OFFICE OF INSPECTOR GENERAL
OF THE NEBRASKA CORRECTIONAL SYSTEM

Use of Force Incident at Tecumseh State Correctional Institution

SUMMARY OF INVESTIGATIVE REPORT

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EXECUTIVE SUMMARY

In June 2021, an incarcerated individual with a serious mental illness and a history of disruptive behavior caused a disturbance and threatened staff in the common area of a housing gallery at the Tecumseh State Correctional Institution (TSCI). During an incident that lasted several hours, the individual was shot by a combination of approximately 200 projectiles, receiving wounds all over his body, with three rubber bullets becoming embedded under his skin. After staff removed him from the area, they immobilized him in a five-point therapeutic restraint bed for at least three hours before the individual was placed in a cell in the facility's mental health unit.

The incident prompted a series of internal NDCS investigations which reached conflicting findings.

The Office of Inspector General of the Nebraska Correctional System (OIG) examined this incident with the intent of promoting accountability within the system and identifying possible reforms.[1]

At the conclusion of this investigation, the OIG found:

- The June 2021 incident was mishandled in many ways, from incorrectly utilizing rules for a use of force to the unacceptable amount of time it took to get the situation under control.
- During the incident, there was a lack of clear leadership and directions, in addition to a chaotic and confusing scene, which resulted in the unnecessary use of lethal force and excessive amounts of less-lethal force.
- The experiences of a December 2020 use of force involving the individual did not result in a better reaction to the use of force in June 2021.
- Despite the individual's history of serious mental illness, mental health staff's involvement in the response to this incident was minimal.
- Internal reports after both the December 2020 incident and the June 2021 incident recommended that other less-lethal options be available in some situations.

[1] Such investigations are required pursuant to the Office of Inspector General of the Nebraska Correctional System Act, Neb. Rev. Stat. § 47-901 et. seq.

- The actions of the staff involved in the incident were not consistent with their training and in accordance with the Department's use of force policy.
- Despite then Director Scott Frakes stating that he received "verification" that the individual did not suffer serious injuries in the incident, photographs show the injuries were significant, and did restrict the individual's usual activity.

After careful consideration of these findings, the OIG recommended to NDCS that the agency take the following actions:

1. Update the Department's use of force policy to include attempts at de-escalation by a licensed mental health professional, when time allows, for incidents involving people with known mental health issues.
2. Implement a policy to develop individualized de-escalation plans for people with serious mental illnesses who have histories of volatile interactions with staff.
3. Implement a reimbursement policy for on-call mental health staff by May 1, 2023.
4. Contract with an outside entity which specializes in training of first responders who interact with individuals with a serious mental illness to provide additional training for staff.

NDCS accepted the first recommendation, rejected the third recommendation and requested modifications to the remaining two recommendations.

BACKGROUND

The OIG launched an investigation into a use of force incident after visiting the special management unit (SMU) at TSCI on August 18, 2021, and encountering the individual involved. He was in a single-person cell on a gallery used for acute mental health and restrictive housing placements and sought the attention of the Inspector General of Corrections. The individual was only wearing his boxer shorts and had marks that looked like quarter to golf-ball sized welts or bruises over many parts of his body. When asked what happened to cause the injuries, he shared that he was involved in a use of force incident in June 2021. He said he had been shot repeatedly by pepper balls, rubber bullets and beanbags. He also shared that he had been involved in another use of force in December 2020 in which he had also been shot repeatedly by similar weapons. He shared written documents that seemed to corroborate these claims.

As part of the investigation, multiple documents were reviewed including NDCS policies, relevant state statutes, disciplinary documentation, internal reports related to the incident and other written communication related to the incident. All video recordings of the incident were carefully reviewed multiple times, and related telephone recordings were also reviewed. In addition, interviews were conducted with various NDCS staff and officials involved in the actual incident or later related activity.

About the Individual

The individual at the center of this investigation first entered NDCS custody at age 18 due to a conviction for terroristic threats. He served approximately eight months at the Nebraska Correctional Youth Facility before being released. His most serious misconduct charge during that time resulted in 30 days of disciplinary segregation. He received no misconduct charges for assaults and lost 15 days of good time. His entire stay took place at the Nebraska Correctional Youth Facility. He once again was incarcerated a year later, this time for terroristic threats, cruelty to animals, and use of a deadly weapon to commit a felony. He has received two additional assault charges during his current incarceration, and his tentative release date is in

2038. He is currently eligible for parole. He was placed in a segregation unit[2] soon after entering the system and has spent most of the past 12 years in either a restrictive housing setting or a mental health setting, primarily at TSCI. He also spent eight weeks at the Lincoln Regional Center.

He started receiving misconduct reports about five weeks after starting his second incarceration, losing a month of good time for flare of tempers/minor physical contact. His misconduct reports increased over time and include a variety of offenses, including mutilation of self, disobeying an order, swearing, cursing or abusive language or gestures, disruption, assault, medication abuse, and other offenses. As of this report, he has received over 450 misconduct reports during his current incarceration and has lost all of his good time (4,201 days). A review of his past misconduct reports and incidents found numerous assaults, disruptions, flares of temper, threatening language and more. Some of these resulted in uses of force. He has a long history of being restrained by staff due to a variety of issues and incidents, including being held down so that medication could be provided to him as part of an involuntary medication order (IMO).[3]

Serious Incident Prior to June 2021 Incident

December 2020

The individual was involved in an extensive use of force in December 2020 at TSCI.

According to the NDCS use of force report, the individual was given directions to be placed in restraints in order to be escorted from the mini-yard to the shower area for a strip search. He became aggressive and began yelling and slamming his fists against the door of the mini-yard.

[2] Segregation is a term that is also known as restrictive housing. The two terms may be utilized interchangeably by inmates and others. Laws regarding NDCS's use of immediate segregation and restrictive housing may be found at Neb. Rev. Stat. §83-173.03, and use of disciplinary segregation may be found at Neb. Rev. Stat. §83-4,114.01. These terms generally refer to placement in which movement is limited and an individual has out of cell activities of less than 24 hours per week.

[3] This report contains several references to IMOs. He is given IMOs to assist with his mental health condition.

