OFFICE OF INSPECTOR GENERAL
OF THE NEBRASKA CORRECTIONAL SYSTEM

Death of incarcerated man in 'double-bunked' NSP restrictive housing cell

SUMMARY OF INVESTIGATIVE REPORT NO. 2024-04
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EXECUTIVE SUMMARY

The Office of Inspector General of the Nebraska Correctional System (OIG) investigates all deaths in facilities operated by the Nebraska Department of Correctional Services (NDCS).[1] On October 22, 2024, the OIG submitted an investigative report to the NDCS Director regarding an incarcerated man's death in the restrictive housing unit at the Nebraska State Penitentiary (NSP) in 2022. This summary report describes the findings and recommendations contained in that report.[2]

While most people have single-person cells while in restrictive housing in NDCS facilities, some have cellmates, a practice referred to as "double bunking" or "double celling." In this respect, the case examined in this report bears resemblance to a 2017 death in which an incarcerated man was strangled by his cellmate in their double-bunked restrictive housing cell at the Tecumseh State Correctional Institution (TSCI). An OIG report on that death was released in August 2017.[3]

In the more recent investigation, the OIG determined that while NDCS has made some changes since the 2017 death, the general concerns about double bunking remain. The practice no longer occurs in TSCI's restrictive housing unit, but remains somewhat the norm in restrictive housing at NSP. As before, frontline NDCS staff continue to express concerns about such arrangements, and are the ones who respond when incidents take place.

Specifically, as a result of this investigation, the OIG found as follows:

1. Continued double bunking in restrictive housing is dangerous.
2. Double bunking is driven by space considerations within NDCS.
3. The staff who made the cell assignment decision in this case did so according to departmental policy.

[1] The full text of the Office of Inspector General of the Nebraska Correctional System Act can be found here: https://nebraskalegislature.gov/laws/statutes.php?statute=47-901.
[2] A letter which accompanied the report, as well as the NDCS response to the OIG's recommendations, are attached as exhibits to this summary report.
[3] A public summary of this report can be found on the Nebraska Legislature's website, at https://nebraskalegislature.gov/pdf/reports/public_counsel/2017berry.pdf.

4. Incarcerated people and staff feel pressure to accept double bunking arrangements in restrictive housing despite concerns about safety with this practice.
5. Concerns exist about the violence risk scores used to help make double bunking decisions.
6. The restrictive housing cells at the Nebraska State Penitentiary are not large enough to accommodate two people, under American Correctional Association standards.
7. NDCS policy is unclear on whether double bunking is allowed for people in longer-term restrictive housing.
8. Many staff who responded to this incident had not received specific training for restrictive housing or were not up-to-date on refresher training.
9. Corrective actions taken following this incident were limited and will not help future staff who encounter similar situations.

The OIG encourages NDCS to consider the following recommendations:

1. Stop double bunking in restrictive housing.
2. Prohibit the practice of double bunking in departmental rules and regulations.
3. Review training requirements for staff who work in restrictive housing and similar units, including special management units and mental health units. This includes staff who fill in on these units on a regular basis.

As long as double bunking continues within NDCS facilities:

4. Require warden-level approval or higher for double bunking placements in restrictive housing.
5. Clarify policy regarding double bunking in longer-term restrictive housing.
6. Update policy to clearly prohibit double bunking of codefendents while in restrictive housing.
7. Review the violence risk score used on cell assignment sheets to determine if these scores can be updated periodically or should be removed from the sheets altogether.
8. Prohibit placing cellmates with people in restrictive housing who are considered to be a high risk of violence to other incarcerated individuals.

CONTENTS

BACKGROUND

The individual who died in this case (referred to in this summary as "John Doe") had been in NDCS custody since 2018. This was his first period of incarceration with NDCS, although he had several prior convictions. He was recommended to take a residential substance use treatment program and a domestic violence prevention program while in NDCS custody, but it appears neither program was ever offered to him.

While in prison, he was found guilty of drug or intoxicant abuse or related charges numerous times, for homemade alcohol, synthetic marijuana, and homemade cigarettes. He also had "a history of being found in possession of homemade weapons or weapon making material." He had previously been assigned to restrictive housing on two separate occasions, each for about three months, for suspected weapons being found in his cell.

About five months before John Doe's death, a staff member at NSP saw him accept an item from another incarcerated person who was about to be searched. Staff then searched Doe and found a 5-inch homemade weapon in his pocket. He was placed in immediate segregation (IS) in the NSP restrictive housing unit, which is within Housing Unit 4 (HU4), and was eventually assigned to longer-term restrictive housing (LTRH) on that unit.[4]

About three months before he died, staff who oversaw Doe's unit recommended his removal from LTRH. They noted that he had maintained appropriate behavior and was nearly finished with the nine booklets in the "Courage to Change" series, a journaling activity which NDCS recommends for people in LTRH. Doe indicated that he wanted to live on a relatively calm unit at NSP and that he wanted to stay focused on positive changes at NSP so he could return home to his young son.

The NDCS multi-disciplinary review team (MDRT), which consists of the deputy director of prisons and other administrators, denied Doe's removal from LTRH, indicating that his behavior

[4] Immediate segregation is a shorter-term assignment to restrictive housing, generally 30 days or less. Longer-term restrictive housing generally last longer than 30 days and requires higher levels of approval. NDCS rules and regulations describe LTRH as a "behavior management intervention for inmates whose behavior continues to pose a risk to the safety of themselves or others" (Title 72, Nebraska Administrative Code, Chapter 1).

"presents continued risk to staff/inmate safety" and that he was a high risk based on his "(s)erious act of violent behavior (possession of a suspected homemade weapon)." The MDRT also noted that "intensive supervision and intervention as identified on Behavior/Programming Plan is warranted. Program participation is strongly recommended."[5]

In the days prior to his death, Doe's unit staff were once again preparing to recommend him for removal from LTRH. He had completed all nine "Courage to Change" booklets well as three different nonclinical programming books available on the unit. In an "inmate accountability statement" the week of his death, he wrote the following:

> *"I have had no serious problems with COs or other inmates since my placement & have taken every new cellmate regardless of how annoying they end up being. My time down here reading the Programming books has taught me a lot of things I hope to use when I get back to the yard & the real world. I have learned better ways to be more responsible with my thinking, having better self-control over my actions in the moment, triggers that can possibly jepordize [sic] my freedom, & better advice on things I could be doing with my time while incarcerated like other programming & finishing school. In the past I have dealt with my own deal of depression & family problems & other things I have no control over but hopefully if recommended for release back to the yard I could take better control of my life & get more programming out of the way & finish school as well. I really do want to make a change & I am not saying that just to get out the hole, I really do want to change my life around & educate myself more & become a better person for myself & my son on the streets. Last but not least, I again apologize for being in possession of dangerous contraband in this facility & promise not to put anyone including myself in harms [sic] way."*

Doe was scheduled for a review to determine whether he should be released from LTRH. This review would have taken place three days after he died. In preparation for the hearing, his unit staff once again noted that he had been compliant with his behavior/programming plan and had maintained appropriate behavior on the unit.

