FROM THE OFFICE OF THE DIRECTOR
SCOTT R. FRAKES

FOR IMMEDIATE RELEASE
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NEBRASKA DEPARTMENT OF CORRECTIONAL SERVICES
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NDCS releases Tecumseh incident report

Report recommends management improvements, finds staff "responded appropriately"

Lincoln – Today, Nebraska Department of Correctional Services (NDCS) Director Scott Frakes announced the release of the critical incident review (CIR) of the disturbance at the Tecumseh State Correctional Institution (TSCI). Report was authored by Tomas Fithian, Administrator of Security & Emergency Management at Washington State Department of Corrections.

"I greatly appreciate the efforts of Mr. Fithian and the NDCS team that completed this thorough review of the disturbance", said Director Frakes. "The report provides an realistic assessment of the events of May 10-11, and makes recommendations that will enhance operations across the agency. In addition to identifying needed improvements, the report also highlights the courageous actions of staff and in the dedication shown since the disturbance. "

The Critical Incident Review Team report made the following findings:

- Unclear practices for TSCI's over the counter (OTC) pill line contributed to allowing more inmates out of the living units than anticipated by staff
- At the time of the incident, staff "responded appropriately and performed well…"
- The coordinated response by law enforcement and TSCI staff ensured that public safety was never compromised
- Repairs at TSCI must be completed before the facility can return to normal operations

The report also included the following recommendations:

- Improvements to the response team structure and the introduction of a system of phased response
- Additional preventative measures to protect correctional facility staff and approve written tactical plans

- Various physical plant improvements
- Review and revision of policy, procedure, and post orders directing security operations

The Critical Incident Review report also includes:

- Incident summary
- List of major events
- Summary of incident events
- Response to the incident
- Management of the incident
- Causal factors
- Comprehensive list of recommendations

TSCI is currently operating with restricted movement, gradually returning to normal operations. Emergency staffing patterns remain in effect for most of the employees at TSCI, with security staff working 12 hour shifts, 4 days per week.

A formal corrective action plan to address the recommendations of the review team will be completed and published by the end of July. Improvements to practices consistent with many of the recommendations are already underway.

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Critical Incident Review Team

Final Report

Nebraska Department of Correctional Services
Tecumseh State Correctional Institution

A Critical Incident Review of the Events Surrounding the Inmate Disturbance on May 10-11, 2015

June 2015

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Executive Summary

Nebraska Department of Correctional Services (NDCS) is comprised of 10 institutions, Adult Parole Administration, Staff Training Academy, and Cornhusker State Industries.

Each of the 10 institutions serves a specific purpose in the overall management of the inmate population within NDCS. The institutions are:

1. Diagnostic and Evaluation Center (DEC), located in Lincoln, serves as the intake/assignment facility.
2. Nebraska Correctional Center for Women (NCCW), located in York, is the women's intake and housing facility.
3. Nebraska Correctional Youth facility (NCYF), located in Omaha, houses minimum, medium and maximum custody youth inmates. This facility serves as the reception center for all inmates who are 18 years of age and under.
4. Nebraska State Penitentiary (NSP), located in Lincoln, is the oldest facility and houses medium to long-term inmates.
5. Lincoln Correctional Center (LCC), located in Lincoln, houses medium and maximum custody inmates. LCC also manages special populations, such as in-patient mental health, sex offender program, protective custody, as well as a general population.
6. Omaha Correctional Center (OCC), located in Omaha, houses minimum and medium custody inmates.
7. Community Corrections Center – Lincoln (CCCL), located in Lincoln, serves as a co-ed center for minimum custody inmates.
8. Community Corrections Center – Omaha (CCCO), located in Omaha, is a co-ed center for minimum custody inmates.
9. Work Ethic Camp (WEC), located in McCook, is an individualized/specialized program for probationers and parole violators
10. Tecumseh State Correctional Institution (TSCI). *Note: See institution detail below.*

Tecumseh State Correctional Institution (TSCI), located just outside Tecumseh, Nebraska, is a 960 bed facility designated to hold death row*, maximum and medium custody inmates in four separate living units. On the day of the disturbance, the total inmate count was 1,024. With the exception of the Special Management Unit and Death Row, both maximum and medium inmates are housed together in one of three living units.

**Note: The death penalty was administered at the Nebraska State Penitentiary, but inmates sentenced to the death penalty were housed at TSCI. Nebraska repealed the death penalty on May 27, 2015.*

The total number of staff on duty May 10, 2015, 2nd Shift (1400-2200), was 57, of those; six were on voluntary overtime and there was no one on mandatory overtime. The minimum staffing requirement was identified as 61, however, two program areas and two evening recreation periods were prescheduled to be closed that weekend which reduced the number of staff required to 57.

On May 10, 2015, beginning at approximately 1432 hours, and lasting well into the early morning hours of May 11, 2015, TSCI experienced what has been described as a large inmate disturbance. Several hundred inmates, from three living units, the gymnasium, and courtyard refused orders to disperse and started on a destructive 10+ hour rampage.

The uncontrolled inmates assaulted two staff, seemingly ignored warning shots and actual use of deadly force, and essentially entrapped and taunted numerous staff members in buildings overrun by inmates. Throughout the disturbance, inmates severely damaged the interior of multiple buildings, including staff offices and contents, and lit several destructive fires. Upon regaining control of the facility on May 11, 2015, while staff were conducting security and inmate welfare checks, two inmates were found deceased in a living unit that had been besieged by inmates.

The extent of damages are estimated to exceed hundreds of thousands of dollars, and extensive repairs are required before the facility can begin new normal operations. It is difficult to evaluate the long-lasting effects a large disturbance such as this can have on staff, facility and executive management, members of the public, and inmates.

Throughout the incident, there were countless numbers of NDCS and TSCI staff who responded appropriately and performed well, especially in light of extremely difficult circumstances. In cooperation with TSCI staff, local first responders including emergency medical services, fire fighters, sheriff's deputies, state troopers and many others initiated measures to ensure public safety, which was never compromised.

In light of this incident, Director Frakes assembled a Critical Incident Review (CIR) team to review the details surrounding these incidents and to offer recommendations to assist the NDCS and TSCI in post-incident recovery. A thorough critical incident review of any incident or significant event is important in order to recognize systems that functioned well, as well as identify those that may need improvement.

In correctional facilities, emergency management and response is not just something done when an incident or significant event happens, it is a part of the work staff do every day. The presence of a well-organized emergency management system is essential for the reduction of serious prison incidents and the ability to effectively manage them. The initial actions of staff will have a tremendous impact on the overall outcome of any emergency or incident.

Prevention, preparation, response, and recovery are the fundamental elements of any facility's emergency management system. Although a facility can avert many critical incidents through comprehensive prevention and preparedness efforts, some will inevitably occur. Consequently, a facility must be prepared to respond at any time by training all staff on their responsibilities

during an incident or significant event, and ensuring there are sufficient, well-equipped resources to effectively respond.

Regardless of the nature of the incident or significant event, an immediate, well-organized, and managed response is key to attaining a successful resolution. Moreover, for the emergency management program to be effective, all staff must be familiar with the overall program and understand their individual responsibilities. Most importantly, all staff must work together to prevent, prepare for, respond to, and recover from any critical incident.