At 1005 hours a cell extraction team was assembled, but before it arrived he broke an arm bar from the wall, and it became a potential weapon. He did not comply with any orders to come to the hatch at the door to be restrained. At 1045 hours, staff deployed 10 pepper ball rounds to his legs, chest and arms.[4] He continued to refuse to comply with the directives, and four 40 mm projectile rounds were deployed to his legs.[5] He again refused to comply. Five to six bursts of a chemical agent were then deployed to his upper brow.[6] He refused to comply. Three more 40 mm rounds were deployed to his legs. He did not comply, and five to six more bursts of the chemical agent were deployed to his upper brow, followed by an additional five bursts. After he again refused to comply with the directives, five more bursts of a chemical agent were delivered, followed by 40 more pepper ball rounds at his legs, chest and arms. He refused to comply, and one 40 mm OC Direct Impact round was fired at his chest, followed by 10 more pepper ball rounds. This was the first of a series of six deployments of an additional 10 pepper balls each, for a total of 110 up to that point. Over the next several minutes, five additional 40 mm OC Direct Impact rounds

Another December 2021 Incident

Later on that same day, another incident took place in that same restrictive housing gallery, involving an individual with a serious mental illness who was accidentally let onto the gallery. Staff attempted to talk to him through the door at the entrance of the gallery, and the incarcerated individual attempted to spray them using a chemical bottle that was left on the gallery. He refused their orders to secure himself in the gallery shower.

A use of force team was assembled and he ran to the back of the gallery with a shower brush. He again refused their orders and an Exact Impact round from the 40 mm launcher was fired at him. Shortly after that staff deployed one round of direct impact OC. The individual ran into the shower but refused to secure the shower door. As a result, nine Live X pepper balls were deployed at him as well an additional 40 mm projectile.

At this point he secured the shower door. Staff interacted with him for about 20 minutes before the use of force team entered the shower. He resisted and a staff member used two closed fist strikes on him. He fell on top of a staff member and began to choke them. Additional strikes were delivered to him, including hand and knee strikes. He eventually was properly restrained.

[4] A pepper ball round is a hard plastic frangible sphere that is designed to burst upon impact and release a chemical agent.

[5] A 40 mm round is basically an impact round fired from a type of projectile launcher that can utilize various payloads. One payload that was used at some points during this incident was an OC Direct Impact round that carried a chemical agent.

[6] Staff have canisters that contain a chemical agent called Oleoresin Capsicum and use that to spray individuals.

were fired at him along with additional bursts of a chemical agent.

The individual eventually submitted. All of this took place in the small mini-yard which is about the size of two cells. After the incident, the TSCI major provided the TSCI warden with a use of force review memo dated January 13, 2021. It listed nine observations made as a result of reviewing the use of force packet. Relevant comments included:

- When direct impact rounds (40mm and/or pepper ball) are showing to be ineffective then alternate actions need to be considered.
- There needs to be one person in charge and one person giving verbal directives.[7]

NDCS did not conduct an internal critical incident review (ICIR) of this incident. An ICIR can be conducted as a follow-up to a serious incident to gain additional insights. The review team examines the incident making findings and recommendations. As will be discussed later in the report, the top leaders of NDCS were not made aware of the December 2020 incident, including not receiving the completed use of force report, until after the June 2021 incident.

[7] January 13, 2021 Memo from the major to the warden.

JUNE 2021 INCIDENT

Lead-up to Incident

Leading up to the incident the individual had some interactions with mental health staff while in Housing Unit 1 at TSCI. Housing Unit 1 consists of six galleries containing inmates who have sought protective custody. On May 27, 2021, he was "acting irrationally on the gallery" and was placed in the skilled nursing facility and placed on 15 minute checks. After returning to Unit 1, he met with mental health staff a few days later who found him to be verbally aggressive toward staff and was showing a labile mood.[8] The next day he was highly agitated and verbally aggressive toward mental health staff. The psychologist ended the contact as a result and left the gallery.

Use of Force Incident

On the day of the incident at 1630 hours, the individual was in a housing unit at TSCI. It was during dining time, and the corporal in the unit noticed his "unusual and aggressive behavior" and that he acted aggressively and was screaming. A later conversation was captured via audio from a handheld video camera in which the corporal provided additional specifics and said that the individual was "mad dogging" and threatening him after claiming the corporal was trying to poison him via the food. At that point, the corporal exited the gallery. The corporal also discussed in that audio from the handheld video camera how staff were told the individual had "lost his cool" the day before and threw a tray. Staff who worked the previous day also said he had requested to be placed in an observation cell but then changed his mind and asked to speak to mental health staff.

Within five minutes, the entire gallery of the housing unit was cleared of all staff and inmates with the exception of the individual involved in the incident.[9] At 1648 hours, the major was notified via telephone by a sergeant (who was the acting lieutenant) about the situation and a

[8] A labile mood is often characterized by emotions that shift in a drastic and uncontrollable manner.
[9] The inmates returned to their cells.

decision was made to assemble a use of force team. In addition, the individual had begun barricading the doors that led to the gallery.

As the incident unfolded, the major contacted the warden via telephone. When the major later returned to the facility, he maintained contact with the warden via telephone during the incident. The warden maintained contact with NDCS Deputy Director Robert Madsen throughout the incident via telephone. At some point a corporal, who was the acting sergeant in Housing Unit 2, was called to the scene. He was told to have response and movement staff help, but the facility did not have any that day due to being short of staff.[10]

After barricading the doors, the individual began moving around the unit and assembling small weapons. After the use of force team members arrived, one staff member tried to talk to him at 1715 hours, and the individual said he would stab the staff in the neck and murder them when they entered the gallery.[11] At 1739 hours staff used a pepper ball launcher to fire 10 rounds into the gallery via the main doorway to saturate the area with a chemical agent. The rounds were fired at his chest after he refused orders to drop his weapons and lay on the ground. A few minutes later, nine additional pepper ball rounds were fired at him. At 1809 hours a single round from a 40 mm launcher was fired at him when he refused directives. After that, five additional rounds were fired at him from the 40 mm launcher plus an additional 14 pepper ball rounds were also fired for direct impact of him and to further saturate the area with a chemical agent.[12] When those didn't work, an additional seven pepper ball rounds were fired at his chest. During this time, staff briefly entered the external entrance to the gallery and moved obstructions. A few minutes later they did the same from the main entrance, after an additional 40 mm OC extended range round was fired into the area for chemical saturation.

At 1902 hours (147 minutes after the gallery was cleared of staff and inmates), the warden was briefed via telephone by the major after the major arrived at the facility. The major decided not to take command of the incident upon his arrival and left the sergeant in charge. He did provide

[10] The minimum staffing level for that shift was 70 employees and the critical staffing level was 47 employees. At 1400 hours the facility had 49 employees.

