

STATE OF NEBRASKA
OFFICE OF INSPECTOR GENERAL OF CORRECTIONS

State Capitol, P.O. Box 94604
Lincoln, Nebraska 68509-4604
402-471-4215
Toll Free: 1-800-742-7690
oigcorrections@leg.ne.gov

Fire at Lincoln Correctional Center Restrictive Housing Unit

INVESTIGATIVE REPORT (SUMMARY)
AUGUST 9, 2022

Doug Koebernick, Inspector General
Zach Pluhacek, Assistant Inspector General

CONTENTS

Executive Summary	2
About the OIG.....	3
Introduction.....	4
About Person A.....	6
Examination of Issues	7
Staffing During Fire.....	7
Fire Safety and Response.....	8
Housing Conditions	12
Other Areas of Review.....	16
Findings.....	18
Recommendations.....	19

EXECUTIVE SUMMARY

On Oct. 23, 2021, an inmate in the restrictive housing unit (Unit C) at Lincoln Correctional Center (LCC)¹ set fire to his mattress using a broken TV cord. While the fire itself did not spread beyond the cell, it produced a significant amount of smoke, which took several minutes for facility staff to notice due to the area being left unattended. Responding staff extinguished the fire, rescued the inmate, referred to in this report as Person A, from his cell with help from a fellow inmate, and evacuated part of the unit, all while hindered by thick, dark smoke that filled the gallery.

Person A, who has a diagnosed developmental disability and a serious mental illness, was hospitalized. Three staff members of the Nebraska Department of Correctional Services (NDCS, or Department) also were taken to a local hospital, including a sergeant who was admitted overnight due to smoke inhalation.

This redacted summary report, released pursuant to Neb. Rev. Stat. § 47-912, documents an investigation of the fire by the Office of Inspector General of the Nebraska Correctional System (OIG). The OIG assessed the state of the facility and on Unit C leading up to the fire, the conditions of Person A's confinement, and the Department's response to the fire, with the goal of identifying possible improvements to policies and procedures of the correctional system. The OIG examined reports by staff, emergency responders and fire investigators; reviewed emergency radio traffic and recordings from the facility's security camera and radio systems; and interviewed rescue workers, NDCS staff and inmates with knowledge of the incident or the systems involved.

At the conclusion of this investigation, the OIG found as follows:

- Due to the unit being left unattended and fire detection systems not immediately activating, the fire response was delayed, likely contributing to the severity of injuries;
- The physical layout and structure of the Reception and Treatment Center (RTC) complex, which includes LCC, impedes emergency response and does not allow for easy removal of smoke from living units in the event of a fire. This is a more significant problem at this facility than at others within NDCS;

¹ LCC and the adjoining Diagnostic and Evaluation Center (DEC) have since been merged under the name Reception and Treatment Center (RTC). This report uses LCC and DEC to reference events from 2021 and before.

- NDCS utilizes chronic mental health beds to house individuals who do not require the defined level of care for those beds, but who engage in serious misconduct and cannot legally be held in long-term restrictive housing; and
- Staff who responded to this emergency saved the life of at least one person, which is particularly notable given the staffing shortages at the facility during this time.

The OIG makes the following recommendations for NDCS:

- Develop a specific plan to ensure all housing units at NDCS facilities are consistently monitored in the event of a staffing crisis;
- Improve fire safety at the RTC;
- Use chronic care mental health housing only for inmates who require that form and level of care; and
- Update policy to provide better procedural protections for individuals placed on these units.

About the OIG

The OIG is an office of the Legislature, tasked with providing independent oversight of the state prison system and with making recommendations to help improve the system. The OIG's statutory responsibilities include investigating serious injury incidents in facilities operated by the Nebraska Department of Correctional Services (Department, or NDCS), which includes LCC.² These investigations are independent of and separate from criminal and grand jury investigations, and from internal investigations conducted by NDCS.

² Neb. Rev. Stat. § 47-905.

INTRODUCTION

The fire on Oct. 23, 2021, happened during a period when staffing at LCC and the adjoining Diagnostic and Evaluation Center (DEC) routinely fell to critically low levels. The day of the fire, staffing between the two facilities was at the minimum recommended level as determined by NDCS.

Housing Unit C, where this incident took place, held approximately 65 inmates in wings designated for restrictive housing or acute/subacute mental health care. These inmates spend a majority of their time locked in their cells, alone, and are entirely beholden to staff to monitor their activity and attend to their needs.³ Inmates also occasionally kick open their cell doors and surprise staff working the unit. Unit C tends to be loud, with inmates shouting through their doors to get attention from staff or to communicate with each other. Staff are expected to document virtually all activity on the unit.

LINCOLN CORRECTIONAL CENTER HOUSING UNIT C

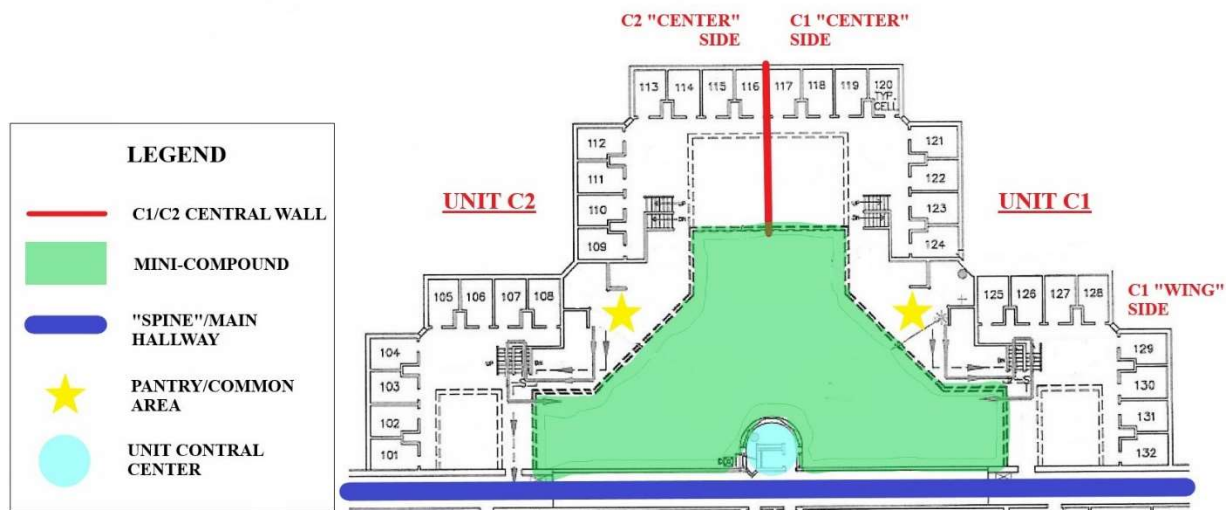


Figure 1: At the time of the fire, Housing Unit C was divided into four galleries: restrictive housing was on the “wing” side gallery of Unit C1 (right side of map), while the other side of C1 and all of C2 comprised the facility’s secure mental health unit. The environment on Unit C was highly controlled: Movement within the unit, out-of-cell time, and interaction with other inmates was limited. The unit has two tiers with eight cells each. The map shows the top tier. At the time of the Oct. 23 fire, no staff were present on the C1 side of the unit.

³ While many of these individuals have been relocated to the RTC’s new mental health unit since the completion of this investigation, this characterization of their confinement remains accurate.

Shortly after 11 a.m. on Oct. 23, as a caseworker left Unit C1 unattended after finishing an area check of the “wing” side of the unit (see Figure 1), a security camera captured footage of flashes inside Person A’s cell on the upper tier of the unit. This was followed by smoke, which accumulated inside the cell before pouring out from under the door and onto the unit. Wing-side inmates kicked and pounded on their doors for several minutes, calling for help, before the caseworker heard them and reentered the unit from the “center” side. He saw smoke as he approached the wing side of the unit, and called for an emergency response team (ERT). The facility shift commander called 911, as did a woman who was on the phone with her husband, an inmate in Unit C.

Responding staff first tried using a fire extinguisher through the open hatch in the cell door, but the fire extinguisher failed. After grabbing a second fire extinguisher, they opened the cell door and used it to knock back the fire. They found Person A face-down on the floor, unresponsive,



Figure 2: NDCS staff use a gurney to bring Person A down the “spine” at LCC.

and the room filled with thick, black smoke. While Sgt. Michael Cordonier (the ERT supervisor) began opening the remaining wing-side cell doors and directing those roughly 15 inmates to the mini compound outside, a second sergeant dragged Person A from his room and off the unit, with help from another inmate who helped carry Person A down the stairs. Sgt.

Cordonier then went to the main hallway to check on Person A, who appeared to be gurgling but not breathing, so Sgt. Cordonier performed chest compressions until Person A regained his breath. Other staff went to the mini compound to place flex cuffs on the remaining inmates, who were unrestrained until that point.

As an ambulance was leaving with Person A, Sgt. Cordonier and other staff continued checking inmates from the remaining sections of Unit C to see if they required medical attention. During this time, an inmate⁴ with a serious mental illness on the “center” side of C1 demanded to be let out of his cell, wrapped a cable around his neck, then grabbed a sharpened pencil and threatened to kill anyone who opened the door. Staff spoke with him for about 20 minutes before he started banging his head against the door and stabbing himself with the pencil, then broke the pencil and flushed it down the toilet. The inmate was moved to Unit C2 and placed on suicide watch, but continued to try and harm himself for more than an hour. Facility medical staff treated his injuries.

Person A and Sgt. Cordonier were admitted to a local hospital due to smoke inhalation. Sgt. Cordonier told the OIG he was held overnight for observation. Two additional staff were assessed at the hospital, as well. Person A was diagnosed with acute respiratory failure with hypoxia and remained in the hospital for three days, spending most of that time sedated and on a ventilator, according to hospital discharge papers contained in his NDCS medical records.

ABOUT PERSON A

Person A is 27 years old and has a developmental disability and a serious mental illness. He has been in NDCS custody since March 2019, will not be eligible for parole until 2030 and is not set for mandatory discharge until 2049. He has spent time in general population areas as well as restrictive housing, mental health and protective custody units, mostly at the RTC but also at the Tecumseh State Correctional Institution and the Nebraska State Penitentiary.

Custody and mental health staff who have worked with Person A describe him as needy, vulnerable, easily manipulated by other inmates, inclined to manipulate others, impulsive, and prone to misbehavior. He has described himself as a “sex addict,” and reported that he was physically abused by his father growing up and “walked in on (his parents) having sex ‘all the

⁴ (Name redacted.)

time,’ because they did not lock their door and he did not have his own room.” He became a state ward at age 9 and said he experienced sexual abuse in some of his out-of-home placements.

At the time of the fire, he was being held in the restrictive housing portion of Unit C, pending a protective custody investigation.

EXAMINATION OF ISSUES

Staffing During Fire

A caseworker was the only staff person assigned to Unit C1 at the time of the fire, due to it being a Saturday and shortages leaving the entire facility well below its assigned staffing level. The OIG’s 2021 annual report contains significant information about the NDCS-wide staffing crisis during this time.⁵

In an incident report, the caseworker said he arrived 30 minutes late for work that day and immediately fell behind:

“Between feeding, picking up trays, medicating, fulfilling inmate requests, and answering inmate questions, I did not have time to catch up my logs. ... While doing area checks, I was constantly interrupted by inmates asking questions, needing something, making demands, needing to be calmed, or redirected. I have found that on C-1, if inmates [sic] requests are delayed for any reason, things escalate quickly. In my experience, this leads to threats, arms out of hatches, flood, self-harm, and other serious circumstances. The constant interruptions led to me to [sic] some areas not being completely checked.

“During my shift of C Unit on October 23rd, 2021, I had several brief conversations with (Person A). I cannot recall all interactions with him, but I asked him several times if he felt ok, due to some vomiting he had experienced a couple days earlier. Another time I asked him to uncover his face during a round, to make sure I saw him.”

The caseworker told an emergency specialist who conducted an internal review for the Department that as Person A sparked the fire, the caseworker was going to the C2 (mental health) side of the unit to get a printout from a fellow staff person.⁶ Unlike other facilities within

⁵https://nebraskalegislature.gov/FloorDocs/107/PDF/Agencies/Inspector_General_of_the_Nebraska_Correctional_System/600_20210914-140850.pdf.

⁶ NDCS Internal Critical Incident Review of Oct. 23 fire.

NDCS, LCC (now RTC 2) does not typically staff its unit control centers, or “bubbles.”⁷ With no staff on the floor, and no one in the bubble, C1 was left unattended.⁸

American Correctional Association Standards include a “nonmandatory expected practice” that correctional officer posts are “located in or immediately adjacent to inmate living areas to permit officers to hear and respond promptly to emergency situations.”⁹ This standard includes a comment that, “The presence of correctional officers within hearing distance of inmate living quarters can help prevent inmate misbehavior and avoid disturbances.” (NDCS was ACA accredited at the time of the fire and had recently received an award from the organization.¹⁰)

One caseworker told the Department’s internal reviewer that Unit C1 needs more than one staff person assigned, even when locked down, due to the high-need populations on that unit. The internal review was submitted to and signed by RTC Warden Taggart Boyd and NDCS Deputy Director Robert Madsen. An action plan submitted along with the internal review says RTC staff were instructed to stop using C Unit as a “pull post” to assist staff in other areas of the facility.

Staff and supervisors noted that, once they became aware of the fire, the response went well considering how shorthanded they were. Some staff left other units unattended to help respond, which one supervisor noted was “not uncommon with this current staff pattern,” according to the Department’s internal review of the incident.

Fire Safety and Response

The OIG examined several issues related to the fire response. Some were also addressed in the Department’s internal review.

⁷ The unit control centers at RTC 2 are small rooms along the “spine” with views into the galleries of each unit from across the mini-compound.

⁸ Unlike most facilities within NDCS, LCC does not typically staff its unit control centers, small rooms with views into each gallery that can be used to monitor a unit when staff aren’t physically present on the unit. No one was inside the C Unit control center at the time of the fire.

⁹ 5-ACI-3A-03, American Correctional Association. (2021). Performance-Based Standards and Expected Practices for Adult Correctional Institutions, Fifth Edition.

¹⁰ <https://corrections.nebraska.gov/ndcs-receives-national-award-aca-conference-0>.

BREATHING APPARATUS AND VENILATION

Staff reported that heavy smoke made it difficult to breathe or see inside Unit C during the initial emergency response. The smoke continued to spread into the main hallway or “spine” which connects all five housing units as well as other parts of the facility. (See attached map.¹¹) The first responding firefighters were initially escorted through the facility by a corrections staff member, but this person had to stop due to the smoke, leaving a pair of firefighters to find their way to the unit without knowing for sure if it had been evacuated or if all inmates had been secured.¹² The firefighters then made contact with a second staff person closer to the unit, who confirmed the unit was secure and the fire had been extinguished.

Throughout the incident, corrections staff tried using disposable dust masks and other items, like rags, to make it easier to breathe. Ultimately, three of these staff members were taken to a local hospital for evaluation.

One longtime staff person who responded to this incident told the OIG that NDCS previously provided self-contained breathing apparatus (SCBA) for staff, even requiring new recruits to meet physical standards that included climbing stairs while wearing the SCBA gear.

However, this is no longer the case. The OIG asked Lincoln Fire and Rescue officials whether providing staff with SCBA or similar equipment would be advisable for NDCS. LFR responded that custom-



Figure 3: C1 "wing" side before and during the fire.

¹¹ Exhibit A: Map of RTC.

¹² Exhibit B: Lincoln Fire and Rescue reports for incident number 2021025666.

fitting and training requirements, cost, liability concerns, and inconsistent staffing patterns and turnover within NDCS facilities would make this very difficult if not impossible.

However, in a meeting with the OIG, LFR administrators and managers who directly oversaw the response to the Oct. 23 fire suggested that better ventilation at RTC could have helped. While facility staff promptly began opening doors and using fans for air flow, this did not prevent a significant amount of smoke from accumulating and spreading throughout the main hallway of the facility.

Warden Boyd told the OIG that the air handling system at RTC is not equipped to quickly remove smoke and replace it with fresh air, which LFR officials said is a common feature in newer, large-scale buildings. (The Lincoln Correctional Center portion of RTC was built in the late 1970s.) In fact, the system is designed to stop airflow in the event of a fire to prevent smoke from spreading. Additionally, the physical layout of the housing units actually traps smoke inside. LCC's units are three stories tall, with return vents and exterior doors on the ground level. The main doors to the facility spine and to the pantry areas between each gallery are on the second level. As a result, in the Oct. 23 fire, smoke naturally rose to fill the top two floors of the gallery, then flooded the spine once that door was opened.

RTC LAYOUT

LCC and DEC are interconnected and were in the process of formally merging their operations at the time of the fire. Now called the RTC, this facility continues to undergo significant expansion, including a new skilled nursing facility, mental health unit, front entrance and administrative areas, as well as a 384-bed high-security unit which is physically separate from the rest of the RTC.

This layout is different from the open-air design of other NDCS facilities, and can make it difficult to navigate for people who are unfamiliar with RTC.

Initial plans for more expansion at the RTC add more pieces to this puzzle, tucking a new unit for geriatric inmates into an area between the former LCC and DEC, and placing units for inmates with chronic mental illnesses and other special needs at the far end of the DEC area.¹³

FIRE EXTINGUISHERS

On their way to Unit C, emergency response staff grabbed a fire extinguisher from LCC's turnkey area, which is where most inmates and staff enter the main hallway or spine connecting the housing units. This fire extinguisher failed, prompting staff to retrieve a second fire extinguisher from the Unit C pantry office, which worked.

NDCS policy and National Fire Protection Association standards require that fire extinguishers be visually inspected on a monthly basis.¹⁴ The RTC safety specialist showed the OIG the inspection card for the turnkey extinguisher, which had been signed and dated earlier in October. One staff member suggested it was possible that the extinguisher pin was bent in error during the fire response, causing it to fail.

