OFFICE OF INSPECTOR GENERAL
OF THE NEBRASKA CORRECTIONAL SYSTEM

Deaths by Suicide

An Investigation of the Deaths of Three Individuals in NDCS Custody

SUMMARY OF INVESTIGATIVE REPORT NO. 2024-02

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EXECUTIVE SUMMARY

Multiple deaths take place each year within the Nebraska correctional system. These can vary from natural causes to accidental deaths to homicides. They can also include deaths by suicide. This report investigates three deaths by suicide between December 2021 and June 2023.

As a result of this investigation, the Office of Inspector General (OIG) found:

1. Two of the individuals in this report hung themselves by tying a bed sheet to the upper bunk. In 2016, an internal critical incident review (ICIR) completed by the Nebraska Department of Correctional Services (NDCS) staff recommended that the Tecumseh State Correctional Institution (TSCI) should remove the second bunk and cabinet from all special management unit (SMU) cells.
2. Individual A died by suicide 16 days after a different attempt to die by suicide. After his first attempt, he was placed on Plan A status, then Plan B status, and placed back in his regular gallery approximately one week later.
3. NDCS Policy 115.30 states the "Chief Psychologist for Mental Health Services will designate a Mental Health team member who is not assigned to the affected institution to complete a Psychological Autopsy for all suicides and, as he/she deems appropriate, for attempted suicides." The OIG requested the psychological autopsies for Individual A and Individual B but did not receive them from NDCS.
4. NDCS staff appeared to respond appropriately and expediently to all three incidents. In reviewing these responses, the recording of audio and video from the body cameras at one facility was especially helpful and informative. At the current time, body cameras are only provided to some staff at two facilities. They are not provided to any staff at the Reception and Treatment Center (RTC) despite it being the home of mental health and high security units.[1]
5. Two of the incidents resulted in recommendations in the ICIRs that staff should know the nature of the emergency to which they are responding.
6. In all three ICIRs for these deaths, none of the ICIR teams interviewed incarcerated individuals who may have either witnessed the death or had information regarding the

[1] A recommendation regarding body cameras has previously been made by the OIG. (https://nebraskalegislature.gov/pdf/reports/public_counsel/2022_NDCS_controlled_movement_units.pdf – page 26).

individual who died. According to NDCS policy, "The ICIR shall be comprehensive and meticulous in detail specific to the incident encompassing all relevant policy, procedure and practices/actions with the primary focus being to identify things done well and things to improve."[2] The policy does not state incarcerated individuals should or should not be interviewed as part of this process. In these cases, interviewing other incarcerated individuals would have provided additional information which would have allowed for a more comprehensive review.

7. A review of past investigations found NDCS established a work group in 2018 to look at suicides. It was led by staff from the NDCS health services division. They met several times and made multiple recommendations but only one was enacted. The enacted recommendation was eventually ended by NDCS.

The OIG recommended to NDCS to consider taking the following actions:

1. NDCS should review the past work of the 2018 suicide work group and determine whether a special team should be established to focus on deaths by suicide and attempted deaths by suicide.
2. NDCS should review the requirement regarding psychological autopsies found in Policy 115.30 and determine whether these have been done in the past and whether this requirement should continue to be in NDCS policy.
3. NDCS should revisit the past NDCS recommendation regarding the removal of the second bunk and cabinet in all SMU cells.
4. NDCS should review the need to have staff wear body cameras in facilities other than TSCI and the Nebraska State Penitentiary and consider providing them to staff assigned to each shift's emergency response team.
5. NDCS should review the ICIR process and determine whether interviews with individuals other than NDCS staff should be conducted in order to gather additional information related to this "comprehensive and meticulous" review.[3] If they determine such interviews would provide for a more complete review, Policy 203.02 should be changed to reflect this determination

[2] NDCS Policy 203.02.
[3] NDCS Policy 203.02.

The full report was provided to the NDCS Director and he later responded to the OIG via email and wrote, “I have received the report and will consider the recommendations.”

The OIG later learned that on June 25, 2024, NDCS issued a policy directive to amend existing policy signed by Director Rob Jeffreys which went into effect immediately and stated:

> *“The mental health director/designee will designate a psychologist who is not assigned to the affected facility to complete a psychological autopsy for all suicides and, as he/she deems appropriate for attempted suicides.”*

This would appear to be a result of Recommendation #2 in the report.

