fearful; however, some are, which leads them to not address issues;

- Unit 2A/B has always been a problem especially because of the Surenos gang members, they have no regard for anyone and think should be able to do what they want while incarcerated;

- Staff are so used to it and with no consequences resulting even when inmates are drunk that they are wondering why we can't enforce more appropriately to cut the supply for hooch out or give more of a sanction than loss of TV or cell restriction (which we can't really enforce);

- On the day of the disturbance, "they" had one caseworker and the case manager on duty in Unit 2 A/B, pulled in a Sergeant to do searches for the

hooch. Unit 2A/B is short of staff often because no one wants to work there or bid that post;

- There really are not many safeguards for staff in this unit, believe staff may have been a target but with the discovery of the hooch it became an opportunity for inmates to create disturbance, and hit two of the inmates they may have been targeting.

When staff were asked what may have prevented the March 2, 2017 disturbance, common responses included:

- More activities, programs for inmates to keep them busy and provide some reformation opportunity;
- Unit 2 inmates are especially idle;
- Need to enforce rules, talk to inmates, and tell them what is happening;
- For the last couple of years, inmates are more non-compliant with rules and staff feel their hands are tied;
- So much hooch made and found in the last six months, it is like a normal activity;
- Inmates are used to having it, can get drunk and still do not go to Immediate Segregation or Segregation;
- A slap on the hands, staff wants some tools back;
- Staff communication is not great, many of us still don't know much about the disturbance other than they burnt and destroyed property and killed two inmates; and
- 2AB staff state unit not strict on inmates and there is a need to gain respect for staff from inmates.

Inmate Interviews/Summary

Recommendations:

Re-evaluate Inmate Housing Assignment Process. Look at the distribution of the various custody populations not only at Tecumseh, but at the other NDCS facilities overall to determine if there are any options to redistribute problematic, higher custody inmates and avoid high concentrations in one or two locations. Give consideration to different criteria and housing strategies based on classification, gang affiliation and

other indicators such as mental health status, escape history, predatory criteria, vulnerability criteria, age, etc. Consider movement strategies to keep groups/gangs off balance while recognizing that such strategies must consider the possibility of spreading problems to other locations.

Implement Increased Programs/Activities. While it is a repetitive issue raised by the inmates at TSCI and the review team understands and supports the need, inmate programs and activities can only successfully exist in a safe, secure and controlled environment. Safety for staff, inmates and the public must always be the first and primary objective of all correctional facilities/systems. Initially, a degree of safety, security and control must exist, followed by an appropriately managed variety of programs and organized and structured activities. Such programs can augment, strengthen, and complement sound custody and control efforts.

Cognitive programming, such as Thinking for a Change, has proven to be helpful in assisting inmates in making positive behavior changes. Volunteer led alcohol and drug treatment programs are a low cost, but invaluable addition to efforts in this area. Academic and vocational education programs are a mainstay of institutional programing efforts and are also valuable.

Organized recreational activities are often overlooked as contributors to overall institutional safety. When such outdoor activities are supervised both by staff on the ground and armed staff in the interior tower post (who can confidently utilize the options available to them when appropriate and necessary), the potential for serious disruption and violence can be significantly reduced.

Meaningful clubs such as Lifers, Veterans, etc. that are carefully supervised in a controlled setting can also provide positive benefits. When not supervised well and when the inmate participants are left to their own devices, some clubs can be abused to organize inappropriate clandestine activities and have done so in a number of jurisdictions across the country. This is a consideration when making such clubs available to the inmate population.

Discussion:

This includes the collective messages from the inmates interviewed and of the inmate conversations in units and work areas conducted by the review team:

- The lack of cognitive programs is a cause of some resentment at Tecumseh by the inmate population;

- The institution seems like a powder keg with all of the idle inmates. "I am a lead porter but younger inmates act out all the time." This makes it hard for most of us to do our time;

- They put all the bad guys in one unit, what do they expect to happen, especially because that is where there are the most idle inmates;

- The staff pushed the issue with the inmate who was bumped and that just fed fuel on the fire and started the whole mess. Institution was starting some cognitive programs like MRT prior to disturbance.

- They took away clubs, there's no vocational training, nothing for inmates to better themselves before they get out.

- No change agent for the inmates here, most are just warehoused and have taken over control of their own environment. Most do not feel there is anything staff can do to them so why not;

- "I used to be housed in 2A/B but moved. I took care of some of the guys in here, if you know what I mean (canteen, etc.);"

- No way for younger inmates to burn off their energy. It's the same day in and out; get up find trouble then go to bed, do it all again tomorrow;

- So much taken away, no mental health programs, no A/A or N/A programs. Can accept the Drug and alcohol programs are for minimum inmates at minimum institutions but they could have volunteers do A/A and N/A; and

- The remainder of inmates talked to had similar or same issues as stated here, none talked in negative terms about grievances or kite responses;

Inmate Grievances

Recommendations:

Consider the implementation of an automated master inmate grievance tracking system. The Agency may want to consider a consistent, automated master tracking system for all inmate grievances at all levels. The use of such a system would allow for comprehensive reports to be easily prepared on a frequent basis, enabling management to analyze patterns and/or concerns associated with inmate grievances. The usefulness of such 'indicators' can be very helpful in proactively identifying problems and addressing them early. It is difficult at this time to gather the necessary documents because different staff maintains copies of grievance packets from each inmate and subsequently, the originals are placed in the inmate file with no master tracking system by the grievance coordinator. Grievance data can be a valuable tool for management if properly organized and made available in a user friendly manner.

