

# OMBUDSMAN'S REPORT

IN THE MATTER  
OF  
NIKKO JENKINS

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## Introduction

The situation involving former correctional inmate Nikko Jenkins, and the serious allegations that have been filed against Mr. Jenkins, have commanded public attention ever since he was first singled out for multiple murder charges on September 4, 2013. Of course, Mr. Jenkins is innocent until proven guilty, and is entitled to assert appropriate affirmative defenses to the charges against him. However, given the extent of our information about Mr. Jenkins' long, long history of odd, troubling, and sometimes antisocial, behavior, together with the serious questions that have been raised about his mental health, I believe that it is useful to examine his case to determine whether that history has any lessons to teach us about how our criminal justice system works, and about how the system might be changed to better manage those troubled/dangerous individuals who represent the system's "most difficult cases."

Nikko Jenkins has a history of involvement in the criminal/juvenile justice system that goes back at least to when he was seven years old, and was first placed in foster care by the State. In fact, even before he was first sent to prison in 2003, Nikko Jenkins had been incarcerated in the Douglas County Juvenile Detention Center multiple times. As a juvenile, Mr. Jenkins had multiple placements in group homes, and was also placed in the Youth Rehabilitation and Treatment Center in Kearney for about six months beginning in August of 2001, when he was fourteen years old. It goes without saying that Mr. Jenkins must take personal responsibility for his most recent criminal actions, if any, but even if he is not guilty of the allegations against him, his extensive history of troubling behavior and involvement in the criminal and juvenile justice systems is likely to be a deep and productive resource for those of us who are seeking insights into how those systems work...and into how those systems can sometimes fail.

Mr. Jenkins first entered the Nebraska correctional system in November of 2003, and the Ombudsman's Office has had a history of contact and involvement with Mr. Jenkins going back to May of 2007, when he initially contacted us to complain about his continued placement in Administrative Confinement, a classification that confined him to a segregation cell for 23 hours every day. Our involvement with Mr. Jenkins and his situation continued over the years right up to the time that he was discharged from the Nebraska State Penitentiary on July 30, 2013, and was thus no longer in the custody or control of any agency of State government. Over the years, our work in investigating Mr. Jenkins' complaints, and (in some instances) advocating on his behalf, covered three general areas:

1. Whether (and/or when) Mr. Jenkins should be released from Administrative Confinement (i.e., segregation);
2. Whether Mr. Jenkins was receiving proper and necessary services to address his mental health and/or behavioral health issues; and
3. Whether it would be desirable for the Nebraska Department of Correctional Services to develop and execute a comprehensive transition plan for Mr. Jenkins, so that he could receive all needed programming, and be gradually moved out of his solitary confinement in a segregation cell, and returned to the institution's general population before he was finally discharged and reintegrated into the larger community.

During our work on Mr. Jenkins' complaints, Ombudsman's Office had an opportunity to examine his situation in some detail, and to collect a large number of documents relating to his situation. Based upon this information, the goal of this report is to offer a narrative of our long involvement with Mr. Jenkins.

Needless to say, our prisons are occupied by many desperate, volatile, and sometimes very dangerous people, many of whom have significant mental health issues, and some of whom suffer from a serious mental illnesses. Mental health practitioners could, and did, differ over the question of whether Nikko Jenkins was mentally ill in the strict, clinical sense, but it seems to have been clear to nearly all mental health specialists who came into contact with Mr. Jenkins that he, at the very least, had some serious behavioral issues, with the potential for dangerous behavior. Throughout his career as an inmate in our correctional system Mr. Jenkins exhibited violent behaviors that repeatedly got him into trouble, and that resulted in his being placed in a segregation cell for a high percentage of his time in the system. During these periods of segregation Mr. Jenkins was locked up alone in a cell for 23 hours per day, and was, by definition, separated from most normal human contact with others for many months at a time. He was also isolated from all but the most rudimentary programming that might otherwise have been made available to him. Programming (for example the Department's violence reduction program) is generally available to inmates in the Nebraska correctional system, but those inmates in segregation are not allowed to have access to this programming, even though they often are some of the most troubled and dangerous inmates in the entire system. All of this might have mattered only to Mr. Jenkins and his family, if Mr. Jenkins had been destined to serve a long sentence in the Nebraska correctional system, but the cold, hard reality was that Mr. Jenkins was an inmate - an often antisocial, deeply troubled, and potentially psychotic inmate - who was likely to be released from State custody in mid-2013.

One of the most important issues involved in the analysis of Mr. Jenkins' case boils down to the basic question of whether he truly suffers from a mental illness, or whether his issues are merely behavioral in nature. Obviously, all of this matters very little to Mr. Jenkins' victims, and to their families, but the whole question of Mr. Jenkins' mental health, and whether he, in fact, has a "serious mental illness," is extremely important in analyzing how he was treated and managed in the criminal justice system. Of course, whether Nikko Jenkins in fact has a serious mental illness is a question that the Ombudsman's Office does not have the expertise or capacity to answer. As the reader of this report will see, however, there were a number of well qualified experts who have offered an opinion on this question (although those experts tended to arrive at sharply differing opinions on the subject). Our purpose in writing this report is not to weigh in on any side in the argument over whether Mr. Jenkins is mentally ill. Instead, insofar as that subject is concerned, we will simply provide an account of the basic facts that we have access to, and do so in the most straightforward and matter-of-fact way possible, to allow the reader decide for himself/herself what those facts disclose.

Our intent in writing this report is not to depict Nikko Jenkins as either the victim or the victimizer, or to demonize or dignify the actions of the Department of Correctional Services. Instead, our purpose is to simply state the facts as we know them to be, and let those facts speak for themselves. We are in a position to do this because we have extensive files of copies of Mr. Jenkins' mental health records that were provided to us while he was incarcerated in the correctional system. We are also able to do this because we have a release signed by Mr. Jenkins that authorizes us to collect additional medical/mental health records, if needed, and to disclose the content of those records. (Please see Attachment #1) We will begin with a summation of the history of Mr. Jenkins' placements within the Nebraska correctional system, and will end with a narrative of various interventions that the Ombudsman's Office had made in response to Mr. Jenkins' many complaints. We would, of course, recommend that those interested in this subject read the entire length of the report. However, those looking for a "shortcut" can get a good sense of the realities of the case by reading the report's final section, which is entitled "Impressions and Observations."

## **History of Mr. Jenkins' Placement in the Correctional System**

Nikko Jenkins was introduced into the Nebraska correctional system on November 11, 2003, when he was placed in the Nebraska Correctional Youth Facility following his conviction on multiple offenses which included two counts of Robbery, and one count of Use of a Weapon to Commit a Felony. Mr. Jenkins' sentence at this point was for an indeterminate term of fourteen to fifteen years. Later on, he was also sentenced to two years for one count of Assault in the Second Degree, which related to an assault that he committed while at NCYF. Mr. Jenkins' sentences for all of these four offenses were to be served consecutively, and, in the aggregate, provided for imprisonment for an indeterminate term consisting of a minimum of sixteen years and a maximum of seventeen years. It should be noted that when he received his first sentence (fourteen to fifteen years) Mr. Jenkins was given credit for 268 days of jail time, for months that he was held in custody prior to his sentencing. According to Nebraska's laws pertaining to good time and sentencing, this meant that Mr. Jenkins would be required to serve a minimum of eight years before he would be eligible for parole, and a minimum of eight and one-half years before he would be subject to discharge. However, in 2011 Mr. Jenkins was given an additional consecutive sentence of two to four years for Assault on a Correctional Employee, Third Degree, which extended his basic sentence to a term of from eighteen to twenty-one years. Of course, the calculation of this term would have to be adjusted to consider jail time credits, and also good time taken away from Mr. Jenkins by the Department of Correctional Services for acts of misconduct while incarcerated.

Mr. Jenkins would have been seventeen years old at the time of his commitment, which explains why he was first placed at NCYF. After being an inmate at NCYF for more than a year and one-half, on July 4, 2005, Mr. Jenkins was involved in aggressive actions in the yard of NCYF that the staff later characterized as being a "riot," or "near-riot" situation. One staff to witness this event described Mr. Jenkins as having hit another inmate in the head with his fists "more than ten times." The reports on this incident indicate that when the NCYF staff tried to intervene Mr. Jenkins ignored directives, and evaded staff for up to ten minutes, while he was engaging in physical attacks on other NCYF inmates. In all, as many as nine NCYF inmates were involved in this altercation. After this incident, Mr. Jenkins was placed in the segregation unit of NCYF, where he remained for 40 days. In addition, Mr. Jenkins was also processed through the DCS institutional disciplinary procedure, and lost 30 days of good time as a result of this event. Finally, a felony charge for Assault in the Second Degree was filed against Mr. Jenkins in Douglas County in connection with his having hit and kicked another inmate in the head, and he was ultimately sentenced to serve an additional consecutive term of two years for that offense.

Mr. Jenkins was placed in segregation at NCYF for an additional five days from December 15, 2005, through December 20, 2005, although he was destined to soon be transferred from NCYF to a different facility. This happened on February 20, 2006, when Mr. Jenkins was transferred from NCYF to the Lincoln Correctional Center (he was approximately nineteen and one-half years old at the time). On April 9, 2006, while still at LCC, Mr. Jenkins was placed in segregation, where he remained until he had to be transferred to Douglas County Jail for court proceedings. He remained in Douglas County from April 24, 2006, until May 9, 2006, when he was returned to LCC, where he was placed back in a segregation cell until May 11, 2006. Mr. Jenkins was back in Douglas County again from June 15, 2006, until August 31, 2006, when he was again returned to LCC. Mr. Jenkins received a misconduct report, and lost 30 days of good time for "tattoo activities" on October 20, 2006, and records indicate that on October 26, 2006 he was transferred from LCC, which is a maximum custody facility, to the Omaha Correctional Center, which is a minimum custody facility.

On January 4, 2007, Mr. Jenkins was allegedly involved in the assault of another inmate at OCC, with the other inmate being injured to the point that he required nine stitches to his upper lip. Mr. Jenkins was then placed in segregation at OCC, where he remained from January 4, 2007, through January 26, 2007. Mr. Jenkins was later charged with an act of misconduct under the DCS disciplinary system in connection with this alleged assault, however, when Mr. Jenkins' case was finally heard by the OCC Disciplinary Committee Mr. Jenkins was found not guilty of the assault, and the charge of misconduct was dismissed by the Committee. As a result, Mr. Jenkins did not lose any good time in relation to the alleged assault at OCC. (Please see Attachment #2)

On February 7, 2007, Mr. Jenkins was transferred back to LCC. However, a mere ten days later, on February 17, 2007, Mr. Jenkins was involved, along with two other inmates, in the assault of a Native American inmate. Because the target of this attack was supposed to be a leader of one of the gangs that were operating underground at LCC, and because Mr. Jenkins was understood to be a member of the Crips gang, it was assumed that the assault was gang-related. Mr. Jenkins allegedly struck the other inmate several times in the head, and one of the other assailants supposedly used a heavy padlock to bludgeon the Native American inmate. In fact, there were numerous fights at LCC on February 16 and 17, 2007, and it was assumed that they all might be gang-related. Following the assault on the Native American inmate on February 17, 2007, Mr. Jenkins was placed in the segregation unit at LCC. He was charged with misconduct through the institutional disciplinary process, and lost 45 days of good time in connection with the assault at LCC. Mr. Jenkins was later transferred to the Tecumseh State Correctional Institution on June 8, 2007. After his arrival at TSCI, Mr. Jenkins was immediately placed in TSCI's segregation unit as a classification action (Administrative Confinement), with the expectation that he would remain there indefinitely.

After more than a year in segregation at TSCI, Mr. Jenkins had progressed to the point that by August of 2008 he was included on the waiting list for placement in the Transition Program at the Nebraska State Penitentiary. The NSP Transition Program was the idea of former Director of Corrections Robert Houston, and was specifically designed to facilitate the gradual transition of inmates in Administrative Confinement (i.e., those in segregation) back into the institution's general population. However, it was during this period that Mr. Jenkins was heard articulating certain "homicidal ideations" and "threats to hurt others once he is released from incarceration," and so his name was ultimately removed from the waiting list for the Transition Program based on the recommendations of unit staff and TSCI's mental health staff.

Mr. Jenkins remained in segregation at TSCI from June 8, 2007, until December 4, 2008, when he was moved into a different unit at TSCI. On January 26, 2009, Mr. Jenkins approached staff in the TSCI yard and was taken inside for a search, which disclosed a homemade weapon (a toilet brush sharpened to a point) concealed in his waistband. At that point, Mr. Jenkins was returned to segregation and went through the TSCI disciplinary process resulting in the loss of 90 days of good time. Mr. Jenkins was disciplined two other times in 2009, on March 16 for Use of Threatening Language, and on May 8 again for Use of Threatening Language. On each of these occasions, Mr. Jenkins went through the institutional disciplinary process and lost 45 days of good time.

Mr. Jenkins remained in the segregation unit at TSCI until December 17, 2009, when he was given a temporary Travel Order that allowed him to be taken to Omaha under escort to attend the funeral of a relative. While he was at the church to attend this funeral, Mr. Jenkins attempted to escape from the

DCS staff, struck the escort in the face, and attempted to bite the staff person, as he was being secured in restraints. After Mr. Jenkins was secured, he was immediately transported back to TSCI, and was returned to segregation. Mr. Jenkins again went through the institutional disciplinary process, and lost 90 days of good time in connection with the incident in Omaha. Mr. Jenkins would also remain in segregation at TSCI until February 13, 2010, when he was transferred to the Douglas County Jail in connection with the adjudication of the criminal charges filed as a result of his aborted escape attempt.

Mr. Jenkins remained at the Douglas County Jail for approximately seventeen months, from February 13, 2010, to July 19, 2011. Although the Jail has its own version of segregation, it is our understanding that Mr. Jenkins remained in the Jail's general population through most of his stay there. Mr. Jenkins was ultimately convicted on the charge of Assault of a Correctional Employee in the Third Degree, and had an additional consecutive sentence of from two to four years added to his sentence. On July 19, 2011, he was returned to TSCI where he was immediately placed in segregation. While he was back at TSCI Mr. Jenkins lost more good time, including 90 days in October of 2011 for the Refusal to Submit to a Search, 45 days in January of 2012 for the Use of Threatening Language, and another 45 days in May of 2012. Mr. Jenkins would remain in segregation at TSCI for approximately twenty months until he was transferred from TSCI to the Nebraska State Penitentiary on March 15, 2013. The transfer to the Penitentiary would supposedly allow Mr. Jenkins to participate in the Transition Program at NSP. In reality, Mr. Jenkins never received the transition programming, and was kept in segregation status in Unit 4D while at NSP, until he was finally discharged from custody on July 30, 2013.

Altogether, Mr. Jenkins served a sentence that lasted from October 17, 2003, through July 30, 2013, a total of roughly 116½ months. However, because a significant portion of his sentence was served while in the Douglas County Jail, Mr. Jenkins was actually in the custody of the Department of Correctional Services for a total of about 97 months. Of that 97 months, approximately 58 months were spent in a segregation cell. In other words, Mr. Jenkins was being held in a segregation cell for nearly 60% of his time in the Department's custody. For the most part, that time served in segregation was the result of violent actions by Mr. Jenkins, including his involvement in a near-riot at NCYF on July 4, 2005, his alleged assault on another inmate on January 4, 2007, while at OCC, his involvement in an attack on an inmate at LCC on February 17, 2007, and his assault on a correctional employee on December 17, 2009, when he was in Omaha on a travel order. While he was serving his sentences in the correctional system, Mr. Jenkins lost a total of 555 days of good time in connection with his acts of misconduct as an inmate. However, a block of 30 days of good time was restored to Mr. Jenkins in November of 2007, while he was at TSCI.

## **History of Mr. Jenkins' Psychological and Behavioral Treatment in the Nebraska Correctional System Prior to February 13, 2010**

Throughout his stay as an inmate in the Nebraska correctional system Mr. Jenkins exhibited a proclivity toward violent/assaultive behavior, most of it directed at other inmates. However, Mr. Jenkins assault of a correctional employee on December 17, 2009, was definitely a watershed event in his history with corrections. Mr. Jenkins also exhibited a tendency at times to injure himself, including on August 17, 2009, when a DCS Sergeant reported that Mr. Jenkins threatened to choke himself, saying "I have a evil half and I'm going to kill it." This incident resulted in Mr. Jenkins being placed in an observation

cell. On April 8, 2012, Mr. Jenkins had to be placed in therapeutic restraints after he made threats to harm himself, and then on May 10, 2012, Mr. Jenkins was observed as having two large cuts on his face and forehead, which staff suspected had been self-inflicted by banging his head against a metal shelf in his cell. Photographs of Mr. Jenkins show a man with heavy tattooing on his neck and on the left side of his face, with additional facial scarring that appears to be the result of self-inflicted wounds.

Mr. Jenkins also had a significant history of verbalizing threats of violence against others while he was incarcerated in the correctional system. On August 25, 2008, Mr. Jason Hurt, a Unit Manager at TSCI, reported on two conversations that he had with Mr. Jenkins. According to Mr. Hurt, he spoke with Mr. Jenkins on July 22, 2008, at which time Mr. Jenkins said "he's just going to randomly go to suburban houses and start killing people outside of North Omaha, maybe go to Tecumseh or Syracuse with his gang members and start killing people." Mr. Hurt also reported that he had spoken with Mr. Jenkins on July 31, 2008, at which time Mr. Jenkins "expressed the same desire to kill the administration and other people when he gets out of prison." In addition, Mr. Hurt indicated in his Incident Report that he had reported both of these two conversations to the TSCI Mental Health staff, and that one of those Mental Health professionals, Connie Boerner, had stated that "she has had similar conversations with Jenkins and...that he is a very dangerous individual." In fact, Ms. Boerner has recorded her observations of Mr. Jenkins in a memorandum sent to Mr. Hurt, and dated August 11, 2008. That memorandum included the following language:

Inmate Jenkins has expressed having ongoing homicidal ideations and has made threats to hurt others once he is released from incarceration. He went into detail as to how he would kill others, similar to the recent Von Maur shootings. Inmate Jenkins appears sadistical and potentially harmful, due to homicidal ideations and ongoing verbal intentions to hurt others upon release.

Ms. Boerner indicated that she was providing this information to Mr. Hurt "to assist in determining Inmate Jenkins's suitability for the Transition Program."

Mr. Jenkins' odd behavior continued in 2009, although for a time it appeared that he might be making progress. In fact, Mr. Jenkins was released from segregation from December 4, 2008, until January 26, 2009, a situation which probably put him less "under the microscope" in the sense of being audited by staff at TSCI. However, on January 15, 2009, Heidi Widner, a Mental Health Practitioner at TSCI, had a conversation with Mr. Jenkins in which Mr. Jenkins complained to her about what he characterized as "institutional wrongdoing." The TSCI Mental Health Contact Notes from that meeting relate that:

(Mr. Jenkins) denied difficulty adjusting to (general population), but said the two years he did in segregation had ruined him for life and made him very mentally ill due to the abuse he suffered at the hands of staff. (Mr. Jenkins) said that he was unjustly held in segregation as he had gone two years MR free. (Mr. Jenkins) said that this is a breeding ground for the criminally insane and that staff intentionally berate and abuse inmates because staff want inmates to go kill their own kind when they get out...(Mr. Jenkins) spoke about the life of crime that awaits him once he is out...that his crimes and killing will not be limited to just his own kind...and that it was the worst thing possible for him to have been thrown in the hole for two years. (Mr. Jenkins) also talked about how dismissed he felt and that he had been in the system for a long time and that no one has

provided him with the skills or tools to make his life different.

The Mental Health Contact Notes for January 15, 2009, further indicate that Mr. Jenkins “talked about being sexually abused when he was younger, and being exposed to violence at a very young age,” and that he said that “it was helpful to come and vent and get everything off of his chest.”

After he had been returned to segregation in late January of 2009, Mr. Jenkins was again in contact with TSCI Mental Health staff, in this case with Ms. Boerner. On February 23, 2009, Mr. Jenkins spoke with Ms. Boerner and expressed his frustration with “the isolation in seg that he feels is making him 'homicidal.’” Mr. Jenkins indicated that he “fantasizes of 'killing' others once he is released.” Mr. Jenkins also stated that “he sees himself 'destined' to be a 'homicidal maniac.’” In the Mental Health Contact Notes relating to the interview, Ms. Boerner said:

No specific person identified by inmate, but MHP is concerned about inmate's intention to act upon HI (presumably “homicidal ideations”), once released. Inmate denies any intention to harm anyone while incarcerated. MHP will consult with Dr. White/Weilage for further guidance. (Note: Dr. Cameron White is the Department's Behavioral Health Administrator, and Dr. Mark Weilage is the Assistant Administrator for Mental Health.)

Following this interview, Ms. Boerner decided that it would be advisable to “refer (Mr. Jenkins) to Dr. Weilage for further evaluation and assessment,” and also to prepare an Incident Report on the interview “to warn staff to be careful given (Mr. Jenkins') comments.”

Following the referral discussed in the February 23 Contact Notes, Dr. Mark Weilage, the Department's Assistant Administrator for Mental Health, interviewed Mr. Jenkins in the TSCI Segregation Unit on March 27, 2009. Dr. Weilage's Notes from that interview include the following:

He discussed his belief that he is schizophrenic and multiple personalities. His personalities are a serial killer, an (?) gangster, and Nikko...He is interested in “rehab” and the MHU (Mental Health Unit) at LCC.

With respect to the idea of sending Mr. Jenkins to the DCS Inpatient Mental Health Unit at LCC for treatment, Dr. Weilage noted that it was “not clear if he would be appropriate.” Dr. Weilage said that he would “follow up in 2 weeks.” As a matter of fact, Mr. Jenkins was never transferred to the Inpatient Mental Health Unit at LCC at any point before his eventual discharge on July 30, 2013.

On May 13, 2009, TSCI Unit Manager Shawn Sherman submitted a Mental Health Referral reporting that Mr. Jenkins “claims to be hearing the voice of an Egyptian god...telling him to massacre children.” Two days later, another Mental Health Practitioner, Stacy Simonson, met with Mr. Jenkins in response to this referral. After speaking with Mr. Jenkins, Ms. Simonson reported that Mr. Jenkins “does not appear to be psychotic,” and suggested that his statements were “attention seeking” in nature. In the Mental Health Contact Notes, Ms. Simonson also observed that Mr. Jenkins was “highly narcissistic, anti-social,” and that he had a “personality disorder.” She also mentioned that Mr. Jenkins “refuses consideration of any intervention.” On July 17, 2009, another mental health professional reported a discussion with Mr. Jenkins at his cell door. The Mental Health Contact Notes relating to that event mentions that it was “the opinion of long-term custody staff that (Mr. Jenkins) is basically afraid of



everyone and is a 'coward.'" However, the Mental Health Contact Notes also include the remark that Mr. Jenkins "appears to be at considerable risk for reoffending and for interpersonal violence."

As previously noted, on August 17, 2009, Mr. Jenkins threatened to choke himself, and was placed in an observation cell with a directive for unit staff to conduct checks of his status every 15 minutes. On August 27, 2009, the psychiatrist at TSCI, Dr. Norma Baker, visited with Mr. Jenkins and found that he reported that he was "feeling better." Dr. Baker summarized her observations of Mr. Jenkins by using terms like "cooperative with good eye contact," "less agitated, remains intense," "speech spontaneous," and "talkative with rapid speech." Dr. Baker also related that Mr. Jenkins' was "extremely narcissistic" although his "thoughts appear fairly well managed." It is notable that, in fact, this was a period during which Mr. Jenkins was actually receiving medication for his mental health/behavioral health issues, in particular Risperidone and Depakote. Although Risperidone is characterized as being an "antipsychotic drug," it is our understanding that Risperidone and Depakote will typically be prescribed not only for patients with a "serious mental illnesses" like schizophrenia, but also for patients who have other kinds of mental health issues, including major depressive disorders, bipolar disorders, PTSD, self-injury, and and panic disorders, among others. In other words, the simple fact that Mr. Jenkins had been receiving these two drugs would not necessarily be inconsistent with the diagnosis that Mr. Jenkins' problems were not, in fact, a case of schizophrenia or of a schizoaffective disorder. On the other hand, this also demonstrates that a patient, like Mr. Jenkins, would not need to suffer from schizophrenia in order to be prescribed, and benefit from, these medications. Dr. Baker related that during the August 17 meeting with Mr. Jenkins she discussed with him "coping skills, anger issues," and also "the importance of med compliance." Finally, in her notes from that meeting, Dr. Baker discussed her plans to continue, and to adjust, the Risperidone and Depakote being prescribed for Mr. Jenkins.