ABOUT THIS REPORT

The Office of Inspector General of the Nebraska Correctional System (OIG) was established in 2015 to provide oversight and accountability for Nebraska's correctional system, including the Nebraska Department of Correctional Services.[4] As part of its statutory responsibilities, the OIG is required to investigate all deaths that take place within NDCS facilities.

Many deaths within state correctional facilities are due to natural causes. While it is important for the OIG to review these deaths and the circumstances surrounding such deaths, unexpected deaths due to accidents, suicide or even homicide typically involve a more extensive investigation. While the Nebraska State Patrol investigations and the grand jury process seek to determine whether criminal action took place when an incarcerated individual has died, the OIG plays a separate role when reviewing deaths. The OIG death investigations focus on the circumstances of the death and a more extensive understanding of the actual death and events or actions of NDCS leading up to the death, as well as the NDCS response to the death, and to make recommendations for improvement based on an overall look at the situation.

In December 2021, August 2022 and June 2023, three incarcerated individuals died by suicide.[5] This report will provide information on these three deaths. Two of these deaths took place in an SMU. The SMU houses individuals who have been placed in a restrictive housing gallery, a mission specific housing gallery, or the ISDP gallery.[6] A third death took place in a cell in a general population unit at another correctional facility. All three died due to asphyxiation after using a bed sheet to hang themselves.

This report resulted from a review of NDCS documentation and reports, reviews of videos, phone calls and e-mail messages, and interviews with staff, incarcerated individuals and a family member of one of the deceased individuals.

[4] Office of Inspector General of the Nebraska Correctional System Act, Neb. Rev. Stat. § 47-901 et seq.
[5] Recently, guidance has been provided by mental health professionals to use "died by suicide" or "death by suicide" rather than stating someone committed suicide. See https://www.camh.ca/-/media/files/words-matter-suicide-language-guide.pdf.
[6] The gallery where these individuals are housed is commonly referred to as "Death Row."

DEATH OF INDIVIDUAL A

About Individual A

Individual A, age 45, had been incarcerated within NDCS since August of 2006. However, he had been incarcerated on earlier occasions, including:

- From March 1993 to April 1993 for the charges of escape and theft. He was released after his sentence was vacated.
- From October 1993 to February 1998 for the charges of escape and two counts of theft by receiving of stolen property. He was mandatorily discharged on his release date, about three months after his parole eligibility date.
- From February 2000 to June 2003 for the charge of theft by unlawful taking (over $1500). He was mandatorily discharged on his release date, slightly over two years after his parole eligibility date.
- From August 2006 to the date of his death for multiple second-degree forgery charges, first-degree murder and use of a deadly weapon to commit a felony. For the murder charge, he received a life sentence. While incarcerated, he murdered his cellmate and was convicted after that of first-degree murder and use of a weapon to commit a felony.

Individual A was incarcerated at a single facility for the majority of his sentence. Prior to the murder of his cellmate, Individual A had spent the vast majority of his time either in a restrictive housing setting or another high-security setting with more limited movements than a normal general population unit.

Individual A had an extensive misconduct history although he had not received any misconduct reports during the 11 months prior to his death. He was recommended for residential substance abuse programming which he never received while incarcerated. He was also recommended for violence programming which he finished in December 2019.[7]

[7] The Nebraska Center for Justice Research recently completed a report on this program. See https://www.unomaha.edu/college-of-public-affairs-and-community-service/nebraska-center-for-justice-research/documents/vrp-eval-report-2-2024.pdf.

Initial Incident

In August 2022, Individual A cut his wrists and then told staff what he had done. When the staff responded, they found him lying on his bed with his left arm hanging off the bed. Under the arm was a large puddle of blood. He was transported to the medical unit within the facility where they noted the wound was 12 cm in length and 0.5 cm in width. Individual A shared with the medical staff he had used a razor blade which was later found by custody staff. During this time, he also shared that we was not suicidal but had harmed himself due to the effects of using K2. He was taken to an outside hospital for additional medical treatment, including stitches.

A staff member found a note in a small brown trash bag during a search of Individual A's cell that stated, "I…will all my property to my daughter…" This would appear to conflict with Individual A's statement to the medical staff in which he said he was not suicidal. When asked about the note, he told one staff member he did not recall writing it.