[11] Note: In addition to this staff member, other staff also attempted to talk with the individual throughout the incident.

[12] Some chemical agents are delivered so that only the chemical is dispersed but they the projectiles containing the chemical agent can also be used to impact the individual.

advice to the sergeant throughout the incident and maintained communication with the warden during the incident.

At 1933 hours, the major informed the sergeant that he had requested permission to use less-lethal shotguns and lethal force.[13] At 2035 hours, the sergeant received approval to use the less-lethal shotgun but the use of lethal force was denied. The sergeant was informed by the major, who had been informed by the warden. The warden received permission for less-lethal shotguns from Deputy Director Madsen. There is no conclusive evidence that anyone clearly thought lethal force had been approved, but there was confusion surrounding this during the incident. A staff member did shoot the pepper balls at the individual's head, which is considered lethal force. He received initial disciplinary action as a result of his actions.

There were several conversations by staff who expressed concern during the incident about the individual having a history of chemical agents not having an effect on him. This was one reason the major requested permission to use less-lethal shotguns. The major also allowed staff to fill the pepper ball hoppers to their limit instead of 10 at a time.[14]

Prior to entry, staff were gathered outside the entrance to the gallery. During that time, one unidentified staff member discussed with others the effect of the 40 mm launcher on the individual which was recorded on the video camera. He said, "Last time we unloaded on him and it didn't affect him, so the more the merrier." At 2040 hours (over four hours after the start of the incident) the use of force teams were briefed by the sergeant regarding the plan to enter the housing unit in order to subdue the individual. Ten minutes later, two teams entered the housing unit from the internal and external doors after first deploying flash bang grenades, which were authorized by the warden. However, at the time he did not know what type of flash bangs the facility had and believed them to be a different type of flash bang that was more disorienting for the individual near their deployment. As they entered they deployed multiple less-lethal shotgun rounds, 40 mm rounds and pepper ball rounds at him. Staff repeatedly gave him multiple

[13] See https://www.supremecourt.gov/opinions/URLs_Cited/OT2015/14-10078/14-10078-3.pdf. A good definition of less lethal is a weapon or device that is designed and primarily employed to incapacitate targeted personnel while minimizing fatalities and permanent injury, but there is no force option that would be considered completely non-lethal.

[14] One NDCS policy limits the filling of the hoppers to ten pepper balls at a time. This will be discussed later in the report.

directives, and the two teams slowly moved toward him. The individual sought shelter in the shower room, and when this happened the warden directed the major via the telephone to approve the use of the flash bang grenade in the shower. The staff member with the flash bangs decided against deploying them in the shower due to the glass and the potential impact of the sound on the individual, who would have been in a confined area. While the staff member did not follow the order directed to him, it was a thoughtful decision that took the well-being of the individual under consideration.

He was eventually subdued at 2100 hours after being hit with a barrage of rounds. The total number of rounds fired at the individual before he was taken into custody by staff were the following:

- Eleven 40 mm OC rounds for saturation and direct impact (chemical agent deployed when the projectile impacts the target);
- One 40 mm round to the lower body (strictly a projectile without a chemical agent);
- Three 12-gauge beanbag rounds and 6 12-gauge high velocity stinger ball rounds to the torso[15];
- One 12-gauge beanbag less-lethal round;
- Two 12-gauge high velocity stinger rounds;
- Four 12-gauge beanbag rounds to the legs and abdomen;
- Seven 12-gauge high velocity stinger rounds to the legs and abdomen;
- Unknown (although described as multiple) Live X pepper ball rounds to the shoulder;
- Unknown Live X pepper ball rounds to the crown and left side of the head;
- Unknown (although described as several) Live X pepper ball rounds to the hands;
- Unknown (although described as multiple) Live X pepper ball rounds to the shoulder, head and hip and near him for saturation;
- Multiple Live X pepper ball rounds to the back and back left; and
- 40 Live X pepper ball rounds to the individual's center of mass.

[15] A beanbag is basically a type of round that feels like a beanbag and is designed to impact someone but not in a lethal manner. A stinger round is fired from a 12 gauge shotgun that is intended to be shot at the breast line or below and is considered a medium pain compliance round. See https://www.defense-technology.com/wp-content/uploads/2020/06/12-Gauge-Stinger-32-Cal-Rubber-Ball-Round-HV-3020.pdf.

At 2110 hours, the individual was evaluated by medical staff and received a decontamination shower. After that the individual was placed in five-point therapeutic restraints[16] and received an IMO shot from medical staff after consultation via telephone with the facility psychologist.

At 2230 hours (six hours after the start of the incident) the emergency was declared to be over. Medical staff conducted rounds with the inmates in the housing unit, and the gallery was cleaned. Inmates were allowed to shower due to their exposure to multiple rounds of chemical agents. Some inmates needed breathing treatments on the gallery due to the exposure to the chemical agents.

During the incident, several events or actions took place but due to a lack of an accurate time/date stamp on any handheld video camera or body camera, a specific time could not be assigned to them. These included the following:

- Staff and a peer support inmate attempting to talk to the individual;
- The individual hitting himself with his weapons and also talking "like a snake" and saying he was going to kill them.
- Multiple staff mentioning his resistance to force and chemical agents.
- Staff attempting to have other staff removed from his line of sight due to it possibly impacting him in a negative manner. There were many staff staged or gathered outside the entrance to the gallery, which took them away from their responsibilities.

Earlier this year, the individual was currently receiving mental health medications through an IMO and had been residing in a mental health unit.

Injuries

When the individual was assessed by the medical staff, they noted multiple shallow open wounds all over his body, a cut on the left ear and large bruising on his left flank. They did not note that he had a broken finger. The nurse observed that some of his wounds were oozing blood but that the individual did not want the wounds looked at during the initial assessment.

A review of medical records found the following statements after the June incident:

[16] It is unclear when these were actually removed although it may have been at least three hours later according to one NDCS report.

- "Patient has multiple wounds on body from pepper balls."
- "Numerous open shallow rounds present and bleeding."
- "Large abrasions on flank."

The report, possibly due to a lack of cooperation from the patient, did not note that at least three of the 40 mm rounds (rubber bullets) entered through his skin and stayed there. A review of his medical records found no mention of rounds being embedded under his skin prior to this time period which appears to indicate that there was no documentation about these embedded rounds for at least two months after the incident. There is a record from September 7, 2021 when he reported to medical that he had rubber bullets under his skin. No action appears to have been taken at that time.