Dr. Baker next saw Mr. Jenkins on October 8, 2009. In her notes from that meeting, Dr. Baker reported that Mr. Jenkins was "compliant and tolerating medications." Dr. Baker reported that he denied that he was having any "difficulty with energy or concentration." Dr. Baker also observed that Mr. Jenkins' "thoughts appear fairly well organized," and were "less paranoid overall." In addition, she observed that Mr. Jenkins was "a little calmer...remains somewhat intense and narcissistic," with "less paranoia overall," and less difficulty with "anger/aggressive behaviors." Once again Dr. Baker discussed her plans to continue the medication regimen, and to eventually make adjustments to the Risperidone and Depakote dosages that were being prescribed for Mr. Jenkins.

These relatively positive reports on Mr. Jenkins started to change when Dr. Baker next saw him on December 3, 2009. Dr. Baker's notes reflect that Mr. Jenkins told her that he had discontinued taking his medications three days earlier "as he doesn't feel they help him and he does not want to take them." She reported that Mr. Jenkins had denied "feeling depressed or anxious," or any "feeling of anger/rage towards society in general." However, Mr. Jenkins again mentioned hearing the voice of an "Egyptian god" who wanted him "to harm others," and although Dr. Baker's notes used terms like "less paranoid overall," and "fairly stable," she also noted that Mr. Jenkins appeared "more hypomanic/agitated." Dr. Baker's notes further indicate that Mr. Jenkins said that he was willing to continue to work with Mental Health staff, and that he "feels 'counseling' is most beneficial for him." Because Mr. Jenkins stopped taking the medications, Dr. Baker said that she intended to discontinue the Risperidone and Depakote scripts due to his "refusal." Dr. Baker's notes for December 3 concluded with the statement that Mr. Jenkins "appears to be meeting his basic needs at this time," and that he "is not an imminent danger to himself or others at this time." Dr. Baker said she intended to see Mr. Jenkins again in two months, or

“sooner if needed,” but circumstances with Mr. Jenkins' case were dramatically altered just two weeks later, on December 17, 2009, when Mr. Jenkins had his travel order to Omaha, and attempted an escape which resulted in the assault of a correctional staff person.

Immediately after his escape attempt and assault of the corrections employee on December 17, 2009, Mr. Jenkins was returned to TSCI, and placed in segregation. The next day, December 18, 2009, Mr. Jenkins spoke with Katherine Stranberg, another Mental Health Practitioner working at TSCI. The notes from that meeting indicate that Mr. Jenkins “seemed upset and regretful over the events” of the previous day, but that he “did not take responsibility for his actions, choosing instead to blame the evil Opophus who dwells in him.” According to the notes, Stranberg suggested that Mr. Jenkins “should consider taking medications to weaken the voice of Opophus,” and the notes reflect that Mr. Jenkins “seemed willing to consider the possibility, and stated he would send a medical request to Dr. Baker.” The notes from the December 18 meeting also reflect that Mr. Jenkins “reported that he wanted to go to the Inpatient Mental Health Unit (at LCC) because there he would be able to get the ongoing treatment he needed.” In fact, this request/statement by Mr. Jenkins was but one of many such requests that he would make in which he was asking, in essence, to be hospitalized for his mental health issues. As a matter of fact, however, Mr. Jenkins would never be hospitalized for treatment of mental health issues.

On December 28, 2009, Mr. Jenkins sent a Health Services Request Form to Dr. Baker reporting that the “voice” in his mind was telling him to “hurt guards,” and to “start war between good and evil,” and that he would “take the pills,” because he did not want to “feel this way.” Dr. Baker responded the next day, December 29, 2009, by re-initiating the prescriptions for Risperidone and Depakote, which the doctor said “should help stabilize (Mr. Jenkins') symptoms.” Dr. Baker's next notation that concerned Mr. Jenkins is dated December 31, 2009, just two days after she had prescribed the Risperidone and Depakote. In that December 31 note, Dr. Baker reported that after a discussion of Mr. Jenkins' “mental status” with the TSCI Mental Health staff, she concluded that Mr. Jenkins' symptoms “***are inconsistent and more behavioral/Axis II*** (i.e., personality disorder) ***in nature.***” (emphasis added) In addition, Dr. Baker's notes also suggest that Mr. Jenkins was actually attempting to use his mental health symptoms “for secondary gain, including to avoid legal consequences in court for (his) recent behaviors.”

As a matter of fact, while this December 31, 2009, diagnosis by Dr. Baker might seem inconsequential to the layperson, the reference to Mr. Jenkins having “Axis II” disorders is significant in terms of the kind of treatments that TSCI staff might be offer to Mr. Jenkins in terms of helping him to manage his thoughts and his actions. Also, an Axis II diagnosis for Mr. Jenkins is not something that was clearly reflected in earlier mental health notes that we have seen relating to Mr. Jenkins' problems, and how those problems might be correctly categorized. It should also be noted that the TSCI Mental Health records further indicate that on the same day that this Axis II diagnosis was made, the prescription for Mr. Jenkins to receive Risperidone was ordered to be discontinued, even though that medication had just been prescribed by Dr. Baker a mere two days earlier.

Mr. Jenkins' behavior in early 2010 is notable. On January 9, 2010, Mr. Jenkins sent a Health Services Request Form to Dr. Baker asking to know “the reason I was taken off Risperidal,” saying that “I need that medication it helped my symptoms of the voice of Opophis and remaining stable in reality.” On January 10, 2010, TSCI Caseworker Howell reported in a Mental Health Referral that Mr. Jenkins had “exhibited increasingly aggressive behavior in the past week...claiming to hear voices telling him to injure staff.” On January 11, 2010, Mr. Jenkins' prescription for Depakote was discontinued, with the

notation of “due to refusing.” The answer to the Caseworker's referral from the TSCI Mental Health staff was, “Thank you for the information, Mental Health will follow up.”

## **History of Mr. Jenkins' Psychological and Behavioral Treatment in the Douglas County Jail from February 13, 2010 Through July 19, 2011**

On February 13, 2010, Mr Jenkins was transferred from TSCI to the Douglas County Jail in connection with the adjudication of the new criminal charges against him relating to the incident on December 17, 2009, when he assaulted a correctional employee while he was in Omaha on a travel order. Mr. Jenkins was to remain in the Douglas County Jail until July 19, 2011, which was about one week after he had been sentenced for that offense by District Judge Gary B. Randall. Throughout his time at the Douglas County Jail, Mr. Jenkins was in frequent contact with the Mental Health staff at the Jail. To understand the treatment that our criminal justice system provided for Mr. Jenkins in connection with his mental health/behavioral health issues, it is important to provide an account of how his case was handled by the mental health professionals at the Douglas County Jail.

On the same day of his arrival at the Douglas County Jail, Mr. Jenkins was seen by the Jail's medical staff. Mr. Jenkins told the medical staff that he had a “diagnosis (of) Bipolar and Schizophrenia...and was on Risperdal and Depakote.” He also told the medical staff that he was “hearing voices all the time.” As a result, he was immediately referred to the Jail's mental health staff via a Staff Referral Form including the notation “inmate states Tecumseh prison was holding medication, no meds since December 2009.” It should be emphasized that Correct Care Solutions, which is a private medical care provider, had been retained to provide medical and mental health services at both the Douglas County Jail, and at the Tecumseh State Correctional Institution.

Throughout his stay at the Douglas County Jail, Nikko Jenkins' condition was closely monitored by a Licensed Mental Health Practitioner, Denise Gaines. It appears that Ms. Gaines first saw Mr. Jenkins on February 16, 2010, three days after he had arrived at the Jail. At that time, Mr. Jenkins informed Ms. Gaines that “he was on meds at Tecumseh until December '09,” which Ms. Gaines recorded, along with the notation that Mr. Jenkins had said that he “began refusing his meds.” Ms. Gaines met with Mr. Jenkins again on February 19, 2010, and the Mental Health Progress Notes from that meeting reflect that:

Patient provided an extensive history of abuse (physical/sexual) and history of drug, alcohol abuse as well. Patient indicated he has been institutionalized starting at age 11.

Ms. Gaines' notes from February 19 further indicate that Mr. Jenkins “spoke openly about (his) anger issues...(and) spoke about having other personalities that he fights to control.” Ms. Gaines also noted that Mr. Jenkins said that he “was on Depakote and Risperdal at Tecumseh and would like to resume taking these meds.” In offering her own observations of Mr. Jenkins, Ms. Gaines said that:

inmate is or appears to (be) intense...Patient reported hearing voices in his head. Patient may benefit from medications as it appears he may have problems with intermittent explosiveness...Patient was calm, cooperative, grandiose at times, no suicidal/homicidal ideations, delusional (?).

Ms. Gains' notes conclude with the statement that a follow up visit would be scheduled, and that she would “refer to psych for evaluation.”

Mr. Jenkins' situation was first addressed by the psychiatrist at Douglas County Jail, Dr. Eugene Oliveto, on February 22, 2010. On that day, Dr. Oliveto wrote orders reflecting a need to “reorder medications prescribed at Tecumseh.” Dr. Oliveto's orders also note the need to obtain the “records from Tecumseh prison to order medications - need doses of Risperdone and Depakote.” Ms. Gains next saw Mr. Jenkins five days later on February 27, 2010, and visited with him in greater depth about his condition. Ms. Gains' notes on that meeting include the following entry:

Patient also talked about the horrific acts that the Egyptian god Opophus (sp.) wants him to inflict on Catholics, whites, and children...Patient stated he knows these things are wrong, but the god-Opophus tells him to do these things.

Significantly, the notes of the February 27 meeting included the notation “mental health will continue to meet with inmate weekly or more if needed.”

Ms. Gains next saw Mr. Jenkins on March 1, 2010, when she spoke to him briefly “in Mod 20,” at which time Mr. Jenkins “went on a rant about getting his meds before he becomes more violent.” The Physician's Orders relating to the time that Mr. Jenkins was at the Douglas County Jail indicate that he was seen by the psychiatrist, Dr. Oliveto, on March 3, 2010, and that Mr. Jenkins was eventually given a prescription for Risperdal - 1 mg., and Depakote - 500 mg. Also, on March 4, 2010, Dr. Oliveto added a notation to the Physician's Orders to the effect that Mr. Jenkins “needs a forensic psychiatric evaluation at Lincoln Regional Center.” It would appear that medications were actually commenced on or about March 10, 2010. However, in a note that is dated March 15, 2010, Dr. Oliveto indicated that he was going to discontinue the Risperdone and Depakote due to the fact that the “patient refused after asking for them.”

The next notation of a visit by Ms. Gains with Mr. Jenkins is dated April 8, 2010. The notes of that meeting reflect that Mr. Jenkins talked about personal issues, and about how “different relationships affect him.” Ms. Gains reported that she advised Mr. Jenkins that “Mental Health and patient need to create a treatment plan.” Ms. Gains said that she observed that Mr. Jenkins was “cooperative, (with) good eye contact, no suicidal/homicidal ideations, pleasant.” However, Dr. Oliveto again remarked in the Physician's Orders, dated April 23, 2010, that Mr. Jenkins “needs forensic psychiatric evaluation at Lincoln Regional Center.” There is also a document from April 23, 2010, that appears to reflect Dr. Oliveto's own diagnosis of Mr. Jenkins' condition, which reads as follows:

Axis I – *Schitzoaffective disorder vs. bipolar I* (emphasis added)

Axis II – Anti-social/Impulsive/Obsessive

(Please compare this diagnosis to Dr. Baker's note of dated December 31, 2009, indicating that Mr. Jenkins' symptoms were “inconsistent and more behavioral/Axis II in nature.”) The April 23, 2010, document signed by Dr. Oliveto also includes, once again, the notation that Mr. Jenkins “needs to be

evaluated at LRC.”

Part of the adjudication of the pending criminal charges against Mr. Jenkins involved an evaluation to determine whether he was mentally competent to stand trial on those charges. This evaluation was to be done by psychiatrist Dr. Y. Scott Moore. Dr. Moore had familiarized himself with the police report on the allegations against Mr. Jenkins, and also met with and interviewed Mr. Jenkins at the Douglas County Jail on July 20, 2010, at which time Mr. Jenkins described his psychiatric symptoms, including hearing “voices.” In summarizing his impressions of Mr. Jenkins' condition in a July 20, 2010, letter to Judge Randall, Dr. Moore said:

***I think that the possibility of a psychotic illness is present, but I do not think that it is a very good possibility. The descriptions that Mr. Jenkins gives me of his psychotic symptoms appear to me to be thought out and probably acquired from someone else.*** They don't really follow the usual path of auditory hallucinations. It also appeared to me that when I did not instantly accept his description of the symptoms, he began to add to them and sort of “played it by ear” adding more and more symptoms to the mix that he had. I believe ***his major diagnosis is Antisocial Personality Disorder, and I doubt the presence of psychosis.*** (emphasis added)

Dr. Moore concluded that Mr. Jenkins was competent to stand trial, and that Mr. Jenkins did not have a condition that would qualify him to raise an insanity defense to the criminal charges pending against him. Dr. Moore's fundamental conclusion with regard to Mr. Jenkins' condition was that while “there is the possibility that Mr. Jenkins does indeed have a psychotic illness, I don't think this is a very good possibility.”

Records reflect that Ms. Gaines again saw Mr. Jenkins on August 7, 2010. Ms. Gaines' notes on that meeting include the following entry:

Patient stated that he continued to feel as though he is losing grip and “Opophus” is taking over...Patient stated that he is trying to get help but the system is not listening. He said that Opophus is telling him that the day is coming soon that “they will see.” “When Opophus takes over that's it.” Patient spoke of how he is fighting the voice in his mind (Opophus) to destroy Catholics and Christians...continued with homicidal rant about Opophus taking him over and him killing others once released from prison if he doesn't get some help.

Ms. Gaines followed up with a meeting with Mr. Jenkins on August 12, 2010. At that meeting Ms. Gaines observed that Mr. Jenkins was “cooperative, good eye contact, calm, still appears delusional (i.e., Opophus).” In her notes Ms. Gaines said that Mr. Jenkins “continued to state that he wants help fighting his 'mental illness' because he wants to be there for his family,” and that Mr. Jenkins had also acknowledged that it was “helpful to speak with the Mental Health Professional weekly.”

Ms. Gaines had a routine follow-up session with Mr. Jenkins on September 14, 2010. On that occasion, Mr. Jenkins “stated that he feels more and more that 'the evil is overwhelming the good in him.’” Ms. Gaines reported that at this meeting Mr. Jenkins also continued to “express his desire to get the proper mental health care before leaving NDOC.” Ms. Gaines added the personal observation that she was

“concerned that this client is going to act on the delusion of Opophus once released from prison.” One week later, on September 21, 2010, Ms. Gaines again met with Mr. Jenkins because he had requested “to be on his meds again.” Ms. Gaines' notes from this session indicate that Mr. Jenkins “stated he is losing his grip and doesn't know how much longer he can maintain,” and that “Opophus is taking over and nobody believes him or wants to give him the proper treatment needed.” She also noted that Mr. Jenkins was “mad at 'the system' including this MHP because he feels as though he is not getting the proper psychiatric mental health care.” Ms. Gaines referred Mr. Jenkins to the psychiatrist, presumably because of his interest in reinstating the medications.

Dr. Oliveto saw Mr. Jenkins on the following day, September 22, 2010. Dr. Oliveto's Follow-up Notes include these remarks:

Still psychotically obsessed with plot to kill him or set him up to kill others here like in Tecumseh. He is psychotic, delusional, but has refused meds. Was evaluated by LRC psychiatrist, but no transfer done. Appears intense with dramatic behavior that can evoke fear in others...Has refused medications but wants them now if I can guarantee no one will tamper with them.

On this occasion, Dr. Oliveto's diagnosis of Mr. Jenkins' condition was summarized as follows:

Axis I – *Schitzoaffective disorder vs. paranoid schizophrenia* (emphasis added)

Axis II – Anti-social/Obsessive/Impulsively dangerous to others/Explosive

Dr. Oliveto's September 22, 2010, Follow-up Notes on Mr. Jenkins conclude with the statement “needs transfer to LRC.” In conjunction with his observations, as reflected in his Follow-up Notes, Dr. Oliveto wrote an order that included a prescription for Risperdone - 2 mg., and Depakote - 500 mg. (It should be noted that the prescription for the Risperdone was double the dosage that had been prescribed by Dr. Oliveto on March 3, 2010.) Dr. Oliveto's Order also included the following statement: “*Needs transfer to LRC before his discharge to stabilize him so he is not dangerous to others.*” (emphasis added)

Ms. Gaines had a regular follow-up session with Mr. Jenkins on October 8, 2010. Ms. Gaines' Progress Notes from that session state:

Client discussed that he is trying to get help for his mental disorder. Client states “he doesn't want to kill Christians and Catholics.” Client expressed sadness about being mentally ill, but was adamant that he needs help...Client continued to complain that the system does not believe that he will follow through on killing people when he gets out of prison.

Ms. Gaines concluded her October 8, 2010, Progress Notes with the following observation - “This writer sincerely believes that this client wants help, but is giving up on anyone (the system) providing him with help.”

Ms. Gaines' had another follow-up session with Mr. Jenkins on November 13, 2010. The records of that session reflect that Mr. Jenkins returned to the recurring theme of his odd delusions. In her notes,

Ms. Gaines said that Mr. Jenkins “continues to talk about the destruction that Opophus wants him to inflict on Caucasians, Christians, and Jews.” She said that he had denied “wanting to follow on this, but continued to ask for ‘the proper help.’”

All that had gone on up to this point in terms of the sessions that Ms. Gaines and Dr. Oliveto had with Mr. Jenkins led up to the production of a document which summarized their professional opinions, and their profound concerns, in regard to Mr. Jenkins, his condition, and the implications for society. The document in question is a December 1, 2010, letter addressed to the Nebraska Board of Parole, a letter signed by Ms. Gaines. (It is our understanding that the Department of Correctional Services received a copy of this letter and/or that DCS staff had access to it in Mr. Jenkins' mental health records.) In this letter Ms. Gaines said the following:

*I have worked with Mr. Jenkins since he arrived at our facility in February, 2010. He has been evaluated by Dr. Eugene Oliveto, the attending psychiatrist at Douglas County Corrections. He was diagnosed by Dr. Oliveto with Schitzoaffective disorder vs. paranoid schizophrenia and in his last evaluation, it was recommended by the psychiatrist that he be transferred to Lincoln Regional Center for treatment before being discharged (from the correctional system) for “stabilization so he is not dangerous to others.”*

During the time that I have worked with Mr. Jenkins, he has been compliant and has not acted out behaviorally since coming to Douglas County Corrections. He has been on and off psychotropic medications since being detained here; however, he refused to take them because of how he felt on the medication.

*Based on his history, current psychiatric state (i.e., fixation with Apophis - Egyptian god of war) and recommendations by Dr. Oliveto, it is requested that Mr. Jenkins continue to receive mental health treatment at a facility (if possible) and if paroled, mental health treatment to be a condition of parole. He has expressed to this writer that he desires to “get well” and would like to get the treatment he needs in order to work through issues such as grief and getting rid of “Apophis.” (emphasis added)*

Obviously, it is possible for reasonable mental health professionals to differ in their diagnosis of the condition of the same patient, but in Mr. Jenkins' case there was a rather surprising convergence of different opinions, from Dr. Baker's conclusion that Mr. Jenkins' symptoms were “inconsistent and more behavioral/Axis II in nature,” to Dr. Moore's opinion that “there is the possibility that Mr. Jenkins does indeed have a psychotic illness, (but) I don't think this is a very good possibility,” to Dr. Oliveto's diagnosis of “Schitzoaffective disorder vs. paranoid schizophrenia,” with a recommendation that Mr. Jenkins would need to be transferred to the Lincoln Regional Center “before his discharge to stabilize him so he is not dangerous to others.” (Please see Attachment #3)

Shortly after writing this letter, Ms. Gaines again saw Mr. Jenkins for a routine follow-up on December 11, 2010. Ms. Gaines Progress Notes from that session include the following:

Met with client in the medical clinic. He was very open and expressive during this session. Client seems scared about being released because of the violence that he is (through Apophis) inflict on people and police. Client expressed fear about losing

control and does not want to.

Mr. Jenkins expressed a similar concern to Ms. Gaines at a routine session on March 25, 2011. In that instance, Ms. Gaines' Progress Notes recorded that Mr. Jenkins "continued to express thoughts about doing murderous acts on society (i.e., killing/torturing nuns, children, etc.)." She also recorded that Mr. Jenkins "continues to struggle with thoughts and indicates that he doesn't want to do these things, but feels the destructive acts at his hand are inevitable."

On July 11, 2011, Mr. Jenkins was sentenced by the District Court of Douglas County in connection with the Assault on an Officer, Third Degree, charge connected with the escape attempt and assault at the funeral on December 17, 2009. Mr. Jenkins had entered a plea of No Contest to the charge, and was sentenced to a term of from two to four years, which sentence was to run consecutively to his other sentences. The sentencing Order, signed by sentencing Judge Gary B. Randall, is remarkable for the inclusion of the following paragraph:

The Court notes for the benefit of the Department of Corrections that at the sentencing the Defendant requested treatment for his mental health issues. The record in this case would support the Defendant's request, although competent to stand trial, and not mentally incapacitated at the time of committing this crime, the Defendant has a long and serious history of mental illness which inhibits his ability to be rehabilitated. ***The Court therefore recommends to the Department of Correctional Services that assessed and treated for issues regarding his mental health.*** (emphasis added)

We should particularly note that when Judge Randall included this language in his sentencing Order he had presumably already seen Dr. Y. Scott Moore's assessment of Mr. Jenkins, and nevertheless made his recommendation for Mr. Jenkins to receive an assessment and treatment "for issues regarding his mental health" based upon an acknowledgment by the Judge that Mr. Jenkins had a "long and serious history of mental illness." (Please see Attachment #4) Of course, while the Department of Correctional Services Mental Health staff might have followed up on Judge Randall's recommendation, presumably their action or inaction in that regard would have been partly influenced by the fact that Dr. Baker had already determined, on December 31, 2009, that Mr. Jenkins' symptoms were actually "inconsistent and more behavioral/Axis II in nature."

### **Management of Mr. Jenkins' After His Return to TSCI on July 19, 2011**

On July 19, 2011, with the adjudication of his criminal charges in Douglas County having finally been completed, Mr. Jenkins was returned to the Tecumseh State Correctional Institution. During the time that he was held at the Douglas County Jail, Mr. Jenkins had received more or less regular counseling sessions with Ms. Gaines, a Licensed Mental Health Practitioner, and had also received, off and on, medications to address his perceived mental health issues. It is our understanding that Mr. Jenkins had been able to function with a relative degree of success in the general population of inmates during the roughly seventeen months that he was at the Douglas County Jail. However, upon his return to TSCI Mr. Jenkins was immediately returned to a segregation cell, where he was to remain for almost all of the remaining two years of his incarceration in the Nebraska correctional system. Notwithstanding the unusual recommendation from Judge Randall to the effect that the Department of Corrections should see to it that Mr. Jenkins was "treated for issues regarding his mental health," the involvement of DCS



Mental Health staff with Mr. Jenkins after his return from the Douglas County Jail was, for the most part, limited to evaluation and occasional visits at Mr. Jenkins' cell door. Mr. Jenkins did not receive any psychotropic drugs after his return to the custody of DCS in July of 2011, although arguably that was due to the fact that he had stopped taking those drugs when they were prescribed for him in the past. On some occasions, Mr. Jenkins described this refusal as being motivated by a lack of trust for the DCS Mental Health staff.