[5] People assigned to LTRH are generally placed on one of two "paths," according to NDCS administration. In most cases, they are expected to complete the "Courage to Change" independent study program. Those who commit serious staff assaults or other significant acts are sometimes assigned a more intensive program called "The Challenge Program" (TCP). TCP, which has been replaced by NDCS since this report was issued, has been discussed in previous OIG reports.

Assignment of Cellmate

Another man (referred to in this summary as "John Smith") had been moved into Doe's restrictive housing cell, making them cellmates, two days prior to Doe's death. Before that, John Smith had lived for more than 100 days with a different person in restrictive housing.

In a memo and incident reports submitted after Doe's death, unit staff described the events leading up to Smith's cell change and staff contacts with the two men following the move:

- Three days before Doe died, Smith refused to leave the shower on HU4 and return to his previous cell until a mental health staff member came to speak with him. Staff determined he was concerned about recent misconduct reports hurting his chances of being released from LTRH. A mental health practitioner came to the unit and spoke with Smith, who was then placed in a single cell.
- The next day, "there was a need to utilize the single cell that (Smith) was occupying so he was told that he would be moved back to his prior cell." Instead, Smith asked to live with Doe. Staff completed the required documentation and reported that they checked with Doe to ensure he was comfortable living with Smith. (One staff member later told the OIG that the two "looked good on paper.") Smith was moved into Doe's cell.
- The day before Doe died, a case manager spoke with Doe and Smith separately while Smith was in the shower. Neither expressed concerns about sharing a cell at that time.

DEATH OF JOHN DOE

On the day of John Doe's death, shortly after 1600 hours, an NSP caseworker who was conducting rounds found Doe on the floor of his cell. The caseworker summoned a corporal for a second look, and the corporal peered through the cell window. Doe was on the floor, unresponsive.[6] The caseworker announced a medical emergency over the institutional radio at 1606 hours.

Staff placed Smith in wrist restraints through the door hatch, then opened the cell door at 1608 hours as a sergeant arrived on the unit. They escorted Smith from the cell, and tried waking Doe before lifting him onto a gurney. Meanwhile, a corporal in the facility's central control room called 911 at 1610 hours. Staff on HU4 then used the gurney to carry Doe off the unit while performing limited CPR. They rolled the gurney and Doe across the yard and into the facility's turnkey area, inside the main building, at 1614 hours.[7]

Inside the turnkey area, while prison staff waited for outside paramedics to arrive and enter the facility, they worked with a pair of NDCS nurses to take Doe off the gurney and resume attempts at life-saving measures. They applied an automated external defibrillator (AED), which did not advise a shock, administered oxygen and a naloxone injection in case of possible overdose, and continued CPR.

Lincoln Fire and Rescue medics arrived at the facility at 1617 hours and reached the turnkey area at 1622 hours, then pronounced Doe dead 3 minutes later. His body was taken to a room in the Penitentiary's skilled nursing facility (SNF) until outside investigators arrived. In all, the immediate response lasted approximately 25 minutes.

An autopsy conducted two days after Doe's death found that he died of asphyxia with a ligature.

[6] Note: The OIG has omitted some details about the scene due to an ongoing criminal case related to this incident.
[7] This is based on an OIG review of video of this incident and staff reports.

Reviews Following Death

Internal Review

NDCS conducted an internal critical incident review (ICIR) of Doe's death. The team which ultimately completed the ICIR included the Department's emergency preparedness coordinator and two lieutenants from the facility.

The ICIR team interviewed seven staff members who were directly involved in the emergency response, and reviewed photos and videos of the incident. The review team was generally complimentary of the staff response, but made four recommendations (reordered for this report):

1. That NDCS provide additional guidance for how to handle emergencies in double-bunked restrictive housing cells;
2. That staff receive refreshers on conducting CPR and the locations of automated external defibrillators (AEDs);
3. That a single staff member on each shift be assigned the "hook knife" (a dull knife used to remove a noose); and
4. That NSP change the area it uses for triage, as the turnkey area can have a significant amount of traffic.

NDCS took some action on the first two of these recommendations but decided against the other two for logistical reasons.

The ICIR team did not examine or make recommendations related to the cell assignment for Doe and Smith. However, after reading the ICIR, an administrator directed staff to review that process as well, "to ensure policy/procedure was adhered to and sound judgement was utilized in making this cell assignment." This further review was conducted by an NSP unit administrator, and it does not appear any fault was found with the staff who made the decision to place Smith with Doe.

The NDCS health services division also conducts a morbidity and mortality review (MMR) any time a person dies in the Department's custody. The OIG has examined these documents in past

cases but has been unable to do so in recent years due to restrictions on the OIG's access to medical records.[8]

OIG Investigation

The OIG was notified of Doe's death within a few hours of the incident.[9] The OIG performed initial investigative work almost immediately, then suspended its investigation pending further investigation by law enforcement. The OIG remained in contact with law enforcement officials during this time.

In August 2023, the Nebraska Attorney General issued an advisory opinion questioning the constitutionality of the OIG. Immediately after the opinion was issued, NDCS suspended the OIG's access to its facilities, records, and staff. This access was partially restored in February 2024 pursuant to an agreement between the Legislature and the Executive Branch. After conferring with law enforcement, the OIG resumed its investigation of Doe's death in April 2024. The remainder of this report documents the OIG investigation.

[8] This issue has been explained in detail in previous OIG reports.
[9] The notification consisted of an email from an NDCS official with the subject line "NSP suicide" and contained only the deceased's first and last name, with no additional details.

‘DOUBLE BUNKING’ IN RESTRICTIVE HOUSING

The OIG’s investigation of Doe’s death included a thorough review of the setting in which he was housed at the time. As of this report, the gallery where he died is the only restrictive housing unit within NDCS where people are regularly placed with cellmates (“double bunking”). This practice was more widespread in the past.