On February 23, 2022, the individual submitted a medical kite[17] referencing the embedded rubber bullets. The response to the kite was that he was on the list to be scheduled for an appointment. He sent a follow-up medical kite on February 28, 2022 and wrote that he felt they should be removed. He received a response that said the doctor "doesn't intend to remove them. It's not infected."

On April 11, 2022, the NDCS medical director was again contacted about the bullets as the individual had not had them removed and had indicated he would still like them removed. On April 25, 2022, one was removed from his thigh but they were unable to remove another one.[18]

[17] A medical kite is an inmate interview request form that is submitted to the medical team that typically requests medical assistance.
[18] It is unclear what happened to the third rubber bullet.

EXAMINATION OF ISSUES

Mental Health and De-escalation

Staff contacted the facility psychologist during the incident; however, no licensed mental health staff member visited the unit to talk with the individual as the incident unfolded. The psychologist talked to staff members via telephone during the course of the incident in order to keep up with what was going on so that he could make a determination after it concluded on whether or not the individual needed to be placed on suicide watch or a type of restraint.

The incident started at 1630 hours, or 4:30 p.m. Licensed mental health staff at TSCI and other correctional facilities typically work during the day and are not scheduled to work evenings or weekends. Outside of normal work hours, a licensed mental health staff member is on-call, although if they are to report to a facility during their on-call time they are not reimbursed for their mileage or travel time, plus they do not receive any other compensation despite this taking place during time outside their regularly scheduled hours.

The NDCS policy[19] regarding uses of force provides direction regarding attempts to de-escalate a situation, including:

> *"If time and circumstances permit, staff should use verbal skills and techniques to resolve conflicts which may include use of alternative resources such as another staff member attempting to deescalate or shift focus or, if available in the facility and appropriate to the circumstances, allowing a trained inmate Peer Support specialist to resolve the conflict. When verbal resolution has been tried or it has been determined such would be ineffective, use of force may be necessary. As resistance decreases or increases, the amount of force used must also decrease or increase to a point where reasonable control is maintained."*

It also provides the following direction to the officer in charge (OIC) when there is an opportunity to plan strategy in advance of a use of force:

> *"Before initiating the use of force, the supervisor on site will make a reasonable attempt to listen to the inmate's side of the issue. The OIC will then advise the inmate what he/she expects and outline the alternatives that the inmate faces. This action minimizes the*

[19] NDCS Policy 116.02 (2020) – this was the policy in effect at the time of the incident. This policy has been updated since that time.

chance of any misunderstanding. Medical staff must be notified of and consulted prior to any planned extraction and are readily available during and after the extraction."

There were several attempts made to talk directly with the individual during the incident, including by staff members and a peer support inmate. The individual appeared unreceptive to these attempts to engage with him.

NDCS policy provides minimal guidance as far as the use of a licensed mental health professional with these attempts to de-escalate a situation. It does provide that the OIC review a list of individuals at the facility who have been identified as being seriously mental ill or having an IMO. If it is found that someone is on the list, the OIC is supposed to call mental health staff to determine the appropriate course of action.

The American Correctional Association has a non-mandatory standard that recommends the following to correctional agencies: "Written policy, procedure, and practice provide that staff members attempt to gain compliance of an inmate who is refusing to comply with lawful orders, prior to a planned extraction."[20] In the comments regarding this standard they stated that "Staff members i.e. religious advisor, housing unit manager, health services staff, trained negotiator or other staff should attempt to gain compliance, prior to executing a planned extraction."

Use of Force

NDCS internal reports found lethal force was used during the use of force event when projectiles were shot at the individual's head. However, there are conflicting accounts as to whether or not it was actually authorized when orders were given to staff on the use of force teams. As mentioned previously, the major stated that he informed the sergeant that he had requested permission to use less-lethal shotguns and lethal force and that the use of lethal force was denied by the warden and Deputy Director Madsen. The sergeant believed that lethal force was allowed if necessary.

This conflict appears to be a result of some staff interpreting various directives as allowing lethal force. For instance, one staff said team members were told to shoot the individual wherever they needed to in order to get him under control. The major indicated he was asked by the team what

[20] ACA 5-ACI-3A-39.

to do if they could not get away from the individual when on the unit, and he told them they would need to do what was necessary to defend themselves. This is consistent with NDCS policy, which states, "Deadly force may only be used as a last resort when there are no safe and reasonable alternatives" including to "prevent imminent serious bodily injury/death to yourself or another person."[21] As a result, some believed they could use lethal force if they felt it was necessary. As described above, an extraordinary amount of less-lethal force was used in this incident, including various projectiles, chemical agents and flash bang grenades.

Disorganized Response

The response by staff was disjointed. Part of this was due to short staffing, with a sergeant acting as lieutenant and a corporal acting as sergeant. The sergeant, the acting shift supervisor (a lieutenant post), was not with the use of force teams despite her background and training as the leader of that team, and continued operating out of the facility's central control center which is in a different building. The major was on site, and some believed he was in charge, but technically the sergeant was in charge. The major was receiving directives from the warden, who was on a phone in Lincoln. The warden was also on the phone and receiving directives from Deputy Director Madsen, who was also in Lincoln. Deputy Director Madsen was in contact with Chief of Operations Diane Sabatka-Rine. The Deputy Warden offered to go to the facility, but was never asked to report despite his over 20 years of experience at TSCI.

One internal NDCS report stated, "With the tools available and lack of direction, the situation became confusing and chaotic."

NDCS Reviews

As noted above, departmental leadership was aware of the June incident as it was happening. Three days later the issue was raised as part of a meeting of NDCS security administrators at the Department's Central Office. Those in the meeting viewed video from the incident and discussed what took place.

[21] NDCS Policy 116.02, "Use of Force."

Internal Critical Incident Review (ICIR)

NDCS policy requires a warden to review all use of force incidents that take place at their facility. Upon review, the warden may identify possible further actions, including an internal investigation or an ICIR. ICIRs are conducted by NDCS staff, who review the incident and make findings and recommendations. TSCI leadership requested an ICIR the day after the incident. The ICIR was assigned to be led by an administrator from the Nebraska State Penitentiary.

The completed ICIR report was submitted to the agency security administrator on July 26, 2021. The report described the incident, included a timeline of the incident, and summarized the numerous interviews the review team conducted. ICIR reports include a section titled, "Things Done Well." This ICIR found the one thing done well was the recognition of the escalating behavior and the actions of staff to remove themselves from the gallery. However, once the individual was isolated on the unit he was able to manufacture weapons, blockade the exits and lose one-on-one contact with any staff member who may have been able to de-escalate him or even convince him to lock down in his room.