Discussion:

Following a review of inmate grievances including a sampling of approximately six (6) months, it appears that staff are answering grievances in a timely manner according to policy and at all levels. It appears that the most frequently submitted grievances are for medical issues and complaints about staff. The sampling of grievances directed about staff were not for excessive force or against any individual staff member consistently. The most frequent issue from the sampled grievances were (1) an underlying frustration with 'surface' replies at times and (2) idleness. The review team found no indication of repetitive grievance types being submitted by many inmates in any specific time period. This indicates that there was no individual staff or entity grieved repetitively for the same type of grievance issue.

Tool and Chemical Control

Observations:

Although these areas were generally observed to be adequate managed in the TCSI shops and Kitchen, some areas of concern included:

- Inclusion required of needles and some metal parts in the overall tool inventory;

- Inmate porters are allowed to issue and sign out tools in the wood shop;

- Chemical agent control in laundry was observed to in need of improvement. There is a certified weight scale in use, however, the actual weights of extremely flammable and hazardous chemicals contained in the cabinet behind locked doors are not recorded on the enclosed inventory;

- Small bottle containers in the outside shop areas were observed to be problematic (i.e., flammable oil was in a small 6 oz. bottle, unmarked and not containing the same chemical as the substance in the cabinet. Inmates said it was the same, but staff confirmed it was not.) Staffs were not aware of the issues with quantity determination, identification, etc.;

- Chemical agent review in the Wood Shop revealed better weight control on total quantities in large containers; however, flammable thinners and chemicals are placed in bottles for daily use so inmates acquire these bottles and use them independently throughout the day. These bottles are out all day and are not weighed again when placed back in locked storage area; therefore, rendering the process ineffective. There was an aerosol can of silicone spray (full) out on a counter, not accounted for in the master inventory; and

- It should be noted that time constraints did not allow for a check of tool control or chemical control in maintenance area. While there are no inmates from TSCI working in the actual maintenance shop, inmates have access to maintenance tools and chemicals on the carts brought inside the institution for use when working with maintenance staff.

Searches of Inmates Leaving Correctional Industries

Recommendations:

Conduct a security audit to thoroughly review and identify functioning and deficient operational controls. Although the observations in the discussion above are not necessarily related in any direct manner to the March 2nd disturbance, the fact that flammable and accelerant substances were used to start fires and relatively sophisticated manufactured weapons were discovered in the area after the disturbance, points to the relevance of this and consistently applied security practices. The relatively brief review of the areas discussed above by a Review Team member is a strong indicator that other areas of concern in the core security areas likely exist at TSCI. We recommend that a thorough security audit be conducted at TSCI by either senior, experienced agency security practitioners or that such an audit be conducted by an outside entity.

Again, as noted in the contraband control area discussed earlier in this report, the Review Team's observations in this area cause concern about the level of functional supervision being provided by the TSCI custody and operations supervisors at all levels. Attention to day to day security detail must be emphasized frequently and its importance demonstrated to subordinates by the attention the supervisors and administrators give to it. This is particularly true considering the inexperience level and youth of the line staff and the difficulty they face daily in managing the TSCI inmate population.

Discussion:

Searches of inmates leaving this area were observed by the review team. In all cases, inmates were not required to remove their hats. Seventy-five (75%) of the inmates had Chap Stick with them; however, no one asked, looked at, or manipulated the Chap Stick to ascertain that the tube did not contain contraband such as needles from the sewing are, pieces of hack saw blade, or other small items. The walk-through metal detector was not functioning properly(e.g., it would alarm when inmates went through, they subsequently removed nothing and walked through second time in a different manner to result in no alarm). Though it had been calibrated that morning, it was still giving false readings.

Conclusion:

The final debrief of this review was attended by Director Frakes and the executive team of the Nebraska Department of Corrections. The majority of the information gathered during this review process was collected by interviewing staff and offenders at the Tecumseh State Correctional Institution. It was during these interview sessions, the consultants found an overwhelming concern/perception by a majority of staff that they were not valued as correctional professionals. As a result of those feelings and a perceived lack of support from supervisors/management, it appears as though a systemic breakdown of protocols may have resulted. Staff believes an example of not being valued is the fact that after the May 10, 2015 incident, the agency allowed 25 offenders who were considered to be active participants to remain at the facility. This created a sense of powerlessness on the behalf of staff to offer sanctions.

The rate at which the misconduct reports have risen has caused staff to have concerns referencing their safety while at the facility on a daily basis. In conjunction with this, is the fact that there is a significant vacancy level at the facility, again causing staff concern. It should be noted that this facility is in a remote location, approximately 1.5 hours from the larger cities of both Lincoln and Omaha, Nebraska, thus making it difficult for potential employees to consider the facility as a viable place for employment.

Despite these issues, the agency and institution have made attempts to ensure the safety of the staff, community and offenders at this facility. The warden and his team are making good faith efforts to engage the staff on every level to ensure they have the tools needed to create a safe and secure environment.

Subsequent to this assessment, Director Frakes requested that the National Institute of Corrections return to the agency and provide security audit training for the staff at Tecumseh and the facilities in the Lincoln area. This training will further demonstrate the agency's commitment to safety and security.