Custody staff are required to complete 40 hours of annual in-service training.¹⁵ According to the RTC safety specialist, this includes a refresher course on how to properly use a fire extinguisher. This course has been done remotely via computer for many years at several facilities, including RTC, beginning prior to the COVID-19 pandemic. However, at least two NDCS facilities — the Nebraska State Penitentiary and Tecumseh State Correctional Institution — have hands-on training systems that simulate real fires using a laser-equipped training extinguisher and screen. The OIG found an online listing for this system with a price of \$13,572.25.

FIRE DETECTION/SUPPRESSION SYSTEM

Person A's cell was equipped with a heat-activated sprinkler, which did not trip, and the facility's smoke alarm system did not sound until after staff discovered the fire, by which point a significant amount of smoke had accumulated.

¹³ Exhibit C: Program statement for 96 bed RTC addition.

¹⁴ NDCS Policy 111.04, "Fire Safety & Emergency Evacuation Procedures."

¹⁵ NDCS Policy 114.05, "In-Service Training."

The State Fire Marshall's Office investigated the fire and concluded that it probably did not produce enough heat to activate the sprinkler head.

The OIG was not able to determine if the smoke detectors in the area were working properly. An investigative report by the Nebraska State Fire Marshal does not contain this information, and a lack of working smoke detectors was not mentioned in any of the recent inspection records that were provided by Fire Marshal's office. However, when the OIG toured Unit C soon after the fire, new smoke detectors were in the process of being installed. The NDCS engineering administrator said in an email that detectors were being "added to the existing system to provide proper coverage of the area."

Housing Conditions

Part of the OIG investigation of this incident included a review of Person A's housing situation and the conditions of his confinement.

On Oct. 18, 2021, five days before the fire, Person A was moved from general population to the restrictive housing part of Unit C pending a protective custody investigation. State law prohibits NDCS from placing members of vulnerable populations, including those with a developmental disability or serious mental illness, in longer-term restrictive housing. However, these individuals may be assigned to immediate segregation to protect themselves, "staff, other inmates, or inmates who are members of vulnerable populations pending classification."¹⁶ For example, the Department regularly uses immediate segregation for inmates who have requested protective custody, to keep them safe while staff investigate their requests. NDCS defines immediate segregation as a short-term restrictive housing assignment which should not exceed 30 days without approval from the director or designee.¹⁷

While on Unit C, Person A made repeated requests of staff, and one fellow inmate said Person A had been harming himself and that he warned staff he was going to light a fire. Person A told the

¹⁶ Neb. Rev. Stat. § 83-173.03.

¹⁷ 72 Neb. Admin. Code, ch. 1, § 002.06.

OIG it was not his intent to cause a significant fire, that he didn't realize the caseworker had left the unit at the time, and that he started the fire for attention and because other inmates dared him.

Since the fire, Person A has been living in the mental health area of Unit C. During that time, he has broken out of his restraints, and assaulted or spat on staff at least three times, losing 510 days of "good time" credits as a result.¹⁸ Person A and the staff who work with him have attributed much of his misbehavior to frustration over his housing situation, as well as boredom due to being confined to such a restrictive environment.

Mental health providers at RTC told the OIG that while Person A has a mental illness, his needs differ from others on the mental health unit and are not best met by the services there. Staff identified three other inmates with similar situations¹⁹, and said these individuals have a tendency to "derail" the mental health treatment of others.

The Department's restrictive housing rules and regulations, updated in summer 2022, describe chronic care mental health units as an "alternative to restrictive housing for individuals in need of residential mental health treatment due to chronic and unstable mental illness or developmental disabilities or traumatic brain injuries that interfere with their safety or ability to function effectively in other housing settings."²⁰ These units are supposed to "provide a focused therapeutic environment."²¹

In the case of RTC, the restrictive housing unit and the chronic care mental health unit are in the same unit, Unit C. Inmates assigned to mental health beds are offered more opportunities for out-of-cell time than those in restrictive housing, but still spend a majority of their time locked in their cells, and are generally unable to leave the unit for programming, dining, and other activities. (The Department is in the process of opening a new mental health unit at RTC, which will offer a similarly restrictive environment.)

¹⁸ For a better understanding of "good time" review a Nebraska Center for Justice Research report which can be found at <https://www.unomaha.edu/college-of-public-affairs-and-community-service/nebraska-center-for-justice-research/documents/examining-the-effects-of-nebraska-good-time-laws.pdf>.

¹⁹ (Names redacted.) While each of these individuals has been diagnosed with a serious mental illness, their "level of care" as determined by the Department as of early June 2022 do not require placement in designated beds or mission-specific housing under NDCS Policy 115.22.

²⁰ 72 Neb. Admin. Code, ch. 1, § 002.04.

²¹ 72 Neb. Admin. Code, ch. 1, § 006.09.

While housing conditions are similar for chronic care mental health inmates and restrictive housing inmates, the procedural protections for these two groups are distinct.

NDCS rules require a multidisciplinary review team (MDRT) — led by the deputy director for prisons with input from behavioral health, intelligence and classification staff — to review all inmates assigned to longer-term restrictive housing, with follow-up reviews at least every 90 days. Placements lasting longer than 365 days must be approved by the Director of Corrections, and reviewed every 30 days by the Director and the MDRT. The “guiding focus” of restrictive housing is ultimately to “facilitate the inmate’s capacity to live successfully in general population and return successfully to the community.”²² State statute also requires, for inmates in restrictive housing, that departmental rules and regulations “provide for individualized transition plans, developed with the active participation of the committed offender, for each confinement level back to the general population or to society.”²³

While every inmate assigned to a chronic care mental health bed must have an individual treatment plan, the Department’s rules and regulations do not outline a review process for these individuals like the one for restrictive housing inmates. NDCS policy, adopted prior to the 2022 rule revision, states as follows:

“Mental Health Residential Treatment Units are available for those inmates with impairment in behavioral functioning associated with a serious mental illness and/or impairment in cognitive functioning. The severity of the impairment does not require inpatient LOC [level of care], but the inmate demonstrates a historical and current inability to function adequately in the general population. There should be a specific mission/goal of the program, sufficient qualified staff to meet needs of program, screening process for the program, Individual Treatment Plans for inmates in the program, safe housing to meet the therapeutic needs of the inmate and transition plan upon discharge from the residential treatment unit.”²⁴

Inmates with a mental health “level of care” meriting placement in a chronic care mental health unit are expected to “progress through a levels/phase system to receive incentives and assess stabilization and progress.” Treatment plans for these individuals are to be reviewed weekly by a

²² 72 Neb. Admin. Code, ch. 1, § 004.03.

²³ Nev. Rev. Stat. § 83-173.03.

²⁴ NDCS Policy 115.22 (2021), Mental Health Levels Of Care.

qualified mental health practitioner and every one to two months by a multidisciplinary team which “typically” consists of mental health, housing, custody and/or educational staff. This policy does not specify whether this requirement also applies to inmates with a lower “level of care” who are nonetheless housed in a chronic care mental health unit, as is the case with Person A.

A separate policy requires “joint consultation” between the facility warden and mental health “prior to taking action” regarding housing and program assignments, disciplinary measures, transfers to other institutions, or uses of force including chemical agents, when involving inmates with special needs.²⁵ There is not, however, any requirement for ongoing review by the warden, the Director, or deputy director, or any stated requirement or goal that these inmates be transitioned to other settings.

At one point facility staff and administration worked with Person A on a plan to transition him to a less-restrictive setting, but this plan was abandoned after Person A continued to act out. Since then, Person A has repeatedly told the OIG that he has no transition plan, and that he feels he has no means of contesting his continued placement in the mental health unit.

The OIG recommended in 2016 that NDCS launch a pilot program to serve people with developmental disabilities. Director Scott Frakes acknowledged this was an “important issue” and responded that NDCS would have housing dedicated to “cognitively impaired inmates” by January 2019.²⁶ This did not happen, nor did the Department request funding from the Legislature for such a project. Without a formal request from Frakes, the Legislature later appropriated \$18 million for a 96-bed expansion of the RTC, to include housing for special needs individuals.²⁷ The program statement for the project calls for a 32-bed unit for cognitively impaired inmates, as well as an adjoining transitional mental health unit and a separate unit for geriatric inmates. These units are not expected to be fully occupied until November 2024.

²⁵ NDCS Policy 115.12 (2021), Special Needs Inmates Programs.

²⁶ OIG 2017 Annual Report, Page 95. https://nebraskalegislature.gov/pdf/reports/public_counsel/2017_oig-ncs.pdf.

²⁷ State of Nebraska FY2021-22 / FY2022-23 Biennial Budget, <https://nebraskalegislature.gov/pdf/reports/fiscal/2021budget.pdf>.

In the meantime, NDCS has identified roughly 50 inmates, including Person A, with diagnoses which meet the statutory definition of developmental disabilities.²⁸ It is unclear how many of these individuals would benefit from placement in a specialized unit or how such a unit would be operated.

Other Areas of Review

The following were examined by the OIG as part of this investigation but did not result in any formal findings or recommendations:

DEPARTMENTAL INTERNAL REVIEW

The Department's internal review of this incident focuses mainly on the agency's emergency response, and does a good job of examining issues related to incident management.

RECALL SYSTEM

The internal review and staff who spoke with the OIG noted problems with the OnSolve CodeRED recall system, which was used to alert off-duty staff of the facility's need for additional assistance in response to the fire. Issues included calls coming from a random number that resulted in many phones screening them as spam, and technical problems when calls were answered. This contributed to overall low response rates by staff. The response rate for the October 2021 fire was 14 percent, and Tecumseh State Correctional Institution saw response rates of 30 percent and 22 percent when its correctional emergency response team (CERT) was activated for a pair of 2021 incidents where inmates started fires and threatened to riot, according to a memo compiled by the RTC emergency specialist and attached to the Department's internal review. It is worth noting the Tecumseh facility had deadly riots in 2015 and 2017.

In spring 2022, the OIG learned that OnSolve planned updates to CodeRED which staff hoped would resolve many of their concerns. However, staff expressed frustration with the original transition to CodeRED, which is provided under a contract with the Department of Administrative Services and is available to a variety of state and local government entities. These staff members said the switch from a different provider to OnSolve was a statewide decision.

²⁸ "Corrections Active: DCS > All Current Vulnerable Population Members," NICaMS data accessed via Oracle Business Intelligence.

These contracts are managed by the Office of the Chief Information Officer (OCIO). The OIG has no oversight over the OCIO.

COORDINATION WITH OUTSIDE RESPONDERS

In a meeting with the OIG in January 2021, Lincoln Fire and Rescue staff suggested better ongoing coordination with NDCS may help in the event of future incidents. This includes regular facility tours by LFR, which had not been taking place at Lincoln Correctional Center due to the COVID-19 pandemic and staff turnover at both agencies. The OIG shared this suggestion with Warden Boyd, who later said he met with representatives from Lincoln Fire and Rescue, the Lancaster County Sheriff's Office and Lincoln Police Department in May 2022 and plans to have quarterly meetings with these entities going forward.

FELLOW INMATES

A fellow resident of Unit C helped rescue Person A from the fire. With the exception of a mentally ill inmate who threatened suicide immediately after the fire, the men living on the unit were "surprisingly cooperative," as noted in the Department's internal review.

One supervisor commented about the need for a better plan to separate inmates who have requested protective custody or have conflicts with others in the restrictive housing unit. While these inmates are typically kept separate, this is challenging during an emergency situation and highlights a potentially serious safety risk with the use of restrictive housing units.

ELECTRICAL OUTLETS

The Fire Marshal's Office investigator found a disassembled TV power cord and a piece of metal with electrical arc burns in Person A's cell. A power outlet inside the cell also appeared to have arcing damage.

The cells inside Unit C do not have tamper-resistant power outlets which could help prevent inmates from using them to start fires. (Although this is not by any means the only way to start a fire in a prison cell.)

As this report was being completed, the OIG learned the cells in the new acute mental health unit at the RTC do not have electrical outlets or TV connections. Staff expressed concern about this,

given the amount of time these inmates spend locked inside their cells, the limited number of activities available to them, and the difficulty some of these mentally ill inmates have in socializing with others for lengthy periods of time. The OIG is concerned this will be a source of conflict on the new unit.

FINDINGS

- 1. Due to the unit being left unattended and fire detection systems not immediately activating, the response to the Oct. 23, 2021 fire was delayed, likely contributing to the severity of injuries.** Given the population in Housing Unit C, this unit should not be left unattended. Staff were stretched so thin on the day of this fire that they were unable to provide adequate supervision of an area that houses some of the most troubled and troublesome inmates in NDCS. A fire which could have been noticed and addressed almost immediately, instead resulted in serious injuries to inmates and staff.
- 2. The physical layout and structure of the Reception and Treatment Center (RTC) complex, which includes LCC, impedes emergency response and does not allow for easy removal of smoke from living units in the event of a fire.** This is a more significant problem at this facility than at others within NDCS. Housing units are accessed via a maze of hallways and staircases, rather than an open yard. While this design has advantages (such as during inclement weather), it also presents challenges.
- 3. NDCS utilizes chronic care mental health beds to house individuals who do not require the defined level of care for those beds, but who engage in serious misconduct and cannot legally be held in long-term restrictive housing.** Mental health units offer slightly greater out-of-cell opportunities than restrictive housing, but they lack the same procedural protections available to inmates in restrictive housing. Placing inmates with different or lesser mental health care needs in these beds blurs the mission of this type of housing, and potentially

hinders the treatment of others. In the case of Person A, his placement on the mental health unit appears to be for disciplinary reasons, rather than for treatment.²⁹

4. Staff who responded to this emergency saved the life of at least one person, which is particularly notable given the staffing shortage at the facility during this time. Sgt. Michael Cordonier (now a case manager) led a shorthanded emergency response team into Unit C and revived Person A after helping rescue him from his smoke-filled cell. While Sgt. Cordonier is specifically named in this report, several staff members acted quickly to prevent further harm as a result of the fire and evacuation of Unit C.

RECOMMENDATIONS

After considering the findings from this report, the OIG recommends that NDCS take the following actions:

1. Develop a specific plan to ensure all housing units at NDCS facilities are consistently monitored in the event of critically low staffing levels. This plan should be crafted in consultation with the labor unions representing NDCS workers and other stakeholders, and should be completed by July 1, 2023.

Director Frakes response: Reject

2. Improve fire safety at the RTC. This specifically includes the following:

- a. Install clear signage (possibly lit signs activated during emergencies) within the RTC to assist emergency responders;
- b. Examine the feasibility of installing secure vents in the ceilings of the facility's older housing units to more effectively remove smoke; and
- c. Avoid designs for future expansion which contribute to the facility's mazelike layout.

²⁹ Director Frakes took exception to this characterization in his response letter to the OIG, which is attached to this summary report.

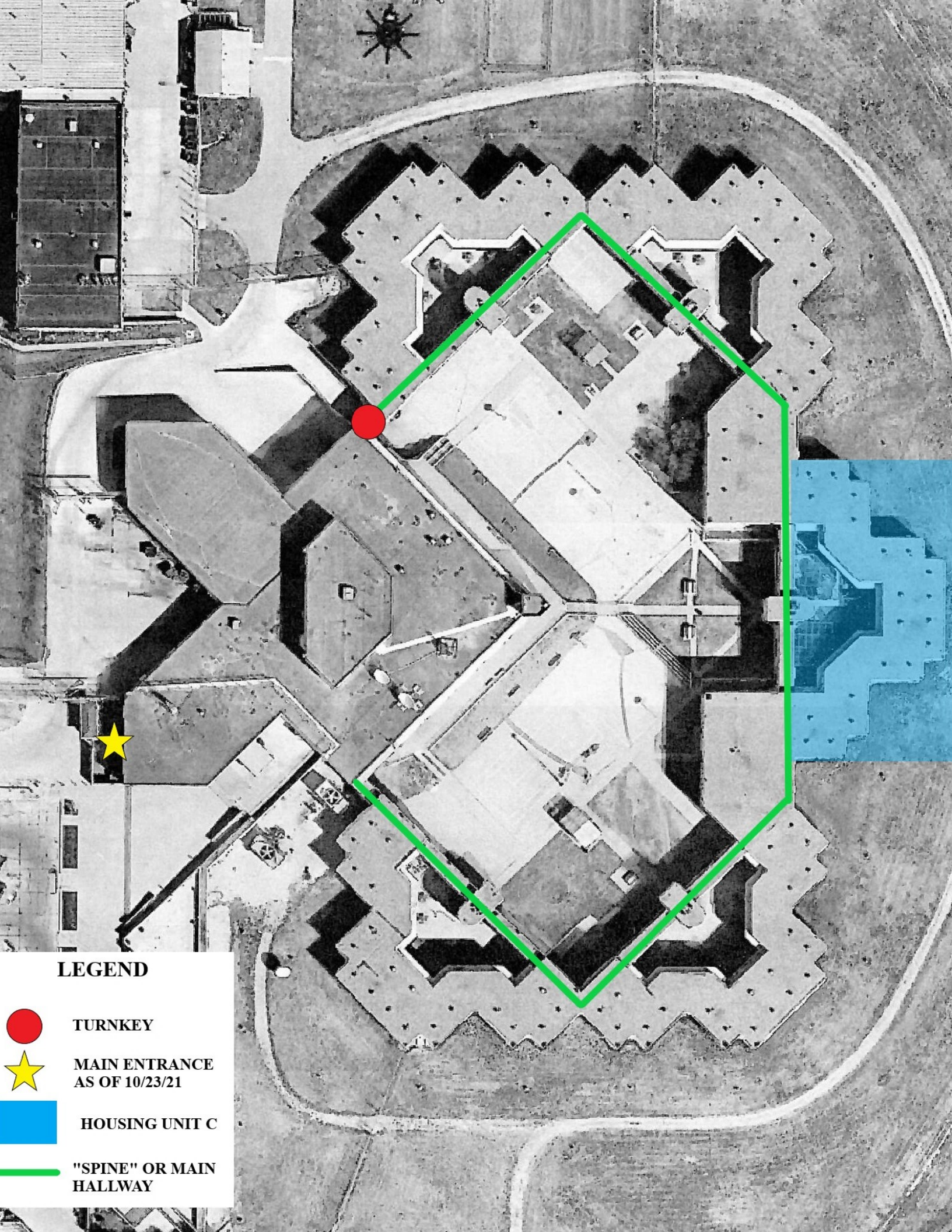
Director Frakes response: Accept

3. Use chronic care mental health housing only for inmates who require that form and level of care. Clinical staff who work directly with Person A say the mental health unit is not a good fit for him, and that he is not a good fit for the unit. It appears NDCS has placed him in this setting due to his misbehavior and for lack of a better option, to the possible detriment of Person A and others around him. If a better option doesn't exist, the Department should create one.