Another section is titled, "Recommendations for Improvement." The ICIR found that the staff member's targeting of the individual's head was not a justified level of force and that this use of force needed a formal review. The review team also noted that staff were aware chemical agents and less-lethal munitions had little effect on him in the past, and that these staff had voiced for the need for alternative tools to handle the situation. The ICIR recommended that the use of tasers in these situations be reviewed, if used by CERT or a special operations response team (SORT).[22] The review also found that a sergeant was running shift and that the warden was not aware that a sergeant was left in charge of the entire facility. As a result, the review team recommended that the use of sergeants to run a shift and the corresponding approval process be reviewed. Additionally, the team found the emergency should not have been declared, according

[22] This is a reminder that one of the observations made after the December 2020 incident by the major was "When direct impact rounds (40mm and/or pepper ball) are showing to be ineffective then alternate actions need to be considered."

to NDCS policy: that the major should have taken on the role of incident commander;[23] and that a review regarding the activation of Incident Management Teams be conducted.

Deputy Director Madsen signed the ICIR on August 11, 2021, and wrote a response to the recommendations in the report. Those responses included assigning a separate investigation upon completion of the Use of Force Review Committee's review of this incident and not being supportive of adding Tasers to equipment currently authorized for facility use.

Use of Force Review Committee

On August 16, 2021 the NDCS Use of Force Review Committee provided a response to Deputy Director Madsen and the warden. The committee members found that there was a need for an application of force but that the relationship between the resistance and the level of force was not proportional. To explain that finding they wrote:

> *"If the inmate would have been advancing it would have made more sense. Staff knew the inmate's history and had dealt with him in situations like this prior. Staff involved stated different/contradictory information/directions in regards to lethal/non-lethal force. Staff was told not to advance until he did not have the weapons. Ultimately the inmate did have weapons which would justify the use of lethal force."*

The committee also found that the extent of the subject's injuries were proportional to his level of resistance or threat to the staff and that the force was applied in good faith, based upon the perceptions of a reasonably trained officer and the objectively reasonable facts the officer had at the time of the incident. They did add the following explanation to the last finding:

> *"With the tools available and lack of direction, the situation became confusing and chaotic. Everyone acted in good faith."*

The committee also listed numerous concerns and observations including:

- Too many people were yelling at the individual;
- The continuing order for the flash bangs was confusing;
- The major gave the order to fill the pepper ball hoppers which gave them approval for unlimited use despite knowing that the individual did not respond to chemical agents and had a high pain tolerance;

[23] An Officer in Charge, according to Policy 116.02, is a supervisor who is to be on the scene when there is a cell extraction. An Incident Commander is someone who is command after an emergency is declared and who also is responsible for approving the use of force plan. In this incident it would appear that the sergeant was thought by some to be both.

- More masks should have been provided to the staff due to the use of chemical agents;
- Central Office approved the use of less lethal shotguns;
- Since the sergeant was the CERT leader for TSCI, she would have been more effective in the unit where she could have directly led the teams; and
- The use of a five-point restraint was ordered to be discontinued at 0150 hours but he was restrained until 0235 hours due to a shortage of staff.

The committee's response also highlighted various statements made in the video footage by staff that were concerning.

Additional Review

A separate review of the incident was conducted by Warden Loretta Wells of the Nebraska Correctional Youth Facility on orders from Deputy Director Madsen. The written review was provided to Deputy Director Madsen on September 20, 2021. This review was conducted to provide additional information to NDCS leadership in order to determine whether disciplinary action needed to be taken.

The review's conclusions included:

- It was not clear to some who the incident commander was during the incident;
- The sergeant believed that a directive to use lethal force came from the major, who she believed gave a direction to use lethal force if necessary, but the major said he did not do this;
- Filling the pepper ball launch hopper with more than 10 rounds was a violation of policy; and
- Lethal force was used on the individual, but there is disagreement among those involved over whether or not a directive to do so was given.

NDCS initiated disciplinary action against three people based on the use of force event. Two people were disciplined.

The Warden no longer works for NDCS.

Recorded Telephone Call

Recorded telephone calls between the major and the warden were requested from NDCS on October 12, 2021. On October 13, 2021 the NDCS Chief of Staff notified the OIG via email that "We're looking into what might be retrieved. Will let you know."

On October 18, 2021, the warden was informed via letter by Director Frakes that he had been made aware on October 12, 2021 of a recorded telephone call between the major and the warden that took place during the incident. During the call, the warden stated, "I'd love to shoot him with a Mini-14[24] and be done with it." This letter followed up a telephone call on October 13, 2021 between the warden and Director Frakes about the recordings. Director Frakes later confirmed that he became aware of the calls and listened to them as a result of that request.

Even though the calls were retrieved on October 12, 2021, they were not provided to the OIG until October 19, 2021. In an interview, Director Frakes said that they were not provided until later because he "needed time to process" the calls.[25]

Director and Chief of Operations Roles/Reactions

Director Frakes and Chief of Operations Sabatka-Rine were interviewed together regarding the incident. As shared previously, Chief of Operations Sabatka-Rine was contacted by Deputy Director Madsen during the incident, and he told her he would provide updates. They talked at least one more time during the incident. Director Frakes was on vacation.

Regarding the ICIR, Director Frakes said this was a priority. He indicated he wanted it to be completed by July 14, 2021, but it was not completed until mid-August.

[24] A Mini-14 is a lightweight semi-automatic rifle.

[25] A later request for additional information was also met with a delayed response, and it was only by prompting by the OIG that the information was provided one month after first requested. Neb. Rev. Stat. § 47-908 requires that employees of the Department shall cooperate with the OIG including the production of records and information upon request. Neb. Rev. Stat. § 47-911 requires that parties subject to OIG oversight have "a continuing obligation to immediately forward to the office any relevant records received, located, or generated after the date of request."

Director Frakes discontinued the use of the pepper ball launchers on July 29, 2021 due to heightened concern following the incident and after learning about the similar incident in December 2020. (There was also another incident at a different facility that raised concerns.) On September 8, 2021 it was decided that pepper balls would be deployed in the future using a pistol launcher that can only utilize six rounds at a time. However, NDCS special teams members would be able to use the previous pepper ball launcher during an official deployment.

Regarding the individual's injuries, Director Frakes said he did not consider the individual to have been seriously injured. He did not provide any additional context for how he came to this conclusion.

