DOUG KOEBERNICK
Inspector General

STATE OF NEBRASKA
OFFICE OF INSPECTOR GENERAL OF CORRECTIONS
State Capitol, P.O. Box 94604
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SUMMARY OF THE INVESTIGATION OF THE SMU FIRE AT THE TECUMSEH STATE CORRECTIONAL INSTITUTE ON MAY 25, 2017

INITIAL INCIDENT

On May 25, 2017 a fire was started during the evening in the Special Management Unit (SMU) Lower E Gallery at the Tecumseh State Correctional Institution (TSCI). Inmate YYYYYYY started the fire after originally being let out of his cell at approximately 1851 hours in order to proceed down the gallery and use a different door to access the mini-yard for that gallery. Instead of proceeding directly to the mini-yard door, Mr. YYYYYYY spent time in the hallway and eventually assisted in passing envelopes from one cell to another. As a result, the staff in the SMU decided that he would lose his opportunity to utilize the mini-yard. Mr. YYYYYYY was upset by this decision and would not go back to his cell and instead roamed up and down the gallery. He would not lock down and he encouraged other inmates to put water under their doors, break sprinkler heads and kick doors. He then began to tie bed sheets from one side of the gallery to the other. At approximately 1914 hours another inmate passed him fire under the cell door and Mr. YYYYYYY used the fire to start a bigger fire after lighting a pile of papers that he had either retrieved from his cell or had been given to him by other inmates. The fire filled the gallery with smoke and the fire alarms began to sound at 1925 hours. At approximately 2000 hours Mr. YYYYYYY came to the entrance and asked to be taken to medical. He was eventually restrained by staff and taken to medical. At that time, staff extinguished the fire and over the next few hours brought several other inmates to the medical area. Mr. YYYYYYY was assessed by medical staff and was then placed in a restraint chair until approximately 2230 hours.[1]

[1] May 25, 2017 Disciplinary Misconduct Report

BACKGROUND

Mr. YYYYYYY began an 18 month to 36 month sentence in 2013 and was later charged with another crime and is now serving a 13 to 20 year sentence.

In the early morning hours of April 6, 2017 17 inmates were transferred from the Nebraska State Penitentiary (NSP) to TSCI and placed in the SMU. They were placed in Immediate Segregation, a short term risk assessment housing placement that should only last for up to 30 days. The primary reason for these moves was that the inmates were considered to be active members of a Strategic Threat Group (STG) or gang. At the end of the thirty days, all 17 of the inmates were placed in Longer-Term Restrictive Housing (LTRH), a classification assignment that results in the inmates being placed in a restrictive housing setting for a longer period of time. While in this setting they are typically in their cell for approximately 23 hours per day. Their status is reviewed approximately every 90 days. LTRH is for inmates who "pose a risk to the safety of themselves or others and includes inmate participation in the development of a plan for transition back to general population or mission-based housing."[2] Mr. YYYYYYY was one of the 17 inmates and has been in the same SMU cell for over four months. At the time of the incident, he had been in a restrictive housing cell for approximately seven weeks.

At the time of the incident, there was a general mood of frustration building within the 17 inmates and others who had been similarly placed in restrictive housing at TSCI for STG activities. This is based on letters to the OIG (Office of Inspector General) and conversations between the OIG and some of those inmates and also interactions between the Ombudsman's office and that population. Many of the inmates felt that they were not receiving due process because they were being held there and not being provided any specifics regarding their reason for being there. In addition, some of these inmates were also being double bunked in the SMU which caused even more issues in their eyes. During interviews with those inmates they stated that they would like to have jobs, that they felt like "hamsters in a cage," that their concerns and complaints were not listened to and that there was an overall tone of "dismissiveness" from the administration and staff.[3]

[2] Excerpt from Administrative Regulation 210.01
[3] OIG interviews with SMU inmates