Director Frakes response: Reject. New behavioral health unit provides options to address the issues raised.

4. Update policy to provide better procedural protections for individuals placed on these units. Given the use of chronic care mental health units as an “alternative to restrictive housing,” and the similarities between these two settings, inmates in both should receive similar protections. This includes regular, formal review by the Director or deputy director, and a detailed, personalized plan with the stated goal of facilitating their successful return to the general population and to society.

Director Frakes response: Reject. Residential mental health beds are not restrictive housing.



LEGEND

-  **TURNKEY**
-  **MAIN ENTRANCE
AS OF 10/23/21**
-  **HOUSING UNIT C**
-  **"SPINE" OR MAIN
HALLWAY**



Lincoln Fire Rescue

LFR0240



Incident Number 2021025666 **Call Type** FIRE-CHARLIE **Date** 10/23/2021 **Address** 3216 W VAN DORN ST

Property Value **Property Loss** **Contents Value** **Contents Loss**

Fire

Detector

Area of Origin:
Item Ignited:
Ignition Cause:
Heat Source:
Material Ignited:

Installed:
Type:
Operational:
Effective:
Failed:

Automatic Extinguishing System

Installed:
Type:

Operational:
Number Sprinklers:

Unit Times

Unit	Dispatched	Enroute	Arrived	Clear	Service	Bill
A14A	11:23:29	11:24:40	11:40:30	12:58:35	01:35:06	
E3A	11:36:36	11:37:40	11:45:55	13:02:49	01:26:13	
E4A	11:36:36	11:38:40	00:00:00	12:40:40	01:04:04	
E8A	11:23:29	11:24:48	11:30:00	13:14:12	01:50:43	
E11A	11:23:29	11:25:13	11:33:33	13:02:56	01:39:27	
E13A	11:23:29	11:24:30	11:29:12	13:08:15	01:44:46	
T1A	11:23:29	11:24:56	11:33:50	12:56:50	01:33:21	
T8A	11:23:29	11:24:15	11:30:36	13:01:31	01:38:02	
M3A	11:23:29	11:24:47	11:33:50	12:39:36	01:16:07	
M7A	11:37:59	11:37:59	11:48:30	12:35:51	00:57:52	
B1A	11:23:29	11:23:56	11:31:23	13:20:18	01:56:49	
B2A	11:23:29	11:25:03	11:34:09	13:20:04	01:56:35	
M2A	11:36:36	00:00:00	00:00:00	11:37:46	00:01:10	
M8A	11:23:29	11:38:44	11:45:16	13:04:01	01:40:32	
EMS1A	11:36:41	11:36:41	11:46:29	13:04:05	01:27:24	
M10A	11:36:36	11:38:29	00:00:00	11:38:44	00:02:08	
IBH	11:23:29	11:34:53	12:12:12	12:42:41	01:19:12	
			Total Time:		23:09:31	

Comments

Unit

Comment

Dispatch FIRE IN C UNIT ///MC AT FRONT ENTRANCE. 1123 /// FIRE POSSIBLY OUT INMATES ARE OUTSIDE RPT OF IT BEING SMOKY GET RE ADY FOR VENTATLION

A14 WAS DISPATCHED TO 3216 W VAN DORN ST ON A FIRE C. A14 RESPONDED CODE 1 FROM QUARTERS AND ARRIVED ON LOCATION TO STAGE IN THE PARKING LOT. I SHUTTLED SCBA BOTTLES AND BOTTLED WATER TO A FORWARD STAGING AREA CLOSER TO THE POINT OF ENTRY. I SWITCHED OUT SCBA BOTTLES

A14A

FOR CREWS THAT WERE WORKING INSIDE. E3 REQUESTED A 4 GAS MONITOR FOR POST FIRE AIR MONITORING SO I RETRIEVED E13S AND STARTED IT UP AND COMPLETED A FRESH AIR SETUP AND GAVE IT TO E3. I WAS THEN RETURNED TO SERVICE BY B1 COMMAND.

E3A E3 DISPATCHED ON A SECOND ALARM RESPONSE TO A FIRE AT LCC. E3 ARRIVED ON LOCATION AND IMMEDIATELY GAVE THEIR MEDIC TO THE MEDIC UNIT TO ASSIST WITH CARE. E3 NOW PAR 3 ENTERED THE BUILDING WITH THE TASK OF FIRE ATTACK/VENTILATION ASSISTANCE. E3 TOOK FULL GEAR AND TOOLS AND WALKED BACK TO C BLOCK WHERE THE FIRE ORIGIN WAS. ONCE BACK THERE; THERE WAS EXTINGUISHER MATERIAL ON THE GROUND OUTSIDE THE CELL THAT WAS BURNED AND A PARTIALLY BURNED MATTRESS ON THE FLOOR. E3 FOUND VERY LITTLE SMOKE IN THAT AREA AND TOLD THE STAFF TO SAVE THE MATTRESS BUT REMOVE IT TO THE FRESH AIR SO IT COULD OFF-GAS OUTSIDE. E3 THEN HAD TO WALK BACK TO THE ENTRANCE TO GET A 4-GAS MONITOR. ONCE BACK IN C BLOCK WITH THE 4-GAS MONITOR; E3 MONITORED THE AIR QUALITY IN EACH CELL AS WELL AS ALL THE COMMON WORKING AREAS FOR THE GUARDS. THERE WAS NO HAZARDOUS GASSES DETECTED IN ANY OF THE CELLS OR IN ANY OF THE COMMON AREAS TO INCLUDE THE HALLWAYS LEADING FROM THE ENTRANCE BACK TO BLOCK C. E3 ALSO GAVE INSTRUCTIONS TO STAFF TO LOCK AND KEEP CLOSED THE CELL THAT HAD THE FIRE IN IT AND DON'T THROW AWAY THE MATTRESS EITHER AS THE STATE FIRE MARSHAL WILL WANT TO LOOK AT THOSE FOR HIS INVESTIGATION. THEY SAID THANK YOU. E3 WALKED BACK UP TO THE FRONT AND EXITED THE BUILDING THEN RETURNED TO SERVICE.

E4A E4 WAS DISPATCHED AS A SECOND ALARM COMPLEMENT TO LINCOLN CORRECTIONAL FACILITY FOR A REPORT OF A FIRE WITH MULTIPLE VICTIMS. E4 RESPONDED CODE 3 FROM QUARTERS. UPON OUR ARRIVAL E4 IS DETAILED TO SECURE A WATER SUPPLY. WATER SUPPLY IS LOCATED HOWEVER THERE IS SIGNIFICANT INCIDENT TRAFFIC WITH LFR AND DEPT OF CORRECTIONS OFFICERS RESPONDING. E4 STAGED FURTHER BACK TO ALLOW TRAFFIC TO CONTINUE TO FLOW. E4 STAGED THROUGHOUT THE INCIDENT. E4 WAS RELEASED FROM THE SCENE BY COMMAND. E4 RETURNED TO SERVICE. ROBERT M. TREASURE FIRE CAPTAIN

E8A E8 RESPONDED CODE THREE FROM QUARTERS ALONG WITH MULTIPLE LFR UNITS ON REPORTED CONFIRMED FIRE. E8 ARRIVED ON LOCATION AND INITIALLY ASSIGNED TO LEVEL ONE STAGE ON OUR ARRIVAL. WHILE STAGING E8 WAS ASSIGNED TO PATIENT (PT) CARE BY B1 COMMAND. WHILE MAKING OUR WAY INSIDE I WAS ASSIGNED TO MEDICAL GROUP SUPERVISOR. WE HAD INITIAL REPORTS OF UP TO FOUR PT. ONCE INSIDE CORRECTIONS STAFF REPORTED THEY HAD ONE PARTY NEEDING MEDICAL THAT WAS JUST ABOUT TO THE LOBBY. AT THIS TIME I WAS ATTEMPTING TO FIND OUT HOW MANY MORE PT WERE GOING TO NEED MEDICAL ATTENTION. I ALSO ADVISED EMS1 THAT THE FIRST PT WAS GOING TO PROBABLY NEED RSIED. I CONTINUED TO ASK STAFF HOW MANY MORE PT THEY HAD AND NO ONE WAS ABLE TO PROVIDE THAT ANSWER TO ME. B2 WAS NOW MEDICAL GROUP SUPERVISOR AND EVERYONE INVOLVED WITH MEDICAL GROUP MOVED TO TAC 5. E8 NOW STAGED INSIDE THE MAIN ENTRY ALONG WITH E11 STANDING BY FOR THE POSSIBILITY OF MORE PT. I CONTINUED TO UPDATE MEDICAL GROUP SUPERVISOR AS I RECEIVE INFORMATION. WE ATTEMPTED MULTIPLE TIMES TO FIND OUT HOW MANY MORE PT MAY NEED MEDICAL ATTENTION AND EVERY TIME WE WERE NOT PROVIDED AND ANSWER. FINALLY AFTER ASKING MULTIPLE TIMES SOME ONE SAID THAT STAFFING NEEDING CHECKED OUT WERE GOING TO BE HEADING OUR WAY SOON. CORRECTION STAFF NEEDING CHECKED OUT STARTED TO APPEAR IN THE MAIN LOBBY AND E11 HANDLED MOST OF THE ASSESSMENT AS I ATTEMPTED TO COORDINATED OPERATIONS IN THE LOBBY. E13 AND M8 MADE THEIR WAY INSIDE THE LOBBY AND THEY ALSO STARTED TO CHECK OUT CORRECTION STAFF AS THEY APPEARED. TO THE BEST OF MY MEMORY EIGHT CORRECTION STAFF MEMBERS WERE EVALUATED. PLEASE SEE TABLET PCR REPORTS FOR FURTHER PT INFORMATION. AFTER ALL STAFF MEMBERS WERE EVALUATED THAT WANTED TO BE CHECK ON I ADVISED MEDICAL GROUP THAT WE WERE FINISHED INSIDE AND ALL CREWS WERE EXITING THE MAIN LOBBY. AFTER EXITING THE LOBBY AND HAVING A FACE TO FACE WITH MEDICAL GROUP E8 DEPARTED THE SCENE AND RETURNED TO QUARTERS TO RESTOCK AND CHECK OUR EQUIPMENT. ONCE ALL EQUIPMENT WAS BACK IN A READY STATE E8 RETURNED TO SERVICE IN QUARTERS. CAPTAIN CHRIS KLUSAW

E11A E-11 RESPONDED CODE 3 PAR 4 ALS TO A REPORT OF A FIRE CHARLIE AT LCC. UPON ARRIVAL E-11 STAGED LEVEL 1 FOR ABOUT 5 MINUTES UNTIL COMMAND GOT A BETTER UNDERSTANDING WHAT WAS GOING ON INSIDE. E-11 WAS THEN TOLD TO STANDBY AT A HYDRANT. WE GOT INTO POSITION FOR THAT WHEN A REPORT OF PATIENTS INSIDE THE FACILITY CAME ACROSS. E-11 WAS THEN TOLD TO LEAVE WATER SUPPLY AND GO INSIDE TO ASSIST WITH PATIENT CARE. E-11 MOVED OUR RIG AWAY FROM HYDRANT AND WENT INSIDE TO HELP WITH PATIENT CARE. E-11 ASSISTED WITH ASSESSING MULTIPLE CORRECTIONS OFFICERS FOR SMOKE INHALATION. ALL PATIENTS ASSESSED REFUSED MEDICAL CARE AND TRANSPORT. REFUSALS WERE COMPLETED ON ALL. AFTER COMPLETING THIS TASK E-11 RETURNED TO SERVICE AND

QUARTERS.

E13A

E13 WAS DISPATCHED ON A CHARLIE FIRE ALARM RESPONSE TO LCC FOR A CONFIRMED FIRE WITH SEVERAL LFR UNITS. UPON E13 ARRIVAL; E13 REPORTS NO SMOKE OR FIRE SHOWING FROM FACILITY. E13 ASSUMED COMMAND AND ASSIGNED ALL INCOMING UNITS TO STAGE LEVEL ONE UPON ARRIVAL. E13 MADE CONTACT WITH LCC GUARD. GUARD STATED THE FIRE IS LOCATED ON C BLOCK IN AN INMATE ROOM. E13 GATHERED HI-RISE PACKS AND WATER CAN BEFORE ENTERING STRUCTURE. E13 ADVISED E8 THAT A HYDRANT WAS NEXT TO E13. MYSELF AND FF SCHAAF FOLLOWED GUARD TO C BLOCK WHICH WAS A LONG DISTANCE FROM WHERE E13 ENTERED STRUCTURE. AS E13 WAS ENROUTE TO C BLOCK LOCATION 3 GUARDS WITH AN INMATE ON A STRETCHER PASSED E13. THE INMATE WAS COVERED IN SOOT FROM THE FIRE AND APPEARED UNCONSCIOUS. E13 REPORTED THIS TO ALL UNITS AND REQUESTED MEDICAL MEET GUARDS IN LOBBY OF ENTRANCE TO WAIT FOR THIS PT. E13 CONTINUED TO REQUEST INFORMATION FROM GUARD ON FIRE CONDITION AND IF ANY OTHER INMATES NEEDED MEDICAL ASSISTANCE. GUARD HAD A HARD TIME GETTING ANY INFORMATION ON HIS RADIO BUT BELIEVES THERE COULD BE POSSIBLY 4 MORE PTS. AND ALSO REPORTS HE HEARD RADIO TRAFFIC THAT THE FIRE COULD BE POSSIBLY EXTINGUISHED. E13 REPORTED THIS INFORMATION TO INCOMING UNITS. B1 WAS ON LOCATION AND ASSUMED COMMAND FROM E13. E13 DID GET TO A POINT PRIOR TO C BLOCK THAT WE NEEDED TO STOP AND PUT OURSELVES ON AIR DUE TO THE HEAVIER SMOKE WE WERE ENCOUNTERING. E13 REPORTED THIS TO COMMAND. IT WAS DETERMINED AT THIS POINT THE GUARD WOULD NOT CONTINUE ON WITH E13. GUARD STATED THAT HE THINKS ALL INMATES HAVE BEEN ACCOUNTED FOR AND THEY HAVE BEEN REMOVED FROM THE AREA. GUARD STATED HE IS NOT 100% SURE THOUGH. E13 GAVE GUARD INSTRUCTIONS TO HAVE HIS SUPERVISOR MEET BATTALION 1 OUTSIDE OF DOOR SO THEY COULD WORK TOGETHER ON COMMUNICATION OF NEEDS FOR LFR AND LCC. GUARD STATED HE UNDERSTOOD AND WOULD LET HIS SUPERVISOR KNOW. GUARD GAVE E13 DIRECTIONS TO C BLOCK FROM THAT POINT. E13 REPORTED TO COMMAND INFORMATION ABOUT THE INMATES BEING SECURED BUT THIS WAS UNCONFIRMED INFORMATION. E13 DID HAVE ANOTHER GUARD MEET E13 NEAR C BLOCK WHO STATED IT IS CONFIRMED THAT ALL INMATES ARE EVACUATED AND SECURED. GUARD ALSO STATED THE FIRE HAS BEEN EXTINGUISHED. THIS INFORMATION WAS REPORTED TO COMMAND. GUARD DID NOT HAVE ANY FURTHER INFORMATION ON MEDICAL NEEDS OF INMATES AT THIS TIME. E13 ENTERED C BLOCK TO FIND MODERATE SMOKE. UPON ENTERING THE INMATES ROOM WHERE FIRE WAS LOCATED E13 FOUND A MATTRESS WHICH HAD A SMALL AMOUNT OF SMOULDERING BUT NO FIRE. E13 USED WATER CAN TO EXTINGUISH THE SMOLDERING AREA OF MATTRESS. E13 REPORTED THIS TO COMMAND. E13 ALSO REQUESTED THE TRUCK COMPANIES TO C BLOCK TO DETERMINE VENTILATION NEEDS. WHEN E13 SCBA BECAME LOW E13 NOTIFIED COMMAND. E13 WAS ASSIGNED TO EXIT STRUCTURE TO REHAB AND REFILL AIR. E13 WAS RELIEVED BY E3. AFTER REHAB E13 WAS REASSIGNED TO ASSIST E8 AND E11 INSIDE LOBBY WITH ASSESSING GUARDS INVOLVED IN THE C BLOCK FIRE THAT HAD SMOKE INHALATION AND WANTED TO BE CHECKED OUT MEDICALLY. E13 ASSESSED 2 GUARDS AND FILLED OUT REFUSALS ON BOTH. AFTER ALL ASSIGNMENTS WERE COMPLETE E13 WAS RETURNED TO SERVICE BY COMMAND.