Neither person was aware of the December 2020 incident until after the June 2021 incident was reported to them.

FINDINGS

1. **The June 2021 incident was mishandled in many ways, from utilizing rules for a use of force to the unacceptable amount of time it took to get the situation under control.** In reality, one individual with a serious mental illness armed with three self-made weapons essentially became the focus of the prison for hours as many staff in the facility spent time away from their job duties and the facility was placed in a locked-down status. An August 17, 2021 NDCS memo stated that the individual was left alone in the housing unit for around 15 minutes and he did not have any weapons at that time. There was also no call for immediate assistance initiated.[26] The facility was short staffed at the time, and due to the decision to use two use of force teams, a significant number of staff were diverted from their normal posts. Also, the individual received numerous injuries to his body and other inmates were impacted by the expansive use of chemical agents in their gallery.

2. **During the incident, there was a lack of clear leadership and directions, in addition to a chaotic and confusing scene, which resulted in the unnecessary use of lethal force and excessive amounts of less-lethal force.** As noted in NDCS' internal reviews, the incident was not handled appropriately. The ICIR team assesses the incident very well in their conclusion:

> *"As this incident evolved and an emergency was declared, the management structure never evolved with it. Starting with the lack of response from the facilities IMT to provide onsite oversight and management of the response and the major's not taking on the role of the Incident Commander…Although this incident ended with no injuries to staff or serious injury to [the inmate], this could have been resolved with significantly fewer amount of chemical agents and less lethal munitions. The number of chemical agents used on the gallery left the rest of the uninvolved inmates exposed for an extended period. Staff involved in the response and management of this incident were aware that these tactics have little effect on [the inmate] based on previous incidents. The activation of all or part of NDCS's tactical teams would have given TSCI the needed resources to not only have staff specifically trained to handle this type of situation but also allow them to have adequate staff to manage the non-affected areas of the facility. Tactical teams likely could have achieved the same result with significantly less force being used. Additionally, a lethal force contingency was requested at one point during this incident. When faced with a situation where you're contemplating this level of force, tactical teams*

[26] August 17, 2021 ICIR Memorandum from Deputy Director Madsen to the warden.

should be activated. The staff that responded to this incident on the two UOF teams were a mix of TSCI CERT members and general custody staff. This incident involved over 20 staff, most of which were pulled from other posts, leaving the non-affected areas of the facility vulnerable if another incident would have occurred."[27]

3. **The experiences of the December 2020 use of force involving the individual did not result in a better reaction to the use of force during the June 2021.** During the 2020 incident, a significant amount of chemical agents were deployed in the mini-yard despite those involved in the response knowing the individual has a very high tolerance for chemical agents. It was also known that when he is having such an episode, he is seemingly oblivious to pain, yet he was shot repeatedly by pepper balls, 12-gauge stinger rounds, 40 mm impact rounds, and 12-gauge bean bag rounds. Even though it was a serious incident which involved a significant amount of non-lethal force and chemical agents against an individual with a serious mental illness that resulted in serious injuries to him, departmental leaders were apparently not informed about the December 2020 incident until after the June 2021 incident.

4. **Despite the individual's history of serious mental illness, mental health staff's involvement in the response to this incident was minimal.** NDCS policy provides minimal guidance as far as the use of a licensed mental health professional with attempts to de-escalate a situation. It does provide that the officer in charge review a list of individuals at the facility who have been identified as being seriously mental ill or having an IMO. If it is found that someone is on the list then the OIC is supposed to call mental health staff to determine the appropriate course of action. The facility psychologist was in contact with TSCI during the incident. The only person with a behavioral health background who actually interacted with him during this incident was a behavioral health caseworker – not a licensed mental health provider – who was also part of the use of force team. The individual was part of the use of force team and was dressed in use of force attire. No licensed mental health staff attempted to de-escalate him, despite his significant history of mental health and behavioral issues.

[27] July 26, 2021 NDCS Internal Critical Incident Review Use of Force (page 25)

5. **Reports after both the December 2020 incident and the June 2021 incident recommended that other less-lethal options be available in some situations.** Some individuals are not as impacted by the exposure to chemical agents as other individuals. In this incident, it was known that the individual had a high tolerance for chemical agents yet staff continued to deploy chemical agents against him. The ICIR recommended that consideration be given to allowing for the use of a taser in cases like this. This recommendation was not accepted by NDCS leadership and there does not appear to be any plan in place to address future incidents involving the need for an alternative less-lethal option.

6. **NDCS deliberately delayed its response to the OIG's requests for records in this case.** State statute requires that employees of the Department shall cooperate with the OIG including the production of records and information upon request[28], and that parties subject to OIG oversight have "a continuing obligation to immediately forward to the office any relevant records received, located, or generated after the date of request."[29]

The Department's Central Administration was in possession of recorded telephone calls shortly after they were requested by the OIG; however, the Department gave a misleading explanation regarding the status of the recordings. Director Frakes later indicated that he did not provide them to the OIG after they were found because he "needed time to process" the calls. Delays of this nature impede the OIG's ability to conduct investigations and invite questions about the chain of evidence.

7. **The actions of the staff involved in the incident were not consistent with their training or in accordance with the Department's use of force policy.** The major, Deputy Warden and Warden all signed the use of force report, indicating that they reviewed all of the applicable video and that the actions of the employees involved in the incident were consistent with training and accordance with the Department's use of force policy.[30] The policy says that the "use of force must always be reasonable and appropriate under any circumstance."[31] The individual was

[28] Neb. Rev. Stat. § 47-908.
[29] Neb. Rev. Stat. § 47-911.
[30] NDCS Policy 116.02
[31] Ibid.

shot at around 200 times. As teams entered the housing gallery and surrounded him, they repeatedly yelled at him and shot at him. Their actions seemed to have no effect but to make him more agitated. It was only after his body was pummeled by countless blows from the projectiles fired at him that he laid on the ground and surrendered. This is in conflict with the policy. The policy also states "Careful consideration must be given to the immediate circumstances before chemical agents are used" and that "staff shall use their best judgment in determining if the use of chemical agents is necessary for the safety of staff, inmate or the public."[32] As stated previously, it was widely known that these had little to no impact on the individual.[33]

[32] Ibid.
[33] Attachment 1: Various pictures from the incident

RECOMMENDATIONS

The OIG recommends that NDCS take the following actions:

1. **Update the Department's use of force policy to include attempts at de-escalation by a licensed mental health professional, when time allows, for incidents involving people with known mental health issues.** NDCS should also review related policies, including those for mental health staff, to determine whether additional updates are needed to implement this change. This process should be completed by May 1, 2023.

