

To the reader:

When writing a summary of this report, NDCS shared their concerns regarding the sharing of certain information with the public that falls under Nebraska State Statute 83-178. The statute states that each inmate has an individual file within NDCS and it includes seven specific items and then there is an eighth item listed that is more of what some might describe as a catch-all. It is found in (1) (h) of the statute and it states “Other pertinent data concerning his or her background, conduct, associations, and family relationships.” This is problematic in writing the summary of OIG reports due to the fact that later in the statute it states “The content of the file shall be confidential and shall not be subject to public inspection except by court order for good cause shown and shall not be accessible to any person committed to the department.”

The question that arises is what is all included in the individual file and whether or not the OIG can release any of that information in a report. NDCS no longer keeps an actual individual file but instead information on each inmate is found in a variety of ways, including on the internet. While the OIG has never actually asked for a file, the OIG does have access to many items related to each inmate.

With that said, this summary will be an attempt to not share any specific information on an inmate that is specifically mentioned in (1) (a) through (1) (g) in Nebraska State Statute 83-178 (except for the inmate who is deceased). In addition, there may be parts of the summary that are written in a general way although the reader may wish there were more details included. As the OIG moves forward with future reports, it will be necessary to work with appropriate legal counsels and others to determine the best way to abide with the state statutes.

DOUG KOEBERNICK
Inspector General



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SUMMARY OF THE REPORT ON THE DEATH OF TERRY BERRY

August 28, 2017

INITIAL INCIDENT

At approximately 7:45pm on Saturday, April 15, 2017, Terry Berry was found unresponsive in his cell that he shared with XXXXX XXXXX in a restrictive housing unit at the Tecumseh State Correctional Institute (TSCI). He was not breathing and staff members initiated CPR. Mr. Berry was transported to the Johnson County Hospital and later to Bryan LGH West Hospital in Lincoln. He was removed from life support on April 19, 2017 and passed away.¹

This report will not determine whether or not Mr. Berry was murdered and by whom as that is part of a criminal investigation being completed by the Nebraska State Patrol.

BACKGROUND

According to his obituary, Terry Berry was born and grew up in Scottsbluff, Nebraska. He later moved away from Scottsbluff and graduated from Humboldt Public Schools. He was preceded in death by his parents and a brother. After his death, a story in the *Omaha World-Herald* detailed some of the challenges that Mr. Berry faced growing up. His mother died when he was nine years old, he was made a ward of the state three years later, and his father's parental rights were

¹ April 19, 2017 News Release from the Nebraska Department of Correctional Services

terminated two years later. His life as a youth also included stays at a Kearney area youth rehabilitation ranch and Epworth Village in York, Nebraska.²

Mr. Berry entered the custody of the Nebraska Department of Correctional Services (NDCS) on November 20, 2015 after being convicted of two charges: 2nd Degree Forgery and Assault by a Confined Person. He was sentenced to three to four years and his parole eligibility date was February 23, 2017 and his tentative release date was December 8, 2017. He served time at the Diagnostic and Evaluation Center, the Lincoln Correctional Center, and TSCI. For most of the past year he was either in protective management or restrictive housing.³ Mr. Berry was identified as needing anger management programming on March 7, 2016 and was placed on a waiting list. He never received the programming.⁴

XXXXX XXXXX entered the custody of the Nebraska Department of Correctional Services on August 31, 2016 after being convicted of 1st Degree Murder, Use of a Deadly Weapon to Commit a Felony, and six counts of 2nd Degree Forgery. He has been living at TSCI since 2007 and an extensive amount of that time has been spent in a restrictive housing setting. He is serving a life sentence.⁵ Mr. XXXXX is awaiting a CVORT screening.⁶

INVESTIGATIVE SUMMARY

On April 10, 2017, Mr. XXXXX was asked to move out of his current cell and move to another unit. He told the OIG that he was told if he refused he would be double bunked with another inmate. He was not asked if he wanted to be double bunked and told the staff that it would not work. He found out that his cellmate would be Mr. Berry about fifteen minutes before Mr. Berry moved into the cell. He then told a TSCI caseworker that it wouldn't work but was told that the decision had been made and nothing could be done. Mr. XXXXX had never met Mr. Berry before but said that he had been on the gallery for a long time and had made a lot of enemies and that "he never shut up and was dirty."⁷ Mr. Berry had one inmate listed on his central monitoring list who stated "that the only problem he had was being Berry's cell mate...that Berry has poor hygiene."⁸