T1A

T1 RESPONDED TO FIRE C FROM QUARTERS. UPON ARRIVAL TO STATE CORRECTIONAL BUILDING; ADVISED THERE WAS A FIRE IN BLOCK C; INMATE HAD IGNITED A MATTRESS. T1 ADVISED TO ENTER AND DO A SEARCH OF THE AREA. UPON ENTERING; T1 ADVISED BY BLOCK SUPERVISOR ALL INMATES AND EMPLOYEES ARE ACCOUNTED FOR. T1 REASSIGNED TO ASSIST T8 WITH VENTILATION. THERE WAS LIGHT-MODERATE SMOKE THROUGHOUT THE COMMON CORRIDOR OF THE ENTIRE BUILDING. T1/T8 UTILIZED TANDEM ELECTRIC FANS MOVING BLOCK BY BLOCK TO FORCE IT FROM ONE END OF THE ROUGHLY 1000' HALLWAY BLOCKS A-E. AFTER ALL SMOKE WAS EJECTED FROM HALLWAYS AND CELL BLOCKS WERE ISOLATED BY CLOSING THE DOORS; CELL BLOCK SMOKE EJECTOR FANS WERE ABLE TO CLEAR THE INDIVIDUAL CELL BLOCKS. T1 REFIT ON AIR FROM AIR 14 AND WAS RETURNED TO SERVICE. JON REED

T8A

TRUCK 8 DISPATCHED ON A FIRE CHARLIE TO THE ABOVE ADDRESS ON A REPORT OF A FIRE IN A CELL AT CORRECTIONS. TRUCK 8 RESPONDED FROM STATION 8 CODE 3. ENGINE 3 COMMAND REPORTED NOTHING SHOWING ON APPROACH AND ASSIGNED INCOMING UNITS TO STAGE. TRUCK 8 ARRIVED LOCATION PAR 3 WITHOUT INCIDENT AND STAGED. COMMAND REPORTS THAT THERE IS SMOKE IN THE HALLWAY AND ASSIGNED TRUCK 8 TO VENTILATION. TRUCK 8 MITCHELL AND THOMPSON GATHERED TOOLS AND EQUIPMENT INCLUDING THE BATTERY FAN. WE MET A GUARD INSIDE AND HE WALKED US DOWN TO THE C UNIT WHERE THE FIRE WAS REPORTED. WALKING IN THE HALLWAY THE SMOKE WAS THICKER; MITCHELL AND THOMPSON DONNED OUR SCBA MASKS AND WENT ON AIR; WE CONTINUED WALKING UNTIL WE FOUND THE UNIT AFFECTED. WE MET WITH ENGINE 13 WHO WERE USING A WATER CAN TO THE CELL; THERE IS A SMOKE EJECTOR TYPE FAN RUNNING IN THE AREA WITH AN OPEN DOOR TO THE OUTSIDE YARD. MET UP WITH TRUCK 1 WHO ASSIGNED SEARCH AND TO ASSIST WITH VENTILATION. NO SEARCH WAS NEEDED AND COMMAND ASSIGNED TRUCK 1 TO WORK FOR TRUCK 8. TRUCK 8 AND TRUCK 1 WORKED TOGETHER USING THE TWO BATTERY FANS BY PUSHING SMOKE DOWN THE HALL TO THE OUTSIDE ONE AREA AT A TIME. VENT GROUP HAD GOOD AIR FLOW AND CLEARED THE SMOKE USING A

LEAP FROG TYPE ACTION WITH THE FANS. CREWS WORKED UNTIL THE SMOKE WAS CLEARED. REPORTED TO COMMAND WHEN THE AREA WAS CLEARED AND ADVISED THAT WE WERE COMING OUT. OUTSIDE CREWS REPLACED AIR BOTTLES AND RETURNED TOOLS AND EQUIPMENT BACK ONTO THE RIG. COMMAND ADVISED THAT TRUCK 8 COULD RETURN TO SERVICE. TRUCK 8 WENT IN SERVICE AND RETURNED TO QUARTERS. JEREMY MITCHELL; FIRE CAPTAIN T8A

M3A THIS REPORT WAS COMPLETED IN TABLET PCR

M7A WE RESPONDED TO A FIRE CHARLIE AS EMS TRANSPORT UNIT. WE ARRIVED ON SCENE AND WERE DIRECTED TO STANDBY IF THERE WAS A NEED. THEY DIDN'T NEED US; WE MADE NO PT CONTACT AND WE WERE RETURNED TO SERVICE.

B1A B1A DISPATCHED FROM 27 AND HWY 2 ON A FIRE C AT LCC ON TAC-4; THE FIRE WAS REPORTED TO BE C BLOCK. ENROUTE E13 ARRIVED ON LOCATION AND ESTABLISHED COMMAND. E13 ADVISED STAFF ON LOCATION REPORTED HEAVY SMOKE IN THE AREA OF THE FIRE. B1 ASSUMED COMMAND AT THIS POINT. E13 WAS REASSIGNED TO FIRE ATTACK. E13 WAS ASKED TO VERIFY THE AREA WAS SAFE AND ALL INMATES WERE ACCOUNTED FOR. THEY WERE DIRECTED TO VERIFY THIS BEFORE ENTRY INTO C POD. E13 ADVISED STAFF WAS REPORTING POSSIBLE 4 PEOPLE DOWN AND NEEDED MEDICAL. 2 ADDITIONAL ENGINES AND 2 MEDIC UNITS WERE REQUESTED. AFTER A SHORT TIME STAFF ADVISED THE AREA WAS SECURE AND ALL INMATES WERE ACCOUNTED FOR. E13 MADE ACCESS TO THE FIRE AREA AND ADVISED THE FIRE WAS OUT AND NEEDED VENTILATION. E13 ADVISED THE FIRE WAS OUT AND THEY ONLY NEEDED TO APPLY A SMALL AMOUNT OF WATER WITH A WATER CAN. AFTER E13 EXHAUSTED THEIR AIR SUPPLY THEY WERE REASSIGNED TO REHAB AND THEN THEY WENT TO WORK FOR THE EMS GROUP. E3 WAS DEPLOYED FROM STAGING TO ASSUME FIRE ATTACK AND EVALUATE THE NEED FOR OVERHAUL. E3 ADVISED THE FIRE WAS OUT AND NO OVERHAUL WAS NEEDED. HE ADVISED STAFF WAS DIRECTED NOT TO DISTURB THE FIRE AREA AND WAIT FOR THE NSFM TO ARRIVE AND CONDUCT THEIR INVESTIGATION. E8 WAS DIRECTED TO THE EMS GROUP SUPERVISOR AND PERFORM INITIAL TRIAGE. B2 ARRIVED ON LOCATION AND AFTER A FACE TO FACE THE RESCUE GROUP WAS ASSIGNED TO B2 ON TAC-5 (SEE BAT 2 REPORT FOR EMS GROUP ASSIGNMENTS) T-8 WAS ASSIGNED TO VENTILATION. T1 WAS ASSIGNED TO SEARCH UNTIL VERIFICATION THE AREA WAS CLEAR AND THAT THERE WAS NO NEED FOR SEARCH. T1 WAS REASSIGNED TO WORK WITH T8 ON VENTILATION. IBH ARRIVED ON LOCATION AND ADVISED THIS WOULD BE A NSFM INCIDENT AND REQUESTED LFR TO JUST PRESERVE THE SCENE AS MUCH AS POSSIBLE. NSFM MATZNER ARRIVED ON LOCATION AND A VERBAL REPORT WAS GIVEN TO HIM. HE ADVISED HE WOULD MAKE THE NEEDED CONTACTS WITH CORRECTIONS STAFF. ONCE ALL LFR UNITS COMPLETED THEIR ASSIGNMENTS. ALL UNITS WERE RETURNED TO SERVICE. ACTING BC MIKE SELVAGE

B2A B2 DISPATCHED TO A CONFIRMED FIRE AT A CORRECTIONAL FACILITY. E13 ARRIVED ON LOCATION; REPORTED NOTHING SHOWING FROM THE EXTERIOR; AND ASSUMED INVESTIGATIVE MODE COMMAND. B1 WAS THE FIRST BC ON LOCATION AND ASSUMED COMMAND. B1 BEGAN COMMUNICATING ASSIGNMENTS AND WHEN B2 ARRIVED ON LOCATION A FACE TO FACE WAS COMPLETED WITH B1. REPORT FROM INTERIOR CREW WAS ONE UNCONSCIOUS VICTIM WITH THE POSSIBILITY OF FOUR MORE. AT THIS TIME COMMAND ASSIGNED B2 TO EMS GROUP SUPERVISOR AND REQUESTED TWO ADDITIONAL ENGINES AND TWO MEDIC UNITS FOR PATIENT CARE. B2/EMS GROUP SUP. REQUESTED AN ADDITIONAL TAC THROUGH DISPATCH. ALL UNITS WERE ADVISED THE FIRE GROUND OPERATIONS WOULD CONTINUE ON TAC 4 AND EMS OPERATIONS WOULD BE ON TAC 5. E8; M3 AND EMS 1 WERE ASSIGNED TO THE MEDICAL GROUP TO PROVIDE MEDICAL CARE TO PATIENT #1. E11 WAS ASSIGNED MEDICAL GROUP AND WAS TASKED TO THE LOBBY TO ASSIST E8 WITH DETERMINING VICTIM COUNT AND PERFORM TRIAGE. MULTIPLE REPORTS FROM E8 AND E11 WERE THAT THEY WERE UNABLE TO GET A VICTIM COUNT FROM CORRECTIONAL STAFF. M3 PROVIDED TRANSPORT WITH THE ASSISTANCE OF A MEDIC FROM E3 AND STAFF FROM E8. E8; E11; EMS 1 CONTINUED TO OPERATE IN THE LOBBY AND ATTEMPT TO DETERMINE THE NUMBER OF VICTIMS. M7 AND M8 WAS ASSIGNED TO STAGE WITH ALL MEDICAL EQUIPMENT OUTSIDE OF THE ENTRANCE POINT. MOVE UP OF ENGINE 6 TO STATION 4 REQUESTED THROUGH DISPATCH TO PROVIDE COVERAGE AND PREPARE IF INCIDENT REQUIRED ADDITIONAL MEDIC UNITS. INTERIOR EMS CREWS RELAYED THAT CORRECTIONAL STAFF REPORTED NO MORE CRITICAL PATIENTS BUT SEVERAL STAFF MEMBERS WHO WERE IN THE AREA OF SMOKE NEEDED ASSESSMENT. E13 WAS ASSIGNED TO ASSIST E11 AND E8 WITH ASSESSMENT AND REFUSALS. NO ADDITIONAL OCCUPANTS REQUIRED TRANSPORT. WITH PATIENT CARE COMPLETE; UNITS WERE RETURNED TO SERVICE BY COMMAND. UPON TERMINATION OF THE INCIDENT; B2 RETURNED TO SERVICE. JAMIE POSPISIL - CAPTAIN/OOG BC

M2A

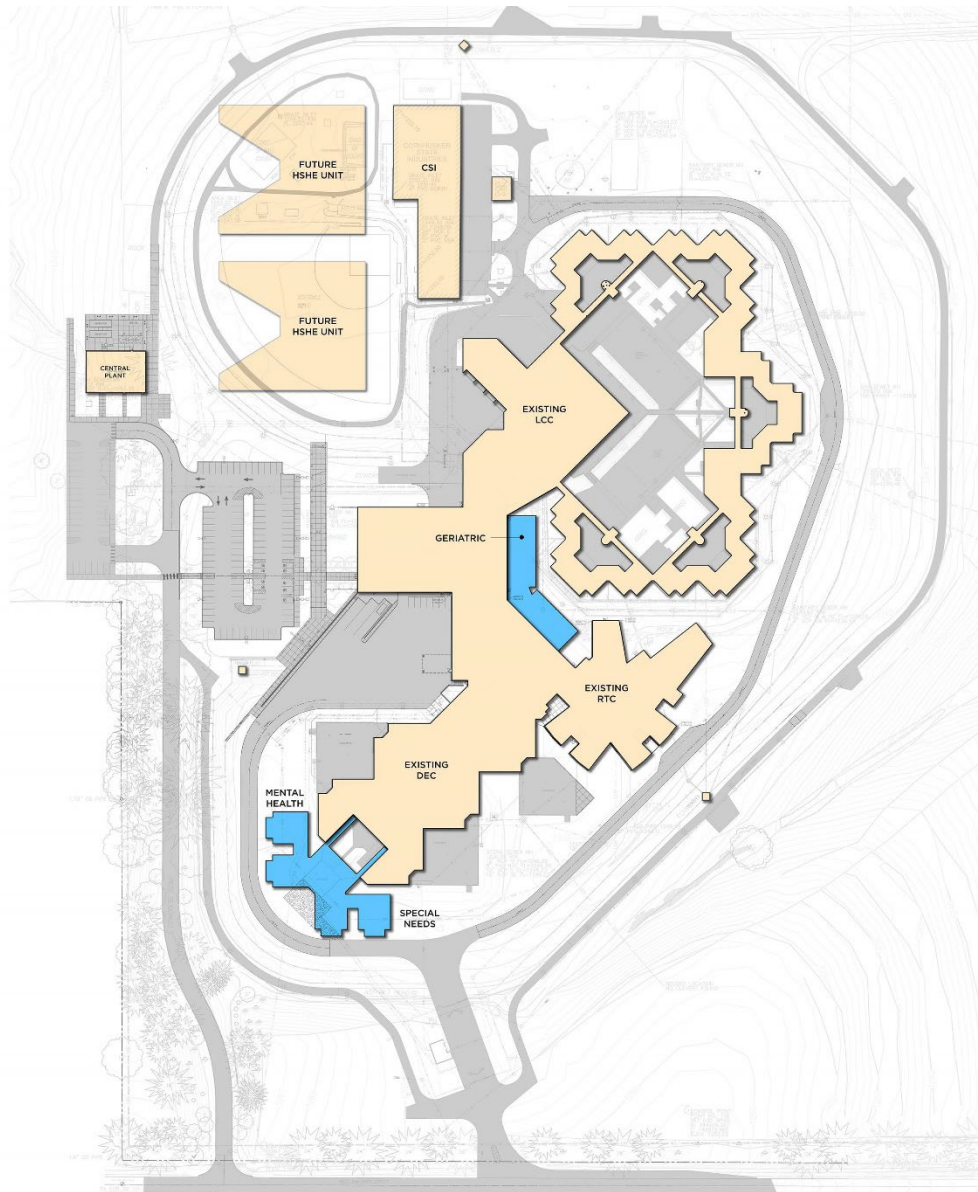
M8A MEDIC 8 ARRIVES ON SCENE AND ASSISTS CREWS WITH OBTAINING VITALS FOR STAFF PERSONNEL. SEE TABLET PCR FOR FURTHER. MEDIC 8 RETURNS TO SERVICE.

EMS1A EMS1 MADE A CODE 3 RESPONSE WITH MULTIPLE LFR UNITS FOR A FIRE WITH INJURIES. EMS1 ARRIVED ON LOCATION AND WAS ASSIGNED TO ASSIST M3 WITH PT CARE. EMS1 ASSISTED WITH ALS SCENE CARE. M3 ADVISED THEY DID NOT NEED EMS1 DURING THE TRANSPORT AND EMS1 RETURNED TO STAGING. EMS1 STAGED WITH OTHER LFR MEDIC UNITS AND WAITED FOR POTENTIAL PTS. THERE WERE NO FURTHER PTS THAT NEEDED EMS1'S CARE AND EMS1 RETURNED TO SERVICE. MARK DEFORGE CAPTAIN/PARAMEDIC

M10A M10 WAS CANCELLED BY M7 FOR CLOSER RESPONSE. NICK DUNBAR PARAMEDIC

IBH TOT TO STATE FIRE MARSHAL; NO ENTRY CONTACTS MADE

RECEPTION & TREATMENT CENTER (RTC) PHASE THREE 96 BED ADDITION, SPECIAL POPULATIONS





5060 Dodge Street
Omaha, NE 68132
402.551.1500

cwparchitects.com

© 2021 CWPA, all rights reserved.

TABLE OF CONTENTS

- 1.0 INTRODUCTION 3**
 - 1.1 Background and History 3
 - 1.2 Project Description 4
 - 1.3 Purpose and Objectives 4
- 2.0 JUSTIFICATION OF THE PROJECT 5**
 - 2.1 Data which supports the funding request..... 5
 - 2.2 National Trends in Criminal Justice and Corrections..... 6
 - 2.3 Alternatives Considered 9
- 3.0 LOCATION & SITE CONSIDERATIONS 11**
 - 3.1 County..... 11
 - 3.2 Town/ Campus..... 11
 - 3.3 Proposed Site..... 11
 - 3.4 Statewide Building Inventory 11
 - 3.5 Influence of Project on Existing Site Conditions..... 11
- 4.0 COMPREHENSIVE PLAN COMPLIANCE 13**
 - 4.1 Year of the NDCS Comprehensive Plan and Updates/ Revisions..... 13
 - 4.2 Consistency with the NDCS comprehensive capital facilities plan 13
 - 4.3 Consistent with the Current Statewide Comprehensive Capital Facilities Plan..... 14
- 5.0 ANALYSIS OF EXISTING FACILITIES..... 17**
 - 5.1 Functions / Purpose of existing programs as they relate to the proposed project..... 17
 - 5.2 Square footage of existing areas 17
 - 5.3 Utilization of existing space by facility, room, and/ or function 17
 - 5.4 Physical Deficiencies..... 17
 - 5.5 Programmatic Deficiencies 18
 - 5.6 Replacement cost of existing buildings 18
 - 5.7 Existing Facility Illustration..... 19
- 6.0 FACILITY REQUIREMENTS & THE IMPACT OF THE PROPOSED PROJECT 21**
 - 6.1 Functions / Purpose of the Proposed Program 21
 - 6.2 Space Requirements 23
 - 6.3 Impact of the Proposed Project on Existing Space 26
- 7.0 EQUIPMENT REQUIREMENTS 27**
 - 7.1 List of Available Equipment for Re-Use 27
 - 7.2 Additional Equipment (if applicable)..... 27

8.0	SPECIAL DESIGN CONSIDERATIONS	29
8.1	Construction Type	29
8.2	Heating and Cooling Systems	29
8.3	Life Safety/ ADA	29
8.4	Historic or Architectural Significance	29
8.5	Artwork	29
8.6	Phasing	29
8.7	Future Expansion	29
8.8	Other	29
9.0	PROJECT BUDGET AND FISCAL IMPACT	31
9.1	Cost Estimates Criteria	31
9.2	Total Project Cost	32
9.3	Fiscal Impact (first full year of operation)	35
10.0	FUNDING	37
10.1	Total Funds Required	37
10.2	Project Funding Sources	37
10.3	Fiscal Year Expenditures for Project Duration	37
11.0	TIMELINE	39

1.0 INTRODUCTION

1.1 Background and History

The Nebraska Department of Correctional Services (NDCS) has identified a need for additional specialty housing units to support the new Mental Health and Skilled Nursing Housing of the RTC. These new 96 beds would provide mission specific housing capacity for Geriatric, Cognitively Impaired, and Mental Health Transitional inmates.