Although Mr. Jenkins received somewhat limited mental health treatment while in the custody of DCS after July 19, 2011, he made it very clear that he was asking for more. In fact, Mr. Jenkins repeatedly asked to be provide with therapy to address his mental condition. In addition, he repeatedly requested to be transferred to the Inpatient Mental Health Unit at LCC. In addition, Mr. Jenkins even lobbied to be committed to the Lincoln Regional Center in order to receive treatment there. For example, when Mr. Jenkins was interviewed by DCS Mental Health staff on August 31, 2011, he said that he wanted to "parole" to the Lincoln Regional Center, and he reported that he "steps in and out of reality and that he was repeatedly being awakened by "terrors" every night when he was trying to sleep. In addition, Mr. Jenkins expressed "concern about his release...managing symptoms when nor in SMU...what would happen (revenge) without treatment including medications and intense therapy.." The notes from this meeting state that "treatment options were discussed."

On September 26, 2011, Mr. Jenkins was seen by Dr. Baker (apparently at his cell door). Dr. Baker observed that Mr. Jenkins had "complained about auditory hallucinations relating to harming others." Dr. Baker's notes state that she had observed "questionable delusions of grandiose type," and that Mr. Jenkins was "angry/verbally aggressive," with "significant narcissistic/antisocial traits/behaviors." In addition, Dr. Baker recorded that Mr. Jenkins told her that he had discontinued taking the Risperdal and Depakote prescribed by Dr. Oliveto at the Douglas County Jail, and that he was refusing to take those medications again, but that he was requesting "daily psychotherapy to help him cope." Dr. Baker also reported that Mr. Jenkins was "very focused on wanting to be transferred to LRC (the Lincoln Regional Center) and states he will only take meds if recommended if he is at LRC." The notes of Mental Health staff from when Mr. Jenkins was seen by two days later (September 28, 2011) reflect that he stated that the "Douglas County Mental Health had recommended psychotherapy and that TSCI Mental Health and the Department of Corrections was refusing him treatment." Those notes also reflect the opinion that Mr. Jenkins "did not present in a manner consistent with someone experiencing hallucinations or other psychotic symptoms," and that there were "no observable signs of mental illness."

It appears that Dr. Baker next saw Mr. Jenkins on December 23, 2011, while he was on the "yard" at TSCI. In her notes from that meeting, Dr. Baker stated that Mr. Jenkins continued to refuse to take psychotropic medications outside of the Lincoln Regional Center. The notes further reflect that Mr. Jenkins had reported that "he does have violent thoughts due to his traumatic past," and that, while he "denies he will harm anyone while incarcerated," Mr. Jenkins "feels he will hurt others when released back into the community." Mr. Jenkins was continuing to complain about his "intermittent auditory hallucinations," but Dr. Baker's impressions of Mr. Jenkins from this meeting included the observation that he was "easily agitated, manipulative, (and) argumentative," and that Mr. Jenkins presented with "questionable delusions of grandiose type." Dr. Baker was interested in having further testing of Mr. Jenkins, but she noted he had not been "cooperative with testing so far." Dr. Baker also mentioned the idea of discussing psychotropics and treatment options with Mr. Jenkins in the future, after "testing is completed and reviewed." Two days later, on December 28, 2011, Mr. Jenkins had an encounter with

Elizabeth Geiger, a DCS Clinical Psychologist. She reported that while Mr. Jenkins “reported going 'in and out of psychotic states all day every day,’” he displayed “no signs of psychosis or anger/agitation,” and that “no overt threats or aggression (were) noted.” She observed that while Mr. Jenkins “stated his belief that others do not take his mental illness seriously,” in this case “no signs of major mental illness (were) noted.”

On February 1, 2012, Mr. Jenkins had a meeting with Dr. Mark Weilage, the Department's Mental Health Director (presumably this was preparatory to a Mental Illness Review Team evaluation of Mr. Jenkins). During this meeting, Mr. Jenkins “specifically requested daily psychotherapy...stated (that) daily psychotherapy would help with his hypomania, stabilize his psychosis, and help him deal with the grief of confinement,” and said that “he would comply with medications, therapy, if transferred to LCC and comply with MHU expectations.” The notes from the meeting also record that Mr. Jenkins stated that “he wants help and if he does not get it from us then his first thought when he gets out is that he needs to 'get some weapons.’” Dr. Weilage's summary of the meeting with Mr. Jenkins included the observation that in all of his interactions with Mr. Jenkins, “his statements and behavior appeared well planned, purposeful and deliberate.” (It should be noted here that in the MIRT Referral/Review Form relating to this meeting with Mr. Jenkins, Dr. Weilage did acknowledge that he had access to, and had reviewed, “Psychiatric Provider Follow-up Notes written by E. Oliveto, M.D., received from Douglas County Corrections Mental Health Department.”)

A document that reflects the results of Dr. Weilage's examination of Mr. Jenkins and his condition for the purpose of the Mental Illness Review Team's evaluation of Mr. Jenkins (dated February 8, 2012) includes the following:

Since returning to Tecumseh State Correctional Institution, inmate Jenkins has been seen by licensed Mental Health staff for evaluation and/or monitoring on 10 occasions. It is the professional opinion of the evaluators that noted signs, and reported symptoms, do not indicate, or support, a diagnosis of Dissociative Identity Disorder (AKA Multiple Personality Disorder), Bipolar Disorder, Schizoaffective Disorder or any Psychotic Disorder. Nor does he meet the criteria for a diagnosis of Post Traumatic Stress Disorder (PTSD), at this time.

The MIRT document indicates that the “most recent diagnosis per Dr. Baker includes Psychosis NOS (“not otherwise specified”), possible Bipolar Affective Disorder with psychotic features or Delusional Disorder, Grandiose Type, Probable PTSD, Relational Problems NOS, Polysubstance dependence (and) Antisocial and Narcissistic Traits.” (The reference “NOS” is a category which would include psychotic symptoms, for instance, delusions or hallucinations, about which there is not adequate information to make a specific diagnosis, or about which there is contradictory information indicating symptoms that do not meet the criteria for any specific psychotic disorder.) Dr. Weilage reported having watched over three hours of video visits that Mr. Jenkins had with his mother and girlfriend, and observed that:

His presentation in video visits is of a person very clear minded and goal directed. He repeatedly instructs his mom and girlfriend to do all sorts of things related to monitoring staff, calling attorneys, filing appeals, making complaints, sending him money. He is very demanding and berates and belittles them.

In light of his review of documentation, including the review of the “records received from Douglas County,” the clinical interview of Mr. Jenkins, and his observation of the video visits, Dr. Weilage’s report to the MIRT team indicated that Mr. Jenkins’ “self-reported symptoms seem more consistent with Axis II diagnosis of Narcissistic and Antisocial Personality Disorder and some post-trauma experiences that have not developed into any Axis I disorder but instead have fostered the development and solidification of the Axis II disorders.” Having determined that “no acute mental health issues (were) noted,” and that the “predominant feature is a personality disorder,” the MIRT team concluded that a “transfer to the (Mental Health Unit) is not indicated or recommended at this time,” although the Team did suggest that Mr. Jenkins be “considered for the transition program at NSP to allow time in GP (general population) prior to discharge next year.”

On February 15, 2012, Dr. Weilage met with Mr. Jenkins at TSCI to “give him feedback about the MIRT review.” Dr. Weilage informed Mr. Jenkins that the team did not find him to be appropriate for a transfer to the Inpatient Mental Health Unit at LCC, and that, in fact, “the evidence seemed to point that there was not an Axis I severe mental illness present” to justify such a transfer. Dr. Weilage also said that he “discussed with (Mr. Jenkins) that there was still treatment that could be made available to him,” and that they “could look at individual therapy and working to get him to transition to general population and back to the community.” According to Dr. Weilage’s notes of the interview, Mr. Jenkins said “that he was not interested in any Mental Health services from (DCS) based on what (Dr. Weilage) had just told him.” Dr. Weilage also reported that, as security staff were escorting Mr. Jenkins back to his cell, Mr. Jenkins yelled back to him, “Remember Dr. Weilage, Tik Tok!”

At a meeting with TSCI Mental Health staff on March 23, 2012, for regular follow-up, Mr. Jenkins again reported problems sleeping, and mentioned “visions,” and that he was being “spoken to by the demonic forces.” In addition, Mr. Jenkins “insisted that he needed ‘intense psychotherapy’ before he was released,” and that the Mental Health staff should recommend that he “be placed in a psychiatric hospital immediately due to the high level of distress he was experiencing.” Instead, he was offered “materials in regard to distress management.”

Dr. Baker saw Mr. Jenkins again at his cell door on April 19, 2012. On this occasion, Dr. Baker said that Mr. Jenkins was “fairly cooperative,” but that Mr. Jenkins was “easily agitated/irritable,” and that he was, as before, having “questionable delusions of grandiose type,” with “significant narcissistic/anti-social traits/behaviors.” Dr. Baker reported that Mr. Jenkins expressed “concerns about what he will do once he is released from DOC,” and that he again said that he would like to be transferred to LCC or LRC for mental health treatment. Dr. Baker also made note that Mr. Jenkins “continues to refuse all psychotropics including Risperdal and/or Depakote until he can be transferred to LRC/LCC.”

On April 28, 2012, Mr. Jenkins made threats toward TSCI staff and threatened to harm himself, which resulted in his being placed in “therapeutic restraints.” On the following day, TSCI Mental Health staff interviewed Mr. Jenkins and recommended that he be returned to his cell, with “limited property,” and checks by staff every fifteen minutes. Apparently, on the same day Mr. Jenkins was again placed in therapeutic restraints after he broke the fire suppression head in his cell, and caused the cell to flood. Dr. Pearson saw Mr. Jenkins on the segregation unit on April 30, 2012. Dr. Pearson expressed that her own “psychological assessment” did not “show any basis for diagnosis (of) mental illness,” with the notation that the “risk for harm to others remains relatively stable to his baseline,” Dr. Pearson also noted that Mr. Jenkins “denies plans, intent or ideation for imminent threat.”

Mr. Jenkins was next seen by Mental Health staff on May 2, 2012, after he was found with two large cuts on his "face and forehead." Blood in his cell suggested that Mr. Jenkins had used a metal shelf in his cell to inflict the wounds to his face. It was reported that at this meeting Mr. Jenkins "expressed the belief that his 'psychosis' is changing and getting worse." In addition, it was noted that Mr. Jenkins had also "expressed frustration regarding the response to his reported mental health issues by Mental Health and Unit staff." When Mr. Jenkins was again seen by TSCI Mental Health staff on May 15, 2012, Mr. Jenkins "insisted that he was not receiving proper psychological/psychiatric/mental health treatment for his mental illness." Of course, back in February the Department's MIRT team had concluded that Mr. Jenkins' condition supported a diagnosis of no serious mental illness, and that Mr. Jenkins did not need to receive residential mental health services, and so at that point it was explained to Mr. Jenkins that he "had been assessed on more than one occasion by Dr. Weilage and it was determined that he did not suffer from major mental illness which required the type of treatment Mr. Jenkins was describing."

In early May of 2012, Mr. Jenkins addressed an Informal Grievance form to DCS Director Robert Houston stating that he had an "emergency need of medical treatment psychologically," and that the "mental health department has very unprofessionally handled (his) case." Mr. Jenkins' grievance also explained that he had been evaluated while in the Douglas County Jail, and that "their findings were very serious," and that they had made a recommendation to Judge Gary Randall to the effect that Mr. Jenkins "suffer from severe psychological disability of mental illness." Mr. Jenkins stated that he was still held in segregation at TSCI, and said that he continued "to be rapidly deteriorating mentally." Mr. Jenkins complained that he was "not receiving psychotherapy sessions," or medication, and added that he wanted to be approved to receive treatment at the "LCC mental health mod for (the) mentally ill." It appears that in this instance Mr. Jenkins' grievance was ultimately routed to DCS Deputy Director for Institutions Frank Hopkins for a response.

On July 2, 2012, Dr. Baker again visited Mr. Jenkins at the door of his segregation cell. As before, Dr. Baker reported her observations of Mr. Jenkins' condition, stating that his "thoughts appear fairly well organized with grandiosity about his abilities/intelligence." The doctor again noted that Mr. Jenkins "continues to refuse all psychotropics including Risperdol, Depakote, or sleep aids." Dr. Baker also noted that Mr. Jenkins had "met with Dr. Weilage in February of 2012 and presented with significant Axis II issues and no major mental illness." Of course, this opinion was consistent with what Dr. Baker herself had determined back in December of 2009, when she concluded that Mr. Jenkins' symptoms "are inconsistent and more behavioral/Axis II in nature."

On September 21, 2012, Dr. Pearson had an unusual telephone conversation with a medical doctor from Omaha (not a psychiatrist) who reported having recently received a letter from Mr. Jenkins. The doctor described the contents of this letter as being "very psychotic and disorganized," and "very disturbing," enough so, in fact, that the doctor spoke with a friend who worked for the Omaha Police Department who recommended that the doctor contact the DCS Mental Health Department. During the course of this telephone conversation the doctor expressed distress over the fact that Mr. Jenkins' tentative release date was less than one year away, and also "asked about procedures regarding release of inmates with Mental Illness who are dangerous to the community." Citing confidentiality, Dr. Pearson said that she "could not release information specific to the inmate," but assured the doctor "that NDSC follows up with Mental Health Board Commitment procedures for inmates with Mental Illness and high risk for danger to self or others."

On January 10, 2013, Mr. Jenkins was seen by Dr. Pearson at his cell door to address “staff reports of suicidal statements.” During this interview, Mr. Jenkins complained about the “perceived refusal of necessary mental health care.” Mr. Jenkins also stated “that he was 'psychotic' and needed transferred to the Lincoln Regional Center for care.” Mr. Jenkins once again referred to hearing the voice of an Egyptian god (Apothis), and said that he was “scared for his safety as he believed that 'Apothis' would harm him.” On the following day, January 11, 2013, Mr. Jenkins was interviewed by Licensed Mental Health Practitioner Larry Murphy, again at his cell door. Mr. Jenkins related to Mr. Murphy “that he had Schizophrenia, that he was not being treated, that being in segregation was harming his mental illness, and that he had previously cut his face because he had been told to do so by an Egyptian god.” Several days later on January 15, 2013, Mr. Jenkins was seen (again at his cell door) in this case by Dr. Gibson, a psychologist. Notes of the meeting reflect that Mr. Jenkins related that he had been “having a 'bad morning' because he was reportedly considering the idea of going to be with his family with psychosis,” and that he “indicated he did not want to do this.” The notes also reflect that Mr. Jenkins had said “he views everyone as 'prey' and followed-up with a number of violent images,” and that he expressed that he “needs to be hospitalized and observed to the aforementioned issue.” Dr. Gibson met with Mr. Jenkins again at his cell door on January 16, 2013. The notes from this meeting indicate that Mr. Jenkins had “reported a belief that he should be hospitalized for psychiatric concerns (particularly being dangerous to others), as he will be released soon.” It was noted that Mr. Jenkins “acknowledged that he has refused care from NDCS employees in the past and reported that he will do so in the future unless he was hospitalized.” Dr. Gibson said that “Mr. Jenkins presented themes of isolation, anger, and violence toward others,” with a “presentation of content (that) seemed grandiose and disorganized at times.” On the night of January 18, 2013, Mr. Jenkins again inflicted significant wounds to his face using a loose floor tile that he had obtained. The following morning, Dr. Gibson received a call from the TSCI medical staff. The nurse reported to Dr. Gibson that Mr. Jenkins had been “screaming about wanting psychiatric treatment, as he is reportedly afraid he will get out and 'rip someone's heart out.” The medical staff made a similar call to Dr. Gibson on the following day, reporting that Mr. Jenkins was continuing to claim that he need psychiatric care.

Mr. Jenkins was returned from medical to his cell in the segregation unit on January 22, 2013. He was placed on a regimen of staff checks every fifteen minutes, and was restricted from having certain items of personal property, including his glasses and “ear-buds.” On each of the following three days, LMHP Murphy spoke to Mr. Jenkins outside of his segregation cell door. After consultation with Dr. Pearson, it was recommended that the restrictions on Mr. Jenkins be continued on January 22, and 23, and the same recommendation was made after consultation with Dr. Gibson on January 24. Mr. Jenkins was next seen on January 25, 2013. The notes from that interview relate that Mr. Jenkins:

requests hospitalization so that he does not harm other people. When asked what he would gain from hospitalization, he was only able to elaborate that he would receive therapy, but did not identify any benefits of therapy. Inmate stated that, when released, he would give in to “apophis” who wanted him to kill “man, woman and child” of “every age group.”

After talking with Mr. Jenkins outside of his cell door on January 28, 2013, and after consulting with Dr. Pearson, Mr. Murphy recommended that Mr. Jenkins be removed from the every-15-minute watch list. This was ordered to be done, however, Mr. Jenkins was returned to 15-minute watch and limited property status on February 2, 2013, when he again damaged a sprinkler head and reported to security

staff that he was hearing voices.

On February 4, 2013. Mr. Jenkins was interviewed in regard to his continued status on fifteen minute checks by Licensed Mental Health Practitioner Brandy Logston. The notes of this meeting indicate that Mr. Jenkins reported that he had “numerous mental health issues making statements such as 'I am a psychotic powerful warrior at the mercy of Aphophis' and 'I am preparing for what is to come.'” Mr. Jenkins also claimed he had been having “difficulty with sleep due to constant hypervigilance and the 'current torture of these deplorable conditions' referring to his limited property status.” Ms. Logsdon reported that Mr. Jenkins was “highly agitated and he endorses high levels anxiety and paranoia,” and that he “continues to refuse any psychotropic medications stating he will not take these because he does not trust staff.” As a result of this interview, it was recommended that Mr. Jenkins continue on fifteen minute checks, and limited property status. There were additional interviews of Mr. Jenkins regarding the 15-minute watch issue conducted by Mr. Murphy at Jenkins' cell door on February the 5<sup>th</sup>, 6<sup>th</sup>, 7<sup>th</sup>, 8<sup>th</sup> and 11<sup>th</sup>, and each time it was recommended that he continue on 15-minute watch and limited property status. The 15-minute watch status was finally discontinued by Dr. Pearson on February 12, 2013. Ms. Logston next saw Mr. Jenkins on February 19, 2013. Ms. Logston reported that Mr. Jenkins told her “he 'wanted it documented' that he was in need of 'emergency psychiatric treatment,’” and also that Mr. Jenkins “expressed that he was 'psychologically deteriorating' as a result of his current living conditions and limited property status.” The notes from this meeting further reflect that Mr. Jenkins “expressed that he was fearful of taking any medications at TSCI because 'they are going to kill me,’” and that Mr. Jenkins “stated he would take medications if housed at a different institution.” Ms. Logston added her own observation that during this interview Mr. Jenkins had “presented all this information...in a logical and calm manner.”

It is notable that Mr. Jenkins sent an Informal Grievance to TSCI Warden Fred Britten on February 17, 2013, just a few months before Mr. Jenkins was scheduled to be released from custody. In the case of that grievance, Mr. Jenkins stated that he was “requesting emergency protective custody and removal from SMU (segregation).” Mr. Jenkins also said that he was “requesting psychiatric hospitalization for severe psychosis conditions of enragement episodes of my schizophrenia disease.” Mr. Jenkins also claimed that he was “suffering psychological and emotional trauma in (his) current confinement,” and specifically referenced the Nebraska Mental Health Commitment Act (**Neb. Rev. Stat.** §§71-901 thru 71-963) in connection with his appeal. The response to this rather extraordinary grievance, in which an inmate who was soon to be released from custody was, in effect, asking that he be sent instead to the Lincoln Regional Center, was disappointing. In place of a response from the Warden, the grievance was answered by a Sergeant Bernard, who replied that the grievance “does not meet the criteria which governs emergency grievances, as you are in no immediate danger of being subject to a substantial risk of personal injury or serious or irreparable harm.” In other words, instead of being given a substantive answer, Mr. Jenkins' grievance was simply dismissed on technical/procedural grounds. Meanwhile, the clock was ticking, and Mr. Jenkins' discharge date was less than six months away.

Mr. Jenkins sent another grievance to TSCI Warden Britten on February 18, 2013. In that grievance, Mr. Jenkins was complaining that his mother had been told that her visiting privileges at TSCI were being suspended for 30 days. (The explanation for this sanction, as stated in a February 14, 2013, letter from TSCI Unit Administrator Shawn Sherman, was that Mr. Jenkins' mother had “taken 2 pieces of paper and the pen from the Gatehouse desk and were taking notes during your visit.”) In his February 18 grievance, Mr. Jenkins explained that his mother “was writing down a petition of notification under

Nebraska State Law Mental Health Act...to be submitted to the County Attorney of Johnson County for direct forwarding to the Mental Health Board.” Mr. Jenkins mentioned in his grievance that he was “set to be released July 30, 2013,” and that his mother was “seeking the emergency protective custody order for psychiatric hospitalization.” Once again, Mr. Jenkins' grievance to the Warden was answered by a Sergeant who replied that the grievance “does not meet the criteria which governs emergency grievances, as you are in no immediate danger of being subject to a substantial risk of personal injury or serious or irreparable harm.”

In what is perhaps an extremely important event in this case, Dr. Baker, the psychiatrist, met with Dr. Pearson, the TSCI psychologist, on March 4, 2013, to discuss Mr. Jenkins. The note on that meeting states (in full) as follows:

Discussed inmate with Dr. Baker on this date. Dr. Baker requested inmate be added to list of inmates to be seen by Dr. Wetzel for a second opinion. Her expressed concerns are verification of absence or presence of mental illness due to his previous history of major mental illness diagnosis by other psychiatric providers. Her primary concern is his dangerousness to the community upon release and that he appears to be laying the groundwork for insanity defense if he harms someone in the community. Is requesting that Dr. Wetzel assess him for dangerousness risk. Will relay request to TSCI MIRT representative. M. Pearson, PsyD

Dr. Wetzel would, in fact, interview Mr. Jenkins for the purposes of this evaluation on March 14, 2013 (Dr. Martin Wetzel is a psychiatrist associated with the Inpatient Mental Health Unit at LCC).

Mr. Jenkins was next seen by Mental Health staff at his cell door on March 5, 2013, at which time Mr. Jenkins was told about the intended evaluation to be conducted by Dr. Wetzel. During that interview, Mr. Jenkins stated “that he is mentally ill and disabled and we made him that way” When asked why he refused to take medications for his condition, Mr. Jenkins replied that “he won't take them here.” In addition, on March 5 Mr. Jenkins was taken by the security staff to attend a meeting for a review of his classification. The security staff reported that Mr. Jenkins “spoke as if apophis was in control of him,” however, the security staff also said that “it appeared that Mr. Jenkins was cognizant, aware, and fully in control of the things he was saying during both transport and at his cell.”

Beginning on March 7, 2013, Kathy Foster, a Department of Correctional Services social worker met with Mr. Jenkins to begin planning for his release. This planning was supposed to cover matters like where Mr. Jenkins would reside after his release, and what community services might be available to him after release. (At the time, Mr. Jenkins' tentative release date was set at July 30, 2013.) Ms. Foster made extensive notes of her visits with Mr. Jenkins to help him prepare a discharge plan, and her notes from March 7 include the statement that Mr. Jenkins said that he “does not want to discharge to the community because he will kill people and cannibalize them and drink their blood.” He also made a statement to her “of intended violence that he will commit if he is discharged to the community,” and told her that he was seeking a Mental Health Board commitment. Ms. Foster's notes indicate that she intended to “look into potential community services for discharge follow-up,” and that she would be contacting Mr. Jenkins' mother. Ms. Foster did contact Mr. Jenkins' mother, Lori Jenkins, by telephone on March 15, and talked with her about issues relating to her son's eventual place of residence (either Lincoln or Omaha), about treatment resources, about securing identification documentation for Mr.