When Individual A returned to the facility following his hospital visit, he was placed on "Plan A" status, often known as suicide watch, in the skilled nursing unit at the recommendation of an NDCS psychologist. When placed on Plan A status, an individual receives very limited property, including a security blanket and paper clothing, the individual is also checked every 15 minutes.[8] He was designated as having a level of care of 5, which is the highest level of care and is considered acute care.[9] He was later placed on Plan B status which is a step down from the Plan A status. He was taken off of this status three days later by behavioral health staff and returned to his cell in his regular gallery. He was last seen by behavioral health staff five days after he cut his wrist for approximately 30 to 45 minutes. Individual A denied any suicidal intent during this contact.

On the day he was taken off Plan B status, a drug field test[10] was utilized to screen evidence found in Individual A's cell on the date he cut his wrist. The evidence was a suspected synthetic marijuana smoking device and the test returned a negative result. Another test was completed on some suspected homemade alcohol samples which were found during the same search. The

[8] NDCS Policy 115.30.
[9] NDCS Policy 115.22.
[10] DETECTACHEM MobileDetect Test was used.

sample yielded a presumptive positive test result.

Individual A's Death

Sixteen days after the wrist cutting incident, a staff member made a radio call for an unresponsive inmate at 0100 hours. The sole occupant of the cell was Individual A. Seven staff responded within a couple of minutes. When they entered the cell, they found Individual A in a sitting position with a bedsheet wrapped around his neck and tied to the top bunk of the bed. They used a hook knife to cut the noose, and he was laid on the ground so he could be assessed. He was placed on a backboard and CPR was initiated when it was found he was not breathing. One staff member used a handheld video camera to record the interaction. CPR was continued while he was moved to the medical unit. The registered nurse on duty applied the automated external defibrillator (AED), which stated, "No shock is advised. Do CPR." CPR was continued, but Individual A remained unresponsive and flaccid, and no pulse was found. The on-call medical doctor was communicated with and the time of death was declared.

A review of the log for unit checks showed checks by staff were completed at 9:03pm, 10:03 p.m., 11 p.m., 12 a.m., and 12:59 a.m. on the evening of Individual A's death.[11]

Additional Information

Grand Jury Findings

A grand jury found Individual A "died from asphyxiation due to hanging." During the grand jury proceedings, the Nebraska State Patrol investigator testified regarding his investigation. Among the pieces of information he shared with the grand jury were the following:

- A suicide note was found. The note said the following:

  "The reason I have taken my own life is because I'm tired. I'm going to die in prison. So since there is no way around that, I'm going out on my terms and my time. No one has forced me to do this, and no one else knew I was doing it." In a specific entry to his daughter he wrote, "I'm tired and can't deal with this shit anymore…There's a

[11] NDCS Policy 203.01 requires informal counts to be conducted hourly at irregular intervals and they should be staggered and not more than one hour apart.

lot I want to say but can't find the words. The one and most important thing is I love you and always have. You were my baby girl and I left you behind and for that I am sorry."

- A member of the grand jury asked him if Individual A was on suicide watch and he shared how the unit and Individual A were checked every hour, and how he had viewed video and confirmed the unit check times were accurate;
- He said Individual A was seen a lot by mental health staff and had attempted suicide using razor blades; and
- Information regarding his mental health history, including Individual A being seen by mental health staff after the initial attempt but declining mental health services days before his death.[12]

Phone Calls

The OIG reviewed phone calls made by Individual A over the two and a half weeks before his death.

He called his mother multiple times during this time period. In the first two calls, he didn't mention anything regarding not doing well or anything of that nature.

Six days before his death, he said the "meds got him all fucked off" and she asked what was happening and if he was ok. He said he didn't have enough time to talk about it (it was a five minute call) but that he was good now. During the call he said, "Days I just get tired."

Five days before his death, he made two calls to his mother. Those calls lasted for a combined 35 minutes. During those calls, he shared how he had harmed himself earlier in the month. He said he had sliced his wrist and when asked why he said he was in a "bad place." He indicated he had bled for an hour before they found him. His mother asked if had really tried to kill himself and he said yes and indicated he had been in a dark place then and wanted to die. He stated, "My ambulance ride to the hospital was overrated," and acknowledged his placement on the Plan A

[12] The OIG was unable to review Individual A's institutional medical and mental health records due to statutory limitations on access to this information, as interpreted by NDCS.

status by saying he spent the weekend "butt naked." At the end of one of the calls his mother expressed her concern about him and he told her he was fine.