The Lincoln Correctional Center (LCC) will serve as the location for these new housing units. The intent is that these units are evenly divided with 32 beds for Geriatric Housing, 32 beds for Cognitive Impaired Housing, and 32 beds for Mental Health Transitional Housing.

1.1.1 RTC Campus Existing Conditions

1.1.1.1 History/Mission

Established in mid-1979, this correctional campus was developed initially with two linked facilities, the LCC and the DEC. The Lincoln Correctional Center (LCC) is an adult male, medium/maximum custody facility. This facility works in tandem with the Diagnostic and Evaluation Center (DEC) to support intake and population management functions. They have shared services including visitation, food service, maintenance, inmate records, and staff offices and training functions. The DEC processes all adult male admissions to the department and houses them during the initial intake and classification period. The 142-acre site also includes the Cornhusker State Industries Building, recreation areas and a recycling building. A secure double perimeter fence with surveillance towers encircles most of the site.

Recent major additions to this campus include the just-completed RTC and two HSHE buildings currently under construction. The Rehabilitation and Treatment Center is built in the open space between the LCC and DEC buildings. It includes 32 new mental health beds, new medical unit and intake, visitation, and food service/dining to the entire complex. A new Central Energy Building was completed as part of this project. Under current construction are two High Security Housing Expansion (HSHE) buildings located on the northwest portion of the site within a newly expanded security perimeter. These buildings will house a total of 384 beds.

Beginning January of 2022, this entire campus will be titled as Rehabilitation and Treatment Center (RTC).

1.1.1.2 Physical Plant Issues

RTC does not have dedicated mission specific housing spaces for these inmate demographics. The limitations of the existing physical plant would not allow for the security and supervision of these inmates. Tiered housing units, distance to medical and mental health services, and lack of handicapped accessible housing and services all limit the ability to house these inmates within the existing physical plant.

1.1.1.3 Expansion

The ideal location for this housing expansion is to the southwest or southeast of the facility. It is preferred to not move any existing roads or secured fencing.

1.1.1.4 Challenges and Opportunities

The site constraints regarding topography, existing buildings, roads, and security fencing, all provide challenges and opportunities for the siting of these housing units.

96 Specialty Beds at the Reception & Treatment Center – Program Statement

1.2 Project Description

The project consists of three new housing units at RTC to provide housing for specialty male inmate types:

- Create 32 beds for the Geriatric population
- Create 32 beds for the Cognitively Impaired population
- Create 32 beds for inmates transitioning from Acute Mental Health Care, to General Population

The three units are to be connected to the RTC for access to services and programs. These new units will be strictly for housing. Any necessary treatments for this population will take place in other areas of the facility. The new housing units should be built to Maximum Security standards.

It is assumed that all three units will be single level, no tiered housing will be used.

1.3 Purpose and Objectives

The purpose of this study is to determine the space needs, site plan, parameters and optimal features of a plan for 96 new male beds for housing those inmates that are Geriatric, have Cognitive Impairments, or are transitioning to a lesser level of Mental Health housing.

Operational goals of this expansion include:

- All Male Facility
- 3- 32 bed units
 - i. Cognitive Impairment: Level 4 security
 - ii. Mental Health-Transitional: Level 4 security
 - iii. Geriatric: Low end of Assisted Living, Level 4 Security
- All single level is preferred
- Repurposing existing space should be explored
- Staffing efficiency is top concern
- Flexibility is key
- Everything built to maximum security. No dorms should be considered
- 24 Cells per unit to get to 32 beds
- Transitional Mental Health Unit, level below acute and sub-acute, but above general population
- Double bunks to be 2 beds on the floor, no upper bunks.
- Access to service is critical. Hard connection to existing is required.
- Small exam room on unit.
- Travel to visitation, and video visitation. No on unit visitation
- Limited exterior space needed
- Larger Chases between cells. Rear chases can be looked at.
- Life Skills Lab would be desirable

Functional areas included in the space planning are as follows:

- 3 – 32 bed housing units
- Shared support areas
- Programming and Treatment Areas
- Mechanical, Electrical, and Security Electronics support areas

2.0 JUSTIFICATION OF THE PROJECT

2.1 Data which supports the funding request

Current Inmate (male) special population totals are listed below:

TBI	45
DD	41
Geriatric	35

Additional factors:

The TBI/Cognitively impaired population could be larger, as this represents only those that have a TBI diagnosis. The behavior traits of those more serious TBI include poor impulse control, anxiety, aggression, language challenges, and a variety of other things that work against housing large numbers of people together with diagnosis TBI. The 32-bed unit for TBI/Cog impairment would provide longer term housing for some, and transitional skill building for others that could well in a GP setting with the right coping skills.

The DD population is identified by the community standards for a developmentally delayed diagnosis. Here again, there will be inmates that function best in this mission specific setting – but the goal will always be to provide skill building opportunities that allow those with a DD diagnosis to live in an appropriate general population setting. This is consistent with the community standard of care.

The geriatric population covers a wide spectrum, but the common factor is their ability to carry out their activities of daily living with little or no assistance. These 32 beds will be operated consistent with the community standards for assisted living facilities. Inmates requiring “nursing home care” will be housed in one of the agency’s Skilled Nursing beds. There will be geriatric inmates within the system that require some level of assistance to carry out their ADL’s, but their needs can be met in other general population settings – as is currently done at NSP, RTC, TSCI, and OCC.

Current identified population numbers indicate the beds can all be utilized for their intended purpose, and existing resources can handle any population numbers in excess of 96 beds.

2.1.1 Forecast Data

The following chart is the current inmate population forecast.

HISTORICAL AND PROJECTED NDCS POPULATION 2009-2030						
FY	Male Actual	Female Actual	Total Actual	Male Projected	Female Projected	Total Projected
2009	4,203	383	4,586			
2010	4,259	424	4,683			
2011	4,284	393	4,677			
2012	4,325	384	4,709			
2013	4,639	351	4,990			
2014	4,843	409	5,252			
2015	4,980	419	5,399			
2016	4,893	438	5,331			
2017	4,923	432	5,355			

96 Specialty Beds at the Reception & Treatment Center – Program Statement

2018	4,906	411	5,317			
2019	5,109	431	5,540			
2020				5,308	459	5,767
2021				5,401	470	5,871
2022				5,549	478	6,027
2023				5,704	491	6,195
2024				5,817	504	6,321
2025				5,925	520	6,445
2026				6,086	526	6,612
2027				6,238	531	6,769
2028				6,374	540	6,914
2029				6,610	557	7,167
2030				6,765	562	7,327

2.2 National Trends in Criminal Justice and Corrections

Compared to 20 years ago, today's U.S. inmates are older, sicker, and receiving longer sentences. Many inmates come from underserved communities and have not had adequate access to healthcare prior to incarceration. Besides health concerns, many inmates also require mental health treatments. Among incarcerated adults, rates of mental illness and suicide are two to three times higher and two to four times higher, respectively, than the general population. In addition, over 50 percent of the incarcerated population suffers from symptoms of a psychiatric disorder and between 10 percent and 25 percent suffer from a serious mental health problem such as schizophrenia, as compared to an estimated 10 percent and five percent of the general population, respectively.

Between 1983 and 2008, state corrections spending grew by 674 percent. According to other sources, there has been a 300 percent increase in state spending on corrections since 1980. In 2008, states spent \$52 billion on corrections, which accounted for 3.5 percent of the total state expenditure. The \$50 billion that is spent on corrections is second only to Medicaid as the fastest growing area of government spending.

Geriatric Housing

Of the 35 systems that provided data to the Corrections Compendium (2006), 5.8 percent of those populations could be categorized as elderly. Currently, older inmates account for 10 percent of the prisoner population. From 1990 to 2012, the number of elderly inmates (ages 55 and above) has grown by 550 percent. Between 1993 and 2013, the number of inmates 55 and older grew by 400 percent, from three percent of the total prison population to 10 percent. In that same time period, the median age of prisoners increased from age 30 to 36 years. By the year 2030, it is anticipated that the elderly population in prison will reach 400,000.

Inmates over 50 years old show an increased rate of incontinence, impaired flexibility and sensory issues (e.g. vision and hearing loss), respiratory issues, cardiac disease and cancer, as compared to the general population of the same age. These prisoners also exhibit instability and have a greater risk of falls. Inmates themselves have reported impairments of speech and learning, vision and hearing, and other physical and mental health issues.

Many aging inmates will require access to additional specialists. These could include occupational and physical therapists, psychiatrists, audiologists and ophthalmologists. There is a greater need for specialized nursing in medical, gerontological, and mental health conditions to provide care for this patient cohort. Because of the changes that happen to long-term inmates during their incarceration, as they age, psychiatric nurses are ideal providers to help assist with these changes. Some prisons are also offering counseling by psychologists

96 Specialty Beds at the Reception & Treatment Center – Program Statement

specifically trained in geriatrics. Because of the comorbidities of this population, one study suggests the use of the multi-mobility model of geriatric care. This model shifts care from a single disease focus to one that prioritizes the chronic condition that affects the patient the most.

Aging in the community and aging in prison have different programmatic and service needs. Aging inmates tend to require specialized programmatic needs within environments that are unwilling to break with discipline and order. Older inmates are interested in participating in available prison health promotion programs. One study noted that a robust, proactive health promotion program would lead to healthier aging within the prison environment. Another study noted that prison programs that focus on health improvement, cognitive improvements, and substance abuse could help lower costs and recidivism rates.

Prisons were designed for the younger inmate, and older inmates may have trouble navigating existing prison systems. If the older inmate is not able to negotiate the prison layout, they may isolate themselves from the rest of prison life. Older inmates frequently need areas that are quiet, peaceful and private. The noise, speed and confusion of day-to-day life are hard for them to cope with. This tends to put them in conflict with the general population. Because of the increase in older inmates, many prisons must be adapted to accommodate this inmate-patient population. How that adaptation happens is a major challenge for the prison systems. One study noted that there is not a requirement under the Americans with Disabilities (ADA) for prisons to retrofit their facilities. However physical access must be provided for those people with disabilities. Many prisons are now clustering inmates who require wheelchairs into units designed to meet the ADA requirements.

Treatment for conditions related to aging, protection from predatory younger inmates, and accessibility are reasons older inmates may require specialty housing. Because many older inmates have multiple chronic conditions, as well as issues related to aging, many departments of corrections are locating these inmates in housing units that offer a full range of health coverage. These coverages can include 24-7 medical staff, emergency care, and access to specialists such as geriatrics, pulmonology, cardiology and nephrology. Another reason for moving older inmates into special housing units has to do with victimization. Creating social relationships with younger inmates is a difficulty for the older inmate. Older inmates are normally not a security risk; however, they are a risk for victimization from predatory younger inmates. In addition, because of issues related to impairment, many states are housing older inmates in dedicated housing units. These units may routinely house younger, disabled inmates, as well as older inmates. These units will normally offer special programs for the older inmate, as well as be designed with minimal stairs and shorter distances to other key facilities within the prison, such as the dining hall, or recreation area. Older inmates with dementia are of particular concern for prison administration and health staff. For safety reasons, these patients must be segregated from the rest of the general population.

Housing for the Cognitively Impaired

Cognitive impairment is the most common geriatric syndrome in prisons. Substance abuse, stress, and traumatic brain injury (TBI) are the common factors in aging inmates that drive this result. One study found that cognitive impairments were diagnosed in 40 percent of inmates 55 years old and older. This study suggests annual screening of inmates 55-year-old and older for cognitive impairments. However, these authors also noted that the free-world tests used for cognitive impairment may not be appropriate in the prison environment; they suggested the creation of prison-centric testing.

Dementia is one of the leading causes of higher healthcare costs within prisons. If unrecognized, it can cause other disruptions, such as unnecessary disciplinary actions, victimization and difficulty navigating the parole process. In addition, many older inmates may also suffer from Parkinson's disease and Alzheimer's disease that require constant care. Dementia, depression, anxiety, and other mental health issues can be a challenge for the prison system. Many times, these issues are exacerbated by the prison environment, such as noise, overcrowding, and other inmate behaviors.

96 Specialty Beds at the Reception & Treatment Center – Program Statement

In the United States, traumatic brain injury (TBI) continues to be a major public health concern. An estimated 1.7 million people per year in the U.S. sustain a TBI. In addition, TBI causes 1.1 million trips to the emergency room, as well as 235,000 hospitalizations and 50,000 deaths.

TBI is often referred to as a “silent epidemic” due to limited public awareness of the issues and symptoms involved. TBI is defined as “normal brain functions being disrupted by an external force, or penetrating head injury”. The effects of TBI include: attention problems, decreased cognitive and emotional function, lack of impulse control, and increased aggression. It can also cause co-occurring conditions, such as depression, epilepsy, and substance abuse. Because of these results, researchers hypothesized a link between the potential for criminal behavior and TBI.

Adjustment to prison life can be difficult for inmates with TBI due to the behavioral and cognitive issues that come with the disease. Health conditions such as chemical dependency and psychological problems can affect the inmate’s ability to function, both within the prison and on their eventual return to the community. Having a better understanding of TBI prevalence rates in prisons could help drive rehabilitation programs specifically designed for these conditions.

There is a need for integrated, trauma-informed treatment that is gender-specific, and works not only for the incarcerated inmate, but also for an inmate facing community re-entry.

MH Transitional

Prisons were never intended to be care centers for the mentally ill; however, that is one of their primary functions today. Prisons have been described as “toxic” environments for the seriously mentally ill by many mental health providers. They are overcrowded and tense places where all prisoners struggle to maintain stability, despite the presence of violence, the lack of privacy, the limitations on family contact, and the lack of educational and work opportunities.

The mentally ill are also more susceptible to victimization from other inmates such as, assault, sexual assault, extortion, and exploitation. Their vulnerability is heightened when there is a lack of adequately-trained correctional officers to monitor and protect the mentally ill inmate. Mentally ill prisoners will also find it difficult to consistently comply with prison rules. Some mentally ill inmates exhibit their illness through behaviors such as belligerence, aggression, and violence. These behaviors, though part of their illness, are routinely looked at as disciplinary infractions. One study noted that although mentally ill prisoners account for only 18.7 percent of the prison populations, they account for 41 percent of the disciplinary infractions.

NDCS offers four levels of prison mental health services: acute care, sub-acute care, residential, and outpatient care.

Acute care consists of 24-hour services for patients suffering from:

1. Psychosis.
2. Suicide risk.
3. Level of care that justifies intensive care and other treatments, including forced medication.

Sub-acute care is provided in a contained and safe environment, for patients suffering from:

1. Severe and chronic conditions that require intensive management.
2. Psychosocial interventions.
3. Crisis management.
4. Psychopharmacology interventions.

Residential care is mission specific housing operated to meet the needs of mentally prisoners who

96 Specialty Beds at the Reception & Treatment Center – Program Statement

struggle to remain treatment compliant in a general population setting, and can benefit from greater access to the same services provided through Outpatient care.

Outpatient care is provided in the general population for mentally ill prisoners who need the following treatments:

1. Medication.
2. Psychotherapy.
3. Counseling.
4. Other interventions for non-severe, or chronic conditions, that may be in remission or asymptomatic.

Recent studies note there is a shortage of both acute care and long-term intermediate care beds.

Short-term crisis care is an essential component of a correctional mental health system. Most prisons either have an acute care facility, or they transfer the inmate to a psychiatric hospital or forensic center. Once stabilized, the prisoner will be returned to the general population. There are not enough inpatient beds and acute care facilities for the inmates that need them.

Some states have created specialized intermediate care units for inmates who do not need acute care treatment, but are unable to function in the general population. These facilities are used to provide more mental health treatment and social services than are available in the general population. It was noted that specialized intermediate care units can treat 80 percent of the inmate's mental health problems. While 33 states operate some kind of long-term intermediate care for the seriously mentally ill inmate, most were designed for only the psychotic inmate. Sheltered, supportive, or assisted housing for mentally ill inmates was only provided in five states.

Seriously mentally ill inmates prefer to be housed in intermediate care facilities and even forensic hospitals, because of the treatments and programs available. It is noted that in New York, inmates had lower rates of infractions and violence when housed in the intermediate care facility, than they did when they were housed in the general population. Greater use of intermediate care facilities could break the pattern of cycling between crisis units for stabilization, and general population where they decompensate.

2.3 Alternatives Considered

Alternatives considered include the following:

2.3.1 Renovation of existing housing areas:

The first option that was discussed was the repurposing of existing housing units for these specialty beds. After considering this option, it was noted that the current physical plant would not allow for the visualization, handicapped accessibility and therapeutic environments that were required for this inmate population. There is also not the capacity to lose beds in order to create these new housing units.