This critical incident review seeks to identify any causal factors that may have precipitated the incident, analyze the initial response to the first signs of trouble, and evaluate the actions taken to restore order and control. This report seeks to summarize the events and provide recommendations for improvement in order to mitigate such incidents from occurring in the future.

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Incident Summary

Refusal to Disperse

On May 10, 2015, at approximately 1432 hours, multiple inmates are released from living units 1, 2, and 3 for a scheduled medical call-out (over-the-counter medication retrieval). Upon exiting Unit 1, inmate Washington #73519, rather than proceeding to walk to pill line, is seen by the Sergeant Remple (yard supervisor) turning right out of the unit and begin to head out-of-bounds towards Units 2 and 3. Inmate Washington is then joined by several other inmates from Unit 1 who also head out-of-bounds towards Units 2 and 3. This group of inmates, seemingly being led by inmate Washington join a larger group of inmates from Units 2 and 3 and begin to slowly move about the courtyard.

In response to this unauthorized inmate gathering in the courtyard, as well as their refusal to disperse, Case Worker Guern is asked to exit Unit 1 to disperse the group. As the group of inmates continues to move about the courtyard, with a large group now located near the entrance of Unit 2, Case Worker Glass is asked to step out of Unit 2 to direct the group of inmates to disperse. Upon receiving notification that the group of inmates will not comply with orders to disperse, Yard Supervisor Sergeant Remple makes notification to the Shift Supervisor, acting Lieutenant Ulrick for all available staff to respond to the yard.

It should be noted that this event is significant as it serves as the start of the inmate disturbance. Isolation and containment of this incident is not achieved primarily due to the number of inmates involved, staff becoming quickly outnumbered and surrounded, as well as physical plant design.

Staff Assault

Officer Hatzenbuehler is one of the first additional responders to arrive at the largest grouping of inmates, now located near Unit 1. At approximately 1440 hours, Officer Hatzenbuehler and Case Worker Glass attempt to direct inmate Washington #73519 (identified as a leader by inciting others) to a secured holding area when inmate Gooch #65759 steps in and assaults Officer Hatzenbuehler. While on the ground, and attempting to restrain inmate Gooch, Officer Hatzenbuehler is then kicked in the head by inmate Weikle #35769. Sergeant Sears, while assisting officers with restraining inmates Gooch and Weikle, is then assaulted in the back of the head by inmate Zalme #31008.

In response to a large group of inmates ignoring all directives, becoming more violent, and now assaulting staff, at approximately 1442 hours Officer [redacted] fired a warning shot from the tower. In response to the warning shot, the majority of inmates complied with orders to lay down. However, a few inmates simply squatted, attempted to stand up a couple times, and had to be redirected by staff to remain down.

In response to the growing tensions on the yard, all unit staff are notified by Shift Supervisor, acting Lieutenant Ulrick at 1442 hours to secure their unit entry doors, and at 1449 hours to lockdown their units.

Use of Deadly Force

Following the staff assaults and warning shot, while unit staff were attempting to secure the units, unit staff report that multiple inmates in Unit 2, AB gallery and mini yard, and Unit 3, CD gallery and mini yard, were refusing to lock down. This caused staff to have to evacuate the galleries. The majority of inmates in the courtyard were still laying down at this time. In addition, there is one staff member and approximately 25 inmates from Units 1 and 2 in the gymnasium. However at that time, the inmates in the gymnasium were not actively participating in the disturbance.

At approximately 1452, ten minutes after the first warning shot, in what appears to be in response/support of unit inmates refusing to lockdown, all inmates in the courtyard suddenly stand-up and resume walking in large groups around the courtyard. A large group of approximately 20+ inmates begin to walk to the gymnasium entrance. Retrieving a metal sign pole from the yard, the inmates begin to repeatedly strike the gymnasium door and window in an attempt to breach the door/window.

Inside the gymnasium, inmates begin to pick-up a section of metal bleachers and repeatedly strike the door and window also in an attempt to breach the door/glass. In response to what is believed to be a potential hostage taking situation, Officer [redacted] fires a second warning shot from the tower at 1459 hours.

The inmates do not seem to react to the warning shot, and continue to attempt to breach the gymnasium door/window. Meanwhile, numerous other inmates throughout the courtyard area were beginning to circle around staff, in what appears to be an attempt to purposely block escape routes, effectively trapping staff in the courtyard. A couple of staff were able to run to medical, barely able to safely secure the door behind them. However, several staff were still in the courtyard, with what is estimated to be 40+ inmates.

With the large group of inmates in the courtyard now becoming more aggressive and blocking staff exit routes, coupled with the events unfolding in Unit 2 and Unit 3 (see Inmate Disturbance), the Shift Supervisor, acting Lieutenant Ulrick instructs all staff to get off the yard immediately if safe to do so. The staff members in the courtyard make their way to the tower entrance and secure themselves in the tower.

In response to the totality of the circumstances, and fearing for the safety of the lone staff barricaded in an office in the gymnasium, at 1519 hours, Officer [redacted] fires from the tower at inmate Washington #73519, located near the gymnasium door, striking him in the leg. Although inmate Washington falls to the ground, the other inmates do not seem to substantially react (run, lay down, comply, etc.) to the use of deadly force. The group of inmates then pick up inmate Washington and carry him to the medical door where they are instructed by staff to leave him and move away.

After leaving the medical door, the inmates in the courtyard return to circling the courtyard, however, this time with their hands up chanting, “Hands Up – Don’t Shoot”.

Inmate Disturbance

On May 10, 2015, at approximately 1455 hours, following the staff assaults in the courtyard, an unknown number of inmates in Unit 2, AB and mini-yard are reported as refusing to lockdown. This is followed by reports at 1500 hours that potentially 100+ inmates in Unit 3, CD and mini-yard are also refusing to lockdown. In response, staff are forced to retreat from Unit 2 AB and Unit 3 CD galleries and enter their respective control centers.

Left unsecured, inmates in Unit 2 AB and Unit 3 CD begin barricading doors, covering control and gallery windows, moving laundry carts, a floor buffer, chairs, etc. out to the mini yards. Inmate also begin to attempt to disable cameras by covering them with mud, paper, or striking them. The inmates also begin attempting to breach the gallery and mezzanine doors using mop buckets, ironing boards, and broom/mop handles. At approximately 1530, Unit 2 AB and 3 CD mezzanine doors are breached, and inmates began destroying case worker office contents.

Between 1530 and 1600 hours, inmates in both Unit 2 AB and Unit 3 CD begin to start fires in the galleries next to the control centers as well as in the mini yards. Smoke begins to fill the galleries and control centers. In addition, inmates in Unit 2 AB begin attempting to break through the wall that separates galleries A and B, which is successfully breached at 1556. Unit 2 AB inmates then start a fire inside the wall causing large flames and heavy smoke to saturate the galleries and control center. In response to the heavy smoke entering the control center, staff evacuated Unit 2 AB control to Unit 2 CD control at 1614, and then evacuate Unit 2 CD control to case manager’s office at 1634 hours due to smoke entering Unit 2 CD control.

With the smoke continuing to saturate Unit 2 AB, at 1637 hours, Unit 2 AB/CD cell doors are opened by master control and inmates are instructed to evacuate to mini yards. There are now approximately 200+ inmates unsecured in Unit 2. The inmates from Unit 2 CD then begin to start fires in the galleries and mini yard, as well as attempt to breach doors/windows. In addition, the inmates in Unit 2 CD also breached the wall separating galleries C and D, which was then also destroyed by fire.