INVESTIGATIVE SUMMARY

As explained above, the initial incident took place in the SMU at TSCI in Lower E Gallery when Mr. YYYYYYY was caught passing and receiving materials with other inmates when he should have gone directly to the mini-yard. The incident started at 1849[4] hours when Mr. YYYYYYY left his cell to go use the mini-yard. He appeared to go out through the mini-yard door at 1849:35 hours but then turned around and assisted with passing materials between two cells before returning to the mini-yard door at approximately 1850:17 hours. At that time the door was locked and he did not have access to the mini-yard. At 1852:47 hours he entered his cell and then went back into the gallery. He again went into his cell to remove various items. In addition, there were laundry items in the gallery and he began to take bed sheets and tie them from one side of the gallery to the other.

Picture 1

At 1858 hours he successfully covered up the camera above the gallery door (Picture 1). At that point, a caseworker went and retrieved the handheld video camera and began to shoot video from the door. The handheld camera had audio so the OIG was able to listen to most conversations that were taking place from that time forward. Mr. YYYYYYY then continued to tie sheets from one side of the gallery to the other and to try to open cell doors (Picture 2).

Picture 2

At 1900 hours he attempted to cover up the gallery windows with wet newspapers (Picture 3). At approximately 1902 hours Corporal XXXX asked that Mr. YYYYYYY's cell door be shut because he continued to take things out of his room. At approximately 1908 hours one of the two men in the showers yelled repeatedly for them to shut the water off. In the meantime Mr. YYYYYYY continued to roam free on the gallery and repeatedly tried to open other cell doors. At approximately 1910 hours the water to the showers was shut off.

Picture 3

[4] Author's note: The times in the introduction do not quite match up with the times in this part of the report. The times in this part of the report were determined by the OIG using the video of the incident.

At approximately 1914 hours Corporal XXXX informed another staff member who was there about the situation and said that Mr. YYYYYYY was inciting the other inmates and trying to get them to put water on the floor and to break sprinkler heads. Mr. YYYYYYY then began to talk to other inmates about starting a fire. This was 25 minutes after the incident first began.

At this point the staff at the gallery door talked about assembling a team and it was noted by one staff member that the team was still getting ready. Corporal YYYY, who was the acting Sergeant for SMU East that shift, initiated the use of force team and then that was turned over to Caseworker XXXXXX. Sergeant XXXX assisted Caseworker XXXXX with this effort. Staff discussed the fact that they had four members of the five member team assembled but that the fifth member was told not to report so then they had to find a fifth member. According to NDCS policy the cell extraction team needs to consist of five members.

Picture 4

Picture 5

At approximately 1916 hours Mr. YYYYYYY placed a large pile of papers by the gallery door. More papers were passed to him under the doors and at approximately 1917 hours Corporal XXXX said, "He's going to light it on fire" after Mr. YYYYYYY made a second pile of papers. At approximately 1918 hours fire was passed to him under a cell door and he ignited the second pile of papers (Pictures 4 and 5). This took place approximately 29 minutes after the incident first began.

Picture 6

By 1920 hours the fire was increasing and the fire alarms were sounding (Picture 6). As a result, Caseworker XXXXX utilized a fire extinguisher by spraying it under the gallery door but he was unsuccessful in extinguishing it. Within a few minutes the gallery was filled with smoke (Picture 7). By 1926 hours inmates

were yelling for assistance, inmates were banging on doors, a staff member was asking if medical should come down, and there was some discussion (although difficult to make out) about the extraction team. One inmate yelled, "I can't breathe. I am going to pass out." Due to the smoky conditions, the staff were unable to see Mr. YYYYYYY and did not know if he had any weapons.

Picture 7

Based on the conversations heard in the video of the incident, the OIG believes that it is reasonable to make the assumption that the extraction team had assembled outside the gallery by 1930 hours. However, NDCS did not keep any video of the area outside the gallery so this was not reviewable. This would have taken place approximately 40 minutes after the incident first started and approximately 12 minutes after the initial fire was started.