Jenkins, and about helping Mr. Jenkins to apply for Social Security and Medicaid.

In a letter written by Mr. Jenkins and addressed to Ms. Ester Casmer of the Nebraska Board of Parole on March 10, 2013, Mr. Jenkins stated that he was “now in a very seriously severe emergency need,” because he was “set to be released July 30<sup>th</sup> 2013.” (It should be mentioned that this communication had nothing to do with a parole, since by this point in his sentence it was clear that Mr. Jenkins was not going to be paroled.) In this letter, Mr. Jenkins explained that he was in “isolation 23 hour lockdown (with) no medication,” and with no “therapeutic sessions of psychological treatment for the very severe psychosis condition of (his) schizophrenia disease as well as bipolar disorder and PTSD.” Mr. Jenkins claimed that he was “deteriorating daily physically psychologically and emotionally,” and that he had experienced “another self-harming psychotic episode of self-mutilation that resulted in 11 more stitches in (his) face.” Mr. Jenkins stated that he had “carved...facial wounds into my face with a piece of tile from the gallery floor,” and that a correctional officer “had to spray (him) with pepperspray to get (him) to stop carving into (his) face.” In this letter, Mr. Jenkins also stated that he had filed an “emergency protective custody petition in Johnson County to...be submitted to the Mental Health Board,” under the Nebraska statutes dealing with “dangerous persons of mental illness,” in order to have a “hearing on grounds of release to the psychiatric hospital for mental health treatment.”

In connection with his campaign to have himself committed to hospitalization at the Lincoln Regional Center, Mr. Jenkins had also contacted the Johnson County Attorney (Johnson County was Mr. Jenkins' “residence” at the time because he was at TSCI). On March 11, 2013, Mr. Richard Smith, the Deputy Johnson County Attorney, wrote a letter to Mr. Jenkins acknowledging the receipt of letters from Mr. Jenkins “as well as materials provided by (his) mother and (his) fiancée” regarding Mr. Jenkins' mental health. Mr. Smith's letter included the following explanation:

Please rest assured that I am not taking your situation lightly. In order to file a mental health board petition, however, I need to hear from a mental health expert who can testify as to mental illness and dangerousness. I have been in contact with the psychologists with the Department of Corrections and have explained your concerns. They have assured me that they will continue to evaluate, monitor, and treat your mental health.

Mr. Smith added that prior to Mr. Jenkins' release, “the Department will evaluate whether you are fit to be released or whether to seek further inpatient commitment to treat your mental illness,” and that DCS would “forward copies of its recommendation to (the Johnson County Attorney's Office) as well as to the County Attorney in the County from which you are incarcerated,” at which point “a determination will be made about whether a mental health petition is appropriate.” (Please see Attachment #5) It should be noted that this letter, sent on March 11, 2013, was dated just a few days before Dr. Martin Wetzel was scheduled to meet with Mr. Jenkins for his “second opinion” evaluation. Interestingly, Mr. Jenkins was transferred from TSCI to the Nebraska State Penitentiary on March 15, 2013. Since Mr. Jenkins was no longer located in Johnson County, the question of whether Mr. Jenkins' case should be referred to a Board of Mental Health for a possible civil commitment was no longer a question within the jurisdiction of the Johnson County Attorney.

Dr. Wetzel's interview with Mr. Jenkins was on March 14, 2013, while he was still at TSCI. According to Dr. Wetzel's report, an “ongoing theme throughout the interview” was Mr. Jenkins' assertion that “he



was severely mentally ill and in need of immediate transfer to a psychiatric hospital.” Mr. Jenkins also informed Dr. Wetzel that he was “seen by Dr. Oliveto and diagnosed with PTSD, Bipolar Disorder and Schizophrenia.” Mr. Jenkins reported that “he has nightmares every night,” and maintained that he was “deteriorating physically and (was) severely paranoid.” Mr. Jenkins told Dr. Wetzel that he had been physically abused repeatedly as a child, that he was “allowed to run the streets and was constantly in trouble beginning at a very early age,” that he “began setting fires and engaging in fights” at the age of seven or eight, and also that “at age 9 he was hospitalized at Richard Young for hearing voices.” Mr. Jenkins also said that as a child he had been “placed on Ritalin which made him even more 'hyper and psychotic.’” Mr. Jenkins also admitted that he began using street drugs at a very early age, starting with tobacco, marijuana, and alcohol at the age of seven, and using “PCP and embalming fluid” at the age of fourteen. Mr. Jenkins told Dr. Wetzel about having had auditory hallucinations, and that he had been “on medications for 3 - ½ months, which softened the voices and made them 'lower and slower.’” Mr. Jenkins informed Dr. Wetzel that he was due to be released from prison in July, and that he “wants to be placed in a psychiatric hospital to stabilize for 'modern times.’”

In summarizing Mr. Jenkins' “mental status,” Dr. Wetzel reported that he observed that Mr. Jenkins was, at times, “extremely over activated and restless,” and at other times “generally calm.” Dr. Wetzel further reported that Mr. Jenkins “did express repeated thoughts of harming other people in the form of cannibalism and 'waging war," but Dr. Wetzel added that it was “unclear if he is exhibiting psychotic symptoms.” Dr. Wetzel said that he also observed that Mr. Jenkins “was expressing bizarre, and very unusual auditory hallucinations and delusions, but these did not appear to be consistent with typical symptoms of a psychotic disorder.” Dr. Wetzel summarized his assessment of Mr. Jenkins as follows:

***Bipolar Disorder NOS, Probable***

***PTSD, Probable***

Antisocial and Narcissistic PD (personality disorder) Traits

Polysubstance Dependence in a Controlled Environment

(emphasis added)

In addition, Dr. Wetzel's report includes the following observations and assessment:

This patient presents with a dramatic flair, yet there is enough objective evidence of disruption in sleep cycle, mood and behavior to suggest an element of major mood disorder influencing the clinical picture. The patient has an unusual list of demands, the first of which has been placement in a psychiatric hospital. This could be related to a singular motive or a combination of motives, including malingering and/or a sense of disease...Long-term strategies recommended for this patient include development of a rapport and trust to enhance participation in psychiatric care, ongoing development of objective evidence supporting - - or not supporting - - the presence of major mental illness and the possibility of further psychological formal testing to help clarify diagnostic picture.

By the time that Dr. Wetzel's report on Mr. Jenkins was written and delivered, Mr. Jenkins had already been transferred from TSCI to the Penitentiary. Dr. Baker now had her second opinion, but Dr. Baker no longer had Mr. Jenkins as her patient, although he certainly continued to be a responsibility of the DCS Mental Health Department in general terms.

On March 19, 2013, shortly after his transfer to the Penitentiary, Mr. Jenkins was seen by Licensed Mental Health Practitioner Jeremy Simonsen during a meeting dealing with Mr. Jenkins' classification. The notes relating to that meeting indicate that Mr. Jenkins was hoping "to return to general population (and) to transition to the community," something that was scheduled to happen in about less than six months. According to the notes, Mr. Jenkins "had difficulty taking feedback that the chance for this may be limited, and that he should be open to the Transition Program, which still could afford him contact with others and some programming as he nears discharge." Mr. Simonsen's notes indicate that Mr. Jenkins stated "that he would consider moving to the program." Mr. Simonsen next interviewed Mr. Jenkins on April 10, 2013. He described Mr. Jenkins as having "grandiose and highly narcissistic ideas about his own abilities, intelligence, and knowledge" and that Mr. Jenkins wanted to argue with him "about the definition of schizophrenia, and that he has it," although Mr. Simonsen said that "there is no evidence of current thought disorder or other psychotic symptoms." Mr. Simonsen interviewed Mr. Jenkins for a third time on April 16, 2013. As had been the case so many times before, he found that Mr. Jenkins was demanding "psychiatric treatment," even though he did not "appear to understand that would primarily consist of psychotropic intervention, which does not interest him." Mr. Simonsen also recorded that Mr. Jenkins had expressed that he was willing to participate in behavioral program as part of transition, and that Mr. Jenkins had made "grandiose statements about the damage he will cause when he gets out, and his ability to inflict harm." Mr. Simonsen said that they "discussed symptoms displayed today as indicative (that) a mood stabilizer may assist him with Bipolar characteristics.." Mr. Simonsen also recorded that "evidence of thought disorder was not apparent, though delusional beliefs were present regarding his own abilities." Mr. Simonsen further stated that "stronger evidence persists for Cluster B personality traits" (i.e., antisocial, histrionic, and narcissistic personality disorders), and that he would need to consult with Dr. Weilage and Dr. Cheryl Jack, the psychiatrist at the Penitentiary, regarding Mr. Jenkins' discharge plans.

On April 5, 2013, the social worker, Ms. Foster, again met with Mr. Jenkins. Her notes on that meeting indicate that she told Mr. Jenkins that she had talked to his mother, and that he would need to make a decision on a place of residence after his release. During this meeting, Ms. Foster made arrangements for a telephone interview so that Mr. Jenkins could apply for Social Security. She also told Mr. Jenkins that arrangements could be made later for him to receive mental health services in the community after his release. Mr. Jenkins asked Ms. Foster whether he could talk to the Mental Health Center "today," but Ms. Foster told him that it would be premature to do that now. Ms. Foster's notes from that meeting also reflect that Mr. Jenkins "stated a couple of times that he is 'not kidding,' it will be bad' when he gets out." Ms. Foster had yet another meeting with Mr. Jenkins on April 30, 2013, at which point Mr. Jenkins engaged in his telephone interview with Social Security. He was informed that he would not be eligible to receive SSDI because of his status as a felon, but he was allowed to apply for SSI. They again discussed the Community Mental Health Center and Mr. Jenkins told Ms. Foster that "he would be open to being evaluated for medication and is 'more inclined to take them on the outside.'" The notes also reflect that on this occasion Mr. Jenkins told Ms. Foster "that when he gets out 'it will begin' and he made allusions to killing 'without prejudice.'"

Mr. Jenkins was interviewed by Dr. Jack on April 25, 2013. Mr. Jenkins told Dr. Jack that he did not want medications, but that he "wants to engage in therapy." In her notes from the interview, Dr. Jack stated Mr. Jenkins "appeared to be 'on stage' and performing for" her. Dr. Jack described Mr. Jenkins as being self-aggrandizing, self-absorbed, and flagrantly narcissistic in his presentation and verbiage. Dr. Jack's notes reflect that her "impression" of Mr. Jenkins was - "Axis I: No diagnosis; and Axis II:

Antisocial Personality, with narcissistic features vs. Narcissistic Personality with antisocial features.”

An interesting document in our collection is a copy of an email sent by Ms. Trudy Clark to Mr. Wayne Chandler on May 20, 2013. Ms. Clark is an Administrative Assistant with the Nebraska Board of Parole, and Mr. Chandler is in charge of the Department's Inpatient Mental Health Unit at the Lincoln Correctional Center. In this email, Ms. Clark indicated that the Board of Parole had received more than one odd letter from Mr. Jenkins. Specifically, the email said:

This e-mail is written from a personal level only. Why isn't Nikko Jenkins #59478 in the mental health unit? The Board is getting letters from him that he is going to eat people, specifically Christians and Catholics. This is only one of many bizarre letters the Board has gotten from him. Is he being evaluated for a mental health commitment? As a taxpayer, this guy scares me to death!!

It is our understanding that Mr. Chandler forwarded this email to Dr. Weilage, the Department's Mental Health Director. Our records do not include any answer that Ms. Clark may have received in response to her inquiry. Of course, we know that Mr. Jenkins' case had been evaluated by the DCS MIRT team in February of 2012, and that the team had concluded at that time that Mr. Jenkins' condition supported a diagnosis of no serious mental illness, and that Mr. Jenkins thus did not need to receive residential mental health services.

Licensed Mental Health Practitioner Stacy Simonsen saw Mr. Jenkins on June 6, 2013. She described Mr. Jenkins as displaying “grandiose and highly narcissistic ideas about his own abilities, intelligence, and knowledge.” She also noted that while “delusional beliefs were present, his ability to communicate and articulate his thought process was not impaired.” Ms. Simonsen added that, although Mr. Jenkins referred to himself as being “psychotic,” there was “minimal evidence of thought disturbance,” and “while hallucinations were reported, nevertheless there was no evidence that he was responding to internal stimuli.” Ms. Simonsen again saw Mr. Jenkins On July 2, 2013, less than one month from his discharge date. Her notes from that meeting reflect that Mr. Jenkins “continues to present as grandiose and has highly narcissistic ideas about his abilities, intelligence, and knowledge, but he articulates himself well.” She also said that Mr. Jenkins “spoke at length about his plans for release as he will be discharged later this month.”

On July 25, 2013, the social worker, Ms. Foster, had her last meeting with Mr. Jenkins to see “if any further assistance regarding discharge planning was needed.” During this meeting, Mr. Jenkins told Ms. Foster that he was “schizophrenic,” and said that “he needed therapy while he was incarcerated because medications would...address his mental illness satisfactorily.” Ms. Foster's notes from this meeting reflect that Mr. Jenkins “was less dramatic in his statements of the threat he poses to society.” She said that she gave Mr. Jenkins a document listing “various resources (clothing, food, mental health, etc.) for both Omaha and Lincoln,” but that Mr. Jenkins “did not look at them and left them in the table as we left the room.” At this point, Nikko Jenkins was five days away from being discharged.

Mr. Jenkins was discharged from the Nebraska correctional system on July 30, 2013. Because he was discharged and not paroled, Mr. Jenkins was not under parole supervision, or any other kind of special supervision. After his release, Mr. Jenkins took up residence in Omaha. It is alleged that on August 11, 2013, Mr. Jenkins murdered Mr. Juan Uribe-Pina and Mr. Jorge Cajiga-Ruiz, that on or about August

19, 2013, he murdered Mr. Curtis Bradford, and that on August 21, 2013, he murdered Ms. Andrea Kruger. Criminal charges have been filed in those cases, and Mr. Jenkins case is awaiting disposition in the courts.

## **Narrative of Interventions by the Ombudsman's Office in Mr. Jenkins' Case**

The Ombudsman's Office has a long history of involvement with Nikko Jenkins that stretches back to May of 2007, when Mr. Jenkins initially contacted our office to complain about his ongoing placement in segregation. At the time, Mr. Jenkins was an inmate at LCC, but he was soon thereafter moved to TSCI, where Mr. Jenkins continued to be classified to Administrative Confinement, and to be held in segregation. (Over the years, our contacts in relation to Mr. Jenkins' complaints have included some discussions with Ms. Laurie Jenkins, who is Nikko Jenkins' mother, and who at times was active in advocating on her son's behalf.) Because at that point Mr. Jenkins had only been in segregation for a few (approximately three) months, the decision was made to continue to monitor Mr. Jenkins case, and to wait to see whether there might later be an opportunity to suggest to the TSCI administration that he might be transitioned out of segregation, and back into general population at the facility.

In August and September of 2008, Deputy Ombudsman for Corrections James Davis again worked on the issue of Mr. Jenkins' confinement to segregation. At that time, the subject of Mr. Jenkins' mental health status was raised with Mr. Davis by an administrator at TSCI, who indicated that she would have liked to have Mr. Jenkins' name placed on the list of inmates to be reviewed for possible mental health services, but that the mental health professionals at TSCI had expressed the opinion that Mr. Jenkins did not have a serious mental illness, but was only a case of "behavioral problems." Nevertheless, in September of 2008 Mr. Davis helped to make arrangements for a review of Mr. Jenkins' situation to determine whether he might be suitable for a transfer to the Department's Inpatient Mental Health Unit located at the Lincoln Correctional Center. On that occasion, Mr. Wayne Chandler, the supervisor of the Mental Health Unit, and Dr. Mark Lukin, a licensed psychologist employed by the Department, reviewed Mr. Jenkins' case, and concluded that Mr. Jenkins did not exhibit any indication of a serious mental illness, and that Mr. Jenkins would not be an appropriate individual to be admitted to the DCS Inpatient Mental Health Unit at LCC. On September 26, 2008, Mr. Davis wrote a letter to Mr. Jenkins explaining to him that he had been very close to being sent to the Transition Program at NSP to help prepare him to be released from segregation, but that this idea had been discarded when Mr. Jenkins had threatened staff at TSCI. Mr. Davis advised Mr. Jenkins that the Ombudsman's Office would not be able to advocate for him to be released from segregation unless he acted appropriately, and did not threaten staff or other inmates. As Mr. Davis explained it, the Ombudsman's Office would not be able to "take (Mr. Jenkins') complaint seriously, because of (his own) negative behavior."

Over the years, Mr. Davis has worked on many cases of inmates who were being held in segregation for prolonged periods of time. In most of these cases, Mr. Davis has tried to advocate for the inmate to be given a fresh consideration of how his behavior may have changed, and whether the inmate might finally be a suitable candidate for reintegration into the prison's general population. In this work, it has not been an unusual event to find that the inmate in question is someone who had, or appeared to have, serious mental health issues that could not be adequately addressed in a segregation cell. Although the Ombudsman's Office is not qualified to arrive at a medical diagnosis of Mr. Jenkins' condition, we can

say that Mr. Jenkins' case certainly appeared to be one of these instances. Obviously, this condition issue complicated any effort to help to build Mr. Jenkins up as a prospect for transition back into the general population, because Jenkins' own unpredictable behavior would tend to torpedo those efforts. Nevertheless, the Ombudsman's Office wanted to continue to monitor Mr. Jenkins' situation so that he would not be "lost in the system," as can happen when reviews of segregation cases by the institution's staff become "too routine," and cannot identify any new reason to change the inmate's classification.

Our next contact with Mr. Jenkins' situation happened in late 2009, when Mr. Jenkins' sister, Melony Jenkins, wrote to the Ombudsman's Office saying that she had received a letter from her brother in which he told her that he was "very ill mentally," and that he was not receiving his medications at TSCI. In her letter, Ms. Jenkins reported that her brother "claims he has different personalities and is crying out to me in his letter, that he wants to change and take his medications." Ms. Jenkins also said that her brother had told her that "its hard for him to stay grounded in reality without his medication." Of course, this was shortly after Mr. Jenkins' aborted escape attempt, and his assault on a correctional staff person on December 17, 2009. It was also shortly before Mr. Jenkins was to be transferred to the Douglas County Jail on February 13, 2010. Assistant Ombudsman Jerall Moreland followed-up on the matter by contacting Dr. Melinda Pearson, a psychologist at TSCI. Dr. Pearson told Mr. Moreland that there was a "provisional diagnosis" on Mr. Jenkins that included a possible "psychotic disorder," and that he had been on Risperidone, but that she understood that the medication had been discontinued due to Mr. Jenkins' noncompliance in taking the medication. In fact, as we now know from the records, on December 28, 2009, Mr. Jenkins had sent a note to Dr. Baker asking to restart his medications. Dr. Baker had ordered the medications to be discontinued after a December 3, 2009, meeting she had with Mr. Jenkins at which time he reported to the doctor that he had stopped taking the medications three days earlier. Dr. Baker responded to the December 28, 2009, request by re-initiating prescriptions of Risperidone and Depakote for Mr. Jenkins on the following day, December 29, 2009. A notation made by the doctor at the time said that this was a step that "should help stabilize (Mr. Jenkins') symptoms." However, two days later Dr. Baker discontinued the prescription for Risperidone, and made a notation Mr. Jenkins' chart that she had concluded that Mr. Jenkins' symptoms were actually "inconsistent and more behavioral/Axis II in nature." In any case, by the time that Mr. Moreland had an opportunity to ask about the medications issue Mr. Jenkins had already been transferred to the Douglas County Jail, where the mental health staff eventually renewed the medications. Mr. Moreland did, however, speak later with Melony Jenkins, and asked her to urge her brother to be compliant in taking his meds.

On March 12, 2010, former Senator Brenda Council sent a letter to the Ombudsman's Office requesting a review of the possible "medical mismanagement" of Mr. Jenkins' case while in the Douglas County Jail. Senator Council's inquiry had been occasioned by a contact which her office had received from a friend of the Jenkins family, and once again Assistant Ombudsman Jerall Moreland followed-up on the case. After checking into the matter, Mr. Moreland sent a Memorandum to Senator Council on March 28, 2010. In that memo, Mr. Moreland explained that while at the Douglas County Jail Mr. Jenkins had asked for and received a renewal of his earlier prescriptions beginning on March 10, 2010, although the prescriptions were discontinued on March 15, 2010, because Mr. Jenkins had refused to take the meds. Mr. Moreland reported in the memo that he had spoken with Mr. Jenkins, and that Mr. Jenkins "seems to realize that he needs some sort of treatment to control the voices in his head." Mr. Moreland also reported that had "emphasized to Nikko how important it is that he tries to stay medically compliant to his treatment program." Mr. Moreland also reported his findings on Mr. Jenkins to Senator Council, including the background relating to Mr. Jenkins' transfer to the Douglas County Jail, and the fact that

Mr. Jenkins had asked for, but later stopped taking, medications that he had been receiving at TSCI. Mr. Moreland also advised Senator Council that while there “does not appear to be anything else that this office can do for Nikko Jenkins at this time, I have emphasized to Nikko how important it is that he try to stay medically compliant with his treatment program.”

In November of 2011, the Ombudsman's Office was contacted by Ms. Sherry Floyd, who is a friend of Mr. Jenkins. Ms. Floyd related that she had visited with Mr. Jenkins at TSCI, and that “he is not Nikko any more.” Ms. Floyd said that she was concerned that Mr. Jenkins was not receiving needed mental health services at TSCI. As follow-up to this contact, Mr. Moreland sent an email to Dr. Pearson which specifically advised her that the Ombudsman's Office had a new case relating to Mr. Jenkins involving a complaint that he was not receiving needed mental health services. Mr. Moreland related that Mr. Jenkins was claiming that he had recently been diagnosed, while at the Douglas County Jail, as being Bi-polar, with both PTSD, and schizophrenia. Mr. Moreland also stated that he had learned of the court order for Mr. Jenkins latest conviction wherein Judge Randall had indicated that he believed that Mr. Jenkins “has a long and serious history of mental illness,” and that, according to Judge Randall, the record in Mr. Jenkins' case would support his request for “treatment for his mental health issues.” Mr. Moreland also pointed out that Judge Randall had recommended that the Department of Correctional Services see to it that Mr. Jenkins was “assessed and treated for issues regarding his mental health.” In the email to Dr. Pearson, Mr. Moreland also related that Mr. Jenkins was continuing to “claim that he would like to begin treatment for his mental illness and have an opportunity to discuss the recent loss of family members.” Also, Mr. Moreland emphasized that “it appears that Mr. Jenkins will be available for release in 2013.” Mr. Moreland asked Dr. Pearson whether the “multidisciplinary team” might try to “put in place a plan for Mr. Jenkins to return to general population,” pointing out that he had recently contacted Douglas County staff, and was told that “Mr. Jenkins was able to maintain himself in general population for approximately 17 months, while receiving weekly mental health sessions,” when he was in the jail in Douglas County. Mr. Moreland also inquired after “any MIRT committee evaluation of Mr. Jenkins for the Mental Health Unit at LCC,” and specifically asked Dr. Pearson for her own input as to whether Mr. Jenkins could be placed in the “LCC mental health program.” Mr. Moreland added that during a recent conversation with Nikko, “Mr. Jenkins shared that he is hearing voices and believes he has experienced deterioration while at DCS based on his ability to function at Douglas County.”

Dr. Pearson responded to Mr. Moreland's inquiry as follows:

Nikko Jenkins #59478 is monitored by Mental Health on a monthly basis due to his segregated status. He does not present with signs of major mental illness and has refused psychological assessment for clarification of reported symptoms on February 12, 2010 and October 31, 2011. He was seen by the psychiatrist on September 26, 2011 after self discontinuing his DCC-prescribed medications upon return to NDCS. At that time, he refused re-initiation of psychotropic medications unless he was transferred to the Lincoln Regional Center. There has been no evidence of decline in mental status since his return to NDCS. Mr. Jenkins presents with significant psychopathic traits and does not appear to be mentally ill at this time. Mental Health will continue monitoring him and provide assessment and treatment as clinically indicated.