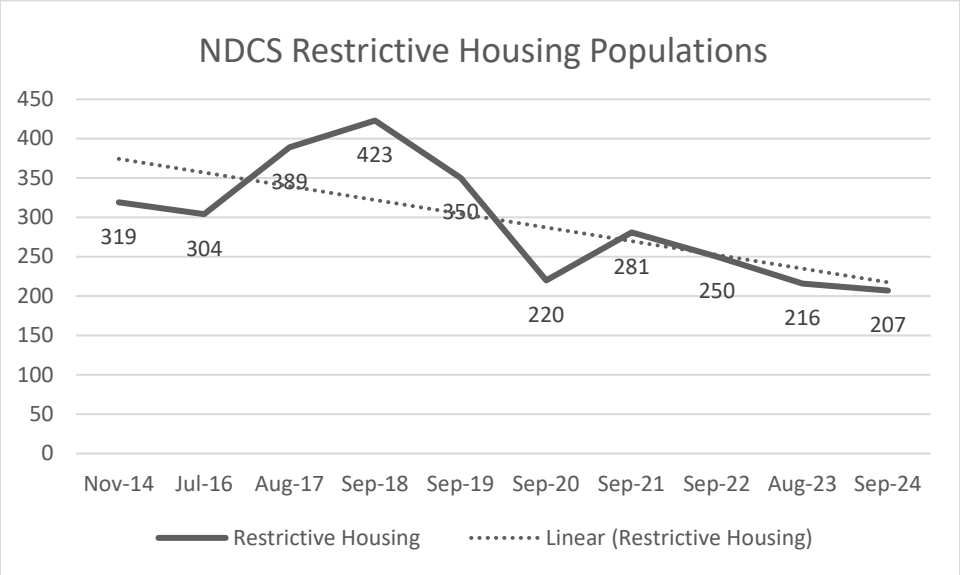
At TSCI, which has the largest restrictive housing unit in the system, the Department stopped double bunking in restrictive housing following the 2017 death of a man who was strangled by his cellmate in their shared restrictive housing cell in TSCI’s special management unit (SMU). The Reception and Treatment Center (RTC) in Lincoln and the Omaha Correctional Center (OCC), the only other NDCS facilities with dedicated restrictive housing units, do not double bunk those restrictive housing cells.

At NSP, double bunking continues despite a decrease in its overall restrictive housing population. In 2019, the facility briefly closed its 36-bed “Control Unit,” a building which was constructed in 1956 and had long been used for restrictive housing. (The unit has since been reopened, but for other purposes.) More recently, a 40-bed gallery on Housing Unit 4 was converted from restrictive housing to general population. Another 40-bed gallery on the unit, which had served as a “limited movement unit” (LMU), was also converted to general population around the same time.

With the exception of the Control Unit, the changes at NSP took place as NDCS was adding 384 new high-security beds at the RTC in 2023. These beds helped reduce the Department’s overall restrictive housing numbers by providing a slightly less restrictive alternative; they also absorbed many of the people from NSP’s general population who were considered most likely to cause the kind of problems which could prompt placement in restrictive housing. The Legislature also enacted new limitations related to the use of restrictive housing in 2015 and 2019.[10]

[10] Legislative Bill 598 (2015) defined restrictive housing in statute and established some controls related to its use; LB 686 (2019) prohibited the use of restrictive housing for members of “vulnerable populations,” including those with serious mental illness.

According to the most recent Restrictive Housing Annual Report from NDCS, the average daily population in restrictive housing declined from 292.24 in FY2019-20 to 192.83 in FY2023-24.[11]



NSP's last remaining restrictive housing gallery consists of 20 cells, 19 of which are configured to allow double bunking. Many people who are placed in these cells are being reviewed for protective custody (PC); others are in immediate segregation (IS) for behavioral reasons; and some are assigned to longer-term restrictive housing (LTRH).[12] For example, on a spring day in 2024 when the gallery held 29 people:

- 16 had requested PC;
- 3 had recently been approved for LTRH; and
- 10 were in IS for assaulting staff, fighting, refusing housing, or being involved in some other kind of incident.

On that day, 10 of the 20 cells were double bunked. The cellmates included:

- 6 pairs who had requested PC;
- 2 pairs who were placed in IS for behavioral reasons;
- A pair who had been involved in the same fight and were now assigned to the same RHU cell; and

[11] https://www.corrections.nebraska.gov/sites/default/files/files/1183/fy2024_rh_annual_report.pdf.
[12] Definitions for these terms can be found in NDCS Policy 210.01 (2023), "Restrictive Housing."

- A pair who had shared a cell where a weapon was found at the RTC and were now assigned to the same RHU cell.

There is no prohibition against double bunking in restrictive housing under departmental rules and regulations or state law.[13] NDCS policy allows people to be double bunked in restrictive housing "so long as the cell assignment provides each cellmate with reasonable safety from assault."[14] Those in segregation pending possible placement in protective custody may only be placed with cellmates who are also pending PC. The policy further notes that "(r)easonable safety is not a guarantee of absolute safety."

Although the policy specifically allows double bunking of people on immediate segregation, it does not directly address double bunking for those in longer-term restrictive housing. This is noteworthy since both John Doe and John Smith were in LTRH when Doe died. Prior to 2021, the restrictive housing policy included specific language that those assigned to LTRH "may be in single cells, moving to a double cell according to the Behavior/Programming plan and/or Individual Treatment Plan."[15]

People assigned to LTRH are usually sent to other facilities where double bunking in RHU does not take place. This has been the case more recently than the incident examined in this report, and is the result of unrelated changes. In the 2024 sample above, two men on HU4 had just been approved for LTRH that day and were promptly transferred. The other person who was assigned to LTRH did not have a cellmate, had been approved for LTRH for about a week, and was back at his original facility within a week after the sample was taken.

As part of this investigation, the OIG asked if double bunking was still allowed in LTRH. An NDCS administrator responded as follows:

> *Assigning a cellmate to someone on LTRH is still permitted and team members follow the process outlined in policy. However, our goal since around the first of 2024 has been to consolidate all individuals assigned to LTRH at TSCI. We*

[13] The relevant regulation is Title 72 Neb. Admin. Code, Chapter 1.
[14] NDCS Policy 201.01 (2023).
[15] This language last appears in the September 24, 2020 revision of NDCS Policy 210.01.