On the same date, Mr. Berry was refusing a move to another cell and was told that if he refused he would be double bunked with another inmate. This double bunking was the result of no single occupancy cells being available in the unit. Mr. Berry asked who he would be double bunked

² May 2, 2017 Article in the *Omaha World-Herald*

³ NDCS Data Sheet on Terry Berry

⁴ NDCS CVORT Treatment Recommendation Sheet on Terry Berry

⁵ NDCS Data Sheet on XXXXX XXXXX

⁶ NDCS CVORT Treatment Recommendation Sheet on XXXXX XXXXX

⁷ OIG Interview with XXXXX XXXXX

⁸ Attachment G: NDCS Central Monitoring Sheet on Terry Berry

with and was told it would be with Mr. XXXXX. Mr. Berry did not express any opposition to the placement at that time.⁹

The decision to place the two inmates together in the unit was made jointly by two unit managers. They completed a worksheet called *Restrictive Housing Assignment of Living Location* to assess the compatibility and safety of the two inmates. They were found to be compatible. One of the keys of this worksheet is how the inmates are assessed in the following categories: Violence to Staff, Violence to Inmate, Victim Potential, and PREA (Prison Rape Elimination Act). They are assessed as low, moderate or high risk in these categories and if they are two risk levels apart (one scores low and the other scores high) then they are deemed not to be compatible. According to Administrative Regulation 210.01 if a decision is made to double bunk two inmates the decision-makers need to “state in writing why, at the time of the cell assignment, the cell assignment provides each cellmate with reasonable safety from assault.”¹⁰ This statement is supposed to be included on the worksheet in the section for comments but this was not done in this case. In addition, in this case both inmates were told that if they did not comply with the directives given to them they would be double bunked with another inmate. This statement was made prior to any assessment of their compatibility or safety with another inmate.

The OIG was informed by unit staff that Mr. Berry actually showed more of an assaultive history when completing the worksheet. He had a history of some assault charges starting at the age of 15 years old prior to entering NDCS custody and had made verbal threats on some occasions while at TSCI.¹¹ However, Mr. XXXXX also had a history of assaultive or threatening behavior including the following incidents (in addition to his conviction of 1st Degree Murder.

During interviews with the OIG some TSCI staff stated that Mr. XXXXX did not want to have a cellmate and that they were concerned about the two inmates being placed together though they did not expect a murder to take place.

Mr. XXXXX also told the OIG that staff would stop by the cell and make comments and laugh at him and that one staff asked if he had killed Mr. Berry yet. No evidence was found that would indicate that this took place.

After the death of Mr. Berry, a TSCI staff member filed an Incident Report that detailed her concerns about the placement of the two inmates in the same cell. She wrote that she was made aware at 1300 hours on April 10, 2017 that Mr. Berry was being placed in the cell with Mr. XXXXX. She described Mr. XXXXX as “an inmate known for his temper.” She wrote, “When I heard this information I personally felt that it was not the best idea since inmate Berry #83145 is

⁹ April 24, 2017 TSCI Memorandum

¹⁰ Administrative Regulation 210.01

¹¹ March 24, 2017 LTRH Referral for Terry Berry

known to be very talkative and bothersome, and I felt as though an inmate (XXXXX #64624) in for life, with a temper would not want someone like inmate Berry #83145 in his cell.” She stated that she called the Lieutenant’s office and spoke to a staff member and was told that there wasn’t much that could be done unless she called the person responsible for making the decision at their home. She also wrote that she talked to two other staff members about her concerns. Only one confirmed that their conversation took place.¹²

After the two inmates were placed together, they lived together until April 15, 2017. On the evening of April 15, Mr. XXXXX notified staff that Mr. Berry was not responsive at approximately 1945 hours. Mr. XXXXX asked a corporal who he would report an unresponsive inmate to and after the corporal asked what he was talking about Mr. XXXXX stepped to the side, turned on the cell light, and pointed at Mr. Berry who was lying on the floor with a towel around his neck. The corporal initiated an ERT call for an unresponsive inmate and asked Mr. XXXXX, “Did you do this?” Mr. XXXXX replied, “Yeah I did it he wouldn’t shut up.” The ERT team showed up at 1946 hours, placed Mr. Berry on a gurney and took him to the medical area.¹³ Mr. Berry was later transported to another medical facility and he passed away on April 19, 2017.