2.3.2 Construct all new housing:

This option has the most flexibility for creating the specialty needs housing for this inmate population. However, it has the most challenges from a site and connectivity standpoint.

2.3.3 Combination of new and existing housing:

This option would use a combination of existing repurposed space and new construction. It may allow for some of the shared support areas to be in renovated space and the housing to be new construction. This would limit the impact of the existing physical plant on the needs of the new housing.

This page intentionally left blank

3.0 LOCATION & SITE CONSIDERATIONS

Due to the existing services including Intake, Dietary, and other housing, the RTC was targeted as the right location for the new 96 specialty beds. The new 96 beds will be designed to meet ACA standards, as well as have some additional shared support areas for treatments and programming. It is also a requirement that these new housing units have a direct connection to the RTC clinical areas.

3.1 County

This proposed project is located in Lancaster County (DAS County #55).

3.2 Town/ Campus

The proposed project is located at the Nebraska Department of Correctional Services (NDCS), RTC.

3.3 Proposed Site

The proposed site for these new housing units on state owned land within the RTC campus. It is preferred that the expansion takes place within the existing fence line. There are two sites currently being considered.

The first site is just to the northeast of the new RTC and the existing Food Service Area. The site would fit in the courtyard between those spaces and the existing RTC Area LA housing. This site is being proposed for the Geriatric unit for its proximity to the RTC clinic and Food Services. It is also in proximity to the existing Intake area and the Medical Building Support Circulation corridor.

The second site is just to the southwest of the housing units formally known as DEC and would connect into the RTC corridor system. This site is proposed for the Cognitive Impaired Unit and the Mental Health Transitional Unit. It is proposed that the new units be located at minimum of 20ft away from the existing housing units. This is both for building code and security issues.

3.4 Statewide Building Inventory

The LCC building inventory tag is 46L0141700B and the existing DEC building inventory tag is 46L0141800B. The new RTC and HSHS buildings have not been assigned tags yet.

3.5 Influence of Project on Existing Site Conditions

3.5.1 Relationship to Neighbors and Environment

The RTC site is suburban and rural in nature. The bulk of the land surrounding the site is agricultural in use. There are some suburban areas a small distance to the northeast of the campus. The RTC is located on the southwest side of a large parcel owned by the state. The parcel also includes one other NDCS facility, (CCC-L). The RTC is located just north of West Van Dorn Street, which is a moderately used arterial street.

The proposed expansion area for the Geriatric unit will have no effect on surrounding neighbors, as it fits within and existing courtyard and is not visible outside the secured fence. The expansion area for the Cognitive Impairment and Mental Health Transitional Unit has the ability to improve the visual image of the campus from West Van Dorn Street, as well as SW 27th Street. This addition will be lower scaled, with larger windows and will therefore have a lesser effect on the surrounding neighborhood.

3.5.2 Utilities

Most utilities for the new additions will be through existing services. Water, Sanitary, Storm, and Power, will all be provided from existing utilities. It is anticipated that each addition will have it's own stand-alone Mechanical systems.

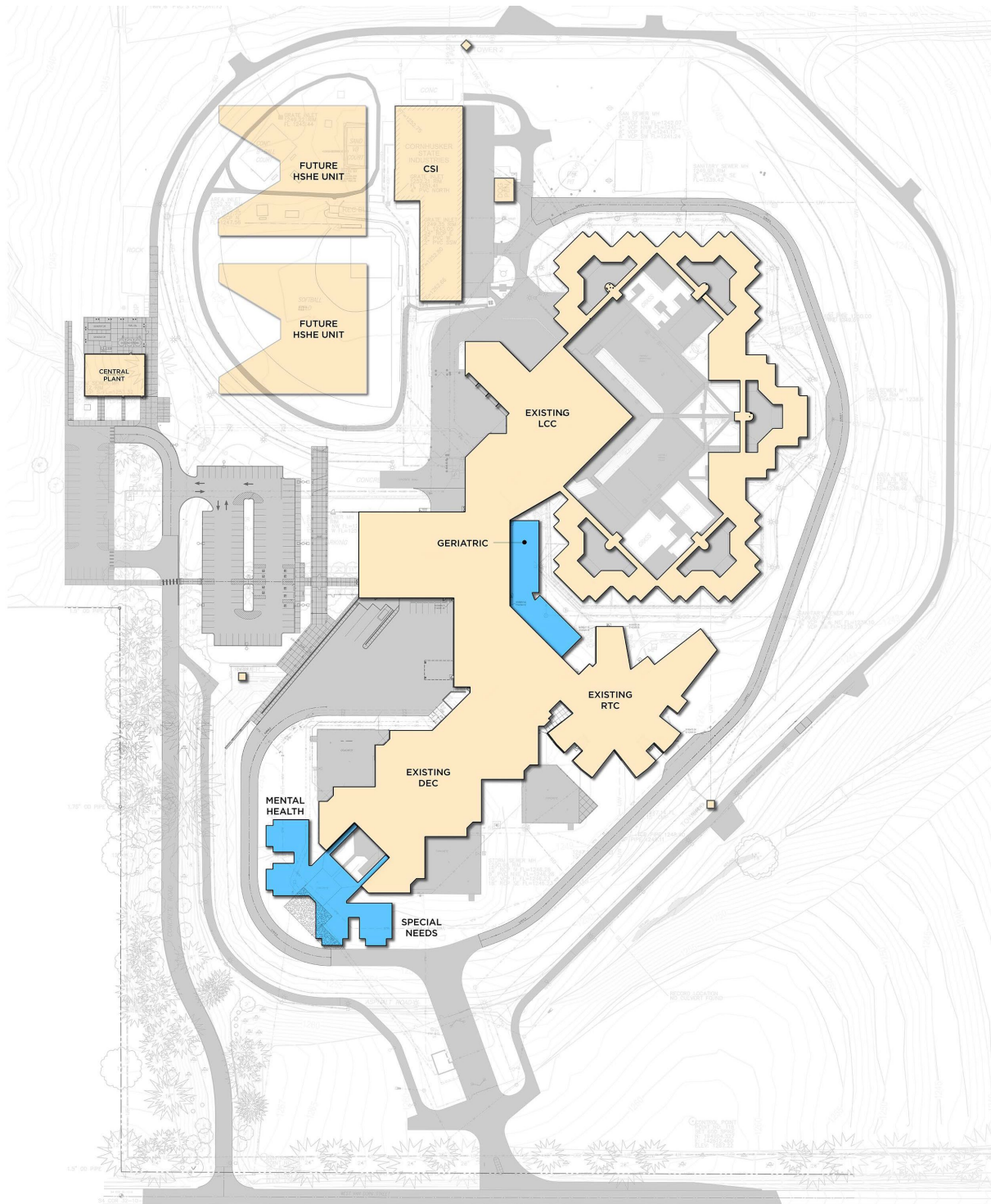
96 Specialty Beds at the Reception & Treatment Center – Program Statement

3.5.3 Parking and Circulation

Because these additions will be constructed within the existing secured fencing and site access roads, existing parking and site circulation will not be affected.

3.5.4 Site Utilization Concept

The diagram below highlights the proposed new housing additions.



4.0 COMPREHENSIVE PLAN COMPLIANCE

4.1 NDCS Comprehensive Plan – Latest Edition

NDCS 2014 Master Plan Report dated October 27, 2014 is the most current strategic Capital Facilities Master Plan. Currently (November 2021) an update to their Master Plan is in development and is scheduled to be released in the summer of 2022.

4.2 Consistency with the NDCS Comprehensive Capital Facilities Plan

The NDCS Master Plan identified several new projects at the DEC / LCC campus as follows:

Phase One (2015 – 2019)

- 358 new beds at the DEC / LCC campus through addition of a new MFS (Medical, Intake, Food Service) facility on the same campus as follows:
 - 150 new Mental Health Stabilization beds at the new MIFS.
 - 80 new 90-day evaluator and safekeeper beds at the new MIFS.
 - 40 new skilled nursing beds (licensed) at MIFS.
 - 88 new unlicensed medical beds at MIFS.
- 80 beds will be added to the system by repurposing the following housing units:
 - DEC Unit 8K: 16 general population beds gained after inmates moved to MIFS.
 - DEC Unit 1P: 32 general population beds gained after inmates moved to MIFS.
 - LCC Unit D: 32 general population beds gained after inmates moved to MIFS.

Phase Two (2020 – 2024)

- Add the appropriate core to support the increased population. The addition of increased beds on this campus would require an addition of some core areas, which should be planned to serve the new beds and the additional capacity gained by double-occupying C and D units. A Program Statement Analysis should be conducted to ensure that only the required core areas are added.

A program statement for a Phase One addition to address the Master Plan recommendations was completed in August 2016. This programming effort redefined the proposed Phase One multiple additions in the Master Plan, which increased capital costs and operational costs. The new programming effort resulted in solutions that combined the DEC and LCC into one functional prison with a well-defined mission—reception and treatment. Following this effort, a subsequent program statement addressed Phase Two of the Master Plan which resulted in two high-security housing units. This proposed Phase Three Program Statement provides for the special population housing mentioned in the Master Plan addressing critical needs for the system at large.

4.3 Current New Construction

Phase One (RTC) and Phase Two (HSHE x2) projects are currently under construction. The Rehabilitation and Treatment Center (RTC) is to be operational in early Spring of 2022. It is built in open space between the DEC and LCC. It includes 32 new mental health stabilization beds and new medical, intake, visitation and food services to serve the entire correctional campus. One existing housing unit at the existing LCC has been converted to a mental health unit.

Phase Two construction are the two High Security Expansion Housing Buildings (HSHE) scheduled to be completed in June of 2022. These units' combined inmate housing is 384, which brings the Phase One and Phase Two inmate capacity to 416 added beds. This is slightly higher than proposed in the Master Plan over seven years ago.

4.4 Consistent with the Current Statewide Comprehensive Capital Facilities Plan

This program statement complies with the Statewide Comprehensive Facilities Plan and the Mission Statement for the Nebraska Capital Construction by addressing a shortfall between the current Master Plan Proposed Capital Solutions and the current new facilities being completed at the RTC campus. The Program Statement's capital solution will address expanded prison population that affects all Nebraskans as well as underserved special needs inmates.

96 Specialty Beds at the Reception & Treatment Center – Program Statement

Mission Statement for Nebraskans Capital Construction:

“This mission of capital construction in the state of Nebraska is to plan, fund, design, construct and maintain facilities to serve the best interest and needs of ALL Nebraskans in an efficient and cost-effective manner.”

4.4.1 Facilities should be accessible and designed / constructed to serve the interest and needs of ALL persons.

The three new housing additions and all new site improvements will comply with all current ADA standards.

4.4.2 Facilities should represent a wise, responsible use of taxpayer funds, which utilizes efficient, cost-effective design and construction methods & modern technology, and results in reasonable ongoing operations / maintenance costs.

The three new housing units will be constructed and equipped using best practice contemporary design with staff efficiencies and reasonable operational costs in mind. Operations and maintenance cost will be minimized without adversely affecting functional operations.

4.4.3 Facilities should be safe, promote health and well-being, and maintain a quality of life for ALL persons.

This safe and secure housing expansion is intended for the benefit of the public, staff, and inmate special needs. Treatment and rehabilitation programs will enhance the health and wellbeing of inmates housed in these units.

4.4.4 Facility decisions and projects should best reflect the state’s stewardship role in protecting and maintaining existing facility assets.

This project provides for the expansion of an existing state facility which will conserve existing resources and eliminate the expense of building a new facility.

4.4.5 Facility decisions and projects best serve the long-term interest of ALL Nebraskans including future generations.

The new housing units will be a long-term asset that will serve the current inmate population. The estimated life of the new and remodeled facilities will exceed 50 years.

4.4.6 Based appropriate evaluations facilities should responsibly support state agencies, their missions & goals, and be of service to Nebraska’s citizens.

The proposed new housing supports the mission, values, goals, and vision of the Nebraska Department of Correctional Services. Nebraskans will benefit from its operation and inmates will receive needed support programs to address their special needs.

4.4.7 Facility project should encourage partnering, cooperation and the sharing of resources between state agencies, local government, and private entities, where appropriate.

The proposed addition of the three special needs housing units demonstrates the desire and need to be a critical partner in this combined NDCS / community effort to serve geriatrics, mental health, and other critical special needs.

4.4.8 State facility planning, design and construction should act as a model for other state and local governments, as well as private entities and institutions.

The new housing units will be a model for current best practice prison solutions for special needs inmates.

4.4.9 State facilities should strike a balance between quality and quantity and incorporate a level of excellence that reflects a high appreciation for the built and natural environments.

The expansion of three housing units will incorporate and provide a balance between quality and quantity and will preserve and enhance an existing state-owned prison campus. The proposed design of the facility will take advantage of outdoor spaces to enhance treatment and help create a calming environment.

96 Specialty Beds at the Reception & Treatment Center – Program Statement

4.4.10 State facilities and those who plan, build and care for them must be accountable to ALL Nebraskans and responsive to their changing need.

This expansion project will aid NDCS with the care & treatment of inmates who have special needs. By addressing these critical inmate special needs with specialized programs and humane living spaces, we believe this project demonstrates accountability.

5.0 ANALYSIS OF EXISTING FACILITIES

5.1 Functions / Purpose of existing programs as they relate to the proposed project

The current purpose of the existing Diagnostic and Evaluation Center (DEC) is to process all adult male admissions to the Nebraska Department of Correctional Services and to house them during the initial intake and classification period.

The current purpose of the Lincoln Correctional Center (LCC) is to house and support male inmates. This is a full-service facility, and it operates in tandem with the DEC to support intake and population management functions.

The soon to be in operation Rehabilitation and Treatment Center (RTC) sited between the DEC and LCC provides contemporary medical, intake, visitation, food service, and mental health housing to the campus.

Currently under construction, two new buildings will add 384 beds of high security housing to the campus.

This proposed project will provide this campus and the corrections system at large critically needed specific housing for geriatrics, transitional mental health, and special needs. These three housing units located adjacent to the DEC and RTC (see site plan) will receive treatment and programs tailored to the challenged inmates' unique needs.

5.2 Square footage of existing areas

The gross square footage of the existing DEC is 88,000 GSF and the existing LCC is 151,000 GSF. The existing building is proposed to be reused with minimal renovations after the current new projects under construction are completed.

5.3 Utilization of existing space by facility, room, and/ or function

The additions are located so that they can plug into existing services and program which are going to be provided in the RTC.

The new Geriatric Housing will be located directly adjacent to the new RTC. This will allow for this inmate-patient population to access needed health and mental health services with minimal movement. It will also allow for medical and mental health staff backup to this housing unit with minimal movement.

The new Cognitive Impairment and Mental Health Transitional Units will be located to the southwest of the existing DEC. This will allow the additions to plug directly into the existing DEC circulation corridor systems, for movement to the existing RTC should clinical, or programmatic needs necessitate this. These two units will also have their own dedicated ancillary support spaces to limit inmate-patient movement back to the existing RTC.

5.4 Physical Deficiencies

The DEC facility is over 40 years old and has experienced many years of crowding. Many improvements have taken place recently due to adjacent new construction of the RTC and a new central energy building serving this campus. Remaining deficiencies listed in the current Master Plan which are waiting for funding/completion, are as follows:

- Replace cell door locks
- Replace variable air volume
- Replace chilled water coil
- Replace toilet flush valves
- Exterior wall repair

96 Specialty Beds at the Reception & Treatment Center – Program Statement

The LCC campus is also over 40 years old and continues to need repair and upgrades. As noted previously the new central energy building has solved some of the major issues. Remaining deficiencies, which are waiting for funding/completion, listed in the current Master Plan are as follows:

- Door and window / structural
- Replace / modernize elevators

5.5 Programmatic Deficiencies

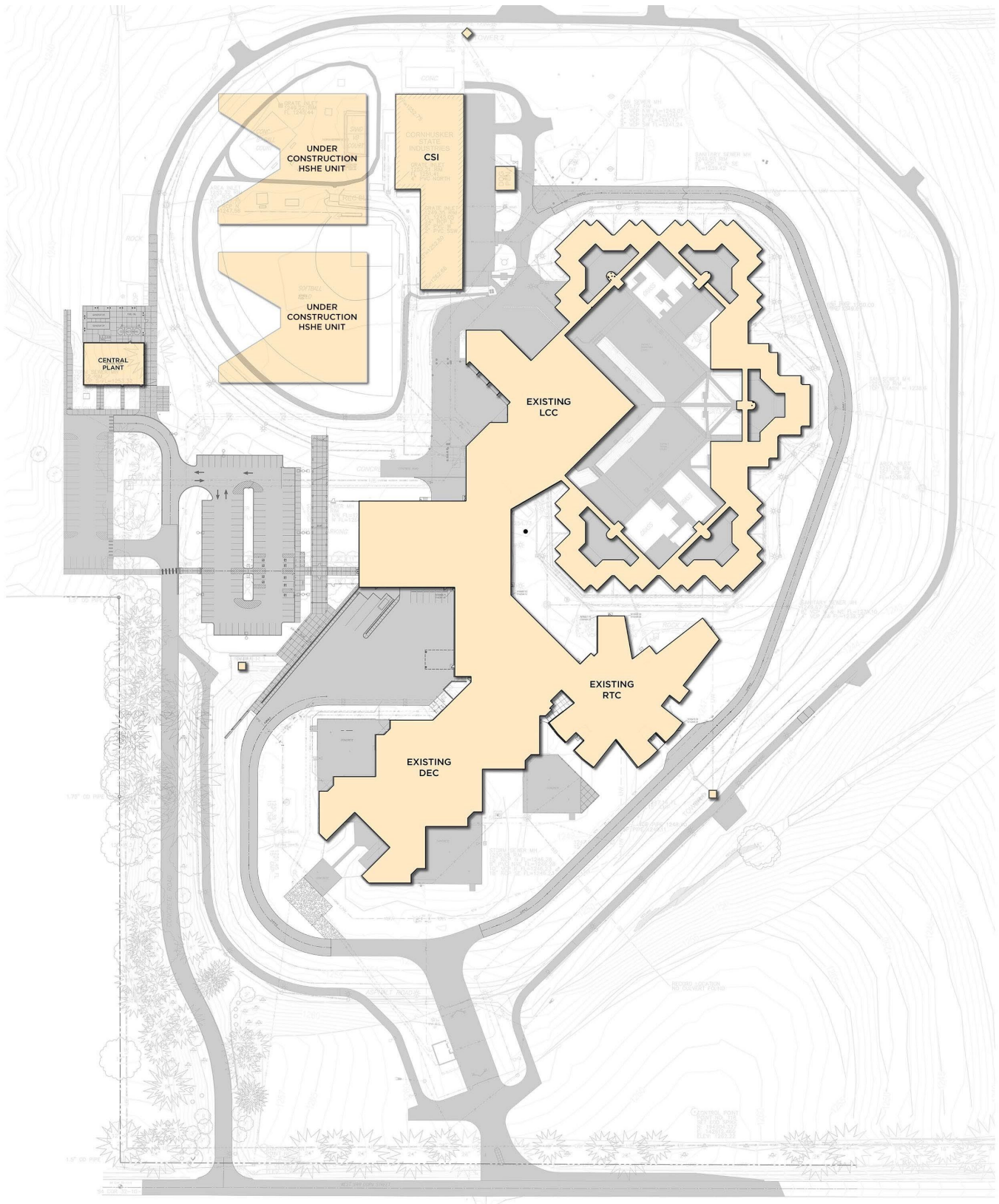
The new building projects soon to be completed will help crowding issues and add or replace essential functions and programming and support spaces. Expansion of the security perimeter and new staff & visitor parking enhances this campus's capabilities.