In total, several hundred (possibly 400+) inmates in Unit 2 ABCD galleries, Unit 3 CD galleries, and the courtyard continue to cause major damage to buildings, furnishing, electronic systems, and infrastructure using fire, homemade weapons, and weapons of opportunity (mops, brooms, ironing boards, file cabinets, etc.). This destructive, riotous behavior continued from approximately 1445 hours May 10th through approximately 0100 hours May 11th at which time staff regained control of the facility and began the process of recovery.

Staff Rescue

In response to several staff trapped in the tower, Unit 2, Unit 3, the gym, and religious services, a staff rescue mission became a top priority for Initial Incident Commander Ulrick and available Special Operations Response Team (SORT) and Correctional Emergency Response Team (CERT) members on site. A tactical plan is discussed, and given the verbal ok from the Incident Commander.

The first priority was the lone female staff barricaded in the gym office. A hurried, ad hoc SORT/CERT squad with lethal weapons performs this rescue.

As more SORT/CERT members and equipment continue to arrive, additional rescues are undertaken that take the team further into the facility which involved more exposure and risk.

The following lists the times, number of staff, and location of rescue:

1. At 1624 hours, 1 staff rescued from the gym.
2. At 1804 hours, 5 staff rescued from Unit 2.
3. At 1813 hours, 1 volunteer and 1 staff rescued from religious services.
4. At 2030 hours, 3 staff rescued from Unit 3.
5. At 2035 hours, 9 staff rescued from the tower (four remained for incident observation).

Inmate Homicide

On May 10, 2015, at approximately 2341 hours, while conducting safety and welfare checks on inmates in Unit 2, AB gallery, staff discovered inmates Peacock #79816 and Collins #71556 deceased on the upper tier of gallery B. The deaths were confirmed on May 11, 2015, at 0316 hours. Appropriate crime scene protocols were established, which included securing the scene pending state patrol arrival and investigation.

It should be noted that the events surrounding the inmate homicides were not within the scope of this critical incident review. The Nebraska State Patrol is the lead investigating agency, and is expected to issue their own independent report.

Chronological List of Major Events

The following chronological list of major events was transcribed directly from incident reports, interviews, camera recordings, command post logs, and additional documentation. Note: some of the times are approximate due to normal discrepancies in times noted on incident documentation.

May 10, 2015

- 1245 hours Visiting, 25 inmates out
- 1315 hours Gym opens, 40 inmates from Units 1A & 2A
- 1400 hours Second shift starts
- 1405 hours Gym half-time, 15 inmates out to units
- 1415 hours Religious services, 29 inmates out
- 1432 hours Over-the-Counter (OCT) medical line called for all three Units
- 1435 hours Officer Hatzenbuehler is called by yard supervisor to escort inmate Washington #73519 to secure holding area
- 1440 hours Tower notices large group, yard supervisor calls unit staff outside
- 1440 hours Unit 2 Case Worker Glass and Officer Hatzenbuehler inform inmate Washington #73519 he is being taken to holding
- 1440 hours More inmates begin to gather outside Housing Unit 1
- 1440 hours Inmate Gooch #65759 struck Officer Hatzenbuehler
- 1440 hours Inmate Weikle #35769 runs over the top of Officer Hatzenbuehler and kicks his head
- 1440 hours ERT call, staff assault in yard, locked Unit F gallery down immediately
- 1440 hours Acting Shift Commander Ulrick reports to Central Control
- 1441 hours Sgt. Sears (ERT Supervisor) is hit in the head by inmate Zalme #31008
- 1441 hours Tower instructed to use bull horn to give inmates directives to assemble a line. The inmates refused directives from the tower
- 1442 hours Shift Commander instructs all available staff need to go to the yard
- 1442 hours Warning shot fired by tower
- 1443 hours Staff notified all units to secure doors, incoming traffic only
- 1445 hours Officer of the Day, Unit Manager Beltz, was contacted by Shift Commander Ulrick informing her of the staff assault and inmates refusing to leave the courtyard
- 1445 hours Beltz and Ulrick agreed to re-call CERT, SORT, CNT and TSCI staff
- 1449 hours Shift Commander advised all staff to secure their galleries
- 1451 hours Tower observes 2 inmates standing outside of Unit 3, calls unit staff
- 1454 hours Unit 2 inmates refusing to lock down
- 1455 hours Large group of inmates in 2 AB yard refusing to lockdown. Instructed to secure doors by Shift Commander.

- 1456 hours Perimeters instructed to watch 2 AB and 3 CD mini yards
- 1459 hours Gym staff notified to tell inmates to get away from windows
- 1459 hours 2nd warning shot fired by tower
- 1500 hours Unit 3 CD inmates refusing to lock down
- 1500 hours CNT is activated
- 1500 hours Yard staff secured themselves in the tower
- 1503 hours Inmates in Unit 2 AB taking out laundry cart and buffer outside
- 1505 hours Inmates in Unit 3 CD barricading
- 1507 hours Gym staff reports securing herself in office
- 1507 hours Staff instructed to lock hatches in control centers
- 1510 hours Shift commander instructs all staff to get off the yard if able
- 1515 hours Inmates have bleacher and are attempting to break gym window
- 1517 hours Inmates outside of gym begin using a no loitering sign to try to break window of gym
- 1518 hours Inmates using mop, broom, and buffer on Unit 3 D door attempting to break window
- 1519 hours Lethal shot fired by tower striking an inmate Washington #73519
- 1520 hours Several inmates bring inmate Washington #73519 to the medical door.
- 1521 hours Unit 3 D inmates using an ironing board to ram glass on door
- 1522 hours Inmates in courtyard ordered to get on the ground, will use deadly force
- 1523 hours Tower begins filming with handheld camera
- 1525 hours Unit 3 CD reports inmates making weapons, 3 staff are secured in control
- 1528 hours Unit 3 CD mezzanine door is breached by inmates
- 1528 hours CNT member [redacted] makes contact with inmates in the gym
- 1530 hours Unit 2 AB mezzanine door open by inmates
- 1530 hours Lt. [redacted] (CERT) arrives at TSCI
- 1533 hours EMS called for inmate Washington #73519
- 1534 hours Unit 3 CD inmates starting fires in both galleries
- 1536 hours Fire started in Unit 3 C gallery – next to control center
- 1539 hours Central advised ambulance arrives
- 1544 hours Unit 2 AB inmates attempting to break down wall separating A and B
- 1550 hours Inmates gained access to the 2A mezzanine covering the camera and gaining access to case managers office
- 1555 hours EMT's at back door of clinic
- 1556 hours Inmates in Unit 2 AB broke wall separating the A and B
- 1600 hours Inmates start fire on Unit 2 D gallery
- 1600 hours Inmate Washington #73519 out via ambulance to hospital
- 1600 hours CNT [redacted] notified and activated by CNT [redacted].
- 1600 hours Beltz arrived at TSCI, acting Lieutenant Ulrick remained initial incident commander
- 1602 hours Unit 2 staff reports fire on wall going into B side.
- 1602 hours Fire alarms are now going off