> *do not double cell individuals at TSCI RH (restrictive housing). There are a few exceptions to this (i.e., an individual assigned to LTRH but currently residing in a residential/secure mental health housing area.*

The administrator later indicated that double bunking largely relates to bed space, and that this practice could cease if NSP consistently had 15 or fewer people in restrictive housing.

Use in Other Highly Restrictive Settings

NDCS also occasionally places people on restrictive housing "status" in settings other than actual restrictive housing units. For example, in June 2024, several men were placed in segregation and confined to their normal cells, double bunked, following an incident at NSP. Segregation also takes place somewhat often in the high-security housing units ("the 384") at the RTC. People living on mental health units might also be on restrictive housing "status," because NDCS intends to return them to a restrictive housing unit once their mental health is stabilized. These individuals generally are in single cells.

In July 2023, NDCS adopted a policy called the "Group Violence Reduction Strategy," in which entire units are placed on "modified operations" following violent incidents, while staff identify those involved as well as their associates.[16] NDCS policy distinguishes modified operations from full lockdowns, but these operational statuses can have essentially the same impact on the incarcerated population: People are often confined to their cells for days or weeks at a time, aside from 20 minutes for showers every few days.[17] Under the Group Violence Reduction Strategy, modified operations are supposed to conclude within 72 hours, but indefinite extensions may be approved by the deputy director of prisons. In the June 2024 example mentioned above, in addition to many men being placed on segregation status, the entire housing unit was confined to their cells, with limited exceptions, for more than two weeks.

[16] NDCS Policy 210.04.
[17] NDCS Policy 203.02, "Emergency Preparedness."

This is important to note because many of the complications and concerns discussed in this report related to restrictive housing would also apply in other situations where two or more people are locked down together for an extended period of time.

Perceptions and History

NDCS is far from the only prison system which double bunks people in restrictive housing. As of 2016, about half the states in the U.S. housed at least some people in two-person restrictive housing cells.[18] Nonetheless, this practice has been criticized by some correctional leaders, mainly due to safety and liability concerns.

In conversations with incarcerated people, staff, and administrators, and reviews of correctional research and other literature, the following were raised as possible *benefits* of double bunking in restrictive housing settings:

- Increased capacity, particularly in overcrowded systems;
- Less isolation, especially considering limited out-of-cell time/activities in restrictive housing;
- Ability to share items;
- Possible reduction in self-harming behaviors or suicide.

The following were perceived as *disadvantages*:

- Lack of physical space;
- Lack of privacy;
- Difficulty searching cells/identifying the owner(s) of contraband found in a shared cell;
- Sense of heightened risk to staff when opening cells during an incident;
- Possibility of sexual victimization without witnesses;
- Possibility of assault or homicide.

[18] "Aiming to Reduce Time-In-Cell: Reports from Correctional Systems on the Numbers of Prisoners in Restricted Housing and on the Potential of Policy Changes to Bring About Reforms." Association of State Correctional Administrators; and The Arthur Liman Public Interest Program, Yale Law School. November 2016. https://law.yale.edu/sites/default/files/area/center/liman/document/aimingtoreducetic.pdf

Most internal housing units at NSP, including HU4, were built in 1981 and were intended for single occupancy. At the time, double bunking in any setting – let alone restrictive housing – was still considered problematic and controversial.[19]

However, the same year HU4 was placed in service, the U.S. Supreme Court held that an Ohio state prison's practice of double bunking was not inherently cruel and unusual. The Supreme Court noted in its decision that violence at the overcrowded facility "had increased with the prison population, but only in proportion to the increase in population" and that the men who filed the lawsuit, who had been double bunked, "failed to produce evidence establishing that double celling itself caused greater violence." Yet concurring opinions and a dissenting opinion in that case raised concerns about the practice of double bunking, particularly should it become the norm due to overcrowding.

In his concurring opinion, Justice William J. Brennan wrote:

> *I have not the slightest doubt that 63 square feet of cell space is not enough for two men. I understand that every major study of living space in prisons has so concluded. ... That prisoners are housed under such conditions is an unmistakable signal to the legislators and officials of Ohio: either more prison facilities should be built or expanded, or fewer persons should be incarcerated in prisons.*

In his dissent, Justice Thurgood Marshall wrote:

> *Until the Court's opinion today, absolutely no one ... had suggested that forcing long-term inmates to share tiny cells designed to hold only one individual might be a good thing. On the contrary, as the District Court noted, 'everybody' is in agreement that double celling is undesirable. ... (T)he only reason double celling was imposed on inmates at (the Ohio prison) was that more individuals were sent there than the prison was ever designed to hold.*
>
> *The conclusion of every expert who testified at trial and of every serious study of which I am aware is that a long-term inmate must have to himself, at the very least, 50 square feet of floor space – an area smaller than that occupied by a good-sized automobile – in order to avoid serious mental, emotional, and physical deterioration.*

[19] Haney, C. (2006). The wages of prison overcrowding: Harmful psychological consequences and dysfunctional correctional reactions. *Washington University Journal of Law and Policy*, *22*(1). https://openscholarship.wustl.edu/cgi/viewcontent.cgi?article=1360&context=law_journal_law_policy

It merits mentioning that the double-bunking arrangements addressed in these opinions included those for general population inmates, not just those in restrictive housing.

Dr. Craig Haney, a psychologist and attorney who inspected the NSP restrictive housing unit in 2018 as an expert witness in litigation against NDCS, observed the following in relation to the conditions there:

> *The kind of forced and strained 'interactions' that take place between prisoners who are confined nearly around-the-clock in a small cell hardly constitute meaningful social contact. In fact, under these harsh and deprived conditions, the forced presence of another person may become an additional stressor and source of tension (even conflict) that exacerbates some of the negative reactions brought about by this kind of segregated confinement. Indeed, in my experience, assaults (and sometimes lethal violence) between cellmates who are in isolated confinement is a serious problem in these kinds of units.*[20]

Unfortunately, empirical research about double bunking in restrictive housing is slim to nonexistent. For example, the OIG was unable to find any comprehensive examination of whether the combined risk of death by suicide or homicide is greater in single- or double-bunked restrictive housing cells. Some research has found that people are more likely to die by suicide in single-cell disciplinary housing; however, the recommended solution was more attention by staff, not double-bunking.[21]

Within NDCS facilities, in the past four years, the same number of people have died by suicide — three — as by suspected homicide. In each of the three possible homicides, the person's cellmate was the suspected killer. Of the three people who died by suicide, one was single-bunked in restrictive housing, one was in general population and had a cellmate, and the third was living in a single cell on the gallery for individuals sentenced to the death penalty ("death row").[22]

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[20] Expert declaration of Craig Haney, Ph.D., J.D., in support of class certification. *Sabata v. Neb. Dep't of Corr. Servs.*, 4:17-CV-3107 (D. Neb. Jun. 8, 2020).