NDCS RESPONSE: Accept. NDCS Policy specifies that if time and circumstances permit, another staff member or inmate Peer Support specialist may be used to deescalate an individual prior to using force. This expectation applies to all incarcerated individuals, not just those with a known mental health issue. Although not specified in policy, it is common practice to call upon licensed mental health professionals to assist in de- escalating situations. A Policy Directive will be issued to implement this current practice as an expectation (new language in bold). "If time and circumstances permit, staff should use verbal skills and techniques to resolve conflicts which may include use of alternative resources such as another staff member attempting to deescalate or shift focus with consideration of using a licensed mental health provider or trained crisis negotiator if available, or, if available in the facility and appropriate to the circumstances, allowing a trained inmate Peer Support specialist to resolve the conflict."

2. **Implement a policy to develop individualized de-escalation plans for people with serious mental illnesses who have histories of volatile interactions with staff.** These plans should be developed in consultation with security, housing and mental health staff; reviewed and updated on a regular basis; and readily available to staff who would lead responses to serious incidents. This policy should be implemented by May 1, 2023.

NDCS RESPONSE: Modify. De-escalation expectations are included in policy and applicable to all incarcerated individuals. All individuals with a serious mental illness are required to have an individualized treatment plan developed by a licensed mental health provider. These plans may include information about de-escalation but would only be available to mental health team

members. Calling upon mental health professionals to assist in de-escalation will assist in this effort.

OIG RESPONSE: The request to modify the recommendation provided information about the current practice and would not result in any change being made by NDCS.

NDCS SECOND RESPONSE: Specific to recommendation #2 on the use of force report, the changes made in response to recommendation #1 will ensure mental health professionals assist with de-escalation when possible. As noted, individualized treatment plans that may include information about de-escalation are only available to mental health team members.

3. **Implement a reimbursement policy for on-call mental health staff by May 1, 2023.**

NDCS RESPONSE: Reject. Reimbursement policies are governed by applicable labor contracts and/or State Personnel Rules & Regulations. Non-exempt team members who serve in the capacity of Officer-Of-The-Day (OD) are compensated consistent with the applicable labor contract. In accordance with State Personnel Rules & Regulations, exempt team members who serve in the capacity of OD are not eligible for overtime compensation or travel time. As such, there are no provisions to allow call-back pay for exempt employees. As a business practice, exempt employees often work more than a 40-hour week. Flexing time to offset excessive work time is permitted as circumstances allow and with permission of the team member's immediate supervisor; however, there is no expectation of an hour-for-hour exchange.

4. **Contract with an outside entity which specializes in training of first responders who interact with individuals with a serious mental illness to provide additional training for staff.** Priority should be given to training staff at TSCI, NSP, RTC and NCCW who are more likely to have to respond to incidents involving people with a serious mental illness. The Mental Health Association provides training like this to various first responders, such as the Lincoln Police Department. This effort should commence immediately.

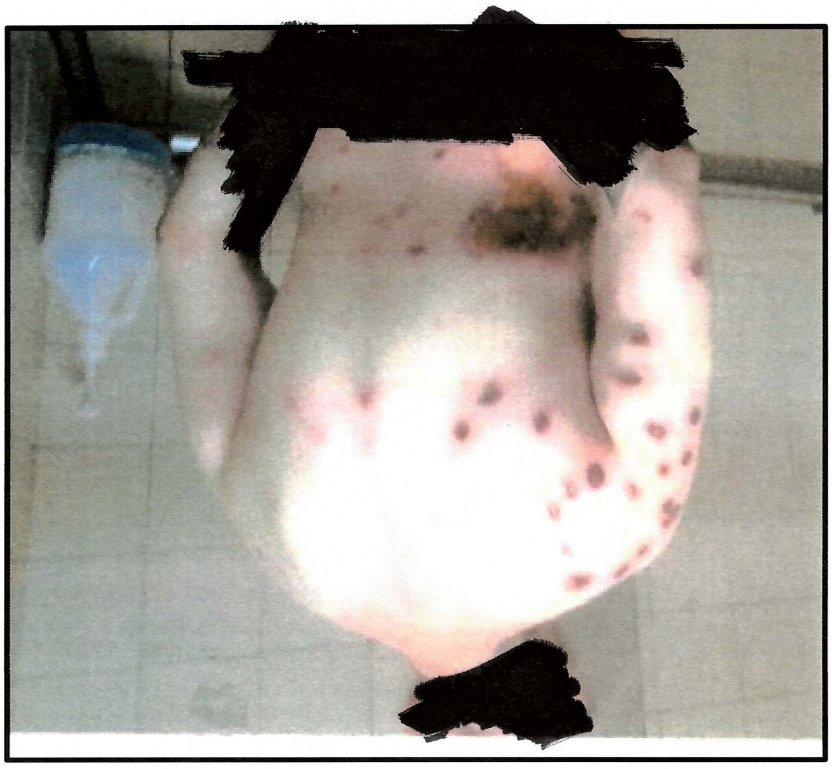
NDCS RESPONSE: Modify: NDCS provides 16 hours of Core Correctional Practices training and 24 hours of Crisis Intervention/Conflict Resolution training, four hours of mental health and suicide issues training, consistent with the standards established by the American Correctional Association. This includes training developed and facilitated by licensed mental health providers.