- 1602 hours Unit 2 staff reports fire growing inside between galleries
- 1607 hours Inmates in Unit 2 A gallery using fire extinguishers as weapons
- 1608 hours Inmates spreading fire in Unit 2 A/B galleries
- 1611 hours Staff report Unit 2 A inmates have put out fire with extinguisher
- 1612 hours Fire continues to grow up Unit 2 A/B wall
- 1614 hours Smoke is entering Unit 2 A/B control heavily.
- 1614 hours Staff evacuated from Unit 2 A/B to C/D control
- 1615 hours Heavy rain/thunderstorm passes through, inmates take cover under shelter
- 1621 hours Ad-hoc SORT team in the courtyard to rescue staff from gym
- 1622 hours Staff report inmates are threatening to come out of the mini yard fence
- 1623 hours Inmates attempting to knock razor wire off the mini yard fences
- 1624 hours Gym staff rescued from the gym and secured in operations
- 1627 hours Unit 2 staff evacuated booth to office due to smoke entering control
- 1634 hours Unit 2 cells opened, inmates told to evacuate to mini yards due to smoke
- 1635 hours Rain/thunderstorm ends, inmates reenter courtyard and mini-yards
- 1638 hours Unit 2 inmates attempting to break doors to gain access to foyer
- 1644 hours Fire department is called
- 1645 hours Perimeter Officer [redacted] fires warning shot into the air
- 1646 hours Third perimeter vehicle placed in service
- 1652 hours Johnson County Sheriff on radio
- 1705 hours Staff told to shut off inmate phones
- 1727 hours Unit 2 A/B mini yard compromised and inmates taking items from mini yards to inmates in courtyard and Unit 3
- 1734 hours Inmates break door in Unit 3 and gain access to the lobby
- 1740 hours SORT (with CERT support) entered the yard from turnkey
- 1740 hours [redacted] in the tower, as authorized by Deputy Warden, shot at an unidentified inmate running from Unit 3 to Unit 2 (through '*no man's land*')
- 1742 hours Remainder of SORT arrives at facility
- 1751 hours Inmates breach Unit 2 door and enter foyer
- 1800 hours CNT [redacted] and Initial Incident Commander Ulrich attempted to negotiate with multiple inmates who refused to identify themselves
- 1804 hours SORT (with CERT support) rescue Unit 2 staff
- 1813 hours SORT (with CERT support) rescue staff and volunteer from religious area
- 1815 hours CNT reports via gym phone, 'diabetics are not doing so well'
- 1818 hours CNT reports via gym phone, 'Inmate has a knife and today is the 'purge', he is going to stab someone'
- 1823 hours Lost phone contact with gym
- 1834 hours CNT reports via gym phone, 'if gym door doesn't come open in 6 minutes I will start stabbing with a homemade weapon'
- 1836 hours CNT reports via gym phone, '5 sex offenders will be stabbed'
- 1840 hours CNT report via gym phone, 'want yard open today'
- 1847 hours NSP CERT arrived at TSCI

- 1900 hours Medical rooms set up as triage rooms in preparations for mass casualty
- 1924 hours CNT is informed phone lines were cut to gym
- 1946 hours CNT is informed that inmates in the gym were trying to make calls all over the institution and that is why the phone lines were cut
- 2020 hours Transfer of command, Warden Gage relieves acting Lieutenant Ulrick
- 2030 hours SORT (with CERT support) rescue Unit 3 staff
- 2035 hours SORT (with CERT support) rescue Tower staff
- 2117 hours 4th perimeter post placed in service
- 2320 hours Hernandez (Victims Assistance Representative) arrives at TSCI
- 2341 hours Two inmates found deceased in Unit 2.

May 11, 2015

- 0023 hours Specialty Teams regain control Unit 2 A/B
- 0042 hours Specialty Teams regain control Unit 2 C/D
- 0056 hours Fire trucks begin to enter facility
- 0100 hours All areas of Unit 2 and 3 back under control of Specialty Teams, inmates secured on mini yards
- 0135 hours Replacement weapon taken to the tower, old weapon out for evidence
- 0138 hours Inmates start fire on the 2D mini yard
- 0155 hours Fire trucks in courtyard
- 0258 hours Fire trucks out of the facility
- 0302 hours Unit 2 and 3 control centers re-staffed and now control units
- 0304 hours State Patrol in courtyard
- 0316 hours Death confirmed for inmates Peacock #79816 and Collins #71556
- 0416 hours Tower reports Unit 2 A/B inmates attempting to start fire in mini-yard
- 0423 hours SORT/CERT enter the gym to secure inmates
- 0432 hours Unit 2 A/B mini-yard reports another fire
- 0728 hours Begin taking inmates out of Unit 2 AB mini-yard
- 0812 hours Gym is full – no more inmates to gym.

Note: There were no further major incidents to list.

Critical Summary of Incident Events

The following section contains a critical summary of details surrounding the incident events, and includes recommendations (if applicable) associated with each event.

1. Over-the-Counter (OTC) Pill Line

   - Multiple inmates are released from Units 1, 2, and 3 simultaneously for OTC.
   - OTC pill line is conducted at the regular pill line window, located outside Medical.
   - Specific inmates are not screened to be let out of the unit for OTC pill line, an honor system is used.
   - OTC pill line occurs when day rooms and mini-yards are open, and recreation, food service, and visiting are also occurring.
   - There are no post-orders or specific policy instructions regarding OTC.
   - OTC pill line is called, which causes inmate movement on the courtyard, when no yard staff are available to monitor movement.
   - The review noted that multiple staff contradicted one another when asked about the 'normal' procedures for OTC movement. Several staff stated one unit at a time is called, other staff noted all units are called at once. Without specific instructions to review, the exact process is unknown.

   Recommendations

   1. Conduct OTC medical pill line in the living units.
   2. Revise the duties and tasks of staff assigned to movement control (courtyard) to ensure ample staff coverage during inmate movement periods.
   3. Develop specific policy procedures and post-orders regarding the delivery of OTC medication.
   4. Ensure that the use of memorandums that establish inmate movement schedules/practice are routed through security/custody channels for approval and dissemination.
   5. Ensure new or modified procedures are added to post orders in a timely manner.

2. All Available Staff Response

   - In response to notification that inmates are refusing to disperse, all available staff are directed to the courtyard.
   - Responding staff are focused on a single inmate, inmate Washington.
   - Responding staff were quickly outnumbered by the inmates, with no additional staff available to assist.
   - Staff working posts identified as Emergency Response Team (ERT) responded to the request for assistance when it was not safe to leave their post.

- Based on the facility custody level, too many inmates may be out at one time compared to the number of staff available to effectively respond to incidents.

Recommendations

1. Consider establishing response and movement posts (16/7) to provide inmate movement coverage and an immediate quick response strike team.
2. As a less effective alternative to establishing response and movement posts, review and revise the posts identified as ERT members so critical post coverage remains (i.e., gym) until areas are secure.
3. Review and implement a system of phased response (Phase 1, Phase 2, and Phase 3).
4. Consider the use of force multipliers (ample quantities of OC, less-lethal options, etc.) for Phase 2 responders.
5. Implement training on first response actions, including isolation and containment as the first priority.
6. Based on custody level and facility staffing, reduce* the number of inmates out of their cells at a given time to enable an effective Phase 2 and Phase 3 response.