Mr. Moreland responded to this message from Dr. Pearson with an email telling her, in regard to the psychological assessment, that “Mr. Jenkins claims to not have refused the assessment,” and that he had

“indicated to me that he would like to take the assessment.” Under the circumstances, Mr. Moreland suggested that the Department should move forward with an assessment of Mr. Jenkins' condition.

In early February of 2012, the MIRT team reviewed Mr. Jenkins' situation and reported on its findings. Mr. Moreland spoke with Dr. Weilage later that month to obtain some sense of what the MIRT team had concluded. Dr. Weilage replied that it was the team's opinion that Mr. Jenkins was not mentally ill, and that there was no indication of PTSD, or other Axis I disorders. Dr. Weilage said that he disagreed with Dr. Oliveto's assessment, and that it was his opinion that Mr. Jenkins was, in fact, purposefully making up his apparent mental dysfunction.

Although in the following months Mr. Jenkins repeatedly contacted the Ombudsman's Office about his mental health condition, and his desire to be transferred to LRC or to the Inpatient Mental Health Unit at LCC, it appeared that the Ombudsman's Office had essentially reached a dead end, in terms of our ability to advocate for different mental health treatment for Mr. Jenkins, in light of the outcome of the MIRT review completed in February of 2012. However, as months passed, and as Mr. Jenkins' custody status (segregation) continued unaltered, the Ombudsman's Office became more and more concerned about the fact that Mr. Jenkins' discharge date, scheduled for July of 2013, was approaching. We were acutely aware that, if circumstances did not change significantly, then Mr. Jenkins would be discharged from a segregation cell directly into the community, with no opportunity to have access to the kind of counseling and transition opportunities that would have been desirable even to make him suitable to live in the general population of a correctional facility. With this in mind, the Ombudsman's Office opened discussions with DCS to try to find a way to “ease Mr. Jenkins back” from the isolation of a segregation cell and into the community, where it was hoped that he would be able to survive, and manage to remain within the limits of the law notwithstanding his apparent mental health difficulties.

Because it was clear that Mr. Jenkins would not be paroled, and thus would not have the opportunity to gradually reintegrate into society through any arrangement which was supervised, the sense within the Ombudsman's Office was that it was even more important that Mr. Jenkins at least be reintegrated into the general population of a corrections facility. We also were of the view that it would be desirable for Mr. Jenkins to go through the Transition Program at NSP, which was specifically designed to help those inmates who had spent long months, and sometimes years, in segregation to deal with reintegrating into a larger community, like a prison's general population. In our opinion, this was far from being an ideal arrangement, but it was, as we viewed it, something that DCS could do that might have some hope of making a difference in terms of Mr. Jenkins ability to cope with release into the community. It should be emphasized, however, that the Ombudsman's Office staff continued to be very concerned about the potential threat that Mr. Jenkins might present to the community after his release. Thus, on February 25, 2013, Deputy Ombudsman for Corrections James Davis sent an email to Dr. Randy Kohl, the DCS Deputy Director for Health Services, requesting a meeting with Dr. Kohl, Frank Hopkins, DCS Deputy Director for Institutions, and Dr. Cameron White, the Department's Behavioral Health Administrator. In that email, Mr. Davis, having noted that “Mr. Jenkins has a tentative release date of July 2013,” went on to express “concerns” that Mr. Jenkins “may pose a safety risk to the community,” if he were to be released “without providing him with the necessary tools to succeed in the community.” In fact, Mr. Jenkins had also written to Senator Ernie Chambers, who also expressed concern about the “treatment plans” that DCS might make “for Mr. Jenkins to return to the community, instead of being released directly from Administrative Confinement (segregation) to the community.” Later that day (February 25), Mr. Houston, who had received a copy of Mr. Davis' email, responded with an email saying that

“Dr. Kohl will be in touch with you.”

Our next effort along these lines was to send a letter to Dr. Kohl on March 5, 2013, to make one last proposal for treatment for Mr. Jenkins. In that letter, signed by Assistant Ombudsman Moreland, the Ombudsman's Office pointed out again that Mr. Jenkins had spent a considerable amount of time in segregation at TSCI, and was due to be discharged soon. Noting that “it appears that the Courts and (the mental health staff at the jail in) Douglas County would agree to the presence of psychosis,” while the Department “has doubts in that regard,” Mr. Moreland reminded Dr. Kohl that “all parties identify a behavioral issue in Mr. Jenkins.” However, Mr. Jenkins himself was “resistant to any explanation other than a major mental illness.” With all of this in mind, Mr. Moreland made the following proposal:

I wonder if any consideration has been given to moving Mr. Jenkins to a different environment that might make it possible for the barrier of resistance to treatment to be cracked or completely broken down. I note that at one time Mr. Jenkins was being treated with psychotropic medications by the Department. I believe this was as recently as January 2010. However, his medications were discontinued due to his refusal and non-compliance. Leaving aside the issue of whether there is a major mental illness, it does definitely appear that something is happening with Mr. Jenkins, in terms of his mental condition, and that this is standing in the way of his getting the needed mental health treatment prior to his discharge.

With the expressed belief that “we all want to help Mr. Jenkins get better before he is released into the community,” and with the understanding that Mr. Jenkins was soon to be released, Mr. Moreland said that he was hopeful that there would be an “attempt to persuade Mr. Jenkins to recognize and address his problems.” In that connection, Mr. Moreland wrote:

In the interest of what is best for the community, and for Mr. Jenkins, I would like to suggest that Mr. Jenkins be told during his assessment by Dr. Weilage (actually by Dr. Wetzel) that the Department is considering transferring him to LCC segregation for the purposes of receiving needed behavioral therapy. If Mr. Jenkins would agree to this treatment, and if he shows progress, then he could be considered for a transfer to OCC in the month of May, shortly before his discharge in June (actually in July).

This letter was sent to Dr. Kohl via email, with an electronic copy going to Director Houston. (Please see Attachment #6) Later, Mr. Houston sent a response stating that he was “redirecting this issue to Larry Wayne (DCS Deputy Director for Programs) as this is a classification issue based on a behavioral health assessment,” adding the assurance that “we are all working to have as good an outcome possible for Mr. Jenkins and the Nebraska community.”

On March 7, 2013, Mr. Moreland followed-up with an email to Mr. Wayne reinforcing the point that the Ombudsman's Office continued to have “concerns” relating to Mr. Jenkins, and the prospect of his “being released directly into the community after spending such a long duration in a segregated status at a high security unit, without a comprehensive discharge plan.” Mr. Moreland said that it would be a good idea “to sit down to discuss possible discharge strategies when dealing with this segment of your population,” and suggested the scheduling of a meeting the following week to address those concerns. Mr. Moreland sent another email to Mr. Wayne on March 15, 2013, thanking him for “moving forward



with the transfer consideration for Mr. Jenkins” (in fact, Mr. Jenkins was transferred from TSCI to NSP on that date), and for his willingness to have “further discussion on strategies pertaining to his discharge plan.” Mr. Moreland explained that he believed that “a system to facilitate the return to lower levels of custody (of) those housed in long-term segregation is important,” and that, unless there were clear and compelling reasons not to, “a person serving a long sentence who would otherwise be released directly to the community from long-term segregated housing, should be placed in a less restrictive setting for the final months of confinement.”

On March 20, 2013, there was a meeting at the central offices of DCS involving staff from DCS (Mr. Wayne, Dr. Weilage, Kathy Foster, and Sharon Lindgren), and staff from the Ombudsman's Office (Mr. Davis, Mr. Moreland, and Mr. Sean Schmeits) to discuss Mr. Jenkins' case. According to our notes of that meeting, the following “discharge plan” for Mr. Jenkins was discussed and agreed to:

1. Moved from TSCI to NSP Control Unit (segregation) Friday, March 15, 2013;
2. After 30 days, he will transition to NSP Transition Unit barring any compelling reasons;
3. Mental Health with treatment (for) Mr. Jenkins every 15 days;
4. After 30 days of being in transition Mr. Jenkins will be reviewed for general population; and
5. Kathy Foster Social Worker, will meet with Mr. Jenkins to assist with the 5 risk factors of discharging.

However, when Mr. Moreland contacted NSP Warden Diane Sabatka-Rine to inquire about Mr. Jenkins on April 12, 2013, he was advised that while Mr. Jenkins had been approved for the transition program, it would take an additional two to four weeks to actually transfer him to that program. On April 23, Mr. Moreland sent an email to Mr. Wayne complaining that the situation with Mr. Jenkins still being in the segregation unit at NSP was not consistent with his understanding of what had been agreed upon at the March 20 meeting. Mr. Moreland recalled that at the meeting “we were told that after 30 more days on (segregation), Mr. Jenkins would transition to (the) NSP Transition Unit,” and that this had not, in fact, happened. In addition, Mr. Moreland reminded Mr. Wayne that “during the meeting, we were told that Mr. Jenkins would be seen by Mental Health every 15 days,” and that it was now his “understanding that these actions were not carried out.” Mr. Wayne responded to this with an email message saying that he understood from Warden Sabatka-Rine that Mr. Jenkins “has been doing well,” but that he had told the Warden that any changes in Mr. Jenkins' classification, and any resulting movements within the system “should occur in line with institutional resources for time and space along with trying to situate Mr. Jenkins to have the best chance of success now and after his upcoming release.” Mr. Moreland's response to this message was to say, via email, that it “does not capture the meeting we had on March 20, 2013...we discussed time lines and action items to assure Mr. Jenkins moved through the system...to make sure (that) issues such as institutional resources, time and any other reason outside of Mr. Jenkins being uncooperative wouldn't negatively affect the transitional plan.”

On April 24, Mr. Wayne sent Mr. Moreland a copy of a message from Warden Sabatka-Rine stating that Mr. Jenkins would be “moved from the Control Unit to (the Transition Unit) no later than April 30th as a part of his 'transition plan.’” However, a month later, on May 29, 2013, Warden Sabatka-Rine sent an email to Mr. Moreland informing him that since the “current Transition Confinement Group” would not complete its programming until June 3, and because the next Transition Confinement Group would not

start its programming until June 10, Mr. Jenkins would not be able to go to the Transition Unit to start programming until June 10. Given that Mr. Jenkins' discharge date was on July 30, this meant that Mr. Jenkins would only "have the opportunity to progress through Week #7 (of the Program) before his discharge from NDCS." In fact, Mr. Jenkins never went through any part of the Transition Program, and he was eventually released from custody in segregation to the community without any meaningful programming.

## **Impressions and Observations**

Those of us who work in the Ombudsman's Office have the greatest sympathy for the victims, and the families of the victims, of the murders that Mr. Jenkins is accused of having committed – in fact, even more so after sifting through records from Mr. Jenkins' incarceration in the Nebraska criminal justice system. Clearly, nothing that happened to Mr. Jenkins while he was incarcerated could possibly justify, excuse, or explain the brutal murder of four innocent human beings. All of those victims were valued and valuable members of our society, and we are all diminished by their loss.

Although the name Nikko Jenkins is prominently featured in this report, in fact, the report is not about Mr. Jenkins, but is actually about the Department of Correctional Services and how it managed the care and treatment of an inmate who was clearly troubled and troubling. The fact that we possess so much information on this subject gives us a rare opportunity to examine in great detail how "the system," particularly the Department's mental/behavioral health system, functioned on an ongoing basis in its efforts to address Mr. Jenkins' needs, not to mention his frequent antisocial behavior. We are acutely aware of the fact that this report is unusual, in terms of the extent of the detail that it presents from the mental health records of the individual concerned. Certainly, this report could have been shorter, and less detailed, but much of the detail that we have included in the report is there in order to be fair to the mental health professionals involved, and to provide a meaningful representation of what they did, and what their opinions were. Of course, we could have written a shorter report that was limited simply to the expression of our impressions based upon what we had observed in the record, but that would have been, to a large extent, a "hollow report," rendered much less meaningful without the critical context that the detail from the records can provide. As it is, a great deal of time and effort has gone into the preparation of this report. We might have done otherwise - indeed, we might have done nothing - but given what we know about the situation, and given the potentially dire consequences of some of the decisions made in the case, we could not have, in good conscience, done less than we have here.

In writing this report, our intention is to draw back the curtain so that the reader can observe how the mental health professionals working for the Department of Correctional Services acted and reacted in the ongoing management of Mr. Jenkins' case. For the most part, we can do this by simply allowing the facts to "speak for themselves." However, in order to give this effort some greater focus, we will need to add an accounting of some of our own impressions and observations.

## **The Segregation Question**

While he was an inmate being held in the Nebraska correctional system Mr. Jenkins spent much of his

time in segregation, in fact, perhaps as much as 60% of his time with the Department. His placement in segregation was supposedly less a punitive matter than a matter of classification, and in technical terms Mr. Jenkins was in a segregation cell because he was classified to a status known as “Administrative Confinement.” In essence, an inmate will be classified to Administrative Confinement (segregation) because he/she is viewed as being an unacceptable risk to the safety and good order of the institution. In Mr. Jenkins' case, there was some reason to believe that he was in a gang, or was a “security threat group” member. But more significantly Mr. Jenkins had repeatedly exhibited violent behaviors toward other inmates and staff that resulted in his being placed in a segregation cell for much of his stay in the State's correctional system. During the periods when he was in segregation, Mr. Jenkins was locked up alone in a cell for twenty-three hours per day, every day. This not only meant that for months at a time Mr. Jenkins was separated from what most of us would consider to be “normal human contact,” but it also meant that he was isolated from all but the most rudimentary programming that is supposed to be made available to the inmate population. Thus, Mr. Jenkins' Administrative Confinement classification, and his placement in segregation for much of his term of incarceration, was a measure that would have broader implications for his progress in terms of his rehabilitation, and potentially his “condition.”

The programming available in the Nebraska correctional system falls into three general categories: (1) anger management/violence reduction programming; (2) sex offender programming; and (3) substance abuse programming. Although he also had a history of substance abuse, the kind of programming that would clearly have been most applicable to Mr. Jenkins' case would be the anger management/violence reduction programming. The Department's Anger Management Program involves participation in what amounts to a twelve session regimen that consists of group therapy. Obviously, an inmate who has to be locked in a segregation cell for safety's sake cannot attend group sessions, or at least not as a group session is normally done. On a couple of occasions over the years, Mr. Houston mentioned the idea of bringing programming to the inmates in the segregation units by providing the programming through television in the inmates' cells, but that has not been accomplished thus far. The other programming that might have been desirable in Mr. Jenkins' case was the Department's Violence Reduction Program, which is designed to be an intensive, inpatient program, with more than one hundred clinical sessions over the period of twelve months. The Violence Reduction Program is supposedly reserved for the Department's most violent inmates and, until very recently, had a capacity that was limited to twelve inmates per year. Because the Violence Reduction Program is an inpatient arrangement, and because it is offered only at the Penitentiary and nowhere else in the system, it would be quite impossible for Mr. Jenkins, or any other inmate living in segregation, to participate in that program, no matter how much the inmate might need it. Furthermore, even if Mr. Jenkins had not been in segregation he would have needed to be transferred to the Penitentiary to receive the Violence Reduction Programming because it is made available only there.

Clearly, the programming provided by the Department of Correctional Services addresses many of the most significant areas where our prison population may need treatment and rehabilitation, but for the inmates in segregation programming is simply not available, even though the segregated inmates are often some of the most troubled and dangerous inmates in the entire system. The Ombudsman's Office has long advocated that the Department find a way to bring meaningful programming to the inmates in the segregation units, but thus far those suggestions have not had positive results. As for a somewhat larger issue, we are also beginning to question whether DCS is short of programming resources across the board. Statistics from DCS for late September of 2013 indicate that only 619 of the Department's total inmate population were in some form of programming. If this is the case, then that would equal

only about 13% of the Nebraska correctional population. Furthermore, it appears that about 450 of those 619 inmates are participating in the Department's substance abuse programs, which means that only about 3.5% of the total DCS population is in something other than substance abuse programming. One of the more positive things that the Department has done over the last several years is to increase its substance abuse programming resources. We are, however, not aware of there being any similar resourcing enhancements in the other DCS programming areas. As the Nebraska prison population now stands, we have reached a point where the Nebraska prisons and community centers are filled to about 150% of their design capacity. Obviously, more inmates necessarily means more programming demands, and over the years, as the prison population has gone up, the Nebraska corrections system may not have adequately supplemented its programming resources to deal with the increased demand. In fact, we know that over the last decade or so the Nebraska prison population has gone up by about 20%, while the correctional budget has been increased by only 7%. At the very least, we would like to suggest that this is a situation that needs to be examined in detail, to see if the current programming resources are sufficient to meet the current needs, including the need to provide programming for the segregation inmates (and for the inmates in protective custody, who are also isolated from access to programming). When we consider how troubled and potentially dangerous some of these inmates can be, and when we consider that most of them will eventually be discharged back into our communities, it would seem that the dollars that would be spent on programming segregation inmates while they are under the control of DCS would be dollars well spent.

The campaign (if we can call it that) by Mr. Jenkins to be transferred from TSCI to the Inpatient Mental Health Unit at LCC so that he could receive mental health therapy there raises yet another interesting question as it relates to Mr. Jenkins' segregation status. In fact, if we are searching for a continuum of access to, and quality of, the mental health services being provided to the inmates in our correctional system, then the segregation units, on the one hand, and the LCC Inpatient Mental Health Unit, on the other hand, would be at the opposite ends of that spectrum. The segregation inmates are supposed to be seen/interviewed by mental health professionals once per month to make sure that they are maintaining their grip on reality, and are not suffering a "breakdown" due to their being locked up alone in a cell for 23 hours per day, or due to any other reasons. An inmate in segregation will also receive visits from the institution's mental health professionals after situations where the inmate had injured himself/herself, or had to be put into therapeutic restraints, or had threatened to commit suicide. However, these contacts are typically done at the door of the inmate's segregation cell, and are often completed in a relatively short period of time, perhaps only a matter of minutes. And, although these contacts can develop into longer conversations between the mental health professional and the inmate, standing in the gallery and speaking to the inmate through a cell door is hardly a setting that is conducive to anything that would be characterized as "therapeutic," not to mention "confidential." It should also be kept in mind that the inmates in segregation are often some of the most troubled and dangerous inmates in the entire system, and therefore are apt to be inmates who could use therapeutic intervention/counseling, even when they do not have a serious mental illness. All of this makes us wonder whether the fact that an inmate like Mr. Jenkins is in segregation might actually create as much of a barrier to his receiving needed mental health/behavioral health therapy, as it does for his receiving needed programming in important areas like substance abuse and violence reduction. Clearly, our correctional system has its share of troubled and dangerous inmates, but the critical, unavoidable truth is that most of those inmates will eventually return to our communities, even if they are not paroled. If providing these inmates mental health *and behavioral health* counseling while they are in prison will improve their chances of being successful, law abiding citizens when they are released, then we would suggest that this be done, even if it means

adding more resources to the DCS budget, and even if it means finding a new way to provide direct counseling to those inmates while they are in segregation.

We would also like to particularly emphasize the point that what we are talking about here is providing counseling/therapy to inmates in segregation, and doing so *without regard to whether those inmates are diagnosed with a major mental illness, or merely a behavioral issue*. We know, of course, that the offices of our Licensed Mental Health Practitioners in the community are filled with people who do not have a serious mental illness, but who nevertheless need to have ongoing counseling/therapy for what would be characterized as “behavioral health issues.” So, as we see it, neither one's confinement to a segregation cell, nor one's diagnosis as not having a serious mental illness, should act as a barrier to their receiving useful therapy. And we would simply add the obvious point that this is something that should be done in some more functional, confidential way than by talking to the inmate through his/her cell door, a practice which is demeaning to the mental health professional, as well as to the inmate.

There is an ongoing debate among correctional authorities and the advocates of reform as to whether, in fact, confinement in segregation for prolonged periods of time can actually lead to symptoms of mental illness, or aggravate the mental illness of individuals who were already suffering from a mental illness when they were sent into segregation. There are many experts who argue that the sensory deprivation and isolation from normal human contact that are the essence of solitary confinement can make a real difference, in terms of exacerbating the condition of those inmates who are already mentally ill. The United States District Court for the Southern District of Texas, in the case of *Ruiz v. Johnson*, 37 F. Supp.2d 855 (1999), has summarized this perspective in looking at the situation in Texas, by saying:

the administrative segregation units of the Texas prison system deprive inmates of the minimal necessities of civilized life. While the court recognizes and appreciates the formidable task of those public servants saddled with the task of dealing with problematic, violent inmates, even those inmates who must be segregated from general population for their own or others' safety retain some constitutional rights. Texas' administrative segregation units violate those rights through extreme deprivations which cause profound and obvious psychological pain and suffering. *Texas' administrative segregation units are virtual incubators of psychoses - seeding illness in otherwise healthy inmates and exacerbating illness in those already suffering from mental infirmities.* (emphasis added) *Ruiz v. Johnson*, 37 F. Supp.2d 855, at 861.

The idea that inmates who spend long periods in solitary confinement can deteriorate in terms of their mental health is supported by the findings of a significant body of experts who have looked at the issue and determined that mentally ill inmates can, and often do, get worse in segregation. For instance, the American Association of Community Psychiatrists has stated in a position paper that, in general terms, “conditions in jails and prisons exacerbate mental illness,” and has also said:

Because of vulnerability to other inmates, or inability to comply with regulations, mentally ill inmates are frequently housed in protective or punitive segregation, where the isolation and enforced idleness lead to further deterioration in their condition. Mentally ill inmates are disproportionately sent to "supermaximum security units", where isolation and sensory deprivation make decompensation the rule. It is not surprising that the rate of suicide in prisons is twice that in the general population. In jails the rate is 9

times higher. (This publication can be found online at <http://psychnews.org/pnews/99-02-05/prison.html>.)

This conclusion was supported by the findings of Dr. Stuart Grassian, a board-certified psychiatrist and former faculty member of the Harvard Medical School, who evaluated the psychiatric effects of solitary confinement in more than two hundred prisoners in various state and federal correctional facilities. Dr. Grassian reported in an article published in the *Journal of Law and Policy* that he saw inmates who had hyperresponsivity to external stimuli, difficulties with thinking, concentration, and memory, perceptual distortions, illusions, and hallucinations, panic attacks, overt paranoia, problems with impulse control, and “primitive aggressive fantasies of revenge, torture, and mutilation of the prison guards.” Based on what he had observed, Dr. Grassian made the conclusion that ***“the harm caused by such confinement may result in prolonged or permanent psychiatric disability, including impairments which may seriously reduce the inmate’s capacity to reintegrate into the broader community upon release from prison.”*** (emphasis added) [Please see *Journal of Law and Policy*, Vol. 22, p. 325 (2006); online at <http://law.wustl.edu/journal/22/p325grassian.pdf>.]

Yet another expert who has looked at this issue extensively is Dr. Craig Haney, who is a professor of psychology at the University of California at Santa Cruz. Dr. Haney was a professional adviser in the *Ruiz v. Johnson* case, and has studied the psychological effects of solitary confinement for more than 30 years. In 2001, Dr. Haney authored a paper published by the United States Department of Health and Human Services (Assistant Secretary for Planning and Evaluation) dealing with the psychological impact of long-term incarceration. In that document, Dr. Haney said that:

The psychological consequences of incarceration may represent significant impediments to post-prison adjustment...The range of effects includes the sometimes subtle but nonetheless broad-based and potentially disabling effects of institutionalization prisonization, the persistent effects of untreated or exacerbated mental illness, the long-term legacies of developmental disabilities that were improperly addressed, or the pathological consequences of supermax confinement experienced by a small but growing number of prisoners who are released directly from long-term isolation into freeworld communities...Over the next decade, the impact of unprecedented levels of incarceration will be felt in communities that will be expected to receive massive numbers of ex-convicts who will complete their sentences and return home...(and) the high level of psychological trauma and disorder that many will bring with them. (See the complete text of Dr. Haney's paper online at <http://aspe.hhs.gov/hsp/prison2home02/Haney.htm#IV>.)