[21] Way, B. B., Sawyer, D. A., Barboza, S., & Nash, R. (2007). Inmate Suicide and Time Spent in Special Disciplinary Housing in New York State Prison. *Psychiatric Services*, *58*(4), 558–560. https://doi.org/10.1176/ps.2007.58.4.558

[22] Although Nebraska's death row is not a general population unit, death row residents enjoy considerably more freedom, group interaction, and out-of-cell time than those in restrictive housing.

Noncompliance with ACA Standards

The American Correctional Association (ACA), through which NDCS is accredited, does not prohibit double bunking in restrictive housing under its standards. However, restrictive housing cells are supposed to have at least 80 square feet of space, including 35 square feet of unencumbered space, plus 25 square feet of unencumbered space for each additional occupant.[23] (Unencumbered space is space that is not filled with a permanent fixture such as a bed, toilet or desk.)

The restrictive housing cells at NSP have approximately 75 square feet of space, with about 32 square feet of unencumbered space in a double cell. This noncompliance with standards was noted in the most recent external ACA audit for the Penitentiary.[24] NDCS indicated to the ACA that its "plan of action" to address this issue is new construction.

Previous ACA standards were less stringent, but the NSP restrictive housing cells were also out of compliance with those older standards.[25] Researchers with the Liman Center at Yale Law School, a respected source on restrictive housing, have suggested even the new standards should go further in addressing double bunking:

> *We suggest that in addition to calling for more space, this Standard should call for areas of privacy, such that the shared toilet space has some way to be screened off, consistent with security needs, so that prisoner-prisoner privacy is maintained. In this regard, we also raise questions about reliance on prisoners, rather than staff, for protecting other prisoners from risks of suicide.*[26]

The poor state of HU4 and the other higher-security housing units at NSP has been well-documented. The restrictive housing unit within HU4 was described as "insufficient" in the 2014

[23] 5-ACI-4B-06, Performance-Based Standards and Expected Practices for Adult Correctional Institutions, Fifth Ed. (March 2021).
[24] ACA external audit for Nebraska State Penitentiary, December 6-8, 2021.
[25] This was noted in the OIG's 2018 *Nebraska State Penitentiary Supplemental Report*, https://nebraskalegislature.gov/FloorDocs/105/PDF/Agencies/Inspector_General_of_the_Nebraska_Correctional_System/679_20181011-082108.pdf.
[26] Liman Program comments on 2016 ACA Restrictive Housing Proposed Revisions, https://law.yale.edu/sites/default/files/area/center/liman/liman_comments_on_aca_restrictive_housing_standards_jan_19_2016_final.pdf.

Correctional Facility Master Plan prepared for NDCS, and the 2022 Nebraska State Penitentiary Useful Life Engineering Study indicated that all five internal housing units needed to be replaced.[27] [28] These reports helped form the basis for the Legislature's decision in 2023 to approve funding for a new correctional facility with approximately 1,500 beds. This facility is intended to replace NSP. In August 2024, NDCS officials told the OIG construction of the new facility is not expected to be completed until at least 2028.

NDCS Process

The section of NDCS restrictive housing policy which describes the process for placing cellmates together has not changed substantially since prior the TSCI death in 2017. Under the policy, before placing someone in a segregation cell with someone else, the restrictive housing unit manager confers with the unit manager of the person's originating unit. (In the absence of one or both unit managers, this discussion may happen with other unit staff and/or the shift supervisor.) The restrictive housing unit manager or other staff member making the decision must also complete a one-page "Assignment of Living Location" form, which includes each individual's history of assaultive behavior, the reason they are being placed in restrictive housing, their central monitoring list (also known as "keep separates"), information from assessments done to determine their risk of committing or being victims of violence or sexual abuse, their STG affiliation(s), and a written statement of why the placement "provides each cellmate with reasonable safety from assault."

In addition to normal security checks, staff are supposed to check with people in double bunked restrictive housing cells at least once per day "to ensure potential compatibility issues are addressed," then meet individually with each person at least once every 30 days that they are assigned to the same cell.

Staff involved in signing off on these decisions had expressed concerns to administrators prior to John Doe's death about certain cellmates they were told to put together, and about the overall practice of double bunking in RHU, according to interviews and documents reviewed by the OIG

[27] Prepared by Dewberry Architects Inc.
[28] Prepared by Alvine Engineering.

as part of this investigation. Specific issues raised included staff's limited access to information about the individuals being placed together, including people who have come from other facilities; concerns about whether the information these staff could access was complete and up-to-date; and feeling pressured to put people together despite their concerns about the practice. One staff member told the OIG that double bunking had become the "expectation" and was being treated as "business as usual" by administrators, something this staff member believed should not be the case.

The month before Doe's death, unit staff were told the decisions they had been making regarding double bunking were in line with departmental policy. They were also directed, in writing, to pair up as many people as possible to "free up as many cells as possible" in the RHU.

Risk of Violence

John Smith and the person responsible for the 2017 death at TSCI both scored "high" for risk of violence toward other inmates, according to their cell assignment sheets. These violence risk scores are generated from behavioral health intake appraisals which are completed by mental health staff during the earliest weeks of a person's arrival in NDCS custody. As part of this investigation, the OIG asked an NDCS administrator how often this information is updated. The response was that, "It does not appear that this information is updated."

Nothing in NDCS policy prohibits someone with a high violence score from being placed with a cellmate in restrictive housing.

As of July 15, 2024, NDCS identified 370 people in its facilities who scored high in this category. In the spring 2024 sample mentioned earlier in this report, just one person whose cell assignment sheet was provided to the OIG scored high for risk of violence. That individual had requested protective custody and was placed in a shared cell (with another person who requested PC) for at least some of his time in the RHU.

Past OIG Recommendations

The OIG has raised concerns in the past about double bunking in restrictive housing, specifically after Berry's death, when this office recommended that NDCS suspend the practice until further examination could be conducted. This recommendation was rejected. The OIG has since encouraged NDCS to end the practice altogether.