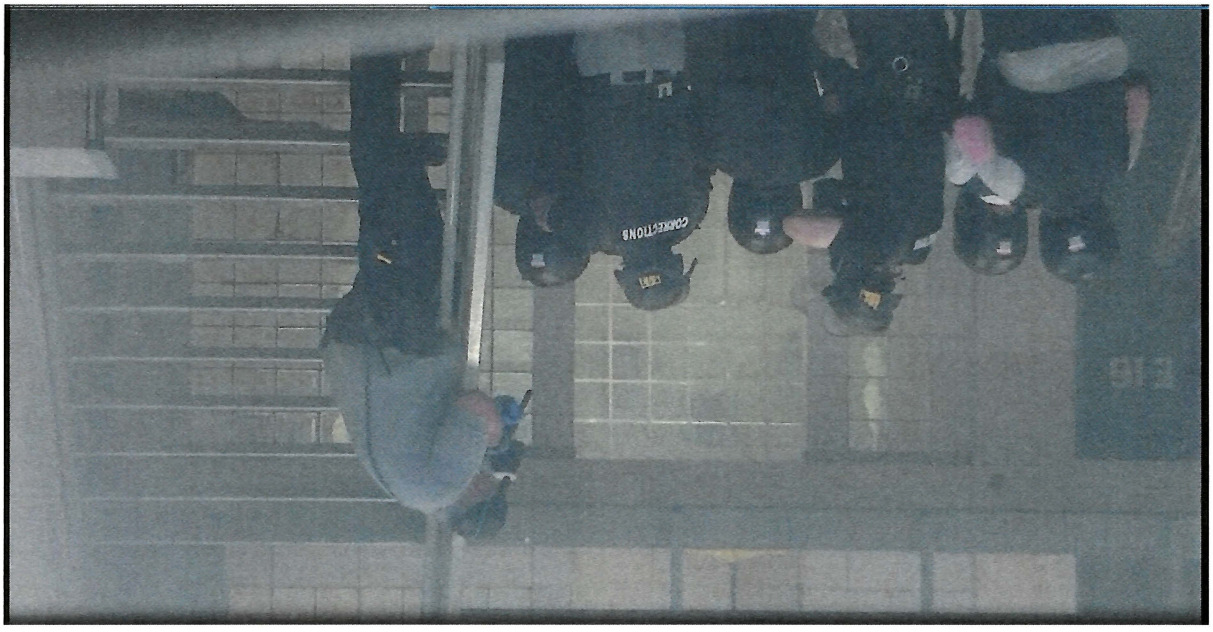
Each of these trainings focus, in part or wholly, on interpersonal communication and communication with individuals with a mental illness. Our training curriculum is reviewed annually; this recommendation will be forwarded for consideration during the next annual review. In addition to NDCS training, a number of staff throughout the agency have attended the Mental Health First Aid training with Region V and the Mental Health Association.[34]

OIG RESPONSE: Modification Accepted: The OIG would request that NDCS inform the OIG when the training curriculum is next reviewed and whether the outcome of that review results in any changes in this area.

[34] Attachment 2: NDCS Response to OIG Report

Attachment 1





Attachment 2

NEBRASKA

Good Life. Great Mission.

DEPT OF CORRECTIONAL SERVICES

Jim Pillen, Governor

January 20, 2023

Doug Koebernick, Inspector General
P.O. Box 90604
Lincoln, NE 68509-4604

Dear Mr. Koebernick:

On January 9, 2023, I received your report concerning the use of the Use of Force Incident which occurred at the Tecumseh State Correctional Institution (TSCI) on June 14, 2021. The events that occurred do not represent the mission, vision, and values of this agency. The review of reports and video I conducted quickly led me to the conclusion that the incident was mishandled and that the actions taken in the incident were not in line with policy. Further, these actions do not reflect my expectations for the treatment of individuals in our custody. Had I been made aware of the incident in December 2020, I can assure you it would also have been addressed. The fact that the warden did not make Central Office aware of the December 2020 incident and found the actions taken in the June 2021 incident to be appropriate speaks to the reason there was not a better response in the second incident. The "time to process" you mention regarding the phone call between the major and warden referred to hearing a warden make such a statement and needing to try to make some sense out of it. That statement was completely unacceptable and, again, is not in line with my expectations or this agency's values.

I appreciate the opportunity to respond to your recommendations in accordance with Nebraska Revised Statute NRS) §47-915.

Recommendation #1: Update the Department's use of force policy to include attempts at de-escalation by a licensed mental health professional, when time allows, for incidents involving people with known mental health issues.

Accept. NDCS Policy specifies that if time and circumstances permit, another staff member or inmate Peer Support specialist may be used to deescalate an individual prior to using force. This expectation applies to all incarcerated individuals, not just those with a known mental health issue. Although not specified in policy, it is common practice to call upon licensed mental health professionals to assist in de-escalating situations. A Policy Directive will be issued to implement this current practice as an expectation (new language in bold).

> "If time and circumstances permit, staff should use verbal skills and techniques to resolve conflicts which may include use of alternative resources such as another staff member attempting to deescalate or shift focus **with consideration of using a licensed mental health provider or trained crisis negotiator if available**, or, if available in the facility and appropriate to the circumstances, allowing a trained inmate Peer Support specialist to resolve the conflict."

Recommendation #2: Implement a policy to develop individualized de-escalation plans for people with serious mental illnesses who have histories of volatile interactions with staff.

Modify. De-escalation expectations are included in policy and applicable to all incarcerated individuals. All individuals with a serious mental illness are required to have an individualized treatment plan developed by a licensed mental health provider. These plans may include

Diane Sabatka-Rine, Interim Director
Department of Correctional Services

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information about de-escalation but would only be available to mental health team members. Calling upon mental health professionals to assist in de-escalation will assist in this effort.

Recommendation #3: Implement a reimbursement policy for on-call mental health staff by May 1, 2023.

Reject. Reimbursement policies are governed by applicable labor contracts and/or State Personnel Rules & Regulations. Non-exempt team members who serve in the capacity of Officer-Of-The-Day (OD) are compensated consistent with the applicable labor contract. In accordance with State Personnel Rules & Regulations, exempt team members who serve in the capacity of OD are not eligible for overtime compensation or travel time. As such, there are no provisions to allow call-back pay for exempt employees. As a business practice, exempt employees often work more than a 40-hour week. Flexing time to offset excessive work time is permitted as circumstances allow and with permission of the team member's immediate supervisor; however, there is no expectation of an hour-for-hour exchange.

Recommendation #4: Contract with an outside entity which specializes in training of first responders who interact with individuals with a serious mental illness to provide additional training for staff.

Modify: NDCS provides 16 hours of Core Correctional Practices training and 24 hours of Crisis Intervention/Conflict Resolution training, four hours of mental health and suicide issues training, consistent with the standards established by the American Correctional Association. This includes training developed and facilitated by licensed mental health providers. Each of these trainings focus, in part or wholly, on interpersonal communication and communication with individuals with a mental illness. Our training curriculum is reviewed annually; this recommendation will be forwarded for consideration during the next annual review. In addition to NDCS training, a number of staff throughout the agency have attended the Mental Health First Aid training with Region V and the Mental Health Association.

Thank you for reviewing this use of force incident and sharing your observations. As a point of reinforcement, I share your concerns with how this incident was handled. Also, please note that mentioning inmates by name/number is in conflict with Nebraska Revised Statute §83-178, as could be including the photographs that would allow for identification of the individual by facial recognition as well as scars, marks, tattoos.

Sincerely,

Diane Sabatka-Rine
Interim Director

c: File