As Dr. Haney has characterized it, ***“the residual effects of the post-traumatic stress of imprisonment and the retraumatization experiences that the nature of prison life may incur can jeopardize the mental health of persons attempting to reintegrate back into the freeworld communities from which they came.”*** (Also, please see Dr. Haney's testimony before the United States Senate's Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights - June 19, 2012, Hearing on Solitary Confinement; online at <http://www.judiciary.senate.gov/pdf/12-6-19HaneyTestimony.pdf> .) And, in the same context, it is worthwhile to emphasize that, in a policy statement issued in 2012, the American Psychiatric Association itself has concluded that:

Prolonged segregation of adult inmates with serious mental illnesses, with rare exceptions, should be avoided due to the potential for harm to such inmates. If an inmate with serious mental illness is placed in segregation, out-of-cell structured therapeutic activities (i.e., mental health/psychiatric treatment) in appropriate programming space and adequate unstructured out-of-cell time should be permitted. Correctional mental health authorities should work closely with administrative custody staff to maximize access to clinically indicated programming and recreation for these individuals.

The American Psychiatric Association added the recommendation that “inmates with a serious mental illness who are a high suicide risk or demonstrating active psychotic symptoms should not be placed in segregation housing...and instead be transferred to an acute psychiatric setting for stabilization.”

It must be noted that this perspective on the harmful effects of solitary confinement has been openly questioned by a study completed in cooperation with the Colorado Department of Corrections in 2010. (See *One Year Longitudinal Study of the Psychological Effects of Administrative Segregation*; online at <https://www.ncjrs.gov/pdffiles1/nij/grants/232973.pdf> ) That study concluded that solitary confinement does not, in fact, cause mentally ill prisoners to get worse. However, the Colorado study has itself been heavily criticized by many experts, including by Dr. Grassian. [For a very recent article discussing the case of Sam Mandez, a Colorado corrections inmate who was apparently normal in mental health terms when he was first incarcerated, but who, after nearly sixteen years in segregation, is now “profoundly, indisputably mentally ill,” see *Half a Life in Solitary: How Colorado Made a Young Man Insane*, by Andrew Cohen, Atlantic Monthly, November 13, 2013, found online at <http://www.theatlantic.com/national/archive/2013/11/half-a-life-in-solitary-how-colorado-made-a-young-man-insane/281306/>.]

Dr. Haney's point about “the residual effects of the post-traumatic stress of imprisonment” helps to put the whole issue of the mental health implications of solitary confinement into a very different, and yet valid, frame of reference. If, in fact, prolonged confinement in segregation does lead to post-traumatic stress disorder that might “jeopardize the mental health of persons attempting to reintegrate back into the freeworld communities from which they came,” then it is probably essential for our Department of Corrections system to provide even more attention to its long-term segregation inmates, first to identify those inmates who are, or may be, experiencing this post-traumatic stress disorder, and then to address the effects of this post-traumatic stress disorder before releasing these potentially dangerous inmates into our unsuspecting and vulnerable communities. In fact, if treating these cases can reduce the risk that these inmates represent to society after their release, then that alone is well worth the commitment of resources involved.

Leaving aside the technical debate among the mental health experts, we would suggest that so long as Nebraska's correctional officials continue to rely heavily on administrative segregation, and so long as there is even the remotest possibility that the highly dangerous inmates who are placed in segregation might decompensate and become more mentally ill, and perhaps even more dangerous, the State should certainly make those inmates a focal point of mental/behavioral health attention and treatment, which is not exactly what we see happening in Nebraska's correctional facilities today. The legitimate security goals of the Department of Correctional Services are achieved by the act of separating these dangerous inmates from others, and securing them in segregation cells. But having thereby separated those high risk inmates from the general population, surely the leadership of DCS would agree that there is no reason why those inmates should be treated as if they were lepers or outcasts, and left without total

access to the range of programming and mental/behavioral health services that are made available to other inmates. On the contrary, if anything the inmates in segregation probably should be receiving far more in the way of mental and behavioral health services than most other inmates. To reiterate the key recommendation of the American Psychiatric Association, *“if an inmate with serious mental illness is placed in segregation, out-of-cell structured therapeutic activities (i.e., mental health/psychiatric treatment) in appropriate programming space and adequate unstructured out-of-cell time should be permitted.”*

In summary, the Ombudsman's Office would offer the following:

- **It is probable that the Department of Correctional Services needs much more in the way of programming resources, if it is going to make serious progress in “rehabilitating” its inmate population, particularly those inmates who are most troubled and most dangerous. This would be particularly true in regard to adding programming resources in the areas of violence reduction and sex offender treatment. As for deciding what the need is, and what resources should be added, it is suggested that the most sensible approach to this would be to ask an independent expert to survey the situation in Nebraska's correctional system, and make recommendations as to the needs of our system. It is possible that the Department of Correctional Services may be able to obtain a grant to help pay for such a study, but it is recommended that the Legislature insist upon having a role in vetting the specific expert/analyst.**
- **With regard to the programming that is offered in Nebraska's correctional facilities, it is suggested that the Department look into the possibility of developing therapy/counseling that is directly aimed at “gang deprogramming.” In fact, the Nebraska corrections system may need to begin treating this “deprogramming-program” in much the same way that it treats existing drug abuse treatment efforts, that is, as a priority program that is based on giving participants new ways to think about how they live their lives, and new skills that will help them cope with the temptation to fall back into old “bad habits.” This program: (1) should not compel the former gang member to be “debriefed,” in the sense of his/her being required or expected to disclose facts about the gang that he/she had formerly been affiliated with; and (2) should include practical enhancements (educational and vocational training, for example) in the programming resources of the correctional system that might be necessary to allow this anti-gang program to provide the former gang members with meaningful opportunities of the kind that will help to lift up the self-esteem of those who might otherwise seek “status” through gang-involvement.**
- **Because the segregation units in Nebraska's correctional facilities often contain some of the system's most troubled and dangerous inmates, it is suggested that the Department of Correctional Services take steps to immediately provide programming of all types to its segregation inmates. The Department should also develop a process for the identification of long-term segregation inmates who are, or may be, experiencing post-traumatic stress disorder, and to address the effects of this post-traumatic stress disorder before they are released from custody.**
- **The Department of Correctional Services needs to provide comprehensive ongoing mental**



**health/behavioral health therapy/counseling to the inmates in its segregation units. It is emphasized that this therapy/counseling should be available not only to inmates who are identified as having a “serious mental illness,” but also to those segregation inmates who are identified as having “behavioral” problems.**

- **Although there are differences of opinion on whether mentally ill inmates in segregation will “decompensate” due to the nature of their segregated environment, the Department of Correctional Services should take the “conservative approach,” by confronting this risk directly, rather than simply hoping that decompensation will not occur. With this concern in mind, Nebraska's Department of Corrections should move forward to implement the recommendation of the American Psychiatric Association, and require its mental health staff to work closely with the agency's administrative custody staff to maximize access to clinically indicated programming and recreation for these individuals.**

## **The Transition Question**

Over the years, the Ombudsman's Office has, in its contacts with corrections leadership, repeatedly advocated for the idea that it is desirable to arrange for inmates, particularly for long-term inmates, to “transition” from institutional confinement to the community at large. The idea is that inmates will be more likely to be successfully reintroduced into the community outside of the prison walls, if they are gradually assimilated into that setting in a controlled, closely supervised way. In most cases, this can be done by moving the inmate in gradual steps first to minimum custody, then to community custody (work detail/work release), and then to parole. We believe that this strategy is not only advantageous for the inmate in question, but it is also desirable from the standpoint of the community, since it is one way that we can make it more likely that the inmate will be a law-abiding citizen after his/her release. And transition is a strategy that is, in fact, implicit in the structure of the corrections system itself, with its obvious “step-downs” from maximum custody, to medium custody, to minimum custody, with its community corrections (work release) facilities, and ultimately with its availability (for some inmates) of a release on parole, where the inmate is actually reintroduced into the community, but subject to very close supervision.

If this idea of “transition” is a desirable strategy in general terms, then we believe that it is even more essential when dealing with cases (like that of Mr. Jenkins) where the inmate in question has been held in close and isolated confinement in a segregation cell for an extended period of time. In fact, by our calculations Nikko Jenkins spent approximately 58 months of his sentence in a DCS segregation cell, a period of time which, in the aggregate, amounted to nearly five years in segregation/isolation. Before the end of his sentence, Mr. Jenkins was in segregation continuously from July 19, 2011, until July 30, 2013, a period of just over two years. And, in fact, we know that there are DCS inmates other than Mr. Jenkins who have spent even longer periods of time in the extreme isolation of a segregation cell, and who would be likely to have a high degree of difficulty adjusting to life in the general population of a prison, let alone in adjusting to life in the community at large. In addition, as we have indicated, the inmates who are kept in segregation are not only isolated in terms of their being separated from other people, but also in terms of their being separated from access to needed programming. So, without any form of transition from segregation to a “normal life,” these inmates are going through the shock of being released directly from an isolation cell to our streets, very often with nothing having been done

for them in the way of programming/rehabilitation.

This “transition issue” was discussed by Dr. Craig Haney in his 2001 paper published by the United States Department of Health and Human Services. In that document, Dr. Haney stressed the point that “no significant amount of progress can be made in easing the transition from prison to home until and unless significant changes are made in the way prisoners are prepared to leave prison and re-enter the freeworld communities from which they came.” Dr. Haney urged that prison systems should “provide all prisoners with effective decompression programs in which they are re-acclimated to the nature and norms of the freeworld,” and emphasized that “prisoners who have manifested signs or symptoms of mental illness or developmental disability while incarcerated will need specialized transitional services to facilitate their reintegration into the freeworld,” programming which should include “pre-release outpatient treatment and habilitation plans.” Dr. Haney also stressed that this process “must begin well in advance of a prisoner's release,” and that “***no prisoner should be released directly out of supermax or solitary confinement back into the freeworld.***” (See online at <http://aspe.hhs.gov/hsp/prison2home02/Haney.htm#IV>.)

While he was the Director of the Department of Correctional Services, Robert Houston took a very important step in this area. Mr. Houston supported the usage of segregation as a tool for maintaining order in the institutions, but he also recognized that it would be desirable at some point to transition long-term segregation inmates back into the prison's general population in the hope that they would be able to succeed in that environment, without causing the problems that had gotten them sent to a segregation cell in the first place. The solution was to create a Transition Unit at the Penitentiary to provide a “neutral setting” where long-term segregation inmates could gradually become acclimatized to living among larger and larger groupings of people, and could receive transition programming to help them learn to cope with the pressures and difficulties of life in the prison's general population. We believe that it is highly desirable for long-term segregation inmates to go through this programming, although unfortunately that does not always happen, even though the Transition Unit was created for that very purpose.

Mr. Jenkins' situation is an example of a case where an inmate did not have the advantage of receiving either rehabilitative programming or transition programming before he was released to the community. As I have indicated, the Ombudsman's Office was struggling to have Mr. Jenkins promoted from his segregation cell and into the prison's general population, almost right up to the very point when he was finally discharged from custody on July 30, 2013. Based on our discussions with DCS officials, it was our understanding that Mr. Jenkins would first be moved from segregation at TSCI to segregation at the Penitentiary's Control Unit on March 15, 2013, and then, after 30 days, Mr. Jenkins was to be moved into the Penitentiary's Transition Unit for preparation to be released into the prison's general population. Of course, this idea was less than ideal, given the likelihood that Mr. Jenkins would be released in July, but it was the best that we could hope for, given the short time that was left. It should be remembered, however, that back in February of 2012, the Department's own MIRT team had recommended that Mr. Jenkins be “considered for the transition program at NSP to allow time in GP (general population) prior to discharge next year.” If this recommendation had been followed (which it was not), then Mr. Jenkins might have been able to receive some meaningful transition programming, and have a real opportunity to acclimate himself to life in a larger (if prison) society before his eventual release. As it is, we will never know whether that programming and transitioning from a segregation cell would have made a difference with Mr. Jenkins, but then that is the problem...we will never know.

Only about 350 inmates out of all the inmates in Nebraska's correctional system are serving some form of Life sentence. All of the rest of our inmates, a number that is somewhere in excess of 4,000 inmates, will eventually be released from confinement, where they will ultimately surface as our neighbors, our friends, our fellow employees, etc. Clearly, this implies that it will be in everyone's interest for all of our inmates to have the best possible chance to succeed after their release, which we know can best be achieved through following a "policy of transition," and by providing comprehensive, evidence-based programming (both during incarceration, and while on parole after release). And if this principle is true generally, then it is even more valid in the cases of segregation inmates who have spent vast quantities of time in isolation from virtually all social contact. With this in mind, **consideration should be given to tracking the fate of those inmates who are released from long-term segregation to measure their recidivism rate (which is apt to be high), and to see whether programming and a transition strategy makes a difference in the success of those inmates after their release. And, in any event, the Ombudsman's Office continues to believe that it is desirable for the Department to require the development of a detailed, individualized, and comprehensive transition plans/programming for all inmates who have spent prolonged periods of time in segregation.**

## The Sentencing/Good Time Question

In the wake of the charges brought against him, some issues have been raised about the sentencing of Mr. Jenkins and how his good time was handled while he was in the Nebraska correctional system. In fact, Mr. Jenkins was sentenced on three successive occasions, and each of the last two sentences was made to run consecutively, and added years to his term of incarceration. Mr. Jenkins' original sentence was in 2003 for two counts of Robbery, and one count of Use of a Weapon to Commit a Felony, and in that instance Mr. Jenkins' sentence was for an indeterminate term of from fourteen to fifteen years. In August of 2006, Mr. Jenkins was sentenced to a term of two additional years for one count of Assault in the Second Degree, a sentence which related to the assault that he had committed while an inmate at NCYF. In 2011 Mr. Jenkins was given an additional consecutive sentence of from two to four years for Assault on a Correctional Employee - Third Degree, a sentence which related to the instance where he assaulted his escort when he was in Douglas County on a Travel Order to attend a funeral on December 17, 2009. In the aggregate, these sentences made Mr. Jenkins' total sentence a term of from eighteen to twenty-one years. In my experience, none of these sentences look unusual or extraordinary to me, in the sense of being either too lenient, or too harsh. Some judges might have given a more lengthy term, some less, but these sentences are within what I would consider the normal range, based upon what I have seen in looking at sentencing orders in the past (if anything, the first sentence of 14 to 15 years might seem to be somewhat long, given the youth of Mr. Jenkins at the time).

It is worth noting that there was at least one more instance during Mr. Jenkins' history in the Nebraska correctional system where Mr. Jenkins might have been given one additional sentence, but was not. On February 17, 2007, Mr. Jenkins and two other LCC inmates were involved in the assault upon a Native American inmate. In that case, it was alleged that Mr. Jenkins had struck the other inmate several times in the head, while one of the other assailants supposedly used a heavy padlock to bludgeon the victim. Unlike the situation in Omaha in 2006, Mr. Jenkins was not, to the best of our knowledge, charged with felonious assault in the 2007 case at LCC. In addition, it does not appear that Mr. Jenkins forfeited any good time in connection with that February 17, 2007, incident. (Mr. Jenkins did forfeit 45 days of good time on February 23, 2007, but records indicate that in that instance he was being punished for "tattoo

activities.”) To the extent that Mr. Jenkins was ever “punished” in connection with the February 17, 2007, incident, it would appear that the “punishment” for that event was limited to his being classified to Administrative Confinement status, and placed indefinitely in segregation.

Like nearly all of the inmates in the Nebraska correctional system, Mr. Jenkins was given “good time” credits which substantially reduced his sentence as pronounced by the courts. (In addition, his term of confinement was also reduced by his being given credit for time served in jail prior to sentencing, as is allowable under Nebraska law.) Given the ultimate length of his sentence, if he had received all of his possible good time credits, it appears that Mr. Jenkins would have been able to discharge from custody perhaps as early as January of 2012. If all of his good time had been forfeited, then Mr. Jenkins would not have been subject to discharge until the end of his full maximum term (less jail credit), or sometime in 2024 (although an inmate that loses all of his/her good time is an *extremely rare* occurrence).

Nebraska's sentencing and good time laws have a long, and rather circuitous, history. The “modern era” of Nebraska's sentencing and good time laws goes back to 1969, and LB 1307 of that year. Even then, the sentencing laws in this state contemplated that most inmates would receive “indeterminate sentences,” that is, sentences with a range that provided for a minimum term and a maximum term, as pronounced by the sentencing court. Good time credits are typically deducted from both the minimum and the maximum. LB 1307 (effective in August of 1969) was unusual in that it implemented an idea referred to as “mandatory parole.” Typically, an inmate's sentences will provide for a parole eligibility date, that is, a date when the Board of Parole may, in its discretion, choose to grant the inmate a parole. However, this was a decision that would always be within the Parole Board's discretion, and there are often situations where the Board of Parole will choose not to grant a parole to an inmate who is eligible (which is what happened in Mr. Jenkins' case). Consistently, throughout the decades, inmates' parole eligibility dates have been determined by subtracting good time credits from the inmates' minimum sentence. And that is how parole eligibility was set under LB 1307 of 1969. However, LB 1307 also provided for a “mandatory parole,” which was a situation where the inmate had to be released into the community before the end of his/her sentence, but would be subject to parole supervision until he/she was finally discharged. The big advantage of a mandatory parole system is that it guarantees that all inmates who are released will have an opportunity to live in the community *under supervision* – that is, no one would be simply released into society cold, without supervision, as had happened in the case of Mr. Jenkins. (Of course, if the inmate on mandatory parole misbehaved while on parole status, then the parole could be revoked by the Board of Parole, in which case the inmate would be returned to custody, typically until the end of his/her maximum sentence.) Under LB 1307, the mandatory parole date of an inmate's sentence was set by subtracting good time from his/her maximum term, and the inmate would then finally be discharged at the point when he/she reached the end of his/her maximum term as set by the judge. The amount of good time allowed under LB 1307 was five days per month plus:

- 2 months per year for year-one of the sentence;
- 2 months per year for year-two of the sentence;
- 3 months per year for year-three of the sentence; and
- 4 months per year for year-four of the sentence, and for every year thereafter.

So, an inmate would receive what amounted to four months of good time credit on his/her sentence in the first year, and would eventually receive as many as six months per year after completing the third year of his/her sentence.

From the beginning there was always the understanding that the inmate could lose good time, if he/she was found to have violated the rules relating to behavior within the institution. Thus, good time credits were not irrevocable rights, in the sense that the credits could not be forfeited. On the contrary, many inmates could very well expect to lose a part, even a significant part, of their good time credits during the course of their stay in the corrections system, if they engaged in prohibited behavior. However, in 1974 the United States Supreme Court in the case of *Wolff v. McDonnell*, 418 U.S. 539, held that good time credits could be taken away from an inmate by the state's correctional authorities only after the state had provided certain minimal forms of Due Process, including notice of the charges being made, and an administrative hearing with a right for the inmate to be heard in his/her own defense.

The good time laws in Nebraska were changed effective August 24, 1975, by the adoption of LB 567 of that year. Under LB 567 the statutory amounts of good time allowed were unchanged, but the idea of mandatory parole was eliminated. As was the case with LB 1307, inmates' parole eligibility dates were to be determined by subtracting good time credits from the inmates' minimum sentence. However, LB 567 provided that henceforth good time reductions from the inmates' maximum sentence would be used to determine when the inmate would be discharged from custody. After 1975 and LB 567, Nebraska's good time and sentencing laws remained unchanged for nearly two decades, until the adoption of LB 816 in 1992. What LB 816 actually changed was the rate of good time credits – now inmates would earn good time credit at a rate of six months per year for *all years* of their sentence. The sentencing and good time laws were next changed by LB 371 of 1995. First of all, LB 371 created a new category of sentences, the “mandatory minimum” sentence, which in the case of certain offenses required the inmate to serve the full minimum sentence, without receiving any good time credits on the minimum. It also created the so-called “positive time” system for awarding good time to inmates in the Nebraska correctional system. Under LB 371, non-mandatory minimum inmates would still receive good time credits of six months per year in order to determine their parole eligibility date. However, instead of automatically receiving six months of good time for every year of their sentence for the purpose of setting their discharge date, the inmates were required to earn half of their good time for discharge-date purposes by actively participating in a “personalized program,” which was to be developed for each inmate by the Department. There were several problems with this system, however. For one thing, there were potentially concerns about fairness, and possible biases that might be involved in judging which inmates had done enough to earn their good time. In practice, there were also concerns about whether inmates with intellectual disabilities, including reading disabilities, would be able to meet the expectations of their personalized program. And, a system that requires meeting the expectations of a personalized program implies that there will be adequate programming resources in the correctional system to make that possible. However, as the population of the Nebraska correctional system went up, it was not at all clear that the system's programming resources were truly keeping up with the rapidly increasing demand, creating a shortage, and putting inmates in a Kafkaesque situation where they were expected to expose themselves to programming opportunities that did not exist.

The Nebraska good time laws were changed again in 1997 with the adoption of LB 364. What LB 364 (effective July 1, 1998) did, in effect, was return the system to one where good time was again awarded at a flat rate of six months per year of sentence, not only for parole eligibility purposes, but also for the purpose of setting the inmates' discharge dates. In other words, LB 364 dropped the LB 371 concept of “earning” good time, and went back to the old system of awarding good time “automatically,” with the understanding that the inmate could lose his/her good time for breaking the rules of the institution, or if

he/she intentionally failed to comply with the personalized plan, in which case the inmate could have disciplinary action taken, and might lose three months of good time per year. The most recent change to Nebraska's good time laws came in 2011 in the form of LB 191. According to LB 191, an additional three days per month could be deducted from an inmate's maximum term, to determine the date when discharge from the custody of the state becomes mandatory, but only if certain conditions were met by the inmate. Specifically, an inmate's maximum term is to be reduced "by three days on the first day of each month following a twelve-month period of incarceration within the department during which the offender has not been found guilty of (serious acts of misconduct)." In addition, LB 191 good time is not subject to being forfeited by the inmate, or taken away by the Department.

When it comes to the practicalities of recording good time credits, it has always been the practice of the Department of Correctional Services to credit the inmates with their good time months "up front," and then subtract the inmates' forfeited good time piecemeal, as the misconduct cases are adjudicated over the years. The handling of the good time is done this way for a couple of reasons. First of all, it helps to give the inmates a set of clear numbers, that is, dates of parole eligibility and tentative discharge, so that they will know with some clarity what they have to lose, if they misbehave. And, if the good time is added in to the sentence calculation "up front," then the inmate will have a sense that he/she has a lot to lose by not following the rules. Second, crediting the good time up front also helps the system to plan, with the Board of Parole, for example, having a sense of when it will have to be seriously looking at the offender because he/she is nearing parole eligibility. And so, while as a bookkeeping matter, the Department could have a process of adding the good time credits in month-to-month increments, that would be a significant departure from the current system, and would diminish the advantages that I have just described.

With the arguable exception of the three days of good time added to the system via LB 191, the inmates are not expected to "earn" their good time by good behavior, however that might be defined. Instead, the system assumes that the inmate's good time is "vested" when he/she begins the sentence, although it is time that can be taken away from an inmate who misbehaves (except, of course, in the case of the LB 191 good time). As the Nebraska good time system has been handled by corrections officials over the years, it certainly was not about being lenient with inmates. Instead, it is all about giving corrections officials a way to try to manage inmates' behavior, mostly by giving them a powerful disincentive to misbehave. Basically, what the good time system is intended to do is to allow corrections officials to discourage their inmates from misbehaving by making it possible for the Department of Correctional Services to lengthen an inmate's sentence, if he/she breaks the rules. So the State's good time system, as the system functions today, is not about being lenient with inmates. On the contrary, it is all about empowering our corrections officials to maintain order in our prisons by giving them the discretion to add time to inmates' sentences.

When a judge in Nebraska sentences a defendant to an indeterminate sentence, for example, a term of from ten to twenty years, presumably he or she knows that through the application of Nebraska's good time statutes the sentence will translate in to something nearer to a term of from five to ten years. But the sentence pronounced by the judge is both setting the absolute maximum of the sentence, and what, in effect, amounts to the absolute minimum of the sentence's perimeters, with the understanding that he or she is giving the Department of Corrections broad discretion to lengthen the inmate's sentence (at least, within a certain range), if the Department feels that doing so is justified because of the inmate's behavior. It is my sense that the Department places great value on having this authority, even though,

since 1974 and *Wolff v. McDonnell*, they have had to provide minimal Due Process before taking the inmate's good time.

