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SUMMARY OF THE REPORT ON THE DEATH OF DAELAN LAMERE

July 24, 2017

Under Nebraska State Statute 47-912, the Office of the Inspector General can release a summarized final report of an investigation if it would bring awareness to systemic issues. The following summary of the report on the death of Daelan Lamere meets that criteria as it shares systemic information regarding the functioning of a correctional facility, the response to an emergency at that facility, and the introduction of illegal drugs into the correctional system. Information from this report will be shared in the OIG's Annual Report that is due on September 15, 2017.

INITIAL INCIDENT

At 0618 hours on May 27, 2017 a call was made regarding a medical emergency in Housing Unit 2D of the Tecumseh State Correctional Institute (TSCI) for the cell housing Daelan Lamere #79082 and [REDACTED]. Staff responded and found Mr. Lamere non-responsive in the lower bunk and struggling to breathe. He was placed on a gurney and moved to the TSCI emergency room. He was transferred to the Johnson County Hospital in Tecumseh at approximately 0700 hours where it was decided that he needed to be moved to Bryan LGH West in Lincoln. Mr. Lamere tested positive for MDMA (ecstasy) and methamphetamines. On June 6, 2017 Mr. Lamere was pronounced dead by the Bryan LGH West medical staff at 2044 hours. Mr. Lamere was 22 years old.

The Department of Correctional Services (DCS) notified the Office of Inspector General (OIG) regarding the incident via an email from Jeff Wooten at 7:56am on May 30, 2017. The death of Mr. Lamere was reported to the OIG via an email by Scott Frakes at 6:36am on June 7, 2017.

BACKGROUND

Mr. Lamere entered DCS on November 7, 2013 when he was 18 years old and was serving a six year to eleven year sentence for Robbery and Use of a Deadly Weapon to Commit a Felony. His Parole Eligibility Date was February 4, 2018 and his Tentative Release Date was September 4, 2020. He was classified as a maximum custody inmate and had also resided in the Nebraska Correctional Youth Facility and the Omaha Correctional Center prior to moving to TSCI on December 3, 2015. Mr. Lamere had previously been incarcerated at DCS after being sentenced for Escape from the Youth Rehabilitation and Treatment Center in Kearney at the age of sixteen years old. He was in the custody of DCS from October 7, 2011 until September 24, 2013. Within three months he was back at DCS as a seventeen year old after attempting to rob a convenience store.

INVESTIGATIVE SUMMARY

At the beginning, the OIG reviewed the cell location history of Mr. Lamere and found that he had been placed in the skilled nursing facility at TSCI on May 21, 2017 and went back to his cell on May 22, 2017. On May 21, 2017 Mr. Lamere had a visitor at TSCI. Upon his leaving visitation, a strip search was conducted on Mr. Lamere and a staff member observed a lump in the cheek of Mr. Lamere. Upon inspection, the staff member observed a blue pouch in Mr. Lamere's mouth and told him to spit it out. Instead, Mr. Lamere appeared to swallow it. He was then restrained and escorted to the skilled nursing facility and placed into an observation cell until May 22. No contraband was ever found on the person of Mr. Lamere although his visits were suspended thereafter, presumably based on the assumption that he did have contraband in his possession shortly after his May 21 visit.

On May 27, 2017, a call was made regarding a medical emergency at 0618 hours for Housing Unit 2D of TSCI. Upon responding staff found Mr. Lamere struggling to breathe and non-responsive. He eventually was placed in Bryan LGH West in Lincoln. According to NDCS the hospital determined that he tested positive for MDMA (ecstasy) and methamphetamines.

During the early morning hours (approximately 0315 hours) of May 27th, Mr. Lamere's cellmate, reported to the OIG and through a DCS statement that Mr. Lamere was having medical issues, had vomited and was generally unresponsive. He visited with another inmate through the vents and stated that they pushed the response buttons in their cells but that staff did not respond. He did recall a staff member coming by the door at some point (most likely 0503 hours) but that Mr. Lamere seemed to be improving and he thought that he would be coming out of it so he did not reach out to the staff member. The other inmate indicated that he did not see any area checks and

despite pushing the button and banging on the windows no one responded until the cell doors opened around 0615 hours. When the doors were opened the cellmate went to seek advice from another inmate who told him to report it. Meanwhile, another inmate applied a wet towel to the head of Mr. Lamere two times before staff responded and indicated that Mr. Lamere's skin was hot to the touch.

Through interviews and reports, the OIG was unable to verify that any staff were aware that any response buttons had been pushed by the inmates. A review was done of the video and written logs on the unit and cell checks by the OIG. In the video, Corporal [REDACTED] enters the unit at 0503 hours to begin cell checks. At 0506 hours the individual appears to pause and look into Mr. Lamere's cell. A memorandum dated June 2, 2017 from Correctional Officer De Los Santos to Major James Jansen at TSCI indicates that Correctional Officer De Los Santos monitored the cell checks done prior to the opening of the cell doors at 0615 hours. Correctional Officer De Los Santos found that Corporal [REDACTED] also conducted the formal 0345 count at 0347 hours. One individual shared with the OIG that they were told that the volume associated with the response buttons had been turned down by the prior shift so this contributed to the lack of a reaction to the pushing of the response buttons but this was unable to be verified by another source. Another individual shared that a fellow staff member indicated that there had possibly been an attempt to notify staff by the inmates previous to 0615 hours but this was also unable to be verified by another source.