   **Note, this recommendation is not meant to limit the programming and idle-reducing activities available to inmates. Rather, the suggestion is to reduce the number of inmates from multiple units participating at a given time.*

3. Staff Assault

- Focusing on removing inmate Washington #73519 from the courtyard, staff failed to recognize the safety and security risks presented by a large group of inmates already refusing to disperse. Staff attempted to control the crowd by controlling a single inmate.
- Staff confronted and attempted to control a large group of inmates without sufficient resources.
- Staff were ill-equipped to safely protect themselves.
- After witnessing the assault, staff failed to immediately isolate and contain the situation, which allowed other inmates to subsequently assault another staff.
- The warning shot fired by the tower, for a short period of time, gained inmate compliance. However, sufficient resources and equipment were not available to capitalize on the situation.

Recommendations

1. Increase the strength of the on-person carry OC spray to 1.3% law enforcement duty aerosol.
2. Consider, in conjunction with establishing response and movement posts (or revised ERT posts) issuing OC spray in larger crowd control quantities (i.e., Mark 9, 1.3% duty aerosol) to posts designated to respond to incidents.
3. Implement training on first response actions, including isolation and containment as the first priority.

4. Add less-lethal options (i.e., 40mm launcher, 12 gauge drag stabilized, OC grenade, etc.) to the tower.
5. Implement policy and procedures that direct staff to immediately control inmate movement following a warning shot resulting in compliance.

4. Attempt to Secure Units

- In response to the events in the courtyard, one staff each from Unit 1 and Unit 2 leave the unit for the courtyard.
- Half of the inmates in Unit 2 (A/B) and Unit 3 (C/D) are out of their cells for dayroom and mini-yard time. Approximately 100+ inmates in each unit are free to move about the gallery.
- While the dayrooms and mini-yards are open, on the day of the incident, approximately 25 inmates are also in the gym, 29 are in the religious area, 25 are in visiting, and 40+ leave the unit for OTC.
- In total, 350+ maximum/medium custody inmates are out of their cells being managed by 14 unit/program area staff.
- Under normal conditions, other available staff would be able to assist in securing the units. For example, two staff that initially responded to the courtyard entered Unit 1 and assisted unit staff in completely securing the unit. However, staff in Unit 2 and Unit 3, which were down by one staff each (who had responded to courtyard), attempted to secure 100+ inmates in each unit but were unsuccessful.

Recommendations

1. Review and revise the posts identified as ERT members so critical post coverage remains (i.e., living units) until areas are secure.
2. Consider reducing the number of inmates that are out for dayroom and mini-yard to a single gallery (i.e., A or B, not A and B).
3. Consider limiting, or reducing, dayroom and mini-yard use to times when major program/activities are not also open.
4. Review the living unit staffing model to ensure sufficient number of staff are available in the right areas. For example, there were 14 staff assigned to the Special Management Unit, where inmates are secured in their cells a majority of the time. In contrast, Unit 2 and Unit 3 are only assigned 4-6 staff, where the inmates are out of their cells a majority of the time.

5. Use of Deadly Force

- The tower officer prepared to use deadly force (if necessary) to protect staff and gain inmate compliance. This occurred after one warning shot and in response to multiple inmates refusing to lock down in Unit 2 and Unit 3, staff being assaulted in the courtyard, and the continued refusal of inmates to disperse.

- A group of 20+ inmates pick up a metal sign pole from the courtyard and begin striking the gym window.
- Shortly after, inmates in the gym pick up a section of metal bleachers and being to ram the gym window and door.
- Knowing that a staff member is trapped in the gym and has barricaded herself in the office, the tower officer fires a second warning shot at 1459 hours.
- Ignoring the warning shot, the inmates continue to attempt to breach the gym window/door from both the courtyard and gym.
- Other inmates in the courtyard become more aggressive and begin to circle around staff and block escape routes.
- In response to the totality of circumstances, in an attempt to quell a riot, at 1519 hours, Officer [redacted] fires a shot that hits inmate Washington #73519 who is located near the gym door.
- The warning shot and the use of deadly force were separated by approximately 20 minutes.

Recommendations

1. Consider adding another officer post (16/7) to the tower during open movement times (i.e., 0600 – 2200).
2. Review the policy on the use of warning shots to ensure they only serve as an imminent warning to the immediate use of deadly force.
3. Add an audible warning system (i.e., alarm) to the tower for courtyard broadcast.
4. Add less-lethal options (i.e., 40mm launcher, 12 gauge drag stabilized, OC grenade, etc.) to the tower.
5. Consider adding a red-dot sight or a scope to the tower weapon to improve accuracy.
6. Consider revising weapons qualification training for tower officers to ensure firing from an elevated position is covered and trained.

6. Multiple Fires

- Inmates in Unit 2, Unit 3, the mini-yards, and the courtyard begin to start fires.
- Inmates gather materials to burn from within their cells, case worker offices, dayroom chairs, and even the sheetrock walls separating the galleries.
- The uncontrolled fires cause heavy smoke that saturates Unit 2 AB & CD and Unit 3 CD control centers and galleries.
- The fires weakened or destroyed gallery door window Lexan.
- The smoke causes staff to evacuate the control booths in Unit 2 AB & CD, and Unit 3 CD.
- The smoke causes central control to open the inmate doors in Unit 2 CD, which were previously secured, doubling the inmates unsecured in Unit 2.

- The smoke, among other things, obscured unit cameras.

Recommendations

1. Review and revise authorized inmate property items to limit flammability and excess paper.
2. Consider relocating the case workers office (and inmate files) to a secured office outside the gallery (i.e., move the office from the mezzanine to the foyer).
3. Consider securing porter/cleaning supplies (i.e., brooms, mops, ironing boards, floor buffer) in the vacated mezzanine space and reinforce/secure access.
4. Revise procedures to ensure only those porter/cleaning supplies that are in use are checked out to inmates, and securely stored when not in use.
5. Review the feasibility of adding smoke evacuation systems (exhaust fans) in the units that are either automatically or manually activated during a fire.
6. Review the feasibility of adding exhaust fans to the unit control centers.
7. Consider adding evacuation/smoke hoods/masks for staff in unit control centers.
8. Review the feasibility of adding escape hatches to unit control centers.
9. Reinforce/harden all exposed window Lexan with security bars.
10. Add handheld cameras to the unit control centers to use, as needed, during incidents occurring in the units.
11. Review the location, housing, and number of fixed cameras located within the units.
12. Review, institution wide, the proper use of fire rated building materials (i.e., replace the sheetrock walls in the galleries with a more secure/fireproof material).

7. Staff Rescue

- The TSCI Emergency Preparedness Coordinator led the tactical planning for staff rescue missions (except the gym rescue).
- The tactical plan for the staff rescue mission was drawn up on a dry erase board, then erased to plan for the next mission.
- The tactical plan is presented verbally to the Initial Incident Commander, who verbally approves.
- The five SORT/CERT members that perform the gym staff rescue enter the facility with deadly force weapons, however, they are not wearing any personal protective equipment.
- The first staff rescue mission occurs at 1624 hours, just shy of two hours after the disturbance began.
- The last staff rescue mission occurs at 2035 hours, six hours after the incident began.
- With the exception of the last staff rescue mission (Unit 3 and the tower) the SORT/CERT tactical plans do not contain a plan for arrest teams.
- Confronted and challenged by inmates outside Unit 2 during the staff rescue mission, the SORT/CERT uses pepper ball guns to attempt compliance.