With the addition of the proposed three special needs housing units this complex addresses a great many of the NDCS needs.

5.6 Replacement cost of existing buildings

This campus will be fully utilized and expanded. It will not be replaced.

5.0 Existing Facility Illustration



This page intentionally left blank

6.0 FACILITY REQUIREMENTS & THE IMPACT OF THE PROPOSED PROJECT

6.1 Functions / Purpose of the Proposed Program

6.1.1 Activity Identification and Analysis

The pre-architectural space program lists the functional space needs required by the proposed expansion of the RTC facility to include specialty housing for Geriatric, Cognitively Impaired, and Developmentally Disabled inmates. The space program also lists the functional space needs for the associated programming and treatment spaces. The requirements of this project will include construction of the three new housing units at the LCC, with the associated pre-design, design, site, and construction phases associated with new construction projects.

6.1.1.1 Correctional Program Goals

- This campus is a Mental Health Center of Excellence.
- Built to a maximum-security standard.
- Increase the design capacity of the facility by 96 inmates.
- Designed to meet ACA standards.
- Connected to the RTC clinical areas in a smart way. A hard connection is required.
- Staffing efficiency is a primary concern.
- Flexibility is key.

6.1.1.2 Inmate Program-Related Goals

- Inmates will travel visitation and video visitation. Minimal visitation on unit.
- Units should include a Life Skills Lab.
- Larger cells with natural light.
- One cell should have a ceiling lift.
- Some treatments areas will be provided in a shared support area, but the bulk of clinical services will be provided in the RTC clinic.

6.1.1.3 Site perimeter and site security goals

- Minimize any changes and modifications to the existing security fencing and access roads.
- Stay away from areas of the site with heavy grade changes.

6.1.2 Projected Occupancy Use/ Levels

This facility is projected to be fully occupied and used.

6.1.3 Personnel Projections

NDCS provided an estimate of personnel to operate the new housing units. This staffing assumption has been broken up into two different staffing grids. One for the Geriatric Unit and the other for the Cognitive Impairment and Mental Health Transitional Unit. These two staffing plans are outlined on the next page.

96 Specialty Beds at the Reception & Treatment Center – Program Statement

GERIATRIC UNIT						
Position	Day Shift	1st Shift	2nd Shift	3rd Shift	Relief Factor*	Total FTE
UNIT OPERATIONS/SECURITY						
Unit Manager	0.33				1.00	0.33
Case Manager	0.33				1.00	0.33
Unit Case Workers		0.33	0.33		1.74	1.15
Unit Sergeants		0.33	0.33		1.25	0.83
Corr. Corporals		1.0	1.0		1.74	3.48
TREATMENT						
TOTAL						
	2.0	3.0	3.0			6.12

COGNITIVE IMPAIRMENT & MH TRANSITIONAL						
Position	Day Shift	1st Shift	2nd Shift	3rd Shift	Relief Factor*	Total FTE
UNIT OPERATIONS/SECURITY						
Unit Manager	0.66				1.00	0.66
Case Manager	1.0				1.00	1.00
Unit Case Workers		0.66	0.66		1.74	2.30
Unit Sergeants		0.66	0.66		1.25	1.65
Corr. Corporals		2.0	2.0	1	1.74	8.70
TREATMENT						
BH Case Workers		2	2	1	1.74	8.70
LMHP	1				1.00	1.00
TOTAL						
	2.0	3.0	3.0	0.22		24.01

The plan is broken up into thirds, Geriatric as one third and Cognitive Impairment & MH Transitional as 2/3rds.

1. The Unit Manager is listed as 1/3 and 2/3 on the two staffing grids. No Relief Factor is applied.
2. The Case Manager is listed as 1/3 and 2/3 on the two staffing grids. No Relief Factor is applied.
3. The Unit Case Worker is listed as 1/3 and 2/3 on the two staffing grids. A 1/74 Relief Factor is applied.
4. The Unit Sergeants are listed as 1/3 and 2/3 on both First and Second shifts. A 1.25 Relief Factor is applied.
5. The Corr. Corporals have 2 staff members covering Third shift. Based on that the grids are using 0.22 and 0.44 respectively. This represents 1/3 and 2/3 of the 2 staff members sharing that shift. A 1.74 Relief Factor is applied.

6.1.3.1 Anticipated Occupancy

This addition will provide a total of 96 specialty beds for inmates who are geriatric, have cognitive impairment issues, or who are transitioning from high acuity mental health treatment. Only male inmates will be housed in these units.

96 Specialty Beds at the Reception & Treatment Center – Program Statement

6.2 Space Requirements

6.2.1 Square Footage by Individual Areas and/or Functions

The space requirements in the form of an architectural space program are indicated in the summary space table. Each functional area is identified using a space number with four decimal places (1.1100, 1.1200, etc.). Details of each functional space area are included in Appendix A. The total space required is summarized below.

1.1000	Housing					
Space #	Components	Units or Persons	# of Spaces	Space Standard	Square Feet	Comments
1.1100	Shared Support Area					
1.1101	Secure Entry	1	1	10	10	Locked door, local control, also monitored by Central Control
1.1102	Staff Office	1	3	120	360	Private Office
1.1103	Multipurpose Room	20	1	20	400	Classroom seating with moveable tables, audio/visual equipment and hookups, whiteboard, lectern
1.1104	Physical Therapy	1	1	200	200	Locked, vision panel, stationary bike, stairs
1.1105	Professional Visit Booth	0	1	30	0	30 NSF each side, locked secure window for paper pass
1.1106	Exam Room	1	2	150	300	Lockable room for simple procedures and for medicine distribution. Handwashing sink, Exam Table, Otolaryngology/Ophthalmology, Blood Pressure Cuff, Exam Light, Sharps Container, Stool, Countertop, Locker upper cabinets.
1.1107	Medical Equipment Room	1	1	200	200	In addition to Warehouse, wheelchairs, walking aids
1.1108	Staff Toilet	1	2	50	100	ADA, male and female, 1 toilet, 1 urinal, 1 lav, lockable
1.1109	Storage	1	1	75	75	Mobile Shelving
1.1110	Break Room	4	1	25	100	Counter with small sink, microwave, coffee, small under counter refrigerator, shelves
1.1111	Inmate Toilet	1	1	50	50	ADA compliant
1.1112	Mechanical & Electrical Room	1	1	75	75	Lockable space
1.1113	IT Systems UDC	1	1	50	50	Lockable space; air conditioned
1.1114	IT Systems DTS	1	1	25	25	Lockable space; air conditioned
Subtotal NSF					1,945	
DGSF Factor					50%	973
Subtotal DGSF					2,918	

1.1000	Housing					
Space #	Components	Units or Persons	# of Spaces	Space Standard	Square Feet	Comments
1.1200	Male Cognitive Impairment Housing - 24 Single + 4 Double					
1.1201	Secure Entry	1	1	10	10	Section door local control by housing officer, interlocked with Unit entry door under Central Control
1.1202	Control Room - 1/3 of 3 x 8-bed male sections	1	1	35	35	Section entry door local control, counter with PC, intercom, storage cabinets under, chair, M&E closet
1.1203	Single Cell	1	20	75	1500	Bed, wall mounted cabinet, writing desk, combo toilet, view to outdoors and sky, cuffing port with deadbolt
1.1204	Single Cell - ADA	1	4	90	360	ADA compliant, bed, writing desk, personal storage in cabinet, combo toilet, view to outdoors and sky, cuffing port with deadbolt
1.1205	Double Cell	2	4	90	720	Double bunked. Combo toilet, writing table with stool, personal storage in cabinet, wall mounted clothes hooks, view to outdoors and sky, cuffing port with deadbolt
1.1206	Dayroom	32	1	35	1120	Moveable round tables w/4 moveable seats each, 1 ADA accessible, water fountain, kiosk for checking schedules, select controlled data access, mailbox, video visiting kiosks

96 Specialty Beds at the Reception & Treatment Center – Program Statement

1.1207	Beverage and Food Cart Station	1	1	35	35	Counter along wall near security vestibule, sink, beverage containers, food cart outlet; Microwave, Ice, Vending
1.1208	Blue Room	1	1	80	80	Quiet space for de-escalation and reflection. TV with nature scenes, soft music, soft furniture, dimmable lighting. Can be used for one-on-one therapies.
1.1209	OMR - Group Multi-Purpose/ Treatment Room	5	0	20	0	Security seating, lectern, white board, A/V capable
1.1210	Showers	1	2	35	70	Single shower, drying space in front, adjacent to dayroom
1.1211	Shower - ADA	1	2	45	90	Single ADA accessible shower with drying space in front, adjacent to dayroom
1.1212	Storage	1	1	40	40	Locked w/shelving, dayroom access, mattresses, bedding, extra clothing in Unit Center Storage
1.1213	Outdoor Recreation Courtyard	8	1	94	752	Enclosed secure area adjacent to dayroom, partial roof, basketball hoop, Included at 50% value since exterior but constructed, 750 NSF is ACA minimum standard size
Subtotal NSF					4,812	
DGSF Factor				25%	1,203	
Subtotal DGSF					6,015	
1.1250	Male Cognitive Impairment Housing Unit Support Services					
1.1261	Mechanical & Electrical Room	1	1	75	75	Lockable space
1.1262	IT Systems UDC	1	1	50	50	Lockable space; air conditioned
1.1263	IT Systems DTS	1	1	25	25	Lockable space; air conditioned
1.1264	Janitor's Closet	1	1	35	35	Shelving, mop sink and mop storage
Subtotal NSF					185	
DGSF Factor				15%	28	
Subtotal DGSF					213	

1.1000	Housing					
Space #	Components	Units or Persons	# of Spaces	Space Standard	Square Feet	Comments
1.1300	Male Mental Health Transitional Housing - 24 Single + 4 Double					
1.1301	Secure Entry	1	1	10	10	Section door local control by housing officer, interlocked with Unit entry door under Central Control
1.1302	Control Room - 1/3 of 3 x 8-bed male sections	1	1	35	35	Section entry door local control, counter with PC, intercom, storage cabinets under, chair, M&E closet
1.1303	Single Cell	1	20	75	1500	Bed, wall mounted cabinet, writing desk, combo toilet, view to outdoors and sky, cuffing port with deadbolt
1.1304	Single Cell - ADA	1	4	90	360	ADA compliant, bed, writing desk, personal storage in cabinet, combo toilet, view to outdoors and sky, cuffing port with deadbolt
1.1305	Double Cell	2	4	90	720	Double bunked. Combo toilet, writing table with stool, personal storage in cabinet, wall mounted clothes hooks, view to outdoors and sky, cuffing port with deadbolt
1.1306	Dayroom	32	1	35	1120	Moveable round tables w/4 moveable seats each, 1 ADA accessible, water fountain, kiosk for checking schedules, select controlled data access, mailbox, video visiting kiosks
1.1307	Beverage and Food Cart Station	1	1	35	35	Counter along wall near security vestibule, sink, beverage containers, food cart outlet; Microwave, Ice, Vending
1.1308	Blue Room	1	1	80	80	Quiet space for de-escalation and reflection. TV with nature scenes, soft music, soft furniture, dimmable lighting. Can be used for one-on-one therapies.
1.1309	OMR - Group Multi-Purpose/ Treatment Room	5	0	20	0	Security seating, lectern, white board, A/V capable
1.1310	Showers	1	2	35	70	Single shower, drying space in front, adjacent to dayroom

96 Specialty Beds at the Reception & Treatment Center – Program Statement

1.1311	Shower - ADA	1	2	45	90	Single ADA accessible shower with drying space in front, adjacent to dayroom
1.1312	Storage	1	1	40	40	Locked w/shelving, dayroom access, mattresses, bedding, extra clothing in Unit Center Storage
1.1313	Outdoor Recreation Courtyard	8	1	94	752	Enclosed secure area adjacent to dayroom, partial roof, basketball hoop, Included at 50% value since exterior but constructed, 750 NSF is ACA minimum standard size
Subtotal NSF					4,812	
DGSF Factor				25%	1,203	
Subtotal DGSF					6,015	
1.1350 Male Mental Health Transitional Housing Unit Support Services						
1.1361	Mechanical & Electrical Room	1	1	75	75	Lockable space
1.1362	IT Systems UDC	1	1	50	50	Lockable space; air conditioned
1.1363	IT Systems DTS	1	1	25	25	Lockable space; air conditioned
1.1364	Janitor's Closet	1	1	35	35	Shelving, mop sink and mop storage
Subtotal NSF					185	
DGSF Factor				15%	28	
Subtotal DGSF					213	

1.1000	Housing					
Space #	Components	Units or Persons	# of Spaces	Space Standard	Square Feet	Comments
1.1400 Male Geriatric Housing - 24 Single + 4 Double						
1.1401	Secure Entry	1	1	10	10	Section door local control by housing officer, interlocked with Unit entry door under Central Control
1.1402	Control Room - 1/3 of 3 x 8-bed male sections	1	1	35	35	Section entry door local control, counter with PC, intercom, storage cabinets under, chair, M&E closet
1.1403	Single Cell	1	20	75	1500	Bed, wall mounted cabinet, writing desk, combo toilet, view to outdoors and sky, cuffing port with deadbolt. 3'-4" clear opening swing door.
1.1404	Single Cell - ADA	1	4	90	360	ADA compliant, bed, writing desk, personal storage in cabinet, combo toilet, view to outdoors and sky, cuffing port with deadbolt. 3'- 4" clear opening swing door.
1.1405	Double Cell	2	4	120	960	Double bunked. Combo toilet, writing table with stool, personal storage in cabinet, wall mounted clothes hooks, view to outdoors and sky, cuffing port with deadbolt. 3'-4" clear opening swing door.
1.1406	Dayroom	32	1	35	1120	Moveable round tables w/4 moveable seats each, 1 ADA accessible, water fountain, kiosk for checking schedules, selectcontrolled data access, mailbox, video visiting kiosks. 2 AED.
1.1407	Beverage and Food Cart Station	1	1	35	35	Counter along wall near security vestibule, sink, beverage containers, food cart outlet; Microwave, Ice, Vending
1.1408	OMR - Group Multi-Purpose/ Treatment Room	5	0	20	0	Security seating, lectern, white board, A/V capable
1.1409	Showers	1	1	35	35	Single shower, drying space in front, adjacent to dayroom
1.1410	Shower - ADA	1	3	45	135	Single ADA shower, drying space in front, adjacent to dayroom
1.1411	Storage	1	1	40	40	Locked w/shelving, dayroom access, mattresses, bedding, extra clothing in Unit Center Storage
1.1412	Outdoor Recreation Courtyard	8	1	94	752	Enclosed secure area adjacent to dayroom, partial roof, basketball hoop, Included at 50% value since exterior but constructed, 750 NSF is ACA minimum standard size
Subtotal NSF					4,982	
DGSF Factor				45%	2,242	
Subtotal DGSF					7,224	

96 Specialty Beds at the Reception & Treatment Center – Program Statement

1.1450	Male Geriatric Housing Unit Support Services					
1.1461	Mechanical & Electrical Room	1	1	75	75	Lockable space
1.1462	IT Systems UDC	1	1	50	50	Lockable space, air conditioned
1.1463	IT Systems DTS	1	1	25	25	Lockable space, air conditioned
1.1464	Janitor Closet	1	1	35	35	Shelving, mop sink and mop storage
Subtotal NSF					185	
DGSF Factor				20%	37	
Subtotal DGSF					222	

Comp. #	Component	# of Beds	NSF	DGSF	BGSF
1.1100	Shared Support		1,945	2,918	4,230
1.1200	Male Cognitive Impairment Housing - 24 Single + 4 Double	32	4,812	6,015	6,917
1.1250	Male Cognitive Impairment Housing Unit Support Services		185	213	245
1.1300	Male Mental Health Transitional Housing - 24 Single + 4 Double	32	4,812	6,015	6,917
1.1350	Male Mental Health Transitional Housing Unit Support Services		185	213	245
1.1400	Male Geriatric Housing - 24 Single + 4 Double	32	4,982	7,224	8,307
1.1450	Male Geriatric Housing Unit Support Services		185	222	255
GRAND TOTAL		96	17,106	22,819	27,117
DGSF to BGSF factor of 15%, except for Shared Support which is 45% to account for the additional circulation			BGSF / Inmate		282

6.2.2 Basis for Square Footage/ Planning Parameters

The architectural space program was developed using the standards from the American Correctional Association (ACA). For areas that are not specifically covered by the ACA standards, anticipated services levels, occupancy load, and industry best practices were used.