Picture 8

At 1935 hours, Mr. YYYYYYY apparently added more paper to the fire and it increased again after it had appeared to diminish. Within the next minute he appeared at the gallery door asking to be let out of the gallery. Staff eventually restrained him and he was escorted off of the gallery via a gurney by the extraction team (which consisted of six staff in their extraction team gear) and at least two other staff and placed in a different cell at approximately 2002 hours. He was eventually placed in a restraint chair but this took place after a use of force when he was wrestled to the floor. Mr. YYYYYYY was verbal during the events leading up to the use of force and was upset about the constant pressure being placed on him in his neck/shoulder area (Picture 8). He briefly resisted the pressure and was taken to the ground by the team (Picture 9). A little over 25 minutes later he was placed in a restraint chair and was left in the cell at approximately 2033 hours. He was removed from the restraint chair at 2230 hours.

Picture 9

After being restrained Mr. YYYYYYY expressed a number of thoughts regarding the incident and his placement in LTRH. He stated that "intel plays games" with the inmates and "acts like it's funny."[5] He also said that "they provoked us for no reason" and "they ain't gonna be happy until they get one of you (staff) killed." He also expressed that he is "in segregation for not doing a thing" and "I'm never gonna get out" and that "this is all intelligence's fault" and they are "making up a story and breaking up a man's family for no reason." Later, when being placed in the restraint chair Mr. YYYYYYY continued and talked about why he acted out after not being allowed to go to the mini-yard. He expressed his frustration with his placement in restrictive housing and said that they should have just written him up and let him go out to the mini-yard. He stated that if they had just done that none of that would have happened.

Picture 10

Picture 11

After the extraction team left the cell, Mr. YYYYYYY talked to Sergeant XXXX about the use of force and how he thought it was unnecessary. He said that he was not resisting as they were trying to remove his clothes and that they had applied unnecessary pressure to his neck.

Meanwhile, the inmates who were in Lower E Gallery and had been in the smoke for an extensive period of time were unable to be promptly seen by medical due to the extraction team being with Mr. YYYYYYY. Even at 2000 hours the gallery was still filled with a visible haze of smoke (Picture 10). Due to the smoke and the camera above the gallery door being covered it is difficult to know what took place on the gallery after Mr. YYYYYYY was escorted to another area and prior to 2009 hours. The floor was filled with debris and it appears as though no one

Picture 12

[5] The word "intel" is a reference to the Department's intelligence operation which collects information on inmate criminal activities, misconduct, gang membership, etc.

walked more than a short distance into the gallery (Picture 11). Based on later observations of the video one of the two men in the showers had been moved across the hall prior to 2009 hours and back into their cell.

At 2009 hours staff entered the gallery and checked on two cells. At 2019 hours, the extraction team escorted the first inmate off of the gallery via a gurney to a medical area (Picture 12). Beginning at 2020 hours staff did fairly continuous checks of all of the cells and spent time at each cell door when they did those checks. The next inmate was removed from the shower at 2045 hours (Picture 13) and the next inmate after that was removed from his cell at 2059 hours. During these initial removals there were eight staff dressed in their extraction gear. At 2106 hours another inmate was removed from his cell, and four staff members escorted him as he left via a wheel chair. At 2137 hours 10 staff member escorted another inmate from the gallery. No one else was escorted off of the gallery before the video ended at 2238 hours. According to a May 27, 2017 memo, eight SMU inmates were seen by medical after the incident.[6]

Picture 13

Picture 14

One of the more interesting occurrences after the fire was extinguished was the amount of "fishing" that went on from cell to cell. Fishing is when inmates use string and other materials to pass notes from door to door.[7] Due to the debris on the floor of the gallery it is rather easy to observe in the video, especially after 2115 hours. Picture 14 shows one example of something being passed diagonally across the gallery floor. The fishing left a number of tracks and paths in the debris but no staff appeared to notice it or comment on it.