- After the pepper balls guns fail to gain compliance, an inmate charges the SORT/CERT, in reaction, team members fire both lethal rounds from an assault weapon and less-lethal rounds from the shotgun in addition to physical force to place the inmate on the ground.
- The inmate was ultimately hit with less-lethal rounds fired by the shotgun and not the deadly force option.
- Without an arrest team immediately available, there is a period of time before the inmate is controlled and restrained with flex-cuffs by a single staff member.
- Once the inmate is brought to his feet, he pulls away from the single staff member attempting escort, and was let go.
- Tactical plans did not contain specific language about the rules of engagement or pre-planned use of deadly force, or what progressive force options the team would employ given resistance.
- Without other alternatives considered, SORT/CERT members that entered the institution with riotous, armed inmates that had potential staff/inmate hostages, had tactical plans that did not allow for an immediate escalation of force if necessary.
- By focusing solely on staff rescues, which is a commendable action, tactical plans forced the team members to gain and control the ground all the way to Unit 2 by 1804 hours. However, the failure to secure inmates with arrest teams, or hold ground gained, tactical plans also forced the teams to retreat.
- Tactical plans did not call for the use of chemical agents (i.e., CS gas) or smoke to provide both inmate compliance from a distance and team concealment upon SORT/CERT entering the courtyard area.
- Tactical plans did not call for clearing the courtyard area of inmates (i.e., moving/pushing into a secured area like the big yard or ball field) as team members advanced from unit to unit.
- A full complement of SORT team members (including all equipment) initially recalled at 1445 did not arrive at TSCI until 1742.

Recommendations

1. Ensure (time and circumstances permitting) that all tactical plans are presented in writing for approval.
2. Consider the requirement to gain authorization for the pre-planned use of deadly force (time and circumstances permitting) from an authority higher than the initial incident commander (i.e., Warden, Director).
3. Revise training and protocol to ensure the consistent use of arrest teams for SORT/CERT missions, including staff/hostage rescue.
4. Reevaluate the continued use of pepper ball weapons as they were ineffective in gaining compliance in the multiple situations in which they were used throughout the incident. Consider replacing with the 40mm platform.
5. Revise training and protocol to ensure tactical plans contain rules of engagement for the specific mission at hand, and the rules of engagement are approved.

6. Evaluate SORT/CERT disturbance control training based on modern correctional disturbance control practices, including force options and equipment.
7. Consider the expanded use of chemical agents for SORT/CERT, whether dispersed from the tower, from observers on rooftops, or from gunners to increase compliance, create stand-off distance, and provide concealment.
8. Evaluate the total number of SORT team members needed, factoring in a 75% recall rate due to leave, injury, and/or on duty status [redacted].
9. Evaluate the storage location and process for issuing SORT equipment.
10. Ensure the SORT and CNT team leaders and members lead the development of tactical plans that involve the preplanned use of deadly force/hostage rescue.
11. Reinforce the requirement for all SORT/CERT members to wear mission specific protective equipment (i.e., helmets, ballistic vests, eye protection) before entering the hot zone.

Response to the Incident

Incident Response

The response to the incident includes the initial actions of first responders and subsequent facility activities that immediately follow an incident or significant event.

Incident Response can be divided into five distinct phases with specific actions to be taken identified for each one.

- *Phases I & II* are critical in limiting both the size and complexity of the incident as quick notification and containment prevent incidents from escalating. Once the situation is reported, first responders are dispatched to provide immediate on-scene assistance.

- *Phase III & IV* involve the planning for, and implementing of, a managed response to resolve the incident.

- *Phase V* includes incident demobilization and recovery actions, including both short and long-term strategies.

Phases of Response

Phase I ~ Detect & Notify:

- Immediately after calling for OTC medication line, the yard supervisor detects inmates entering out of bounds areas.
- The yard supervisor notifies unit staff to exit the unit and direct the inmates to disperse.
- Following unit staff reports that inmates are refusing to disperse, the yard supervisor notifies the Shift Commander.

Recommendations

1. Revise facility communications protocols, specifically what information should be provided and announced using the radio system.
2. Designate Central Control as the location to report all incidents and any requests for assistance.
3. Ensure staff making notification of incidents or requests for assistance first notify Central Control.
4. Ensure only the Shift Commander directs available staff to provide assistance.

Phase II ~ Isolate & Contain:

- In response to notification from the yard supervisor, the Shift Commander directs all available staff to respond to the courtyard.

- Responding staff did not take in the totality of the situation, instead focusing on a single inmate.
- Staff attempted to isolate one inmate from the group, based on directives from the yard supervisor, rather than focus on isolating and containing all inmates present in an out of bounds area,
- Responding staff did not attempt to separate non-involved inmates.
- The decision to begin securing inmates in the living unit should have come in response to the ERT call (request for assistance).

Recommendations

1. Implement a system of phased response (Phase 1, Phase 2, and Phase 3).
2. Consider the storage, issue, and use of force multipliers (ample quantities of OC, less-lethal options, etc.) for Phase 2 responders.
3. Implement training on first response actions, including isolation and containment as the first priority.
4. Revise procedures that direct an immediate restricted movement (i.e., dining, gym) or lockdown (i.e., living unit) in response to requests for a Phase 2 response.
5. Compare existing Emergency Response Team (ERT) structure, staffing, equipment, and training to widely accepted practices for maximum/close security institutions.
6. Evaluate the need to establish specialized on duty response staff.
7. Consider more specific, team oriented training for quick response teams, including additional equipment, and designated a sergeant as the team leader/on-site supervisor.

Phase III ~ Evaluate & Plan:

- The Shift Commander, now Initial Incident Commander, begins to direct staff based on events as they developed.
- The Initial Incident Commander makes prompt notification to the Duty Officer and requested additional resources.
- The Initial Incident Commander mobilized additional NDCS resources, however, external resources (i.e., State Patrol, Sheriff, fire) were not immediately requested.
- Although the Initial Incident Commander continuously evaluated the situation and developed and revised plans based on the continuous flow of new information, there were insufficient on-site resources to effectively isolate and contain the disturbance, let alone begin to resolve.
- Written tactical plans were not developed or made available to the Initial Incident Commander.

Recommendations

1. Notify all staff via Central Control radio announcement of the nature and type of the incident and who has assumed the role of Initial Incident Commander.

2. Create, provide, and train to the use of a 'pocket' quick reference guide for both staff and shift commanders for incident/significant event reference (i.e., a checklist and/or step-by-step reference job aid).
3. Ensure tactical plans are developed and presented to the Incident Commander for approval by the SORT leader.

Phase IV ~ Resolve:

Note: *see Management of the Incident (page 26)*

Phase V ~ Demobilize & Recover:

- Upon rescue, employees that were barricaded/trapped were taken immediately for debriefing with incident management team members.
- Facility staffing patterns were adjusted to 12 hour shifts immediately following the incident.
- Specialty Team members remained at the facility to provide support and assistance during recovery operations.
- Immediately following regaining control of the facility, the focus shifted to facility security, staffing, inmate health and safety, controlled movement, and damage assessment.
- Continuous media/public information releases were generated, and the post-incident documentation process began.
- External investigations were coordinated, including the Fire Marshal, State Patrol, Office of the Public Counsel (Ombudsman), and Critical Incident Review.
- The State Patrol began actively conducting the criminal investigation surrounding the inmate homicides.
- Staff and inmates were being interviewed by the State Patrol in the same space, often waiting together in a hallway.
- Although the facility established controlled/restricted movement, as noted during the review team's time at the facility, inmates were observed being escorted without restraints at times, and escorted in close proximity of maintenance contractors, tools and equipment, and staff rest areas.
- Extensive damage assessments and repairs were underway.
- Specialty Team members were asked to secure the units following regaining control of the facility, however, many staff were exposed to smoke and foul odors for extended periods of time.