He made three more calls in the days leading up to his death but only touched on the topics of the weather, news, baseball, having a pet mouse and predicting that it would be Scott Frost's last year as the Nebraska football coach. He also discussed the need to purchase additional phone time in the future.

Interviews

The OIG interviewed incarcerated individuals who lived on the same unit as Individual A. Two individuals shared their observations and thoughts. One said Individual A was acting "pretty normal" but "seemed depressed" prior to his death. He said it was similar to other periods of depression exhibited by Individual A. Another individual said, "I didn't think he was that bad off."

The OIG also spoke with staff regarding Individual A. One staff member expressed surprise that Individual A was back on the unit so soon after he had harmed himself. Another staff member indicated Individual A was allegedly high on K2 when he harmed himself. It was also shared there was an allegation Individual A owed money to other incarcerated individuals as a result of purchasing K2.

Psychological Autopsy

NDCS Policy 115.30 states the "Chief Psychologist for Mental Health Services will designate a Mental Health team member who is not assigned to the affected institution to complete a Psychological Autopsy for all suicides and, as he/she deems appropriate, for attempted suicides."[13] The autopsy is required to include specific information, including such things as background information, antecedent circumstances, clues of suicide, conclusions, recommendations, and a list of documents examined. The report is to be completed within 30 working days and is to be forwarded to the Medical Director, who then is required to share the report with the NDCS Director and the applicable Deputy Director. Additional direction is

[13] NDCS Policy 115.30.

provided in the policy for recommending policy and procedure changes by the Deputy Director, as well as sharing the report with the applicable warden.

The OIG requested a copy of the psychological autopsy from NDCS. Despite follow-up communication regarding this request with NDCS, it was not provided.

NDCS Internal Critical Incident Review

The Department initiated an ICIR of Individual A's death. The review team summarized the incident regarding the death and established a timeline of the events related to the death. They interviewed staff members involved with the incident.

The ICIR found a psychologist met with Individual A four times over a week, after he cut his arm. Individual A was primarily residing in the skilled nursing facility at the facility under Plan status. Individual A expressed no interest in additional counseling sessions during the last session, and the psychologist was out of the facility during the following week. The ICIR did not make any inquiries into why Individual A was removed from Plan A and Plan B status and moved back to the unit.

The ICIR made three recommendations for improvement. These were:

- Have one person who is on-scene dedicated to communicating radio traffic;
- Have a medical bag, AED, hook knife and camcorder on a gurney in the restrictive housing unit; and
- Ensure responding staff know the nature of the emergency.

Their conclusion included the following:

"Nothing was discovered to suggest (his) death could have been prevented at the time of occurrence as (his) did not make any comments to the staff on the housing unit that he had thoughts of suicide or self-harm."

This conclusion was reached despite the ICIR not reviewing Individual A's wrist-cutting incident. The ICIR would have benefited from reviewing his most recent telephone calls and information related to his drug use and possible owing of money due to purchasing of drugs. In

addition, as part of the ICIR process no incarcerated individuals were interviewed regarding his death. The ICIR may have gained more insights through the interviewing of those who knew Individual A best and interacted with him daily.

DEATH OF INDIVIDUAL B

About Individual B

Individual B, age 45, began his most recent sentence with NDCS in May 2023, with convictions for one felony charge (possession of a deadly weapon by a prohibited person) and two misdemeanors (resisting arrest and attempted tampering with a witness). He had a projected release date of September 2024. He had served two previous terms in the state correctional system, from October 2001 through October 2004 and from July 2013 through March 2015. He was mandatorily discharged upon the completion of both of those terms.

Individual B's Death

In June 2023, an emergency response team at his facility was activated after an unresponsive individual was observed by a corporal during a cell check at 2238 hours in a unit which provides intake services for primarily newly incarcerated individuals. He was found face-down in the middle of the cell next to the lockers with a sheet tied around his neck. A staff member banged on the cell door to wake up the two individuals in the cell. After the cell door was opened the staff entered and removed the bedsheet from the locker while the other individual in the cell was ordered to remain on his bunk. CPR and chest compressions were started on Individual B and staff eventually pulled him out of the cell so they had more room to perform CPR. A hook knife was used to cut the noose around his neck, which was observed to be very tight. Two nurses arrived on the unit and attached the AED to Individual B. The AED did not advise to provide a shock at that time. CPR was continued, and Individual B was placed on a backboard before being carried down a flight of stairs to a gurney. Lincoln Fire and Rescue arrived and a paramedic pronounced Individual B dead.