The OIG received many comments and complaints from the inmates who were living on Lower E Gallery after the incident. Some of their concerns included:

[6] May 27, 2017 memo from Sergeant Joe Johnson to Major James Jansen

[7] PBS' *Frontline* video on fishing can be found at https://www.youtube.com/watch?v=2CvDpAvJR84

- It took seven minutes after they escorted Mr. YYYYYYY off of the gallery before they opened the mini-yard door to let fresh air in the gallery;
- The incident took place on a Thursday but they were not given cleaning supplies for their cells until Sunday and were not allowed to change their bedding until Wednesday;
- They received no mental health checks regarding the incident despite it being a traumatic event due to their being locked in their cells with a fire going and thick smoke enveloping them; and,
- There had been a significant delay in being seen by medical staff after the fire was extinguished.

The OIG was unable to find any record that the Tecumseh Fire Department or the Nebraska State Fire Marshal was contacted about the fire despite such a process being required as stated in TSCI Operational Memorandum 111.04.01.[8] The Nebraska State Fire Marshal's office confirmed to the OIG on August 10, 2017 that they were never notified of any fire on May 25, 2017 at TSCI.[9] Warden Hansen informed the OIG in an August 10, 2017 email that, "Since there was no damage to the facility the only person notified as a result of materials lit on fire was the safety and sanitation person..." In addition, the Nebraska State Patrol was never contacted by NDCS despite this being a possible crime of arson.

EXPANSION OF REVIEW

The incident on May 25, 2017 brought more attention to the situation regarding the 17 inmates from the Nebraska State Penitentiary who were moved to TSCI after 2:00 A.M. the morning of April 6, 2017. The primary reason for moving these inmates from their general population setting in NSP to the SMU in TSCI was that they were identified as Active STG. The Ombudsman's office and the OIG have spent a considerable amount of time discussing these cases with the inmates, staff and administration. Several of the inmates have filed grievances regarding their placement in LTRH, including NDCS not following their own regulations regarding notices, other paper work and reviews. In some instances this appears to be the case.[10]

The OIG has monitored two of these cases more closely than others and is closely following them to gain a better understanding of their concerns and the process. The OIG will continue to work on this issue in the future. One change that NDCS indicated that they will make is to provide more information to the inmate regarding the reason they are placed in Immediate Segregation or LTRH. This is a necessary change so that the inmate has some due process and the ability to counter any information or charges levied against them. Despite this, all 17 inmates

[8] TSCI Operational Memorandum 111.04.01
[9] August 10, 2017 Phone conversation between the OIG and the Nebraska State Fire Marshal's office
[10] Inmate Interview Request from XXXXXX

from NSP are still in LTRH after more than four months have passed since being removed from their cells in the middle of the night.

FINDINGS

There are several findings related to the May 25, 2017 incident at TSCI.

First, there is an overriding concern about the lack of an immediate or even a timely response by staff to Mr. YYYYYYY from the time he was told to go back to his cell to the time that he set the initial fire and even beyond that. While there are safety concerns to consider in situations like these, an outside observer finds it difficult to believe that the appropriate response to an inmate roaming around a gallery for a period of time setting fires is to just let him do that. In this case, Mr. YYYYYYY was creating barriers by tying the bed sheets from one side of the gallery to the other. He then started collecting paper and even said that he was going to start a fire. A staff member even acknowledged this on the video. Mr. YYYYYYY then started a fire and yet there was no response to it other than to watch and try to extinguish it by spraying a fire extinguisher under a door. It might have been more effective to let Mr. YYYYYYY into the mini-yard after about five to ten minutes, and then lock that door, then figure out what action to take next. According to one document, a team consisting of eight staff was assembled at 1900 hours.[11] Yet nothing was done until Mr. YYYYYYY surrendered over 45 minutes after being told to return to his cell and nearly 20 minutes after he started a fire. In one document it was explained that Mr. YYYYYYY's offense was serious "due to participating in mutinous actions such as lighting fires has the potential to result in serious bodily injury and even death to staff and other inmates."[12] In this case, the inmates and even staff on the Lower E Gallery were in harm's way for a considerable amount of time yet it appears that nothing was done to try to resolve the potentially deadly situation for a period of time.