As the reader can see from this account, Nebraska's good time laws have been amended frequently over the years. What we have learned from all this is that, when contemplating further changes in the good time laws, two major points must be considered. First, laws amending the Nebraska statutes on how good time is credited cannot be made to apply retroactively. See *Boston v. Black*, 215 Neb. 701, 340 N.W.2d 401 (1983). Thus, all changes in the good time statutes are prospective only. The effect of this is that our corrections system now has what are, in effect, cohorts of inmates marching through their sentences, while serving their time under very different laws. All of this has made the system for accurately calculating our inmates' sentences into a somewhat complicated process. Second, it is very important to keep in mind that changes in our good time laws can have very significant effects (some of them foreseen, some unforeseen) on the size of the Nebraska prison population. This means that it is advisable to first carefully calculate what the projected population impact will be with respect to any proposed change in our good time laws, particularly those changes that will reduce good time credits, and thereby lengthen sentences.

## **The Mental Health Services Question**

Our access to Mr. Jenkins' files has given us a rare, if not unprecedented, opportunity to observe, in minute detail, how a correctional mental health system interacts with a deeply troubled inmate. In a 2006 report, the U. S. Bureau of Justice Statistics estimated that 56% of state corrections inmates had a mental health problem of some nature. The same report further indicated that as many as 15% of all state prisoners reported symptoms that met the (DSM-IV) criteria for a psychotic disorder, including signs of delusions “characterized by the offenders’ belief that other people were controlling their brain or thoughts, could read their mind, or were spying on them,” and/or hallucinations, including “reports of seeing things others said they did not see or hearing voices others did not hear.” Clearly, Mr. Jenkins would have to be included in that 15% of prison inmates who *reported symptoms* that meet the criteria for a psychotic disorder (for instance, he has reported “hearing voices”). However, as to whether Mr. Jenkins, in fact, suffers from a serious mental illness, that seems to be less a matter of conjecture than a question of which expert you choose to agree with on the issue.

The record in this case clearly depicts a level of uncertainty, or dissonance, over the correct diagnosis of Mr. Jenkins' condition, and particularly over the issue of whether he has a serious mental illness. If we look at the opinions expressed by the four psychiatrists who had the most comprehensive exposure to the question of Mr. Jenkins' diagnosis, we see a situation where different experts arrived at nuanced, but still very different, conclusions. Dr. Baker expressed the opinion that Mr. Jenkins' symptoms were “inconsistent and more behavioral/Axis II in nature,” and that Mr. Jenkins was attempting to use his mental health symptoms “for secondary gain, including to avoid legal consequences in court for (his) recent behaviors.” Dr. Moore said that it was his opinion that “there is the possibility that Mr. Jenkins does indeed have a psychotic illness, (but) I don't think this is a very good possibility,” and that Mr. Jenkins' “major diagnosis is Antisocial Personality Disorder,” with “doubt” concerning “the presence of psychosis.” When Dr. Wetzel examined Mr. Jenkins, he said that his diagnosis was “Bipolar Disorder NOS, Probable; PTSD, Probable; Antisocial and Narcissistic PD (personality disorder) Traits; and Polysubstance Dependence in a Controlled Environment.” Dr. Wetzel also said that when he examined

Mr. Jenkins, there was “enough objective evidence of disruption in sleep cycle, mood and behavior to suggest an element of major mood disorder influencing the clinical picture.” When Dr. Oliveto saw Mr. Jenkins on April 23, 2010, his diagnosis of Mr. Jenkins' condition was “Axis I - Schitzoaffective disorder vs. bipolar I; Axis II – Anti-social/Impulsive/Obsessive.” Later, on September 22, 2010, Dr. Oliveto gave a diagnosis of Mr. Jenkins' condition as being “Axis I - Schitzoaffective disorder vs. paranoid schizophrenia; Axis II – Antisocial/Obsessive/Impulsively dangerous to others/Explosive,” and his Follow-up Notes described Mr. Jenkins as being “psychotically obsessed with plot to kill him or set him up to kill others,” and as being “psychotic, delusional.” (Of course, it was also Dr. Oliveto who recommended that Mr. Jenkins should be transferred to the Lincoln Regional Center “before his discharge to stabilize him so he is not dangerous to others.”)

As we have remarked earlier, it is possible for reasonable mental health professionals to differ in their diagnosis of the condition of the same patient. However, as we can see from the opinions expressed in Mr. Jenkins' case, the development of a firm psychiatric diagnosis for some individuals can sometimes be very difficult, as the doctors try to use their training and insights to penetrate the clouds and develop a clear picture of the patient's condition, and categorize that condition. And when multiple experts are involved, it is even possible to see an array of differing diagnoses falling on a “diagnostic spectrum,” with a range that extends from – *No Serious Mental Illness*, to...*May Have a Serious Mental Illness, but Probably Not*, to...*May Not Have a Serious Mental Illness, but Probably Does*, to...*Has a Serious Mental Illness*. In fact, to a certain extent, we can see this “spectrum” developing in the diagnosis of Mr. Jenkins as proposed by Dr. Baker, Dr. Moore, Dr. Wetzel, and Dr. Oliveto. It would, I believe, be too dismissive of the skills and professionalism of the psychiatrists involved to say that the business of making a psychiatric diagnosis is “more art than science,” but certainly the impression that a layperson gets from reading the various diagnoses of Nikko Jenkins is that our psychiatrists must be given a great deal of latitude when it comes to drawing their diagnostic conclusions, at least in some cases.

If a firm diagnosis of Mr. Jenkins' condition is elusive, there are certain elements of his case that are true beyond any dispute. The indisputable facts of Mr. Jenkins' case include the following:

1. Mr. Jenkins has a history of violence, including the crimes that got him sent to prison in the first place, and the violent acts that he engaged in after his incarceration, (a) his role in a “near riot” in the yard of NCYF on July 4, 2005; (b) his involvement with two other inmates in the assault of a Native American inmate at LCC on February 17, 2007; and (c) his assault on a DCS staff person who escorted him to a funeral in Omaha on a temporary Travel Order on December 17, 2009. In addition, it must also be noted that Mr. Jenkins was found to be in possession of a homemade weapon (a toilet brush sharpened to a point) concealed in his waistband at TSCI on January 26, 2009.
2. Mr. Jenkins consistently reported having psychotic symptoms, in particular, his often repeated statements about hearing the voice of an “Egyptian god” who wanted him “to harm others.”
3. Mr. Jenkins repeatedly threatened/warned/predicted that he would commit violent acts after he was released from DCS custody, including:

On July 22, 2008, when Mr. Jenkins told Unit Manager Jason Hurt that “he's just going to randomly go to suburban houses and start killing people outside of North Omaha,



maybe go to Tecumseh or Syracuse with his gang members and start killing people.”

On July 31, 2008, when Mr. Jenkins spoke to Mr. Hurt about a “desire to kill the administration and other people when he gets out of prison.”

On August 11, 2008, when Mental Health Practitioner Connie Boerner reported that Mr. Jenkins had “expressed having ongoing homicidal ideations and has made threats to hurt others once he is released from incarceration (and) went into detail as to how he would kill others, similar to the recent Von Maur shootings.”

On January 15, 2009, when Mr. Jenkins spoke to TSCI Mental Health Practitioner Heidi Widner about “the life of crime that awaits him once he is out...(and) that his crimes and killing will not be limited to just his own kind.”

On February 23, 2009, when Mr. Jenkins spoke with Ms. Boerner, and indicated that he “fantasizes of 'killing' others once he is released,” and had stated that “he sees himself 'destined' to be a 'homicidal maniac.’”

On May 13, 2009, when TSCI Unit Manager Shawn Sherman submitted a Mental Health Referral reporting that Mr. Jenkins “claims to be hearing the voice of an Egyptian god... telling him to massacre children.”

On December 3, 2009, when Mr. Jenkins reported to Dr. Baker that he was “hearing the voice of an Egyptian god who wanted him to harm others” (Dr. Baker added the observation that that Mr. Jenkins “is not an imminent danger to himself or others at this time,” although just two weeks later he would assault a Corrections employee).

On December 28, 2009, when Mr. Jenkins sent a Health Services Request Form to Dr. Baker reporting that the “voice” in his mind was telling him to “hurt guards,” and to “start war between good and evil.”

On January 10, 2010, when Caseworker Howell reported in a Mental Health Referral that Mr. Jenkins had “exhibited increasingly aggressive behavior in the past week... claiming to hear voices telling him to injure staff.”

On February 27, 2010, at the Douglas County Jail, when Licensed Mental Health Practitioner Denise Gaines spoke with Mr. Jenkins, and later reported that he had talked about the “horrific acts that the Egyptian god Opophus (sp.) wants him to inflict on Catholics, whites, and children.”

On August 7, 2010, when Ms. Gaines again spoke with Mr. Jenkins and reported that he said that “Opophus is telling him that the day is coming soon that 'they will see,' (and)... Opophus taking him over and him killing others once released from prison if he doesn't get some help.”

On December 11, 2010, when Ms. Gaines reported that Mr. Jenkins seemed “scared

about being released because of the violence that he is (through Apophis) inflict on people and police.”

On March 25, 2011, when Ms. Gaines recorded that Mr. Jenkins “continued to express thoughts about doing murderous acts on society (i.e., killing/torturing nuns, children, etc.).”

On December 23, 2011, when Mr. Jenkins told Dr. Baker that he “feels he will hurt others when released back into the community.”

On February 1, 2012, when Mr. Jenkins told Dr. Weilage that “he wants help and if he does not get it from us then his first thought when he gets out is that he needs to 'get some weapons.’”

On April 19, 2012, when Dr. Baker reported that Mr. Jenkins expressed “concerns about what he will do once he is released from DOC.”

On January 15, 2013, when Mr. Jenkins said to Dr. Gibson that “he views everyone as 'prey' and followed-up with a number of violent images.”

On January 19, 2013, when a nurse at TSCI reported having heard Mr. Jenkins saying that he was “afraid he will get out and 'rip someone's heart out.’”

On January 25, 2013, when Mr. Jenkins said to Dr. Gibson that, when he was released, he would “give in to 'apophis' who wanted him to kill 'man, woman and child' of 'every age group.’”

On March 7, 2013, when Mr. Jenkins made a statement to DCS social worker Kathy Foster in regard to the “intended violence that he will commit if he is discharged to the community,” and told her that he “does not want to discharge to the community because he will kill people and cannibalize them and drink their blood.” (Please note that Ms. Foster's notes from her meetings with Mr. Jenkins are incorporated in the Department's Mental Health Contact Notes.)

On March 14, 2013, when Mr. Jenkins met with Dr. Wetzel and expressed “repeated thoughts of harming other people in the form of cannibalism and 'waging war.’”

On April 5, 2013, when Ms. Foster, the social worker, met with Mr. Jenkins, and Mr. Jenkins “stated a couple of times that he is 'not kidding,' it will be bad' when he gets out.”

On April 30, 2013, when Ms. Foster had yet another meeting with Mr. Jenkins, and Mr. Jenkins told her “that when he gets out 'it will begin' and...made allusions to killing 'without prejudice.’”

4. Mr. Jenkins had repeatedly asked for/demanded that he be given treatment for his mental

condition, including, if possible, through a transfer to the DCS Inpatient Mental Health Unit at LCC, or through a civil commitment to the Lincoln Regional Center.

Those of us who work in the Ombudsman's Office do not have the training to express an opinion on the mental health status of Nikko Jenkins, or of anyone else, for that matter. All that we can do, insofar as Mr. Jenkins' mental state is concerned, is to note that the diagnoses offered by the different psychiatrists in this case sound somewhat (perhaps even considerably) different, so much so, in fact, that we could say that there was "a difference of professional opinion" on the subject of Mr. Jenkins' mental health, and whether he suffers from a "serious mental illness." It also appears to us that the whole question of what Mr. Jenkins' correct diagnosis might be was something that, in an odd way, became a barrier to his getting treatment for his condition, whatever it might be. The record, in fact, suggests that a great deal of time was spent by the DCS Mental Health staff in arguing/disputing/debating with Mr. Jenkins over the issue of whether he had a serious mental illness that justified his being sent to the Inpatient Mental Health Unit at LCC, or to the Lincoln Regional Center, when it might have made more sense to try to engage him in some kind of therapy beyond just prescribing medications (which he typically would stop taking after a brief period of time), or to at least develop a long-term plan for trying to "reach" Mr. Jenkins.

The strict question of his diagnosis aside, we know that Mr. Jenkins repeatedly asked the DCS Mental Health staff to provide him with ongoing therapy to address his troubled condition. He requested to be transferred to the Inpatient Mental Health Unit at LCC, and even lobbied to be civilly committed to the Lincoln Regional Center. Examples of this are reflected in the following contacts:

On March 27, 2009, Dr. Weilage visited with Mr. Jenkins, and reported that "he is interested in 'rehab' and the MHU (Mental Health Unit) at LCC."

On December 18, 2009, in a conversation with Katherine Stranberg, a Mental Health Practitioner working at TSCI, Mr. Jenkins "reported that he wanted to go to the Inpatient Mental Health Unit (at LCC) because there he would be able to get the ongoing treatment he needed."

On September 26, 2011, Dr. Baker reported that Mr. Jenkins was requesting "daily psychotherapy to help him cope," and was "very focused on wanting to be transferred to LRC and states he will only take meds if recommended if he is at LRC."

On February 1, 2012, in a meeting with Dr. Weilage, Mr. Jenkins "specifically requested daily psychotherapy...stated (that) daily psychotherapy would help with his hypomania, stabilize his psychosis, and help him deal with the grief of confinement," and said that "he would comply with medications, therapy, if transferred to LCC and comply with MHU expectations."

On March 23, 2012, Mr. Jenkins spoke with Mental Health staff at TSCI and "insisted that he needed 'intense psychotherapy' before he was released," and that the Mental Health staff should recommend that he "be placed in a psychiatric hospital immediately due to the high level of distress he was experiencing."

On April 19, 2012, Dr. Baker spoke with Mr. Jenkins, and reported that Mr. Jenkins expressed "concerns about what he will do once he is released from DOC," and that he again said that he

would like to be transferred to LCC or LRC for mental health treatment, and continued to “refuse all psychotropics including...until he can be transferred to LRC/LCC.”

On May 15, 2012, Mr. Jenkins spoke with Mental Health staff at TSCI and “insisted that he was not receiving proper psychological/psychiatric/mental health treatment for his mental illness.”

In early May of 2012, Mr. Jenkins addressed an Informal Grievance to DCS Director Robert Houston stating that he had an “emergency need of medical treatment psychologically,” and that he wanted to be approved to receive treatment at the “LCC mental health mod for (the) mentally ill.” (It appears that Mr. Jenkins' grievance was ultimately routed to DCS Deputy Director for Institutions Frank Hopkins for a response.)

On January 10, 2013, Dr. Pearson spoke with Mr. Jenkins, and reported that he had stated “that he was 'psychotic' and needed transferred to the Lincoln Regional Center for care.”

On January 16, 2013, Dr. Gibson met with Mr. Jenkins, and reported that Mr. Jenkins had expressed “a belief that he should be hospitalized for psychiatric concerns (particularly being dangerous to others), as he will be released soon.”

After Mr. Jenkins inflicted significant wounds to his face on January 18, 2013, a nurse at TSCI reported to Dr. Gibson that Mr. Jenkins had been “screaming about wanting psychiatric treatment, as he is reportedly afraid he will get out and 'rip someone's heart out.’”

On January 25, 2013, Mr. Jenkins spoke with Mental Health staff at TSCI and requested “hospitalization so that he does not harm other people.”

On February 17, 2013, Mr. Jenkins sent an Informal Grievance to TSCI Warden Fred Britten in which he said that he was “requesting psychiatric hospitalization for severe psychosis conditions of enragement episodes of my schizophrenia disease,” and specifically referenced the Nebraska Mental Health Commitment Act.

On February 19, 2013, Licensed Mental Health Practitioner Brandy Logston spoke with Mr. Jenkins, and reported that Mr. Jenkins told her that “he 'wanted it documented' that he was in need of 'emergency psychiatric treatment.’”

On March 14, 2013, Mr. Jenkins told Dr. Wetzel that he was due to be released from prison in July, and that he “wants to be placed in a psychiatric hospital to stabilize for 'modern times.’”

In short, Mr. Jenkins was asking for help, and although there might perhaps be some doubts about his sincerity in that regard, there can be little reasonable doubt about the fact that he did have a dangerous history, and was expressing dire and dangerous ideas to the DCS Mental Health professionals...over, and over, and over. [When it comes to the question of Mr. Jenkins' sincerity, we should keep in mind Ms. Gaines October 8, 2010, Progress Notes, which include the observation that she “sincerely believes that this client wants help, but is giving up on anyone (the system) providing him with help.”] With all of this in mind, it is difficult to look at this case (indeed, very difficult to look at this case) and not feel that it might have made more sense to deemphasize the whole question of diagnosis, and concentrate

instead on the verifiable facts – the inmate's actions, the inmate's history, the inmate's statements; in short, the inmate's dangerousness. And, having considered the obvious potential that Mr. Jenkins had for dangerous behavior, it would also have made better sense to have formulated a strategy of therapy that might have made a difference in regard to his future behavior, or that, at least, might have given the Mental Health staff a better sense of where he needed to go after he was discharged from DCS custody.

There can be little doubt that some of the mental health professionals who were aware of Mr. Jenkins knew, or should have known, that he was potentially dangerous. Even as early as July of 2008, Connie Boerner, part of the TSCI mental health staff, stated that Mr. Jenkins “is a very dangerous individual.” On July 17, 2009, another TSCI mental health professional, in reporting on a conversation with Mr. Jenkins, expressed the opinion that Mr. Jenkins “appears to be at considerable risk for reoffending and for interpersonal violence.” And, of course, both Dr. Oliveto and Ms. Gaines at the Douglas County Jail were not only very concerned about Mr. Jenkins' dangerousness, but were also very clear in their attempts to warn others about how dangerous Mr. Jenkins might be after release. On September 22, 2010, after he had examined Mr. Jenkins, Dr. Oliveto not only recorded his opinion that Mr. Jenkins' diagnosis included “schitzoaffective disorder vs. paranoid schizophrenia,” but also said Mr. Jenkins needed “transfer to LRC before his discharge to stabilize him so he is not dangerous to others.” These observations, together with Ms. Gaines' own observations of Mr. Jenkins while in her care, resulted in the December 1, 2010, letter that Ms. Gaines addressed to the Nebraska Board of Parole in which she advised the Board that Mr. Jenkins had been evaluated by Dr. Oliveto, who was recommending that Mr. Jenkins should be “transferred to Lincoln Regional Center for treatment before being discharged (from the correctional system) for 'stabilization so he is not dangerous to others.’” Later on in Mr. Jenkins' period of incarceration, on March 4, 2013, Dr. Baker met with TSCI psychologist Dr. Pearson to propose that Mr. Jenkins “be seen by Dr. Wetzel for a second opinion,” so that Dr. Wetzel could “assess (Mr. Jenkins) for dangerousness risk,” due to her concerns about “his dangerousness to the community upon release.”

In a sense, many of these issues - Mr. Jenkins' mental health, his history of asking for treatment of his mental health condition, and the fact that his “serious history of mental illness...inhibits his ability to be rehabilitated” - were pulled together in the sentencing Order signed by Douglas County District Judge Gary B. Randall on July 11, 2011. Noting that Mr. Jenkins had “requested treatment for his mental health issues,” and that “the record...would support the Defendant's request,” the Order signed by Judge Randall included what was an extremely unusual statement: “The Court therefore recommends to the Department of Correctional Services that Defendant be assessed and treated for issues regarding his mental health.” Of course, this was only a recommendation, subject to the informed judgment of the Department's Mental Health staff as to whether it was to be implemented, or not. In fact, we know that Mr. Jenkins was subsequently evaluated by the DCS Mental Illness Review Team (although that did not happen until February of 2012). And Mr. Jenkins was evaluated by Dr. Wetzel at Dr. Baker's suggestion, but that did not happen until March of 2013. We would also note that Mr. Jenkins was returned to TSCI on July 19, 2011, and that on February 1, 2012, Dr. Weilage recorded that Mr. Jenkins had been “seen by licensed Mental Health staff for evaluation and/or monitoring on 10 occasions” since having returned to TSCI. It is probably best left to the reader to decide whether this history of “10 occasions” reflected a meaningful execution of Judge Randall's recommendation regarding assessment and treatment of Mr. Jenkins.

As we have sifted through the deep drifts of records and documents relating to this case, one of the most insightful and impressive remarks/recommendations concerning Mr. Jenkins' situation that we

have seen was the following note written by Dr. Wetzel:

Long-term strategies recommended for this patient include development of a rapport and trust to enhance participation in psychiatric care, ongoing development of objective evidence supporting - - or not supporting - - the presence of major mental illness and the possibility of further psychological formal testing to help clarify (the) diagnostic picture.

While others in DCS seemed to be invested in the idea that Mr. Jenkins did not have a serious mental illness, Dr. Wetzel obviously kept an open mind on the subject. Dr. Wetzel also offered a practical plan for how the Department's Mental Health staff might approach Mr. Jenkins' situation in the future. The key word in Dr. Wetzel's recommendation, in our opinion, is the word "trust." When we read many of Mr. Jenkins' comments, as recorded in the documents discussed in this report, we get the sense that the DCS Mental Health staff were distrusted by Mr. Jenkins and were seen by him as being an extension of the TSCI security staff. (There is much less of this to be found in the records of Mr. Jenkins' stay at the Douglas County Jail.) In its 2012 Position Statement on Segregation of Prisoners with Mental Illness, the American Psychiatric Association noted that "(p)hysicians who work in U. S. Correctional facilities face challenging working conditions, dual loyalties to patients and employers, and a tension between reasonable medical practices and prison rules and culture." Certainly, we can appreciate how powerful and challenging this "tension" can be, and clearly we would agree with the idea that it is important that the DCS Mental Health staff be trained and counseled to struggle against succumbing to this "tension," so that the Department's mental health professionals can accomplish both the image, and the reality, of being separate and independent of the agency's security staff. It should go without saying that the DCS Mental Health staff are not employed in the system for the purpose of advancing/validating the agenda of the agency's security staff. On the contrary, they are there to serve the inmates who are their patients and, by serving those patients, to advance the larger interests of the community in having more stable, law abiding, and "civilized" men and women released into society, when the day of an inmate's release finally arrives. All of this comes down, in our estimation, to having good leadership and, as we see it, the quality of the current leadership of the DCS Mental Health component should be evaluated through the prism of this case, no matter how painful that might be.

In summary, the Ombudsman's Office would offering the following:

- **In evaluating the inmates who come into contact with the DCS Mental Health component, the Department's Mental Health staff should place a high priority on identifying inmates who are, or may be, dangerous, so that those inmates can: (1) be given special attention in terms of providing them with treatment/therapy; and (2) be reevaluated for presence of a serious mental illness as their discharge date approaches, so that informed decisions can be made as to whether those inmates should be referred to the civil commitment process.**
- **The DCS Mental Health component should place a high priority on finding effective ways to develop a positive rapport and sense of trust with the patients that it serves, in order to enhance the inmates' participation in their own mental health/behavioral health care.**
- **In light of the American Psychiatric Association's observation that physicians who work in correctional facilities face "dual loyalties to patients and employers, and a tension between reasonable medical practices and prison rules and culture," the Nebraska Department of**

**Correctional Services should seriously consider whether it would be desirable, as a way of protecting/guaranteeing the independence of its mental health professionals, to privatize the Department's entire mental health component.**

## **The Civil Commitment Question**

As indicated at a previous point in this report, in early 2013 Mr. Jenkins contacted the Johnson County Attorney requesting a civil commitment proceeding to have himself committed to hospitalization under the Nebraska Mental Health Commitment Act (**Neb. Rev. Stat.** §§71-901 thru 71-963). On March 11, 2013, Mr. Richard Smith, the Deputy Johnson County Attorney, wrote to Mr. Jenkins acknowledging the receipt of letters from Mr. Jenkins, “as well as materials provided by (his) mother and (his) fiancée” regarding Mr. Jenkins' mental health. Mr. Smith's letter explained that in order to file a mental health board petition the County Attorney would “need to hear from a mental health expert who can testify as to mental illness and dangerousness.” Mr. Smith's letter indicated that he expected the Department to evaluate whether Mr. Jenkins was “fit to be released,” or whether “further inpatient commitment to treat (his) mental illness” was needed. Mr. Smith also related that when DCS provided “copies of its recommendation...a determination will be made about whether a mental health petition is appropriate.” Of course, as we now know, by the time that a mental health commitment proceeding might have been pursued by the Johnson County Attorney in Mr. Jenkins' case, Mr. Jenkins had already been moved out of Johnson County to NSP.