After TSCI staff were notified by Mr. [REDACTED] at 0618 hours they responded in a quick manner and Mr. Lamere was removed from the unit by staff at 0626 hours. As stated earlier he was then transported to the skilled nursing facility, then to the Johnson County Hospital and then to Bryan LGH West Hospital in Lincoln. The report did not examine what took place in the hospitals.

An autopsy was conducted by Lancaster County and Johnson County will convene a grand jury to review the death of Mr. Lamere at a later date.

FINDINGS

The OIG found that staff appeared to conduct the appropriate cell checks and the response to Mr. Lamere's situation was handled appropriately beginning at 0618 hours. The OIG was unable to determine whether or not staff did know that the response buttons had been pushed by the inmates prior to 0614 hours.

EXPANSION OF REVIEW

The OIG report was expanded to take a longer look at the influx of illegal contraband, including drugs, into Nebraska's prisons. Over the past several months, much attention has been paid to the finding of illegal alcohol in Nebraska's prisons. There is also a continual effort by DCS to deter the flow of illegal contraband into their facilities. A recent article in the *Lincoln Journal-Star*

described the efforts that DCS claims to make to deter this flow. In the article it was stated that DCS “painstakingly searches visitors and the property they are bringing in” and they “also search staff and what they bring in and take out.” As a result, the OIG sent a random Google survey to 500 staff in the ten prisons. A number of these emails did not reach their recipient due to their leaving DCS but 129 individuals did reply to the survey. The survey asked three questions regarding drugs and illegal liquor. The results regarding drugs were focused on the need to provide additional searches of DCS staff, the use of drug dogs as a deterrent, the desire to increase prosecution/discipline for those that are caught bringing in illegal drugs, and the implementation of additional no-contact visits. In addition, the OIG asked DCS for data regarding how many staff and visitors were caught bringing illegal drugs or other contraband into a prison. The data for cases that they opened criminal investigations on were eight staff cases in 2016, zero staff cases in 2017, seven visitor cases in 2016, and four visitor cases in 2017.

RECOMMENDATIONS FOR PROCESS/POLICY IMPROVEMENTS

Due to the inability to determine the level of responsiveness to Mr. Lamere’s condition, the OIG had limited recommendations for DCS. The report made the following recommendations:

- 1) Review the ability to “turn down the volume” as it relates to response buttons;
- 2) Utilize substance abuse treatment staff to initiate a drug awareness campaign to educate inmates and staff regarding the dangers of using illegal drugs;
- 3) Increase the frequency and thoroughness of searches of staff as they enter the prisons;
- 4) Utilize drug dogs on a more frequent basis at the entrances of the prisons in order to act as a deterrent and to catch any illegal drugs that are being brought into the prisons;
- 5) Consider working with law enforcement agencies to assist with staff searches so that an outside entity is conducting the searches on a random basis;
- 6) Review the search policy for visitors in order to determine whether or not it needs to be adjusted to conduct enhanced and appropriate searches of visitors;
- 7) Conduct a review of visitor and staff searches at each prison, including whether or not the searches are being done in the manner prescribed by DCS, whether they are fairly and uniformly administered, and whether the ability to conduct such searches is impacted by staffing levels; and,
- 8) Report any action taken on these recommendations to the OIG.

CONCLUSION

The report concluded by stating that Daelan Lamere was a young man who had lived a challenging life and that his death appeared to be the result of unwise actions taken by himself. However, there were lessons to be learned by this case and the recommendations for process/policy improvements above are possible attempts to learn from Mr. Lamere’s death.

The report was first presented to Ombudsman Marshall Lux and then to NDCS Director Scott Frakes as outlined in Nebraska State Statutes 47-914 and 47-915. Director Frakes accepted the recommendations via an email on July 22, 2017.

Timeline of Events

0315 hours – Mr. [REDACTED] wakes to find Mr. Lamere in distress

0347 hours – Cpl. [REDACTED] conducted the formal count at the Unit

0421 hours – approximately four inmates in lower D Unit leave their cells

0434 hours – those inmates leave the building

0503 hours - Cpl. [REDACTED] begins to conduct cell checks in the Unit

0506 hours – Cpl. [REDACTED] appears to pause and look in Mr. LaMere's cell

0614 hours – Mr. [REDACTED] leaves his cell and goes to other side of the Unit

0615 hours – Mr. [REDACTED], Mr. [REDACTED] and one other inmate talk by the cell

0616 hours – Mr. [REDACTED] goes to the control center

0618 hours – Staff begin to respond to Mr. [REDACTED] request

0626 hours – Staff leave the Unit with Mr. Lamere on a gurney