Second, Mr. YYYYYYY was placed in a restraint chair for two hours after the incident due to concerns for staff safety.[13] As with other cases reviewed by the OIG, specifically at the Lincoln Correctional Center, the standard response when using the restraint chair appears to be to automatically leave the inmate in the restraint chair for two hours. The NDCS policy states that they should be in the restraint chair for no longer than two hours.

Third, the response to the medical needs of the inmate population could also be considered less than responsive or timely. Primarily due to safety concerns each inmate was escorted out by an extraction team to the medical area. As a result there was a considerable amount of time before some individuals were assessed by the medical staff despite being in a fire and smoke filled environment.

[11] May 27, 2017 memo from Sergeant Joe Johnson to Major James Jansen
[12] May 25, 2017 Disciplinary Misconduct Report
[13] May 27, 2017 memo from Sergeant Joe Johnson to Major James Jansen

Fourth, the slower than expected responses by staff were likely impacted by the low staffing levels at TSCI. TSCI is understaffed to a considerable degree. Director Frakes shared that this took place on the second 12-hour shift where "staffing levels are lower in the unit" and that this resulted in "slowing the response time."[14] Interviews between the OIG and staff indicated that there was some miscommunication on who was supposed to respond to the incident and this slowed the response. Staff indicated that there were four team members assembled and ready to go but they were waiting for the fifth due to this miscommunication. Thus, since policy indicates that the team needed five members no action at all was taken. One staff said that it "seemed like forever" until staff responded and that some team members were sent back because they were not wearing lower groin protectors. It was also shared that once the fire started that they needed to have eight team members rather than five, including two members with shields, since there was not any visibility in the gallery. As a result, three additional people had to be pulled from duty on the yard and this took additional time. In addition, this created even more shortages in key areas of TSCI during a time of low staffing.

Fifth, TSCI and NDCS did not follow their own procedures by failing to contact the Tecumseh Fire Department or the Nebraska State Fire Marshal about the fire. They also did not contact the Nebraska State Patrol.

Sixth, Corporal XXXX did an excellent job of videotaping the incident and explaining the events as they unfolded.

Seventh, Sergeant XXXX did an excellent job of communicating with Mr. YYYYYYY when force was used against him and he was placed in a restraint chair. He was calm and understanding and developed a good rapport with Mr. YYYYYYY, which was extremely important under the circumstances.

Eighth, TSCI staff did an excellent job of spending time in front of each cell door a number of times communicating with inmates after the fire was extinguished and the first inmate was moved to the medical area.

Ninth, despite previous communication between the OIG and NDCS regarding the maintaining of video during serious incidents the video facing out from the gallery was not kept by NDCS. This video could have been of great value to the OIG and NDCS when reviewing any actions or lack of action by staff during the incident.

[14] May 28, 2017 Email from Director Frakes to Doug Koebernick and Jeff Wooten

RECOMMENDATIONS FOR PROCESS/POLICY IMPROVEMENTS

As with the findings there are several recommendations by the OIG related to process/policy improvements.

1) Review all policies regarding emergency situations where it involves possible dangerous and even deadly actions by an inmate in situations such as the one that Mr. YYYYYYY was involved. Determine whether action against an individual could have been taken in this case and in future cases in which would allow such situations to be handled in a more timely and responsive manner;
2) Review the incident and determine whether or not Mr. YYYYYYY's cell door should have been closed sooner than it was and whether or not the showers should have been turned off earlier than they were;
3) Always contact the fire department and the Nebraska State Fire Marshal in the case of a fire. In this case, review why those two entities were not contacted and address this lack of appropriate action as soon as possible;
4) Continue to improve the Immediate Segregation and Longer-Term Restrictive Housing placement policies, including the use of active STG in placing inmates in those placements;
5) Work with NDCS Health Services to determine whether medical staff could be moved closer to the location of a serious health incident so that triaging and more timely medical care could be provided;
6) Review an inmate in a restraint chair every 15 minutes in order to determine whether or not he could be safely removed from it rather than placing him or her there automatically for two hours;
7) Keep all video that relates to a serious incident for at least 90 days;
8) Review the Immediate Segregation and Longer-Term Restrictive Housing policies that allow for bedding and other supplies to be left in a gallery while inmates are allowed to walk through the gallery unattended; and,
9) Report all actions related to these recommendations to the OIG in a timely manner.