Required functional spaces are totaled and a Departmental Grossing Factor (DGF) is applied. This factor accounts for internal circulation and interior wall thicknesses. When this factor is applied, it provides for a Departmental Gross Square Foot (DGSF). In addition to the DGSF, a Building Grossing Factor (BGF) is applied. This factor accounts for exterior wall thicknesses, interior columns, mechanical shafts, and any required circulation exterior to the department. When this factor is applied, it provides for a Building Gross Square Foot (BGSF), which is the total area needed for the project.

6.2.3 Square Footage Difference Between Existing and Proposed Areas (Net & Gross)

Because these new housing units are new programs, there is not an existing square footage to compare to.

Proposed NSF: 17,106 net sq. ft.

Proposed BGSF: 27,117 building gross sq. ft.

6.3 Impact of the Proposed Project on Existing Space

6.3.1 Reutilization and Function(s)

It is anticipated that all of the new housing units will be new construction. However, there may be some areas within the existing DEC or RTC that will require renovation for connections.

6.3.2 Demolition

No building demolition is anticipated.

6.3.3 Renovation

Connections from the new housing units into existing buildings will be required.

7.0 Equipment Requirements

7.1 List of Available Equipment for Re-Use

None

7.2 Additional Equipment (if applicable)

7.2.1 Fixed Equipment

- Beverage Bar at 5 Housing Dayroom Areas: Ice maker & hot water dispensers. (\$25,000)

7.2.2 Movable Equipment

Moveable Equipment as follows:

- Defibrillators & CPAP equipment at Geriatrics (\$45,000)
- Moveable furniture at Geriatrics, office, and meeting areas (\$105,000)

7.2.3 Special or Technical Equipment

No special or technical equipment identified at this time.

This page intentionally left blank.

8.0 Special Design Considerations

8.1 Construction Type

The proposed new construction consists of two connected buildings located at the southwest corner of the campus with connections to the end of the Intake (or South) housing units.

Additionally, a linear housing unit for geriatrics is to be located along a circulation corridor at the new RTC and adjacent to the new medical area. The new housing units are to be single story which is appropriate to the special needs of the inmate population served. The construction type for these high security housing units is proposed to be precast, insulated & load bearing perimeter walls with masonry interior partitions throughout. Roof construction is proposed to be low slope steel superstructure with fire resistive cladding material. The exterior image of these buildings will be compatible with the existing adjacent campus buildings.

8.2 Heating and Cooling Systems

It is proposed that the two new connected housing buildings adjacent to the Intake Units have gas fired roof top units for HVAC needs. A penthouse enclosure is desired to facilitate maintenance. This site location is not convenient or cost effective to connect to campus hot & chilled water systems.

The geriatric housing location, attached to the new RTC clinic, is proposed to be connected to the new campus energy systems and nearby new mechanical room located on the upper level of the RTC clinic.

Both proposed HVAC scenarios will be designed with low maintenance & longevity in mind.

8.3 Life Safety/ADA

This project will be designed to meet all applicable life safety/ADA standards and requirements at the time of design.

Emergency generators will provide 100% emergency power to the three new proposed housing units.

8.4 Historic or Architectural Significance

There is no historic significance known regarding the site. It is anticipated that the exterior facades of the new buildings and additions will be compatible with the original and recently expanded facility.

8.5 Artwork

The inclusion of appropriate artwork, while encouraged, is not mandatory for this project. Due to the restricted nature of this facility, public access is limited, and the buildings are not considered public buildings per state statute 82-318. Therefore, the 1% artwork requirement does not apply and is not included in the budget.

8.6 Phasing

It is anticipated this project will be completed in a single phase. This project consists of additions to the existing facility with minimal disruption to existing spaces or functions.

8.7 Future Expansion

After these proposed housing structures are built, future expansion will be limited to the north and east portion of the campus unless the security perimeter is modified & extended. The support spaces for the RTC were designed to meet the needs of a population under 1,300 inmates. If this Phase Three project is funded and built, there will not be support services capacity for any further population expansion at the RTC campus.

8.8 Other

Site utilities will be required to be relocated prior to new construction beginning.

This page intentionally left blank.

9.0 Project Budget and Fiscal Impact

9.1 Cost Estimates Criteria

9.1.1 Sources of Recognized standards, comparisons, and sources used to develop the estimated cost

The project budget cost estimate was developed collaboratively. Historical cost information was compiled by the consultant team consisting of HDR, Carlson West Povondra Architects, and Building Cost Consultants.

9.1.2 Year and month of estimate, inflation factor(s) used

Cost estimates included were developed July thru November of 2021, reviewed and finalized prior to the final document submitted November 15, 2021.

Recent historical construction inflation in Nebraska since the 2020 Covid19 Pandemic (still in effect) has affected construction material increases significantly. In the Lincoln and Omaha Metropolitan Areas, the construction marketplace continues to experience an unusually high amount of new large-scale projects. This work is in addition to a healthy amount of normal- sized commercial and residential construction. As a result, general contractors are currently experiencing difficulties obtaining adequate subcontractor bids. The industry consequence is a local project construction inflation of approximately 5% annually for the next few years.

An 8% inflation factor has been applied to adjust the 2021 based dollars to the anticipated midpoint of construction (2023). Construction inflation will need to be adjusted if the project is delayed beyond the timelines given in Section 11.

9.1.3 Gross and net square feet

Proposed NSF: 17,106 net sq. ft.

Proposed BGSF: 27,117 building gross sq. ft.

9.1.4 Total project cost per GSF (gross square foot)

\$835/BGSF

(Assumptions: Cost = \$22.65M, BGSF = 27,117)

9.1.5 Construction cost per GSF (gross square foot)

\$627/BGSF

(Assumptions: Construction Cost = \$17.01M, BGSF = 27,117)

96 Specialty Beds at the Reception & Treatment Center – Program Statement

9.2 Total Project Cost

9.2.1 Program Planning

This current Program Statement was proposed by the Carlson West Povondra/HDR Team. Sub-consultants include Building Cost Consultants and CGL, Inc. The total cost for this programming effort is \$156,000.

9.2.2 Professional Fees

Under the heading of support expenses are bundled A/E/ fees, surveys and testing, bidding, and reimbursable expenses. The cost for these items is 9.70% of combined site work and building construction cost estimates. Of this amount 7.75% is allocated for A/E fees. Reimbursable expenses for the A/E Team will vary depending on travel, scope, etc.

9.2.2.1 Professional Design Consultants

Prime and / or local firm (60% of total fee)

9.2.2.2 In-House Consultants

Prime and/or local firm (40% of total fee)

9.2.2.3 Other Consultants

None

9.2.3 Construction

9.2.3.1 General Construction

This project consists of construction of three 32 bed special needs housing buildings on the RTC campus in Lincoln. Two of the buildings are linked together and connected to the southeast end of the Intake housing units.

A third housing building for geriatric inmates is proposed to be added to the new RTC clinic building along an access corridor adjacent to the new medical area.

All three housing buildings and connectors to existing facilities will be constructed as maximum-security units. The proposed construction assumed in the cost estimate is insulated precast panels at the exterior perimeter and unit masonry construction throughout the interior. A protected steel roof superstructure is also envisioned. The housing buildings are planned to be single story with slab on grade floors.

The interiors will be constructed of durable, high abuse resistant materials and finishes. Sliding cell doors will be provided in all housing except at geriatric cells which will consist of swinging doors. Security devices will be provided appropriate to maximum security custody level and will be connected to the new systems at the RTC.

Mechanical, Electrical, Plumbing and Technology Systems will be designed with high security devices and maximum fire & smoke protection.

HVAC systems may consist of gas-fired rooftop units at the two new housing units connected to the Intake units as this may be the most cost efficient and cost-effective solution. A penthouse enclosure for similar systems may be considered to facilitate maintenance. HVAC at the geriatric housing building addition is planned to be connected to systems at the new RTC clinic building.

96 Specialty Beds at the Reception & Treatment Center – Program Statement

9.2.3.2 Fixed Equipment

Costs are included in the project for dayroom beverage bars and medical equipment and other miscellaneous equipment identified in the space program.

9.2.3.3 Site Improvements

Site improvements include earthwork to accommodate the three new housing buildings.

Site utilities consist of relocation of existing utilities and connections to existing utilities located along the service perimeter road.

Storm water management costs are included for the new site development

Concrete work includes flatwork for recreation courtyards, and sidewalks.

Other site work includes exterior lighting, landscaping, and site signage.

9.2.3.4 Moveable Equipment

Fixtures, furniture, and non-fixed equipment are all included in the project budget. Non-fixed furniture will be required only in the Geriatric Housing.

9.2.3.5 Special or Technical Equipment

Systems and equipment for surveillance and security appropriate to the maximum-security level are provided in the project budget incorporated in with the security / technology line item. (B3)

9.2.3.6 Land Acquisition

None State-Owned Land

9.2.3.7 Artwork (for applicable projects)

Not applicable

9.2.3.8 Other Costs

An 8% construction inflation factor is included in the budget.

9.2.3.9 Project Contingency

A 10% project contingency is included in the budget.

96 Specialty Beds at the Reception & Treatment Center – Program Statement

9.2.4 Estimated Project Cost

ESTIMATED PROJECT COST	
I. CONSTRUCTION RELATED COSTS	
A. Sitework	
1. Earthwork / SWM	\$605,000
2. Site Utilities (relocated & new)	\$425,000
3. Pavement (new & demo existing)	\$150,000
4. Fencing (temporary & permanent)	\$60,000
5. Exterior Lighting	\$40,000
6. Landscaping / Site Elements	\$42,000
7. Signage / Miscellaneous	\$15,000
Subtotal	\$1,337,000
B. Building Construction (27,117 BGSF)	
1. General / Architecture	\$9,075,000
2. Mechanical / Electrical / Plumbing	\$5,775,000
3. Security / Technology	\$275,000
4. Fixed Equipment	\$550,000
Subtotal	\$15,675,000
C. Support Expenses	
1. Program Statement	\$156,000
2. Surveys & Testing, A/E Fees, Bidding & Reimbursement Expenses	\$1,650,000
3. Fixtures, Furnishings, Non-Fixed Equipment	\$150,000
4. Commissioning	\$100,000
Subtotal	\$2,056,000
A+B+C Subtotal	\$19,068,000
Inflation to Construction Midpoint (8%)	\$1,525,000
Project Contingency (10%)	\$2,059,000
TOTAL COST	\$22,652,000

96 Specialty Beds at the Reception & Treatment Center – Program Statement

9.3 Fiscal Impact (first full year of operation)

9.3.1 Estimated additional staffing costs per year

The program and mission of this facility was reviewed by NDCS and related agencies. Proposed inmate supervision and support and new programs were considered.

GERIATRIC UNIT										
Position	Day Shift	1st Shift	2nd Shift	3rd Shift	Relief Factor*	Total FTE	Hourly Rate	Annual Salary	Benefits	Total
UNIT OPERATIONS/SECURITY										
Unit Manager	0.33				1.00	0.33	\$28.804	\$59,912	35%	\$80,881
Case Manager	0.33				1.00	0.33	\$26.410	\$54,932	35%	\$74,159
Unit Case Workers		0.33	0.33		1.74	1.15	\$20.000	\$41,600	35%	\$56,160
Unit Sergeants		0.33	0.33		1.25	0.83	\$24.000	\$49,920	35%	\$67,392
Corr. Corporals		1.0	1.0		1.74	3.48	\$20.000	\$41,600	35%	\$56,160
TREATMENT										
TOTAL	2.0	3.0	3.0			6.12				\$334,752

COGNITIVE IMPAIRMENT & MH TRANSITIONAL										
Position	Day Shift	1st Shift	2nd Shift	3rd Shift	Relief Factor*	Total FTE	Salary	Total Salary	Benefits	Total
UNIT OPERATIONS/SECURITY										
Unit Manager	0.66				1.00	0.66	\$28.804	\$59,912	35%	\$80,881
Case Manager	1.0				1.00	1.00	\$26.410	\$54,932	35%	\$74,159
Unit Case Workers		0.66	0.66		1.74	2.30	\$20.000	\$41,600	35%	\$56,160
Unit Sergeants		0.66	0.66		1.25	1.65	\$24.000	\$49,920	35%	\$67,392
Corr. Corporals		2.0	2.0	1	1.74	8.70	\$20.000	\$41,600	35%	\$56,160
TREATMENT										
BH Case Workers		2	2	1	1.74	8.70	\$26.435	\$54,984	35%	\$74,229
LMHP	1				1.00	1.00	\$20.000	\$41,600	35%	\$56,160
TOTAL	2.0	3.0	3.0	0.22		24.01				\$465,141

The plan is broken up into thirds, Geriatric as one third and Cognitive Impairment & MH Transitional as 2/3rd's.

1. The Unit Manager is listed as 1/3 and 2/3 on the two staffing grids. No Relief Factor is applied.
2. The Case Manager is listed as 1/3 and 2/3 on the two staffing grids. No Relief Factor is applied.
3. The Unit Case Worker is listed as 1/3 and 2/3 on the two staffing grids. A 1/74 Relief Factor is applied.
4. The Unit Sergeants are listed as 1/3 and 2/3 on both First and Second shifts. A 1.25 Relief Factor is applied.
5. The Corr. Corporals have 2 staff members covering Third shift. Based on that the grids are using 0.22 and 0.44 respectively. This represents 1/3 and 2/3 of the 2 staff members sharing that shift. A 1.74 Relief Factor is applied.

96 Specialty Beds at the Reception & Treatment Center – Program Statement

9.3.2 Estimated additional programmatic costs per year

None

9.3.3 Applicable building renewal assessment charges

In accordance with Legislative Bill 380 (2011), building renewal assessment charges (per LB1100) have been eliminated.

9.3.4 Estimated Operational Costs Total Summary \$

9.3.4.1 Staffing Costs

\$799,893

9.3.4.2 Operational Costs

\$135,585

9.3.4.3 Maintenance Costs

\$27,117

10.0 Funding

10.1 Total Funds Required

A total of \$22,652,000 is needed to complete this project.

10.2 Project Funding Sources

The proposed funding source is the State General Fund.

10.3 Fiscal Year Expenditures for Project Duration

FISCAL YEAR EXPENDITURES FOR PROJECT DURATION		
YEAR	PURPOSE	AMOUNT
FY 2021	Program Statement	\$156,000
FY 2022	Design / Support	\$1,200,000
FY 2023	Design / Support / Construction	\$10,650,000
FY 2024	Construction / Support	\$10,646,000
TOTAL		\$22,652,000

Note: Support funds include A/E fees (design thru construction phase), testing, surveys, and reimbursable expenses.

This page intentionally left blank.

11.0 Timeline

The timeline for this project assumes an expeditious schedule to reduce the cost of inflation. Timely state legislative approval is required to achieve this schedule. Additional inflation must be added to the project budget if this proposed timeline is extended.

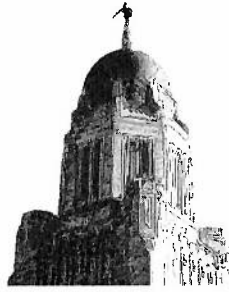
Proposed Project Timeline

1.	Final Draft – Program Statement	October 29, 2021
2.	Program Statement Completion	November 15, 2021
3.	Funding Approved	April 30, 2022
4.	A/E Consultant Selection	June 1, 2022
5.	Design Completed	March 1, 2023
6.	Bidding & Award	April 15, 2023
7.	Begin Construction	May 1, 2023
8.	Midpoint Construction	February, 2024
9.	Construction Substantially Complete	October, 2024
10.	Full Occupancy	November, 2024

This page intentionally left blank

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

July 25, 2022

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

Dear Director Frakes:

The Office of Inspector General has completed an investigation into the fire started by an inmate at the then Lincoln Correctional Center. I have presented our draft report to the Public Counsel and am now providing it to you. According to Nebraska State Statute 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 within the next week so that I could answer any initial questions or discuss any items in the report prior to your required 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,

A handwritten signature in black ink, appearing to read 'Doug Koebernick', written in a cursive style.

Doug Koebernick



Pete Ricketts, Governor

August 8, 2022

Doug Koebernick, Inspector General
P.O. Box 90604
Lincoln, NE 68509-4604

Dear Mr. Koebernick,

I received your report concerning the October 23, 2021 fire at LCC, on July 25, 2022. I appreciate the opportunity to respond to your recommendations, in accordance with Nebraska Statute §47-915.

- Finding #1: Reject
- Finding #2: Accept
- Finding #3: Reject: New behavioral health unit provides options to address the issues raised.
- Finding #4: Reject: Residential mental health beds are not restrictive housing.

Thank you for reviewing this serious incident and providing your opinions. I will again point out that mentioning inmates by name/number is in conflict with Nebraska Statute 83-178. I do take exception to your comment on page 19 that the inmate's assignment to a residential mental health bed was for disciplinary reasons. We do not use housing assignment as a disciplinary sanction.

Respectfully,

Scott R. Frakes, Director
Dept of Correctional Services

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

corrections.nebraska.gov

A handwritten signature in black ink, appearing to read "S. Frakes". The signature is fluid and cursive, with a prominent initial "S" and a long, sweeping underline.

Scott Frakes, Director NDCS

cc: file