Additional Information

Grand Jury Findings

A grand jury found Individual B's cause of death was hanging. During the grand jury proceedings, the Nebraska State Patrol investigator testified as follows:

- Individual B was found sitting on his bed with his feet on the ground by two NDCS staff during their cell check at 2114 hours.[14] He appeared to be reading.
- The next cell check took place at 2238 hours, and he was found face down on the cell floor with a ligature from his neck that was connected to the locker.
- There were marks found on his neck consistent with the ligature (bed sheet).
- His cellmate was asleep on the upper bunk and was awakened when a staff member banged on the cell door.
- The staff member called for another staff member and after they entered the room they cut the ligature off of his neck and started chest compressions and used the AED. The AED advised "no shock."
- There were no signs of a struggle or fight in the cell.
- Two telephone calls completed by Individual B on that day were played for the grand jury.
- Patrol investigators collected the DNA of his cellmate and also checked his fingers.
- The investigator found some cameras on the housing unit were not operable and had obtained one camera view but it only displayed the foot of the door to his cell.
- Individual B had previously been prescribed four different drugs. According to the autopsy, he had all of those in his system except one.

Video Issues

The OIG requested video from the incident. Upon reviewing it, it was discovered that not all cameras in the specific housing unit were in operation at the time of the incident. As a result, no direct views of the response by staff were available, including at the cell door or outside of the cell. This was also noted by NDCS intelligence staff in a memorandum one day after the death.

In order to understand the lack of video coverage, the OIG discussed this with NDCS staff and was told it was due to the updating of the video system. The OIG was directed to contact an NDCS electronics technician who then directed the OIG to the NDCS facilities construction coordinator. The technician indicated there continued to be issues with cameras not working at the facility. The OIG met with the facilities construction coordinator and one other individual. The OIG learned there was an issue with the ticketing process for addressing issues during the

[14] This was four minutes after his last attempt to make a telephone call.

replacement of a camera. In this case, NDCS was updating the camera system and it was being done with a small number of cameras at a time. After installing a camera, NDCS is to turn in a ticket to the Office of the Chief Information Officer (OCIO) and then the cameras should be working within 15 minutes to one hour. In this case, the cameras did not start working, and no one checked to see if they were working or not.[15]

Phone Calls and Emails

On the day of his death, Individual B attempted 99 telephone calls, nearly all to the same telephone number. None were answered until call #44 at 1921 hours. The call lasted approximately seven minutes until Individual B hung up. One minute later, Individual B called the same number and the call lasted approximately 13 minutes until the person he was talking to hung up. Both of those calls were with the same female. In both of the calls, it was apparent there was tension and stress between them, and each call evolved into a very vocal argument. In an interview with the OIG, Individual B's cellmate indicated Individual B argued with the individual he called most every night, and he referred to their communication on that night as their "regular argument." Between 1744 hours and 2110 hours he attempted another 54 calls. Nearly all were made to the number of the person he had previously talked with, but none of the 54 calls were accepted. During this time period, he attempted to make a telephone call every 3.8 minutes.

In neither of the two completed phone calls did he indicate he had any intention to take his own life.

In addition, a review of recent email messages between the two individuals also indicate a relationship with some challenges. The two last exchanged emails the evening before his death, and the exchange appeared normal.

Psychological Autopsy

As in the case of the death of Individual A, the OIG requested a copy of the psychological autopsy from NDCS. Despite follow-up communication regarding this request with NDCS, it was never provided.

[15] This finding by the OIG was shared with facility leadership when discovered and understood (July 2023).

Cellmate Information

Individual B's cellmate contacted the OIG by phone after Individual B's death and was later interviewed by the OIG. The cellmate shared how he and Individual B met while going through substance abuse treatment prior to their incarceration. He also indicated Individual B had been abusing his medications and was "loopy" at night and usually stayed up all night. The night of Individual B's death, the cellmate went to bed around 2000 hours and woke up to tapping on the door when the staff had seen Individual B in an unresponsive state. He jumped down from his bed and was yelled at to untie the bed sheet but when staff entered they had him get back on his bunk. He eventually was let out of the cell. He said Individual B's body was pulled out of the cell, CPR was initiated, then was stopped so they could handcuff him. He said there was yelling between the staff and the incarcerated population.[16] Eventually, Individual B was removed from the unit and his body was placed in the holding area. The cellmate was also placed there, where he could view the now deceased body of his cellmate.