NEBRASKA

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DEPT OF CORRECTIONAL SERVICES

Pete Ricketts, Governor

August 31, 2017

Mr. Doug Koebernick
Inspector General for Corrections
State Capitol, Room 800
PO Box 94604
Lincoln, NE 68509-4604

Dear Mr. Koebernick,

I have reviewed your investigation of the fire in the special management unit (SMU) at the Tecumseh State Correctional Institution (TSCI) on May 25, 2017. Per Nebraska Revised Statute 47-915, I am responding within 15 days.

All fires in a correctional facility are serious as they present a threat to the safety of staff, inmates and the facility as a whole. The fire in the SMU at TSCI initiated by an inmate was a serious incident that the department has reviewed by conducting an internal critical incident review and developing and implementing an associated action plan. I share the concern that every minute counts in an emergency situation and agree that the timely response to these incidents is paramount.

I was pleased to see the findings complimenting staff on their positive interactions with inmates during and after the incident.

As seen in the response to the individual recommendations below, I do not disagree with most of the findings in the report. The fire department and fire marshall should have been contacted and staff are reviewing how they could have responded differently both to the inmate's initial actions and once he began starting a fire on the unit. I have addressed some specific findings in the report below.

Finding number three notes "the response to the medical needs of the inmate population could also be considered less than responsive or timely." However, no evidence to support these facts is provided, other than the comment that inmates were escorted individually to medical by an extraction team. Medical care was provided in a timely manner.

Scott R. Frakes, Director
Dept of Correctional Services
P.O. Box 94661 Lincoln, NE 68509-4661
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Finding number four claims that the slow response time to the incident was due to low staffing at TSCI and that pulling additional staff from other units "created even more shortages in key areas of TSCI during a time of low staffing." This statement is subjective, not supported by evidence and contradicted by the evidence in the report indicating miscommunication amongst staff was the cause for the delay.

The portion of the report titled expansion of review, addressing the placement of 17 individuals from the Nebraska State Penitentiary in restrictive housing at TSCI is unrelated to the fire which, as indicated in the report, was clearly caused by the actions of one inmate. The discussion of the reasons why this inmate or others were classified to restrictive housing is not relevant to how the department responded to the incident.

With regards to the specific recommendations made in your report, statute provides I may accept, reject or request, in writing, a modification. Below are the department's responses to the individual recommendations in the report. Please find below my response to each.

1. Accept – NDCS requires a critical incident review as a follow-up response to serious incidents. An critical incident review has been conducted and the department has implemented an action plan which includes conducting a review of the incident with staff to look at how else the incident could have been handled.
2. Accept – The department requires a critical incident review and action plan as follow-up for serious incidents.
3. Accept – As noted in the report, the fire department and Nebraska State Fire Marshall should be contacted in all situations where there is a fire in a facility. This recommendation has been implemented as part of the critical incident review and action plan. Notification requirements in policy for fires were reviewed with all shift supervisors.
4. Reject – The department is continuing to review and revise its restrictive housing policies as part of the ongoing restrictive housing reform. However, this recommendation is rejected as it is unrelated to the subject of this OIG investigation and because there is insufficient evidence presented in the report to support the recommendation.
5. Reject – It is not practical, safe or a medical best practice to have medical staff leave medical areas to respond to a small fire in a housing unit. There is no evidence presented in the report that the location of medical staff was in any way related to providing adequate treatment.