EXPANSION OF REVIEW

While the focus of this report is on the actions that led up to and resulted in the death of Mr. Berry, the review was expanded to more closely examine the issue of double bunking in a restrictive housing setting. Immediately after the death of Mr. Berry many people questioned why the two men had actually been placed in the same cell since they seemed like such different types of inmates. However, there is an argument to be made that some people who are in for life for murder are possibly less prone to violence because they may be in prison for a one-time action that led to their committing a murder. Regardless, one of the more important questions that has arisen out of this death is whether or not NDCS should allow for double bunking in restrictive housing settings.

In a May 2, 2017 *Omaha World-Herald* article, an NDCS spokesperson said the following about double bunking in a restrictive housing setting, "It is a more efficient use of space and it can lessen the feeling of isolation when another person is in the cell,"¹⁴ The OIG contacted NDCS to ask if there were any studies to back up that statement. The reply from NDCS that was attributed to Director Frakes was the following: “I know of no studies on placing more than one inmate in a restrictive housing cell. There are opinions, but I haven’t seen any studies. I believe, based on my experiences, done correctly, double bunking in RH is as safe as double bunking in general population.” Director Frakes had given a similar response to the news media after the incident.

¹² April 18, 2017 Incident Report and related documents

¹³ April 16, 2017 Disciplinary Misconduct Report

¹⁴ May 2, 2017 Article in the *Omaha World-Herald*

At best, it is unclear whether this is the case, particularly when it is considered that the restrictive housing cells at TSCI are designed to hold one inmate, while all of the other cells at the facility are designed for two-inmate occupancy.

The OIG met with several inmates who were double bunked in a restrictive housing unit and they all felt that it was not a positive situation. They provided a number of reasons why this was the case. In these situations, inmates live with each other for approximately 158 out of 168 hours in a week. The cell itself is 7” by 12’7” and is a total of 88 square feet. The men share a desk, a chair, a sink and a toilet.¹⁵ In addition, the men are in these cells due to actions taken by them that resulted in their removal from the general population. The restrictive housing unit at TSCI is sometimes referred to as “segregation” for a reason, namely because inmates are placed there to be segregated or separated from the rest of the prison population due to the fact that their behavior has been troublesome, or dangerous to the wellbeing of others, including other inmates.

The American Correctional Association (ACA), which accredits Nebraska's prisons, sets standards for housing in prisons. Their current standards state the following:

“4133 – Revised JAN. 2012. Written policy, procedure and practice provide that single occupancy cells/rooms, shall be available, when indicated for the following:

- 1) Inmates with severe medical disabilities
- 2) Inmates suffering from serious mental illness
- 3) Sexual predators
- 4) Inmates likely to be exploited or victimized by others
- 5) Inmate who have other special needs for single housing

When confinement exceeds 10 hours a day, there is at least 80 square feet of total floor space, of which 35 sq. feet is unencumbered.”¹⁶

In the case of the restrictive housing cell at TSCI, it exceeds the 80 square feet of total floor space (88 square feet) and also has 57.4 square feet of unencumbered space. However, this standard is for a single occupancy cell so TSCI does not meet the ACA standard when they double bunk inmates in those cells.

A recent Vera Institute of Justice report to NDCS made the following recommendation:

“Examine the impact of double-celling on the safety and well-being of individuals in double-celled restrictive housing units. Particularly if the assessment reveals negative impacts (such as more assaults or hospital admissions), develop a plan to reform double-

¹⁵ TSCI Cell Space Calculation Diagram

¹⁶ Excerpt from ACA Standards

celling practices. If double-celling is used, always ensure that individuals are carefully matched to minimize the risk of dangerous situations.”¹⁷

The OIG asked for more information regarding the action taken by NDCS to address this recommendation. Director Frakes replied with the following:

“AR 210.01 (pages 14/15) addresses the assignment of two inmates to one cell within Restrictive Housing. The Vera recommendation was considered. The collective memory did not identify a pattern of assaults or other serious negative behavior between people housed together in Restrictive Housing. The attached assessment form is part of AR 210.01, and was used prior to housing Berry and XXXXX together. As per AR 210.01, the two Unit Managers conferred and agreed that the two inmates were safe to house together.”¹⁸