Under **Neb. Rev. Stat.** §71-921(1), “any person who believes that another person is mentally ill and dangerous may communicate such belief to the county attorney,” and “if the county attorney concurs that such person is mentally ill and dangerous...he or she shall file a petition,” as provided in **Neb. Rev. Stat.** §71-921(3), including a “statement that the beliefs of the county attorney are based on specific behavior, acts, attempts, or threats which shall be specified and described.” Following the filing of that petition by the county attorney, **Neb. Rev. Stat.** §71-924 provides that “a hearing shall be held by the mental health board to determine whether there is clear and convincing evidence that the subject is mentally ill and dangerous as alleged in the petition.” According to **Neb. Rev. Stat.** §71-925(1), “the state has the burden to prove by clear and convincing evidence that (a) the subject is mentally ill and dangerous and (b) neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than inpatient or outpatient treatment...would suffice to prevent...harm.” Since the clear standard for a civil commitment is that the person in question is both mentally ill and dangerous, the Nebraska Mental Health Commitment Act includes specific definitions of those two concepts. In that regard, **Neb. Rev. Stat.** §71-907 provides that “mentally ill” means “having a psychiatric disorder that involves a severe or substantial impairment of a person's thought processes, sensory input, mood balance, memory, or ability to reason which substantially interferes with such person's ability to meet the ordinary demands of living or interferes with the safety or well-being of others.” And according to **Neb. Rev. Stat.** §71-908 “mentally ill and dangerous person” means “a person who is mentally ill...and because of such mental illness...presents: (1) A substantial risk of serious harm to another person or persons within the near future as manifested by evidence of recent violent acts or threats of violence or by placing others in reasonable fear of such harm; or (2) A substantial risk of serious harm to himself or herself within the near future as manifested by evidence of recent attempts at, or threats of, suicide or serious bodily harm or evidence of inability to provide for his or her basic human needs.” The burden of proof in civil commitment proceedings is on the county attorney who has filed the petition and, as

indicated above, requires clear and convincing evidence that the person in question is both mentally ill and dangerous. However, the standard for the county attorney in deciding to go forward with a civil commitment proceeding is “probable cause to believe that the subject of the petition is mentally ill and dangerous.”

As we have indicated, the Ombudsman's Office is not qualified to determine whether Mr. Jenkins, or anyone else, has a mental illness. The same, of course, can be said of a county attorney. This is why the standard for the county attorney is “probable cause,” that is, a reasonable belief “that the subject of the petition is mentally ill and dangerous.” What we are left with then, insofar as Mr. Jenkins' case is concerned, is this question: Could a reasonable person (i.e., the county attorney), after looking at the records in this case, conclude that Nikko Jenkins could be proven to be mentally ill and dangerous by clear and convincing evidence? We believe that the answer to that question is...Yes, a county attorney could so conclude. In that regard, we would emphasize the following points:

1. Mr. Jenkins has a history of violence, including the crimes that got him sent to prison in the first place, as well as a series of violent actions that he engaged in after his incarceration.
2. Mr. Jenkins has an extensive history of dangerous/homicidal ideations communicated to DCS staff - beginning in 2008, at the very latest, and continuing up until April of 2013, there were numerous times when he repeatedly threatened/warned/predicted that he would commit violent acts following his release from DCS custody.
3. The record shows that that in addition to his contacts with the Johnson County Attorney's office, Mr. Jenkins also repeatedly told DCS staff that he wanted to be civilly committed to the Lincoln Regional Center, and that he did so at a point in his sentence when his ultimate discharge from DCS custody was only a few months away, which is hardly “normal” behavior for an inmate who is hungering for freedom after many years of incarceration.
4. While some psychiatrists expressed skepticism that Mr. Jenkins was “mentally ill,” Dr. Eugene Oliveto diagnosed Mr. Jenkins on September 22, 2010, and concluded that his condition was “Schitzoaffective disorder vs. paranoid schizophrenia,” and it was based upon this diagnosis that Dr. Oliveto made the recommendation that Mr. Jenkins needed to be transferred to “LRC before his discharge to stabilize him so he is not dangerous to others.”

In fact, when we stand back and consider everything that we have seen in the large volume of records relating to this case, the one sentence that we repeatedly return to is in Dr. Oliveto's Physician's Orders of September 22, 2010 – “*Needs transfer to LRC before his discharge to stabilize him so he is not dangerous to others.*”

We do not have the ability to decide whether Mr. Jenkins suffers from a mental illness, but then we do not need to do that - our question here is whether the Department of Corrections' mental health staff should have referred Mr. Jenkins' case to a county attorney for a possible mental health commitment proceeding. We believe that the Department should have done so. And we believe that the Department should have done so regardless of whether its own doctors had doubts about whether Mr. Jenkins' was, in fact, mentally ill. The case, as outlined above, was enough to take the matter to the county attorney. It is possible, of course, that the county attorney could have decided against filing civil commitment



proceedings, but then at least the Department would have done its duty by bringing the matter to the proper authorities to allow them decide whether to go ahead with a civil commitment or not, as the case may be. It is possible that, even if the county attorney decided to file civil commitment proceedings, the board of mental health might have decided against commitment. We would point out, however, that §71-924 of the Mental Health Commitment Act provides that the board of mental health “shall inquire of the subject whether he or she admits or denies the allegations of the petition,” and that “if the subject admits the allegations, the board shall proceed to enter a treatment order pursuant to section 71-925.” In other words, if there had been a civil commitment proceeding filed in Mr. Jenkins' case, and if he persisted in asking to be committed to the Regional Center, then that alone could have been sufficient for the board to order him to be committed.

We would add that it is by no means unusual for the Department of Correctional Services to present cases like this one to the county attorney for possible civil commitment proceedings. In fact, we have recently been informed that in the last year the Department of Corrections has referred eleven inmates to the county attorneys for consideration as possibly mentally ill and dangerous individuals. (Please note that these numbers would not include individuals who were referred under LB 1199 as possible Dangerous Sex Offenders.) And so we are left with the disturbing image of eleven other inmates being referred to a county attorney for possible civil commitment...but not Nikko Jenkins. **With all of this in mind, we would strongly recommend that the Department of Correctional Services establish a comprehensive process for identifying those inmates who should be referred for a possible civil commitment, with the final decision being placed in the hands of a high-ranking layperson in the Department (i.e., not a mental health professional), so that the final referral decision can be made based upon: (1) the evaluations of the mental health professionals; and (2) the practicalities of the case, including, in particular, an evaluation of the potential “dangerousness” of the individual involved.**

## Conclusion

Sadly, I am well aware that there is nothing in this report for the families of the victims of Mr. Jenkins' alleged crimes. There are no answers here that can give them comfort, or that can ease their pain, or that can explain in cool, rational terms why their loved ones were lost. As investigators and systems analysts, all that we can do is investigate and analyze, and the truly big questions - about fate and bad fortune, the unpredictability of life, grief, loss, gratuitous violence, the shadowy depths of the human psyche, and the sometimes all-too-thin veneer over human nature that we refer to as “civilization,”- are all matters that are far beyond our reach and scope. As far as this report is concerned, in the end, all that we really have to offer is the truth, at least as truth is reflected in the records of Mr. Jenkins' adult incarceration. In the second half of this report we have offered our own impressions and observations from our review of the records, but fundamentally we respect the abilities of the the readers themselves to arrive at their own conclusions, and that is why we have gone to such great lengths to include so much minute detail in this report – to allow the reader to reach his/her own conclusions.

Obviously, one of the most important questions that we are confronted with in this case is the issue of what diagnostic label should be put on the condition of Nikko Jenkins. As we have said earlier, the Ombudsman's Office is not qualified to make diagnoses of the mental condition of inmates. But that does not mean that we simply “defer to the experts.” Over the years, we have been involved in cases of DCS inmates (often inmates who had been held in segregation for long periods of time) who had, or appeared to have, serious mental health issues that could not be adequately addressed in the isolation of

a segregation cell. Although the Ombudsman's Office is not qualified to arrive at a medical diagnosis of the condition of these inmates, we nevertheless have always felt that it was better to err, if at all, on the side of getting these inmates into treatment, or to at least ask that the inmates in question be fully evaluated by the DCS professionals for possible mental health treatment. Mr. Jenkins' situation was one of these cases.

On occasions in the past, when the Ombudsman's Office has criticized the Department of Correctional Services, we have been accused by the Department of "Monday morning quarterbacking." But that is not the case here – in this case we had repeatedly told the Department what we thought should be done, urging that Mr. Jenkins be transferred to (or be given a review preparatory to a transfer to) the Inpatient Mental Health Unit at the Lincoln Correctional Center. And, as he steadily neared his discharge date, we also urged that Mr. Jenkins receive some transition programming at NSP. But the results were that Mr. Jenkins spent the last two years of his sentence locked up in a segregation cell, receiving nothing in the way of mental health/behavioral health therapy, treatment, or programming. Of course, these were not decisions that the Ombudsman's Office could make. In the end, all that we are legally allowed to do is to make our recommendations, and to be persistent when we see something that we feel needs to be addressed. In this case, we were very persistent.

As early as September of 2008, Deputy Ombudsman for Corrections James Davis advocated for a review of Mr. Jenkins' condition, which resulted in arrangements being made (through Dr. Mark Lukin and Mr. Wayne Chandler) for an evaluation to determine whether Mr. Jenkins might be suitable for a transfer to the DCS Inpatient Mental Health Unit at the Lincoln Correctional Center...but a transfer to LCC never happened. Then, in November of 2011, Sherry Floyd, a friend of Mr. Jenkins, contacted the Ombudsman's Office with concerns that Mr. Jenkins was not receiving mental health services that he needed at TSCI. In follow-up, Assistant Ombudsman Jerall Moreland sent an email to Dr. Pearson which emphasized that Mr. Jenkins had been diagnosed while at the Douglas County Jail as being Bipolar, with both PTSD and schizophrenia. Mr. Moreland also told Dr. Pearson that he had seen a court order, signed by District Judge Randall, that indicated that the Judge believed that Mr. Jenkins "has a long and serious history of mental illness," and that Judge Randall was recommending that Mr. Jenkins receive "treatment for his mental health issues." The email from Mr. Moreland pointed out that "Mr. Jenkins will be available for release in 2013," and again suggested that there be an evaluation of Mr. Jenkins to determine whether it might now be appropriate for him to be transferred in order to receive mental health services at the Mental Health Unit at LCC. This evaluation, as we know, was carried out in February of 2012...but a transfer to LCC never happened.

Although these first two evaluations did not result in Mr. Jenkins being transferred to the LCC Inpatient Mental Health Unit, the Ombudsman's Office made one last attempt along those lines through a letter sent to Dr. Randy Kohl on March 4, 2013. In that letter, Assistant Ombudsman Moreland pointed out again that Mr. Jenkins had spent a great deal of time in segregation, and was due to be discharged soon. Noting that "it appears that the Courts and (the mental health staff at the jail in) Douglas County would agree to the presence of psychosis," although the DCS staff had "doubts in that regard," Mr. Moreland pointed out that there was at least a consensus that Mr. Jenkins had behavioral issues, and that "we all want to help Mr. Jenkins get better before he is released into the community." With this in mind, Mr. Moreland suggested that Mr. Jenkins be considered for transfer to LCC segregation "for the purposes of receiving needed behavioral therapy," with a goal of later transferring Mr. Jenkins to OCC, if he should improve. What in fact happened was that Mr. Jenkins was transferred from TSCI into segregation at the Penitentiary's Control Unit and, although he was later moved into the Penitentiary's Transition Unit,

Mr. Jenkins never actually received even the transition programming that had been proposed.

Clearly, one of the most prominent issues raised by this case is concerned with how the Department of Corrections should handle cases where it may be necessary for an inmate who is about to be discharged from custody to be referred to the county attorney for possible civil commitment proceedings. This is not an unusual step for the Department to take - in fact, we are told that DCS has referred eleven such cases to county attorneys for possible civil commitment in recent months. However, in Mr. Jenkins' case this was not done, presumably because several of the Department's "experts" had concluded that Mr. Jenkins was not really a case of mental illness. Nevertheless, considering the clear signs that Mr. Jenkins was "dangerous," and that he was likely to continue to be dangerous following his release from custody, we believe that his case should have been designated for a civil-commitment referral. This is true particularly when we realize that, in fact, there was one psychiatrist, Dr. Eugene Oliveto, who had concluded that Mr. Jenkins was a case of "schizoaffective disorder vs. paranoid schizophrenia."

There are no real heroes in this story, but there are some individuals who should be acknowledged for being perhaps more insightful, and certainly more circumspect, than others might have been. The list, as we see it, of those who must be acknowledged in a positive light include:

- Dr. Eugene Oliveto, who diagnosed of Mr. Jenkins' condition as "Schitzoaffective disorder vs. paranoid schizophrenia," and who also made the recommendation that Mr. Jenkins needed to be transferred to "LRC before his discharge to stabilize him so he is not dangerous to others." It is regrettable, to say the least, that this recommendation was not followed.
- Denise Gaines, who worked conscientiously with Mr. Jenkins during the many months while he was at the Douglas County Jail, and who was so deeply concerned about the potential that Mr. Jenkins might be dangerous that she wrote a letter to the Nebraska Board of Parole to alert the Board to the fact that Dr. Eugene Oliveto had made the recommendation that Mr. Jenkins be "transferred to the Lincoln Regional Center for treatment before being discharged (from the correctional system) for 'stabilization so he is not dangerous to others.'"
- Judge Gary Randall, who was concerned enough about Mr Jenkins that he took the unusual step of including a paragraph in Mr. Jenkins' sentencing order that acknowledged that Mr. Jenkins had been asking for "treatment for his mental health issues," and had "a long and serious history of mental illness which inhibits his ability to be rehabilitated," and who therefore recommended that the Department of Correctional Services see to it that Mr. Jenkins "be assessed and treated for issues regarding his mental health."

Johnson County Attorney Julie Smith, and Deputy Johnson County Attorney Richard Smith, who, in response to letters from Mr. Jenkins asking that he be civilly committed, took the issue seriously, contacted the "psychologists with the Department of Corrections," and indicated they were waiting for more in the way of psychological evaluations before finally deciding whether to move forward with civil commitment proceedings. Unfortunately, Mr. Jenkins was removed from the Johnson County Attorney's jurisdiction before this situation could be taken forward to fruition.

- Dr. Norma Baker, who, while she had earlier concluded that Mr. Jenkins' condition was “more behavioral/Axis II in nature,” nevertheless was concerned enough about the case to recommend the securing a second opinion on Mr. Jenkins case for “verification of absence or presence of mental illness due to his previous history of major mental illness diagnosis by other psychiatric providers,” with her primary concern being her ongoing worries about Mr. Jenkins' potential “dangerousness to the community upon release.” It was this concern that would eventually prompt Dr. Wetzel's evaluation of Mr. Jenkins in March of 2013.
- DCS Social Worker Kathy Foster, who did a very capable, conscientious job during the last few months of Mr. Jenkins incarceration in trying to get him to focus on his impending transition into the community, and who attempted to connect Mr. Jenkins with needed Social Security and community mental health resources.

If there are others who are conspicuous for being excluded from this list, for instance, the leadership of the DCS Mental/Behavioral Health Services component, then their exclusion should not be interpreted as an oversight.

It is not our role in this matter to adjudicate issues of “fault” in this case. We can never know with any degree of certainty what might have happened with Mr. Jenkins, if he and his case had been managed differently by the Department of Corrections. We cannot know whether he would actually have been committed to the Lincoln Regional Center, if his case had been taken before a Board of Mental Health. We cannot know whether he would have acted differently, had he received more in the way of mental health and/or behavioral health treatment and therapy. We cannot know whether his condition might ultimately have been different, if he had not spent so many long months in segregation. Questions like those are imponderables, and we do not now have the power to negotiate that labyrinth of “what if's.” All that we do know is that the many crimes that Mr. Jenkins is now being accused of are bone-chilling, and that the result, if he is, in fact, guilty of those crimes, is not a situation where we can look at the Department's mental health system, and say that the Department did everything that they might have done, in terms of their handling of Mr. Jenkins, particularly with regard to the treatment of his mental health and/or behavioral health situation. And, in fact, we would not say that even if Mr. Jenkins had done nothing wrong after his release, because we believe that his was a case where the circumstances clearly called for the inmate in question to receive meaningful therapy, treatment, and/or programming, something that would have cost the State very little in comparison to the potential benefits that might have been returned, if Mr. Jenkins had succeeded in living a law abiding life in the community after his release.

- Dr. Martin Wetzel, who evaluated Mr. Jenkins on March 14, 2013, and then recommended the implementation of some “long-term strategies” for the management of Mr. Jenkins' case, to include the “development of a rapport and trust to enhance participation in psychiatric care, ongoing development of objective evidence supporting - - or not supporting - - the presence of major mental illness and the possibility of further psychological formal testing to help clarify (the) diagnostic picture.”

As we look at the multiple lessons of this case, and consider the operation of the DCS mental health system on the fundamental level, the one thing that we continue to come back to is the warning of the

American Psychiatric Association (stated in its 2012 Position Statement on Segregation of Prisoners with Mental Illness) that those “physicians who work in U. S. Correctional facilities face challenging working conditions, dual loyalties to patients and employers, and a tension between reasonable medical practices and prison rules and culture.” What the Association is, in effect, saying here is that the mental health professionals who work in prison settings are apt to face some significant challenges, in terms of maintaining their high standards of professionalism in settings where their patients are “objectified,” by security staff, and are sometimes treated more as “risk-factors” than as individual human beings, with unique personalities, and (often severe) mental disabilities that need to be addressed. Our prisons are not run by mental health professionals; they are run by wardens and security staff who will often have agendas that are not wholly consistent with the values that we would normally associate with mental health professionals - values like compassion, service, and resourcefulness. The challenge then is to sustain those values, and maintain high standards of professionalism, in a setting where they may be seen by those in charge as being inconsistent with, or even inimical to, the basic operational goals of the institution. Aside from our suggesting that consideration be given to privatizing the Department's mental health component as a way of guaranteeing the independence of its mental health professionals, we are not able to offer much in the way of addressing this issue. What we can say, however, is that much of this will come down to the quality of the leadership of the DCS Mental Health component, and its ability to insist upon the need for having standards of professionalism that are not compromised just because the mental health practice in question happens to be going on in a prison.

One of the more disturbing impressions created by a review of the records in this case is the definite opinion that the attention to Mr. Jenkins' mental health/behavioral health issues provided at the Douglas County Jail was better, and perhaps even much better, than that provided to Mr. Jenkins while he was at TSCI. Dr. Oliveto not only diagnosed Mr. Jenkins' condition, but also had the foresight to, very early on, emphasize the issue of Mr. Jenkins' dangerousness, ultimately recommending that Mr. Jenkins be transferred “to LRC before his discharge to stabilize him so he is not dangerous to others.” In addition, we note that Licensed Mental Health Practitioner Denise Gaines worked with Mr. Jenkins during the nearly seventeen months that he was at the Douglas County Jail, and closely monitored his condition until he was finally returned to TSCI on July 19, 2011. Ms. Gaines was enough concerned about Mr. Jenkins' condition that she authored a letter addressed to the Nebraska Board of Parole in which she informed the Board that Dr. Oliveto had made the recommendation that Mr. Jenkins be transferred to the Lincoln Regional Center for treatment before being discharged by the State. We understand that Ms. Gaines' involvement in Mr. Jenkins' case included many instances when she talked one-on-one with Mr. Jenkins about his condition. This, we believe, is how it should be when institutional mental health staff is dealing with an inmate as troubled as Mr. Jenkins, but we see very little of this when we look at the records of his stay at TSCI. There, intervention by the mental health staff seems to have too often consisted of brief visits with Mr. Jenkins at his cell door to make sure that he was still oriented to reality, and was not suicidal, etc. It is hard to imagine that these cell-door-visits, some of which might be justifiably described as “perfunctory,” were of any real value in treatment terms. The mental health staff at TSCI should have been doing more than this with Mr. Jenkins (and perhaps with a number of other inmates at the facility, as well), and the fact that more along these lines did not happen probably has to be put down to a lack of good leadership within the DCS mental health component. In short, someone in a position of authority should have insisted on a better performance by the staff at TSCI, but failed to do so.

For a number of years, Dr. Randy Kohl has been the DCS Deputy Director for Health Services, and in

our opinion he has done an excellent job in moving the Department's health services system forward, and making it one of the best around – far better than it was before he took over the job. But Dr. Kohl is neither a psychiatrist, nor a psychologist, and when it comes to matters of DCS behavioral health and mental health services, Dr. Kohl must rely upon his subordinates to see that the DCS system meets its goals of providing the best possible care and treatment to the estimated 56% of DCS's inmate who have a mental health problem of some nature, and to the estimated 15% who have reported symptoms that meet the accepted criteria for having a psychotic disorder (estimates are based on the 2006 report of the U. S. Bureau of Justice Statistics). Much the same could also be said about former Director Houston, who had the foresight to create the Department's new Inpatient Mental Health Unit, but was neither a psychiatrist, nor a psychologist, and thus had to rely upon others to make the system work as he would have wished. Based on the way in which Mr. Jenkins' case was managed, both Dr. Kohl and Director Houston have the right to wonder whether they were well served by their subordinates in this instance.

As for the DCS administrators generally, particularly those at TSCI, their role in this case was most prominent when it came to the decision to keep Mr. Jenkins in a situation where he was locked up in a segregation cell, and thus isolated from programming. By confining Mr. Jenkins to a segregation cell for the last two years of his sentence, from July 19, 2011, when he was returned to TSCI from Douglas County, to July 30, 2013, when he was discharged, we can say that they did make certain that he would not harm anyone else who was living in or working in the institution. However, their job of managing Mr. Jenkins was not complete with that accomplishment alone. Insofar as Mr. Jenkins was concerned, making the institution safe was necessary, but it was not sufficient, and if any of the administrators at DCS thought otherwise, if they somehow supposed that all they needed to do was keep the employees and inmates in the facility safe from Mr. Jenkins, then they were wrong to think that...very wrong to think that.

“Treatment,” “therapy,” “rehabilitation,” call it whatever you will, it is wrong, and, given the possible consequences in Mr. Jenkins' case, grievously wrong, to separate those inmates placed in segregation from access to programming and treatment that will help them to have more self-control, and to make better decisions when they are eventually released into the community. Our corrections administrators have a responsibility not just to make their institutions safer, but to make our streets safer as well. And this means that they have a duty to see to it that the inmates assigned to segregation, who are often our most seriously troubled and dangerous individuals, are not thereby isolated from the programming and mental health treatment that might make them into better citizens on the outside...in our communities and our neighborhoods. The more that we learn about criminal thinking and recidivism, the more clear it becomes that money spent on programming and mental health services in our correctional facilities is an investment. Hopefully, we will always have a Department of Correctional Services that understands the importance of this investment, and that also understands that the Department's basic responsibility to promote “safety and security” does not end at the prison gate.

Respectfully submitted,

Marshall Lux  
Ombudsman