Other Considerations Related to Double Bunking

In reviewing the 29-person snapshot of HU4 from earlier in this section, it is noteworthy that in two instances, cellmates were paired up with someone who was involved in the same incident as them. More recently, the OIG investigated an incident in which two men who were suspected of being "in a romantic relationship and have created their own Security Threat Group" were placed together in segregation, despite being involved in an alleged two-on-one assault at another facility that left another person seriously injured.

This is not prohibited in policy, although an administrator said staff have been encouraged in the past not to place codefendants together in restrictive housing. These kinds of arrangements might be safe: For example, if two people are associates or were cellmates before, they might reasonably be expected to do well together. On the other hand, pairing them up may increase the possibility of one being subject to pressure by the other, or that they might collaborate to undermine investigations of the incident that resulted in their placement in restrictive housing.

Another consideration involves individuals who have requested protective custody. Per departmental policy, people who are pending PC may only be bunked with others who are pending PC. However, not all people who request protective custody are approved, and some request PC with the intent of gaining access to people who are already in PC, to commit violence against them. Additionally, this policy does not address people who haven't explicitly requested protective custody but are placed in restrictive housing for other reasons (e.g. refusing housing) which might be viewed as a round-about way of "checking in" to PC.

In each of these circumstances, unit staff are expected to use their discretion when determining cell assignments. However, if staff are still investigating a request for protective custody or the

circumstances of an incident which resulted in placement in segregation, there is a significant chance they are missing vital information for assigning a suitable cellmate.

EMERGENCY RESPONSE

As noted earlier, the NDCS internal critical incident review (ICIR) of John Doe's death primarily examined the emergency response, as is standard with these reviews. Each ICIR also results in a corrective action plan (CAP), in which facility and agency administrators describe actions which should be taken to address any concerns identified. The ICIR in this case identified areas of possible improvement, which were mentioned earlier in this report but are explored in greater detail here, along with the resulting CAP.

ICIR Recommendations and Corrective Actions

1. Emergencies in Double-Bunked Cells

The wording of the first recommendation in this review was as follows, with some information redacted for this OIG summary report:

> *Policy and/or training need to be implemented in restrictive housing on what to do if one inmate is experiencing a medical emergency and has a cellmate. … Identifying a location for restraining the cellmate for future incidents of this kind would be beneficial as well as creating some sort of checklist on what do if there's an emergency with a cellmate that was in the cell (restrain and take to a holding type area, take photos of cellmate, bag clothing for evidence, etc.) so that staff are aware in case the medical emergency turns into a crime scene.*

The CAP provided the following corrective action (with some redaction by the OIG) for this recommendation:

> *Information will be sent out to team members assigned to Restrictive Housing to inform them to place cellmates in a secure area … in the event the cell becomes a crime scene. Additionally, evidence should be collected as deemed appropriate by the Shift Supervisor.*

The ICIR specifically recommended additional training or a revision of policy to address this issue. Instead, NDCS opted for a one-time reminder to staff. The OIG is unaware of any plans by NDCS to follow up to ensure that future staff are made aware of this information.

2. Triage in Turnkey

The second ICIR recommendation was as follows:

It was recommended by a few team members that a different area be used for triage, so to speak, other than turnkey as there is typically a high volume of inmates in the area going to and from classes and passes.

The CAP response:

Turnkey is the most appropriate area for this instance in regard to transferring the incarcerated individual to the front entrance for emergency services. Turnkey can easily stop traffic by securing doors. When prudent, the population is treated in medical as appropriate.

3. CPR and AED Training

ICIR recommendation:

Medical suggested reminding/training staff about effectiveness of CPR and proper ways to perform CPR. One handed CPR is not effective for life-saving measures. It was also suggested to apply the AED that was available in the housing unit before bringing the inmate to turnkey. Training regarding the locations of AEDs throughout the facility might be beneficial as well as when to apply the AED in emergency situations.

CAP response:

This has since been incorporated into NSP day five training. It is reviewed reminding staff both about the ease of using the backboard down gallery stairs and the effectiveness of compressions for CPR.[29]

4. Hook Knife

ICIR recommendation:

It was suggested for someone posted in restrictive housing to always have a hoof knife on their person or immediately available. This could be problematic if one was accidentally lost, but these are available in the control center of the housing unit, so reminding staff posted in the area of those locations might assist in future emergencies.

CAP response:

The hook knife is located in a designated area for all team members to have access to. If assigning to one team member, it would have to be 'tracked down'

[29] This particular response also addresses the issues staff encountered with the gurney and a suggestion that a backboard should have been used instead. While it was not included in the recommendation, it was mentioned elsewhere in the ICIR.

since team members are completing a variety of tasks all over the unit and could potentially not be able to respond.

As mentioned before, after reviewing the original ICIR, NDCS administration directed that a further review be conducted of the decision to put John Smith in John Doe's cell. This review concluded that the placement was in accordance with NDCS policy, and no further action was recommended.

NDCS Training

As part of its own investigation, the OIG interviewed several current and former staff members who were involved in the incident response. A theme which emerged from these interviews was concern over training: that staff who were posted to the restrictive housing unit hadn't been appropriately trained to work there, and that things they learned in the Staff Training Academy were done differently at the facility.

RHU Training

NDCS rules and regulations specify that "regularly assigned unit staff" shall receive RHU-specific training.[30] Because the term "unit staff" is not defined in the rules but is applied in other contexts to case managers and caseworkers, rather than protective services/security staff, it is unclear whether this training requirement also applies to security staff. However, ACA standards related to specialized training apply to "security staff who work directly with inmates in Restrictive Housing on a regular and daily basis."[31] NDCS policy states that in "facilities with small, short-term restrictive housing units and no specified restrictive housing posts, designated unit and custody team members will receive special training prior to providing coverage in the unit."[32] An attachment included with this policy states that "the following training shall be completed prior to the assignment of the staff member to a post in a restrictive housing unit":

- *Tour of RH (restrictive housing);*
- *RH Overview (2 hrs);*

[30] Title 72, Nebraska Administrative Code, Chapter 1.
[31] 5-ACI-4B-13, Performance-Based Standards and Expected Practices for Adult Correctional Institutions, Fifth Ed. (March 2021).
[32] NDCS Policy 210.01, "Restrictive Housing."