A judge in a recent federal court case involving Alabama¹⁹ included the following in his decision:

“Admittedly, ADOC uses double-celling in some segregation units, which means putting two prisoners into a single segregation cell. At first blush, this practice might seem to mitigate the harmful effects of solitary confinement. However, double-celled segregation has an even more severe impact on the mental health of prisoners. Dr. Haney credibly explained that double-celled prisoners “in some ways ... have the worst of both worlds: they are ‘crowded’ in and confined with another person inside a small cell but—and this is the crux of their ‘isolation’—simultaneously isolated from the rest of the mainstream prisoner population, deprived of even minimal freedom of movement, prohibited from access to meaningful prison programs, and denied opportunities for any semblance of ‘normal’ social interaction.”²⁰

The judge referenced the work of Dr. Craig Haney, a Professor of Psychology at the University of California-Santa Cruz, who has been studying prison segregation for over 25 years. Dr. Haney testified before a United States Senate Committee in 2012 and said the following:

“[Doublecelled prisoners] are ... simultaneously isolated and overcrowded. They ... really can’t relate in any meaningful way with whom they’re celled, and so they basically develop a kind of within cell isolation of their own. And it adds to the tension, and the tensions then can get acted out on each other. It creates hazards for the people who are forced to live that way. It creates hazards for the correctional officers who have to deal with prisoners who are living under those kinds of pressures.”²¹

¹⁷ May 1, 2017 letter from the OIG to Director Frakes

¹⁸ May 5, 2017 Email from Director Frakes to the OIG

¹⁹ *Edward Braggs, et. al., v Jefferson S. Dunn, Commissioner of the Alabama Department of Corrections*

²⁰ <https://www.themarshallproject.org/documents/3878591-Edward-Braggs-et-al-v-Jefferson-S-Dunn#.DSBrzKMIj>

²¹ <https://www.judiciary.senate.gov/imo/media/doc/CHRG-112shrg87630.pdf>

In a 2012 report titled *Boxed In: The True Cost of Extreme Isolation in New York's Prisons*, Dr. Haney and Dr. Stuart Grassian, a psychiatrist who is also a long-time expert on prison segregation, wrote the following:

"In *Madrid v. Gomez*, a case examining conditions of extreme isolation at California's Pelican Bay State prison where "[r]oughly two-thirds of the inmates [were] double celled," the court cited testimony from Professor Haney and Dr. Stuart Grassian in observing: [Double-celling] does not compensate for the otherwise severe level of social isolation The combination of being in extremely close proximity with one other person, while other avenues for normal social interaction are virtually precluded, often makes any long-term normal relationship with the cellmate impossible. Instead, two persons housed together in this type of forced, constant intimacy have an 'enormously high risk of becoming paranoid, hostile, and potentially violent towards each other.' The existence of a cellmate is thus unlikely to provide an opportunity for sustained positive or normal social contact."²²

Despite extensive research, the OIG was unable to find any studies that showed that double bunking in restrictive housing units contributed to a positive environment or improved behaviors by inmates in such settings.

Another part of the double bunking issue is the safety of staff in these situations. During interviews with staff about Mr. Berry's death, some of the staff shared that they do not agree with double bunking in a restrictive housing unit because it can create safety issues for them. They shared that having two inmates in those cells makes it more difficult to extract, move or work with one or both inmates. The OIG was told about one cell with two inmates where both inmates required more than one staff member for any movement. As a result there were at least four staff required at any one time to interact with those inmates. TSCI is in a staffing crisis and according to some staff this only adds to that problem. Recently, the OIG was in the restrictive housing unit at TSCI and interviewed an inmate (who was double bunked) in a separate interview room. When the inmate was returned to his cell, the staff opened the door and the other inmate charged out of the cell and attacked a staff member. Several staff responded and were able to restrain the inmate and place him on a gurney and remove him from the unit.