While in the holding area, he asked to be moved three to four times due to having to be near the body of his cellmate. He was told no each time. One staff member did sit with him and talked with him, which he appreciated. He was later sent back to his unit and was placed in the cell where the death took place for a few hours. After he came back from breakfast, they placed him in a different cell. He talked for a "few minutes" with mental health staff on that day but said he had a breakdown on the following day and went to the holding area because of a "need to get it out." He indicated he had received no other contact by mental health staff as of approximately two weeks later despite having what he described as a "breakdown."

Reaction within the Unit

As indicated above, some incarcerated individuals on the unit interacted with staff during the incident. One individual received a misconduct report for yelling during the incident. It was alleged that he began "yelling inappropriate and demeaning words and phrases such as 'who let these kids work here' and 'these dudes are (redacted) retarded.' He continued to yell and showed signs of aggression which allegedly caused others to join in on this aggression. He received discipline of 30 days loss of good time and 14 days of canteen restriction. After Individual B was

[16] In this unit there were a number of men who slept on cots on the floor so they are not in cells.

removed from the unit, the remaining individuals on the unit were moved into the gymnasium for a short period of time.

NDCS Internal Critical Incident Review

The Department initiated an ICIR of Individual B's death. The ICIR team started to conduct its work in June 2023 but was instructed to suspend its work on July 24, 2023. They were notified on October 26, 2023 to proceed with the ICIR after contact between NDCS and the Nebraska State Patrol. They completed their work in December 2023.

The ICIR found several parts of the incident response were done well, including an immediate and clear request for assistance, appropriate number of responders to the scene, the administration of CPR and the collection of physical and photo evidence. Their recommendation for improvement was to conduct a review of assigned facility SERVES team members and a review of on-call statuses.[17] Among the responders, some indicated they had concerns about the lack of a response by SERVES after the incident. In the conclusion, the ICIR stated:

> *"Though through team member interviews, it was reported that facility staffing was minimal, but the review finds the response was appropriate and necessary tasks were accomplished to manage the situation. It was also reported that after the incident, staffing and some procedures have changed and has impacted the facility in a positive way."*

A review of the case files found no evidence of previous reporting of self-harm or suicide issues related to Individual B. Individual B was seen by a mental health provider five days before his death, and a referral was made to psychiatric but his next visit was to be scheduled in six months.

To be more complete, the ICIR could have reviewed the lack of operable cameras and the impact this had on reviewing the response to the incident. They also did not interview Individual B's cellmate who had information regarding his nightly activities and his abusing of medication.

[17] The SERVES team provides supportive services for staff involved in various incidents. More information on the role of SERVES can be found at https://corrections.nebraska.gov/serves-resources.

DEATH OF INDIVIDUAL C

About Individual C

Individual C, age 25, began his sentence with NDCS in 2019. He had a projected release date of January 2032 and a parole eligibility date in February 2026. He was incarcerated for felony charges of robbery and second-degree assault. He was in the restrictive housing unit at the time of his death. He had been placed in the unit due to being involved in a multiple person altercation in 2021 at a different facility.[18]

Individual C's Death

In December 2021, staff found Individual C sitting on the bottom bunk and unresponsive at 0408 hours. Staff attempted to gain his attention but he did not move so they made a radio call about an unresponsive individual. They knocked loudly on his door then opened the hatch to get a better look. They saw he had a sheet tied around his neck which was secured to the top bunk.

Upon entering the cell, they cut the sheet off of the top bunk and initiated chest compressions after finding no signs of life. While this took place, they were able to loosen the sheet from around his neck. At 0413 hours he was taken to the SNF where he was assessed by medical staff. The AED was placed on his chest and did not recommend a shock. He was declared dead at 0423 hours.

Additional Information

Mental Health History

Individual C was last seen by a mental health provider one month prior to his death. At that time, his medications were reviewed and adjusted. During this contact, he denied having thoughts to hurt himself. He was to be seen next in four to six weeks.

Individual C had previously been referred by mental health staff in order to be evaluated by a psychiatrist. The initial evaluation occurred about three months before his death. He had

[18] Now the Reception and Treatment Center.

previously been diagnosed with multiple disorders. He was not currently on any psychotropic medications but asked to be placed on some due to decreased attention and concentration along with anxiety and depression. He was prescribed two medications during this appointment.