- *RH Security and General Duties (2 hrs);*
- *Proper Completion of Paperwork (1 hr);*
- *Manual Operation of Mechanisms (1 hr);*
- *Managing Offenders with Mental Illness (2 hrs);*
- *Proper Communication with Others (1 hr);*
- *Restraints (1.5 hrs);*
- *Emotional Intelligence (2 hrs);*
- *CICR (crisis intervention conflict resolution) (4 hrs); and*
- *OJT (on-the-job training) (8 hrs).*

In total, these staff are expected to undergo at least 20.5 hours of training specific to working in restrictive housing.

The OIG provided NDCS with a list of nine staff members who were assigned to work on Housing Unit 4 the day of Doe's death or were directly involved in the incident response. As of July 2024, five of the nine were no longer employed by NDCS. Only one of the nine had a record of being RHU certified, meaning they had completed the training. The completeness of these records is unclear, based on interviews with staff, but what is clear is that many if not most staff involved were not RHU trained.

The staffing crisis within NDCS continues. One result of facilities being shorthanded is a lack of fully trained staff to fill in when absences occur. This includes "utility" staff covering specialized posts, and corporals or sergeants filling in for sergeants or lieutenants. In this case and others, staff have expressed concerns to the OIG about how frequently this takes place within NDCS facilities, often with very inexperienced staff.

Another issue the OIG identified in recent years is the widespread use of restrictive housing-type practices outside of restrictive housing units. This includes:

- The addition of high-security special management units at the RTC and TSCI, and the Behavior Intervention and Programming Unit (BIPU) at the Nebraska Correctional Center for Women in York;

- The restrictive conditions in the Department's acute/subacute mental health units,
- The installation and use of "hatch" doors in a variety of settings; and
- The implementation of a "Group Violence Reduction Strategy" policy, which involves placing entire units under "modified operations" — conditions which are in some ways more restrictive than restrictive housing — for days or weeks at a time.

Each of these examples involves processes and conditions which are outside the norm and may necessitate specialized training for the staff involved. In fact, the RTC began conducting special training for staff on its special management units following an incident in May 2023 in which staff were assaulted with weapons, and some were seriously injured.

Academy Training

The standard pre-service training regimen for NDCS protective services and housing unit staff includes six weeks of training through the Staff Training Academy (STA), followed by a week of general training with a field training officer (FTO) at their facility, and another week of on-the-job training (OJT) specific to their position.[33]

The STA is located in a former school building in north Lincoln. Most cadets in STA do not visit their assigned facility until the 16th day of STA training. However, at the time of this report, NDCS was conducting a pilot project where those hired to work at NSP visit their facility on the second day of training, and spend about double the amount of time training inside the facility itself, versus STA.

The OIG learned details of this pilot project in a meeting with senior staff for NDCS professional development in June 2024:

- The project was the result of information NDCS gathered from new employees at NSP and the Reception and Treatment Center. The Department followed two academy classes for their first year of service, checking in with them every two months. Overwhelmingly, those staff said they thought they would have benefitted from more time in the facilities

[33] NDCS Policy 114.04, "Pre-Service Training."

and more OJT. Historically, this has been difficult to do because NDCS has added courses to the STA but has not wanted to increase the length of training to accommodate, thus reducing time available for OJT.

- NSP was chosen as the site for the pilot project because it has two FTO sergeants and a dedicated training space.
- NDCS identified academy courses which were "information only" and could be done online instead of in person at the STA. Switching these courses to online meant they took less time to complete, and cadets could do them on computers inside the prison facility instead of in a classroom at the STA. The Department also adjusted the STA schedule so these cadets learn Pressure Point Control Tactics (PPCT) in week 2 pre-service training instead of week 5, allowing them to be on the yards at their facilities earlier.

NDCS staff who took part in this meeting said they hoped getting cadets to their facilities earlier will give them a much earlier feeling of what it's like to work inside a prison and the culture at their facility, in case they realize they aren't interested. Other stated goals included helping people reconcile what they learn at STA with what happens in the actual facilities, and identifying and addressing discrepancies between STA training and facility operations.

The OIG was told that the NDCS Director initially wanted this program to be expanded Department-wide in September 2024, but adjustments were made following the first academy class in the pilot project, so broader implementation may not take place until at least January 2025.

NDCS Drill Exercises and In-Service Training

Many, if not most, deaths of people in NDCS custody are due to chronic illness, are expected, and take place in a skilled nursing facility or outside hospital. These deaths typically do not prompt an ICIR. Unexpected deaths, particularly those due to homicide or suicide, generally do result in an ICIR. The ICIRs often result in corrective action plans (CAPs) which include having staff run drills to practice specific scenarios related to emergency response.

Staff interviewed as part of this and other OIG investigations have suggested that additional drills might help improve emergency response and team cohesion within the facilities.

All full-time security staff and those in specialist positions who have regular contact with incarcerated people are required to complete at least 40 hours of in-service training each year, which includes training on emergency response procedures. Additionally, NDCS emergency specialists are supposed to conduct four drills at each facility each quarter. These include at least one medical response exercise, at least one orientation exercise (often a learning exercise which includes new or refresher information on specific procedures), a test of the Department's emergency staff recall system, and at least one tabletop exercise for the facility's incident management team (IMT).[34]

The OIG met with NDCS officials in July 2024 to learn more about these routine drills. During the meeting, it was relayed that drills done as a result of ICIR recommendations do not count toward the required number of routine drills, and that facility administrators have the ability to request additional drills. For example, following a recent shuffling of wardens at several facilities, some wardens requested additional IMT drills in part so they could get to better know their command staff. The Department's emergency preparedness coordinator keeps a centralized list of these drills.

Impact of COVID-19 and Staff Shortages

It is important to note that the coronavirus pandemic and critical staff shortages both had significant impacts on NDCS operations in the years and months leading up to the incident examined in this report. Doe's death took place after NSP returned to its normal operating schedule, following a staffing emergency which had been in place there since October 2019. Two other NDCS facilities – the Reception and Treatment Center and the Tecumseh State Correctional Institution – remain under staffing emergencies as of this report. These shortages, along with the pandemic response, impacted virtually every aspect of the prison system, including training and the overall work environment within the facilities.

[34] These requirements are found in policies 114.05 and 203.02, and American Correctional Association standards.