In November 2014, the total number of inmates in restrictive housing units were 319 and the total number of inmates in protective management units was 310. These 629 inmates represented 11.7% of the total NDCS inmate population.²³ According to the NDCS Restrictive Housing Report in 2016, the total number of inmates in restrictive housing units on July 1, 2016, was 304, and the total number of inmates in protective management units was 349. This represented 12.5% of the total inmate population in the system.²⁴ Earlier this month, the total number of inmates in restrictive housing units was 389, and the total number of inmates in protective management units was 447. This represented 15.9% of the total inmate population in the

²² <http://www.boxedinny.org/>

²³ November 24, 2014 Email between Dan Jenkins and Jeff Beaty

²⁴ http://nebraskalegislature.gov/pdf/reports/committee/select_special/lr34_2015/lr34_appendixC-25.pdf

system.²⁵ As this segregated population has grown it would appear as though NDCS has had to turn to double bunking of inmates in restrictive housing settings in order to accommodate the significant increase in inmates who are being placed in those settings.

FINDINGS

Once it was reported that Mr. Berry was unresponsive in his cell, NDCS staff acted appropriately in responding to the situation.

Prior to that, there are legitimate concerns regarding the placement of Mr. Berry and Mr. XXXXX in the same cell. First, there is a policy question that needs to be answered regarding the use of double bunking in a restrictive housing setting. Second, there is a concern about allegations that staff would tell inmates that they would be double bunked if they did not follow an order. Third, there is a concern that staff did not follow the proper procedures when determining whether or not the two men should have been placed in the same cell.

The overcrowding of Nebraska's correctional system was a factor in the situation regarding Mr. Berry. Although Director Frakes declined to say after the death of Mr. Berry whether or not prison overcrowding had "prompted the double bunking,"²⁶ TSCI staff involved in the decision indicated that they had no choice but to double bunk because of a lack of single cells in the special management unit. Nebraska's correctional system is currently the second most crowded correctional system in the country at over 160% of design capacity.²⁷ This overcrowding situation gives NDCS and Director Frakes very little flexibility when it comes to the housing assignment of inmates.

Although understaffing did not play a direct role in Mr. Berry's situation, it may also have been a factor. TSCI was, and continues to be, understaffed throughout the facility. In addition to protective services staff, they are short caseworkers and that impacts the ability of those staff to develop a rapport with inmates. Unit caseworkers have a number of duties, including the observation of inmates to detect abnormalities, problems, or unrest and the counseling of inmates to assist them in adapting to the prison environment.²⁸ If there were more staff, they quite possibly would have had a better opportunity to better articulate why Mr. Berry and Mr. XXXXX should not have been placed in the same cell together or could have worked with them to encourage them to accept placements in other cells.

²⁵ The OIG obtained this information from the Nebraska Inmate Case Management System (NICaMS) that is administered by NDCS

²⁶ http://www.omaha.com/news/crime/inmate-serving-life-sentence-for-murder-is-charged-in-death/article_db70c722-26c9-11e7-a204-9b93cc4138ab.html

²⁷ April 13, 2017 Memorandum to the Judiciary Committee from the OIG

²⁸ Nebraska Department of Administrative Services Job Description of Unit Caseworker

RECOMMENDATIONS FOR PROCESS/POLICY IMPROVEMENTS

The OIG makes the following recommendations to NDCS as a result of this investigation:

1. Immediately suspend the practice of double bunking in restrictive housing units until the NDCS Restrictive Housing Internal and External Work Groups have had the opportunity to review the policy of double bunking in restrictive housing units and issue a recommendation regarding the policy to the Director of NDCS;
2. Review the Restrictive Housing Assignment of Living Location worksheets that have been done since January 1, 2017 in order to determine if they were completed correctly;
3. Continue the efforts by NDCS to reduce the number of individuals in restrictive housing and protective management settings;
4. Examine the possibility of using peer mentors to work with inmates who choose not to follow orders to move to another cell;
5. Conduct a comprehensive review that examines why Mr. Berry was located at TSCI, whether or not he received the services and programming he needed in order to successfully begin to transition into the community, and whether or not a different placement would have been more appropriate for him as a result of his crime, age, behavioral challenges and sentence length; and,
6. Report any action taken on these recommendations to the OIG.

CONCLUSION

Prior to Mr. Berry's parole hearing in February 2017, NDCS Reentry Staff met with him and established a parole residence plan. A plan was approved on April 6, 2017 in anticipation of his parole hearing on April 17, 2017, a mere two days after he was found unresponsive in his cell, and two days before he was pronounced dead.²⁹ Mr. Berry was housed in TSCI as a result of being in a protective management unit and being a certain classification. Typically, at this point in an inmate's sentence, they would begin to move to a lower custody facility in anticipation of eventually being paroled. Instead, Mr. Berry died on April 19, 2017 at the age of 22 years old after allegedly being strangled on April 15, 2017 by his cellmate at TSCI, which hardly seems the optimal setting for a inmate like Mr. Berry who may have been within hours of being paroled.