Grand Jury Findings

During the proceedings, a grand jury found Individual C's cause of death was asphyxia due to hanging. A Nebraska State Patrol investigator testified as follows:

- There were no exact times for the cell checks completed that morning.
- He was found at 0410 hours by staff.
- Staff responded and when the AED was placed on him it recommended "No Shock."
- There were ligature marks observed across his neck where the sheet was attached.
- There was no other trauma found.
- He was not a sex offender but he was to be sentenced in federal court the following week for a sex-related offense.
- A letter to his father was found in his cell. It read:

  "Dad, when I die, I would like to be turned into ashes and put into a coffee can. I don't want no big-ass funeral, just you and (redacted). I don't want to be an SO.[19] *I hate them and hate myself. I'm my own enemy. I love you guys. Take care. Tell (redacted) I'm sorry for getting him into this mess."*

NDCS Internal Critical Incident Review

The Department initiated an internal ICIR of Individual C's death.

The ICIR found several things were done well, including the initiation of the emergency response, proper use of lifesaving measures, and staff coordination during the incident. They made five recommendations for improvement, with the focus being on conducting proper checks of the individuals within the cells. In their conclusion, they found the 30-minute checks were "substandard" and allowed Individual C "more time to complete the suicide attempt."

[19] SO typically refers to a sexual offender.

As a result of the ICIR, disciplinary action was taken toward one staff member due to substandard cell checks. NDCS also initiated a review of the PIPE cell check system with the intent of determining whether an upgrade was needed. The PIPE cell check system is an electronic record system used to accurately record where physical checks are actually done.

PREVIOUS INVESTIGATORY EFFORTS AND RELATED RESEARCH

In 2016, NDCS staff completed an ICIR of a death by suicide at TSCI in which the individual hung himself in the SMU. He did so by tying a bed sheet to a wall cabinet. The ICIR recommended to NDCS that TSCI should remove the second bunk and cabinet from all SMU cells.[20] The ICIR included other recommendations as well as part of their work.[21]

Additionally, NDCS established a work group in 2018 to look at suicides. It was led by the then medical director of NDCS. They met several time and made multiple recommendations, including:

a. Creating a brochure on suicide that will be distributed to inmates and in visiting areas for friends and family;
b. Making changes to the staff training manual;
c. Streaming a suicide prevention video in all facilities;
d. Utilizing an additional screening tool at transfer times and intake; and
e. Advertising a telephone number that people can call when they are concerned about a loved one who is in a state correctional facility so that staff can initiate action related to the contents of the call.[22]

A review by the OIG in 2019 found only the telephone number for concerned people to call was enacted. However, when the OIG called it several times it did not work. It eventually ceased to exist.[23]

Research reviewed as part of this report found death by suicide within correctional systems has typically been a leading cause of death. In fact, from 2001 to 2019 the number of suicides in state prisons increased by 85%.[24]

[20] Some of the cells in these unit were double-bunked when NDCS attempted to turn some galleries into general population units. Previous to that, those cells only had one bed.
[21] https://nebraskalegislature.gov/FloorDocs/105/PDF/Agencies/Inspector_General_of_the_Nebraska_Correctional_System/600_20180911-222502.pdf.
[22] Ibid.
[23] https://nebraskalegislature.gov/FloorDocs/106/PDF/Agencies/Inspector_General_of_the_Nebraska_Correctional_System/600_20190916-012617.pdf.
[24] https://bjs.ojp.gov/library/publications/suicide-local-jails-and-state-and-federal-prisons-2000-2019-statistical-tables.

FINDINGS

1. Two of the individuals in this report hung themselves by tying a bed sheet to the upper bunk. In 2016, an ICIR completed by NDCS staff recommended that TSCI should remove the second bunk and cabinet from all SMU cells.

2. Individual A died by suicide just weeks after an attempt to die by suicide. He was placed on Plan A status, then Plan B status, and placed back in his regular gallery approximately one week later.

3. NDCS Policy 115.30 states the "Chief Psychologist for Mental Health Services will designate a Mental Health team member who is not assigned to the affected institution to complete a Psychological Autopsy for all suicides and, as he/she deems appropriate, for attempted suicides." The OIG requested the psychological autopsies for Individual A and Individual B but did not receive them from NDCS.