Recommendations:

1. Develop a formal demobilization plan (i.e., policy, procedures, checklist, and action items) that outlines each and every activity required to ultimately return the facility to a new normal operation, including short term, medium term, and long term recovery strategies.
2. Until ample facility security features are restored to full operation, ensure inmate security and movement is highly controlled, especially when moving through areas that contain contractors, tools, equipment, and staff with force options.
3. Following a critical, traumatic incident, rescued staff should be offered the opportunity to meet with medical, mental health and victim services representative, the opportunity to clean up, and make quick family notification before being debriefed by incident management team members.
4. Ensure inmates and staff interviewed as part of the criminal investigation are kept separate.
5. Create staff incident report expectations and provide training relative to writing clear, concise, legible incident reports.
6. Emphasize the importance of including dates and times in all incident related reports.
7. Ensure staff required to work in hazardous areas are provided appropriate personal protective equipment for the conditions/environment and provide more frequent, ample breaks that offer the opportunity to seek fresh air and water.

Management of the Incident

Incident management includes those activities that follow the formal designation of an Incident Commander, establishment of the Incident Command Post, and subsequent actions taken to manage the response to the expanding incident.

Summary

- Once notification was made that multiple incidents were taking place, and staff were unable to isolate and control the disturbance, command was established in Central Control, and acting Lieutenant Ulrick assumed the role of Initial Incident Commander.
- The Initial Incident Commander was managing both the incident and facility operations for an extended period of time.
- The Initial Incident Commander did not have the opportunity to review tactical plans in detail, and subsequently approved plans based on conversations with the Emergency Preparedness Specialist.
- External NDCS resources were required to effectively resolve the situation. However, due to the location of TSCI, resources were delayed, in some instances, for extended periods.
- Staff were not immediately dispatched to liaison with external mutual aid agencies arriving on facility grounds, which was frustrating to stakeholders primarily due to the lack of information and/or assistance required.
- The Initial Incident Commander established the initial Command Post in Central Control, while the Warden and incident management team established operations in the Warden's conference room.
- There were several situations that question the authority of the Incident Commander. For instance, during the disturbance both Unit Manager Beltz and Deputy Warden Busboom issued orders to staff.
- Staff family members were not contacted and a family center was not established.
- CNT was actively negotiating with inmates and talking to barricaded staff. Command Post made the decision to cut off phone lines due to inmates using phones. CNT communications were abruptly ended without CNT knowledge or input.
- The title *Initial* and *Ultimate*, in conjunction with Incident Commander, has the potential to suppress the authority, specifically the 'perception of authority', of the Incident Commander position.
- Although this incident was considered complex, and the size of both the response and incident management far exceeded the resources of the facility, the transfer of command from the Initial Incident Commander (acting lieutenant) to the Ultimate Incident Commander (Warden) did not take place until 2030 hours, 6 hours after the incident began.

- The Initial Incident Commander performed other duties not associated with the role, such as taking part in negotiations with inmates in conjunction with CNT, and leaving the command post to establish a perimeter post.

Recommendations

1. Announce (facility-wide) the designation (name, time, location) of the Incident Commander.
2. Conduct drills and exercises with mutual aid partners to ensure seamless response and integration with local law enforcement, fire, medical, and media during an incident.
3. Dispatch a liaison officer to meet and brief responding mutual aid agencies.
4. Consider discussing with stakeholders the possibility of integrating external mutual aid resources into the incident command structure (i.e., Unified Command or resources integration)
5. Once sufficient incident management team members arrive at the facility, ensure the Incident Commander relocates (time and circumstances permitting) to the same location (i.e., leave central control and reestablish command in the main command post).
6. Reinforce the expectation that only one person, the Incident Commander, is in charge of the situation. If necessary, transfer command to a higher level authority.
7. During major incidents or significant events, create a facility operations position (i.e., deputy incident commander, branch director) to manage the unaffected parts of the facility allowing the Incident Commander to focus on managing the incident.
8. Consider implementing the Incident Command System (ICS) as the standard incident management process for all incidents and significant events.
9. Meet with mutual aid agencies to discuss strategies for resources sharing and integration.
10. Establish a staff family notification process, and consider working with local organizations to establish a Family Center, where family members can assemble and received information.
11. Ensure the Incident Commander and Crisis Negotiations Team Leader discuss the status of current negotiations, and ensure command decisions that may affect negotiations are discussed with both CNT and tactical teams before taking action.
12. Remove references to the terms *initial* and *ultimate* incident commander. Revise policy, procedure, and training to ensure staff understand the title, delegated authority, and overall responsibilities of an incident commander, regardless of who holds the position.
13. Although there certainly should remain constraints on the number of times a transfer of command takes place in the critical first hour(s) of an incident, consider reviewing when to initiate a transfer of command to a more qualified individual based on incident/event size, scope, and complexity.
14. Reinforce the expectation that the Incident Commander manages the incident, and needs to delegate the authority to another position to manage facility operations.

Causal Factors

Pre-Incident Intelligence

There is very little pre-incident intelligence that leads to an incident such as this occurring. The review team did not hear from staff or inmates that an incident was to occur, or trouble was brewing. However, after the incident, while conducting interviews, a couple staff noted that inmates had grown increasingly upset with the Wellness League and modified yard schedule.

During an interview, Religious Coordinator Tarn Davis stated that Jason Wolters (religious volunteer) reported that before his program started he and some other inmates noticed there were inmates that showed up (in religious services) that didn't look like they belonged. These inmates looked around and then left before the movement period ended.

During an interview, Captain Connelly stated that several inmates that identify as Rastafarian had planned to present a petition to gain greater access to the big yard. This information was not verified, and no such petition was found.

There were no reports of other pre-incident intelligence indicators, such as reduced mainline participation, increased commissary orders, limited family visits, increased staff leave, etc., that are sometimes present before an incident such as this occurs.

Living Conditions

Quality of Interactions:

The review team noted that there were no out of the ordinary complaints referencing staff and inmate professional interactions. Inmates did not discuss any major staff mistreatment or mistrust, and there were no documents reviewed that lead the team to another conclusion. In addition, staff did not report inmate management issues as their primary concern.

Living Conditions:

Based on conversations with unit staff, primarily case workers, approximately 50% of the inmates assigned to a housing unit are somewhat busy a majority of the day (i.e., kitchen, laundry, maintenance, school, visiting, wellness league, etc.).

In addition, several other inmates are commonly assigned work positions that do not involve a great amount of time (i.e., unit porter, trash, etc.). As such, a good percentage of inmates are spending their time in cells, dayrooms, and/or min-yards.

It appears that several inmates have a large amount of time during the day where they are not participating in meaningful activities, such as programming or idleness reducing activities.

It would be beneficial for NDCS and TSCI to explore ways to increase the amount of programming and idleness reducing activities available, and continue to find creative ways for a majority of inmates to participate.

However, as the department and facility continue to explore ways to reduce inmate idleness, administrators must ensure programs such as the inmate wellness league that require strict requirements to join, are not excluding other inmates unfavorably. As programs and activities are developed, there must be a balance between behavioral incentive activities and other activities that allow a majority to participate in.