OIG Meeting with NDCS

In September 2024, just prior to finalizing this report, the OIG met with an administrator at NDCS Central Office to discuss several aspects of this investigation, including concerns about training and drills. This meeting was positive and constructive. The administrator acknowledged that NDCS fell behind with specialized training and refresher training as a result of COVID and related challenges, and that the Department has been working to catch up. The discussion included ways to increase the amount of training and drills taking place. It is recognized that further training obligations must be balanced with other demands placed on NDCS administration and staff.

FINDINGS

1. **Continued double bunking in restrictive housing is dangerous.** Restrictive housing is a volatile setting, even for a correctional facility, and staff cannot be expected to determine which cellmates are safe and which ones are not in these circumstances. Having a cellmate might reduce a person's risk of suicide, but this is not the responsibility of the cellmate.

2. **Double bunking is driven by space considerations within NDCS.**

3. **The staff who made the cell assignment decision in this case did so according to departmental policy.** The Department's internal review in this case found that the cell assignment policy was followed.

4. **Incarcerated people and staff feel pressure to accept double bunking arrangements in restrictive housing despite concerns about safety with this practice.** NDCS policy specifically states that "(r)easonable safety is not a guarantee of absolute safety" in these situations. This language appears to acknowledge the inherent risks associated with double bunking in restrictive housing. Nonetheless, these decisions are made by unit-level staff with little to no oversight from facility administration or Central Office.

5. **Concerns exist about the violence risk scores used to help make double bunking decisions.** This risk level is determined upon a person's arrival at NDCS and is not updated over time. Additionally, some individuals are placed with cellmates in restrictive housing despite being considered at "high risk" to commit violence against fellow prisoners.

6. **The restrictive housing cells at the Nebraska State Penitentiary are not large enough to accommodate two people, under American Correctional Association standards.** NDCS has indicated that its solution to this is new construction, and that the new facility in northeast Lincoln will be a replacement for NSP. This facility is not expected to open until 2028.

7. **NDCS policy is unclear on whether double bunking is allowed for people in longer-term restrictive housing.** Although NDCS administration has provided some clarification on this to the OIG, the Department's restrictive housing policy only specifically addresses double bunking in immediate segregation, not longer-term restrictive housing. Specific language related to LTRH has been removed.

8. **Many staff who responded to this incident had not received specific training for restrictive housing or were not up-to-date on refresher training.** Efforts to catch up on training for staff are ongoing.

9. **Corrective actions taken following this incident were limited and will not help future staff who encounter similar situations.** One-time reminders are not a substitute for training, drills, or policy changes.

RECOMMENDATIONS

The OIG offers the following recommendations for NDCS:

1. **Stop double bunking in restrictive housing.** This should take place no later than the opening of the NSP replacement facility, ideally sooner.

2. **Prohibit the practice of double bunking in departmental rules and regulations.** This will help prevent double bunking in restrictive housing from resuming, should crowding worsen again in the future.

3. **Review training requirements for staff who work in restrictive housing and similar units, including special management units and mental health units. This includes staff who fill in on these units on a regular basis.** The OIG believes NDCS administration has been making positive changes to its training practices. Training for those who work in highly secure settings is especially important.

As long as double bunking continues within NDCS facilities:

4. **Require warden-level approval or higher for double bunking placements in restrictive housing.** Such approval should be cellmate-specific and be granted beforehand or, in emergency situations, within 24 hours after the placement. This is important given the potential risks involved in these arrangements, and will help ensure assignments are being made in accordance with policy and the expectations of Central Office.

5. **Clarify policy regarding double bunking in longer-term restrictive housing.** If this practice is intended to be allowed, the NDCS multidisciplinary review team (MDRT) should be involved in approving these placements.

6. **Update policy to clearly prohibit double bunking of codefendents while in restrictive housing.** This is apparently discouraged, but was taking place at the time of

this report. Including this in policy would help ensure consistency going forward.

7. **Review the violence risk score used on cell assignment sheets to determine if this can be updated periodically or should be removed from the sheets altogether.** Staff making double bunking decisions could use as much information as possible. However, that information should be reliable, current, and well understood.

8. **Prohibit placing cellmates with people in restrictive housing who are considered to be a high risk of violence to other incarcerated individuals.**

NDCS RESPONSE

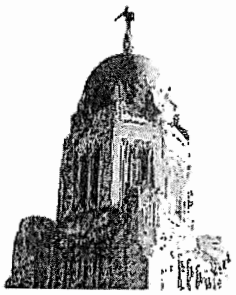
Each time the OIG submits a report to the Director of NDCS, a letter is included which outlines the relevant statutory process. Neb. Rev. Stat.§ 47-915 grants the NDCS Director 15 days to accept, reject, or request in writing a modification of the recommendations made in the report. This report and letter were submitted to NDCS Director Rob Jeffreys on October 22, 2024. The letter also included an offer to meet with NDCS staff about the report prior to the Director's response, and an openness to receiving any input on the summary report.

On November 4, 2024, the OIG received a response in the form of a letter from an NDCS staff member on behalf of Director Jeffreys. The letter indicated the Director would consider the recommendations made in the report. The OIG letter and the NDCS letter are attached as exhibits to this summary report.

EXHIBIT A

DOUG KOEBERNICK
Inspector General

ZACH PLUHACEK
Assistant Inspector General



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

October 22, 2024

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

Dear Director Jeffreys:

The Office of Inspector General has completed an investigation into the death of an incarcerated individual. I have presented our draft report to the Public Counsel and am now providing this report to you. According to Neb. Rev. Stat. §47-915 you have 15 days to accept, reject, or request in writing a modification of the recommendations made in the report.

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

Sincerely,

Doug Koebernick

NEBRASKA

Good Life. Great Mission.

DEPT OF CORRECTIONAL SERVICES

EXHIBIT B

Jim Pillen, Governor

November 4, 2024

Doug Koebernick
Inspector General for Corrections
State Capitol, Post Office Box 94604
Lincoln, Nebraska 68509-4604

Dear Inspector General Koebernick:

This response is in reply to your letter and report that was received in Director Jeffreys' office on October 22, 2024, regarding the death of an incarcerated individual and an investigation by your office. I am responding on behalf of Director Jeffreys.

The Director has received your report (2024-04) and will consider the recommendations.

Please do not hesitate to contact me if you have any questions. I look forward to visiting with you in the near future.

Sincerely,

Geoff Britton
Chief Inspector

Rob Jeffreys, Director
Department of Correctional Services

P.O. Box 94661 Lincoln, NE 68509-4661
Phone: 402-471-2654 Fax: 402-479-5623

corrections.nebraska.gov