4. NDCS staff appeared to respond appropriately and expediently to all three incidents. In reviewing these responses, the recording of audio and video from the body cameras on the staff at one facility was especially helpful and informative. At the current time, body cameras are only provided to selected staff at TSCI and the Nebraska State Penitentiary. They are not provided to any staff at the RTC despite it being the home of mental health and high security units.[25]

5. Two of the incidents resulted in a recommendation in the ICIR that staff should know the nature of the emergency to which they are responding.

6. In all three ICIRs for these deaths, none of the ICIR teams interviewed incarcerated individuals who may have either witnessed the death or had information regarding the individual who died. According to NDCS policy, "The ICIR shall be comprehensive and

[25] A recommendation regarding body cameras has previously been made by the OIG. (https://nebraskalegislature.gov/pdf/reports/public_counsel/2022_NDCS_controlled_movement_units.pdf – page 26).

meticulous in detail specific to the incident encompassing all relevant policy, procedure and practices/actions with the primary focus being to identify things done well and things to improve."[26] The policy does not state incarcerated individuals should or should not be interviewed as part of this process. In these cases, interviewing other incarcerated individuals would have provided additional information which would have allowed for a more comprehensive review.

7. A review of past investigations found NDCS established a work group in 2018 to look at suicides. It was led by staff from the Division of Health Services. They met several time and made multiple recommendations but only one was enacted. The enacted recommendation was ended by NDCS.

[26] NDCS Policy 203.02.

RECOMMENDATIONS

After careful consideration of the findings from this investigation, the OIG recommends the following:

1. NDCS should review the past work of the 2018 suicide work group and determine whether a special team should be established to focus on deaths by suicide and attempted deaths by suicide.

2. NDCS should review the requirement regarding psychological autopsies found in Policy 115.30 and determine whether these have been done in the past and whether this requirement should continue to be in NDCS policy.

3. NDCS should revisit the past NDCS recommendation regarding the removal of the second bunk and cabinet in all SMU cells.

4. NDCS should review the need to have staff wear body cameras in facilities other than the Tecumseh State Correctional Institution and the Nebraska State Penitentiary and consider providing them to staff assigned to each shift's emergency response team.

5. NDCS should review the ICIR process and determine whether interviews with individuals other than NDCS staff should be conducted in order to gather additional information related to this "comprehensive and meticulous" review.[27] If they determine such interviews would provide for a more complete review, Policy 203.02 should be changed to reflect this determination.

[27] NDCS Policy 203.02.

NDCS RESPONSE

Each time the OIG submits a report to the Director of NDCS, a letter is also attached which outlines the relevant state statute regarding the investigatory process. Under state statute, the Director has 15 days to accept, reject, or request in writing a modification of the recommendations made in the report. This letter was submitted along with the report to Director Jeffreys on June 10, 2024. It also included an offer to meet with NDCS staff about the report prior to their response and an openness to receiving any input on the summary report.[28]

On June 24, 2024, Director Jeffreys responded to the OIG via email and wrote, "I have received the report and will consider the recommendations."

The OIG later learned that on June 25, 2024, NDCS issued a policy directive signed by Director Jeffreys which went into effect immediately and stated:

> *"The mental health director/designee will designate a psychologist who is not assigned to the affected facility to complete a psychological autopsy for all suicides and, as he/she deems appropriate for attempted suicides."*

This would appear to be a result of Recommendation #2 in the report.

[28] Attachment A: June 10, 2024 letter from OIG to Director Jeffreys.

DOUG KOEBERNICK
Inspector General

ZACH PLUHACEK
Assistant Inspector General

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OFFICE OF INSPECTOR GENERAL OF CORRECTIONS
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June 10, 2024

Rob Jeffreys
Director, NDCS
P.O. Box 94661
Lincoln, NE 68509-4661

Dear Director Jeffreys:

The Office of Inspector General has completed an investigation into the deaths of three individuals who died while in the custody of NDCS.

I have presented our draft report to the Public Counsel and am now providing it to you. According to Neb. Rev. Stat. §47-915 you have 15 days to accept, reject, or request in writing a modification of the recommendations made in the report.

However, I would like to extend an offer to meet with you or members of your staff so that I could answer any initial questions or discuss any items in the report prior to your response. As in the past, I would also welcome any input on the summary of the report that will be issued at a later date by my office.

Sincerely,

Doug Koebernick