6. Accept – Current NDCS policy provides for 15 minute checks of inmates in a restraint chair and the department is specifically training staff that the two hour policy is the maximum amount of time and not the default.
7. Modify – The department does retain video of serious incidents for use in internal investigations and at the request of the inspector general or law enforcement. The problem in the recommendation as drafted is the lack of a definition of "related to". From the text of the report it appears that video from other housing units, corridors, stairways, etc. showing staff responding to the ERT call, suiting up for a cell extraction or medical staff treating inmates are all related to the incident. Technical storage limitations prevent storage of all video from a facility. NDCS would recommend modifying this recommendation to require NDCS to retain all video requested by the OIG (within a reasonable time period after discovery of the incident – e.g., two weeks) that is related to a serious incident or an ongoing investigation by the OIG.
8. Accept – Policy does not allow for bedding or other supplies to be left on the gallery unattended. This is a management issue and will be addressed with restrictive housing staff.
9. Reject – There are numerous reporting mechanisms in place to update the Office of the Inspector General on recommendations made in this report. NDCS will continue to be responsive to requests from the OIG.

As required by Neb. Rev. Stat. 47-915, you have fifteen days to accept or reject the requested modification to recommendation number 7.

Lastly, I caution that Neb. Rev. Stat. 83-178 protects information in your report and provides and it cannot be released without a court order.

Sincerely,

Scott R. Frakes
Director

DOUG KOEBERNICK
Inspector General

STATE OF NEBRASKA
OFFICE OF INSPECTOR GENERAL OF CORRECTIONS
State Capitol, P.O. Box 94604
Lincoln, Nebraska 68509-4604
402-471-4215

September 1, 2017

Scott Frakes
Nebraska Department of Correctional Services
P.O. Box 94661
Lincoln, NE 68509-4661

Dear Director Frakes:

I have reviewed your letter dated August 31, 2017 regarding the fire in the special management unit at TSCI on May 25, 2017. In it you requested that I modify my seventh recommendation. Under state law I have 15 days to accept or reject the requested modification.

To review, my recommendation was the following: "Keep all video that relates to a serious incident for at least 90 days." The reasoning behind this recommendation was that when a serious incident takes place, there are a number of entities that may investigate such an incident, including the Inspector General, the Nebraska State Patrol, the Nebraska Department of Correctional Services, and possibly others. In the case of the fire at TSCI, the incident took place on May 25, 2017 and on June 7, 2017 I requested the video immediately outside E Gallery. This video was important due to the fact it would have shown the reaction to the incident by staff and any other activity that was taking place in that area. This video was directly related to the incident yet it was not kept by the Department even though it was requested within 13 days of the incident taking place.

After the multiple staff assault incident at the Lincoln Correctional Center, I expressed my concern to you about the lack of video kept in relation to that incident. As part of our communication on this issue you shared (and rightfully so) that the issue was technology and that facility only had 10 days of recording capability and after that the system videotaped over the oldest data. You also shared that modern systems have a larger storage capability and have at

least 30 to 60 days of over-write loops. You then stated that you would get a cost estimate to increase storage capacity at that facility and at the Nebraska State Penitentiary and the Tecumseh State Correctional Institute if needed. You then concluded by stating, "In the short term we will download/store bigger blocks of video on either side of serious incidents."

With that said, I do understand the concerns you expressed regarding my recommendation and find them to be valid. However, I am going to reject your request for the modification that you suggested of my recommendation as I think that it is more important for my office and the Department to discuss this further and come up with a better plan that works for all entities involved in investigations of serious incidents within NDCS. As a result, I propose the following recommendation to take the place of my original language:

"NDCS, the Nebraska State Patrol, the Office of Inspector General for Corrections, and any other relevant parties should meet within 60 days to discuss the policy for maintaining video of serious incidents that take place at facilities operated by NDCS."

I would appreciate your feedback on this suggestion at the earliest opportunity.

Sincerely,

Doug Koebernick