NDCS RESPONSE

The OIG received a response from NDCS with their accepting or rejecting of the recommendation found in the report. The response letter is attached to this summary.

²⁹ Email from NDCS Reentry Program Manager regarding Terry Berry



Pete Ricketts, Governor

August 18, 2017

Mr. Doug Koebernick
Inspector General for Corrections
State Capitol, Room 800
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Dear Mr. Koebernick,

I have reviewed your report on the death of Terry Berry. Per statute, I am responding within the appropriate 15 days.

The death of Mr. Berry is tragic. The responsibility for his death lies with Mr. Schroeder, who has been charged with and admitted to the charge of first degree murder. Mr. Schroeder had multiple avenues with which to address any concerns about his living situation and he chose, instead, to kill Mr. Berry. Staff members conduct gallery checks at least twice per hour and at no time did Mr. Schroeder alert staff that Mr. Berry's life was in danger. He also did not submit an inmate interview request concerning his placement with Mr. Berry.

The placement of individuals in restrictive housing is based on the risk they present. At the time of this incident, neither inmate presented a risk that could not be managed in a protective management (PM) cell. Mr. Schroeder was on longer-term restrictive housing (LTRH) because he refused to leave restrictive housing to return to PM. Had he agreed to move to a PM cell, he would have been double bunked in a PM cell and would not have been on LTRH. Mr. Berry was in restrictive housing because he refused to remain in a PM cell, not because he presented a risk. If they had been in PM, they would have both been in double bunked cells.

I dispute the assumption that more staff would have changed the placement of these two individuals. Developing rapport does not take the place of policy and procedure and, in this case, there is no way to know what the outcome might have been.

You note serious allegations against my staff made by Mr. Schroeder "could not be confirmed," rather than stating the fact that no evidence exists to support the claims. I request you

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acknowledge evidence does not exist to substantiate Mr. Schroeder's claims against NDCS staff members rather than saying it could not be proven.

The section labeled "Expansion of Review" discusses double bunking in a restrictive housing setting. You reference a quote from NDCS wherein we state double bunking in restrictive housing is a more efficient use of space and it can lessen the feeling of isolation when another person is in the cell. I acknowledged no studies regarding double bunking and expressed that, based on my corrections knowledge and my 35 years of experience, double bunking in restrictive housing can be as safe as in general population. You go on to note that my statements were not based on actual studies or from those who reside in such situations and could be misinterpreted by the public as a statement of fact. Again, I will note that my years of experience not only having worked in restrictive housing, but also having led the charge in the state of Washington to reduce the use of restrictive housing provide me the expertise to make such a statement. I have found nothing to disprove my statement and, in fact, as you noted, the recommendations from the VERA Safe Alternatives to Segregation report does not indicate cells in restrictive housing should not be double bunked, but rather advises that double bunking should be done in accordance with written policy. I am not advocating for or against the use of double bunking in restrictive housing. In fact, my preference is to manage individuals in general population to the extent possible.

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

1. Reject – NDCS has reviewed the use of double bunking and will continue to use it according to current policy.
2. Reject – NDCS added daily checks with individuals who are double-bunked to provide the opportunity to report problems.
3. Accept – The efforts underway to reduce the use of restrictive housing and protective management are ongoing.
4. Accept – NDCS is currently developing a peer mentoring program.
5. Reject – Between this report and the internal review, this issue has been addressed. Whether the forms were completed correctly in the past will be of little assistance moving forward. The policy and forms have been reviewed and found to be appropriate.
6. Reject – There are numerous reporting mechanisms in place to update the Office of the Inspector General on recommendations 3 and 4. NDCS will continue to be responsive to requests from the OIG.

Finally, I caution that Neb. Rev. Stat. 83-178 protects much of the information in your report and my response and provides that it may not be made public without a court order. As such, I request that if the decision is made to make the report public, you redact such protected information and not include confidential information contained in my response.

Sincerely,

 Scott R. Frakes
Director