The review team did hear and read reports that inmates are not happy about the modified yard schedule implemented, and would prefer greater access to the yard for all inmates. In addition, inmates view the wellness league as an incentive program that is unfair and gives a growing majority of the population access to additional recreation time that others do not receive.

Security Practices

The campus is designed to house maximum security inmates, however there is a lack of security features, such as window security bars, electronically controlled locks, response and movement control posts, and internal fencing designed to control inmate movement. Additionally, the walls that were built to separate the galleries (that were damaged and destroyed by fire) were not designed with appropriate security features.

The facility is currently managing both maximum and medium custody inmates, however there is no difference in how those two very different populations are managed. NDCS would benefit from a classification review that considers how best to establish the custody and security level of TSCI. As a part of the classification review, consider the establishment of a close custody and security classification for TSCI, then align resources (staffing, security, programming, etc.) based on other correctional agencies' close custody facilities.

The overall physical plant and security features would benefit from a comprehensive security assessment. Certainly at TSCI, perhaps department wide, consider utilizing a proven methodology (such as a vulnerability assessment) to evaluate each area/function of the physical plant and security systems. Once an assessment is completed, begin with correcting those area/functions proven to be most vulnerable.

Consider reviewing other corrections agencies to determine national widely accepted practices for maximum/close security level prisons such as TSCI focusing on physical plant/security systems, operations, staffing, equipment & training.

Facility Management

TSCI maintains a higher than normal vacancy rate. This review identified that 60 positions out of a total of 431 authorized are considered true vacancies, which drives significant overtime, recruitment, and retention issues.

The review also noted that the use of mandatory overtime to fill vacancies continues to be a concern for staff, which has led to low staff morale. Staff noted during interviews that in some

cases, two or more times per week staff may be faced with mandatory overtime. In addition, staff retention at TSCI is a critical issue that requires a creative solution.

It is important to note that of the 210+ custody staff that are employed at TSCI, over 35% have less than two years of NDCS experience. Including custody staff with a hire date of 2013 to 2015, the percentage grows to nearly 45%. The impact on facility operations, including consistency and standardization, is greatly impacted by a large percentage of inexperienced staff.

Staff report that facility administrators should have a more visible presence throughout the facility. Staff report frustration in discussing issues and bringing forth concerns to administrators.

Administrators made the decision to cancel two program areas and an additional court and gym period for the weekend of the disturbance. This decision was in response to number of staff that wanted the time off to attend school graduation events. In order to allow staff to be on leave, while avoiding the use of mandatory overtime, posts were closed to balance the staffing requirements. In addition, the notification of program and evening recreation cancellation was provided to inmates May 7, 2015, just two days prior to the change.

During the disturbance, case workers' offices were broken into and inmate classification files destroyed. Besides the loss of documentation, inmates were seen reviewing confidential classification studies that contain the specific details surround inmates' crimes. Consider developing and implementing an electronic inmate management system (i.e., electronic files).

Comprehensive List of Recommendations

Physical Plant

1. Add an audible warning system (i.e., alarm) to the tower for courtyard broadcast.
2. Add less-lethal options (i.e., 40mm launcher, 12 gauge drag stabilized, OC grenade, etc.) to the tower.
3. Consider adding a red-dot sight or a scope to the tower weapon to improve accuracy.
4. Consider relocating the case workers office (and inmate files) to a secured office outside the gallery (i.e., move the office from the mezzanine to the foyer).
5. Consider securing porter/cleaning supplies (i.e., brooms, mops, ironing boards, floor buffer) in the vacated mezzanine space and reinforce/secure access.
6. Review the feasibility of adding smoke evacuation systems (exhaust fans) in the units that are either automatically or manually activated during a fire.
7. Review the feasibility of adding exhaust fans to the unit control centers.
8. Consider adding evacuation/smoke hoods/masks for staff in unit control centers.
9. Review the feasibility of adding escape hatches to unit control centers.
10. Reinforce/harden all exposed window Lexan with security bars.
11. Add handheld cameras to the unit control centers to use, as needed, during incidents occurring in the units.
12. Review the location, housing, and number of fixed cameras located within the units.
13. Review, institution wide, the proper use of fire rated building materials (i.e., replace the sheetrock walls in the galleries with a more secure/fireproof material).
14. Conduct a comprehensive security assessment of both the physical plant and security features.

Policy/Procedure

15. Revise procedures to ensure only those porter/cleaning supplies that are in use are checked out to inmates and securely stored when not in use.
16. Conduct OTC medical pill line in the living units.
17. Revise the duties and tasks of staff assigned to movement control (courtyard) to ensure ample staff coverage during inmate movement periods.
18. Develop specific policy, procedures, and post-orders regarding the delivery of OTC medication.
19. Ensure that the use of memorandums that establish inmate movement schedules/practices are routed through security/custody channels for approval and dissemination.
20. Ensure any new or modified practices are added to post orders in a timely manner.

21. Based on custody level and facility staffing, reduce the number of inmates out of their cells at a given time to enable an effective Phase 2 and Phase 3 response.
22. Implement policy and procedures that direct staff to immediately control inmate movement following a warning shot resulting in compliance.
23. Consider reducing the number of inmates that are out for dayroom and mini-yard to a single gallery.
24. Consider limiting, or reducing, dayroom and mini-yard use to times when major program/activities are not open.
25. Review the policy on the use of warning shots to ensure they only serve as an imminent warning to the immediate use of deadly force.
26. Review and revise authorized inmate property items to limit flammability and excess paper.
27. Ensure (time and circumstances permitting) that all tactical plans are presented in writing for approval.
28. Consider the requirement to gain authorization for the pre-planned use of deadly force (time and circumstances permitting) from an authority higher than the initial incident commander (i.e., Warden, Director).
29. Revise facility communication protocols, specifically what information should be provided and announced using the radio system.
30. Designate Central Control as the location to report all incidents and any requests for assistance.
31. Revise procedures that direct an immediate restricted movement (i.e., dining, gym) or lockdown (i.e., living unit) in response to requests for a Phase 2 response.
32. Create, provide, and train to the use of a 'pocket' quick reference guide for both staff and shift commanders for incident/significant event reference (i.e., a checklist and/or step-by-step reference job aid).
33. Ensure tactical plans are developed and presented to the Incident Commander for approval by the SORT leader.
34. Notify all staff via Central Control radio announcement of the nature and type of the incident and who has assumed the role of Initial Incident Commander.
35. Develop a formal demobilization plan (i.e., policy, procedures, checklist, and action items) that outlines each and every activity required to ultimately return the facility to a new normal operation, including short term, medium term, and long term recovery strategies.
36. Dispatch a liaison officer to meet and brief responding mutual aid agencies.
37. Establish a staff family notification process, and consider working with local organizations to establish a Family Center.
38. Remove references to the terms *initial* and *ultimate* incident commander. Revise policy, procedure, and training to ensure staff understand the title, delegated authority, and overall responsibilities of an incident commander, regardless of who holds the position.
39. Consider reviewing when to initiate a transfer of command to a more qualified individual based on incident/event size, scope, and complexity.

Staff Training

40. Ensure the SORT and CNT team leader and members lead the development of tactical plans that involve the preplanned use of deadly force/hostage rescue.
41. Ensure the Incident Commander and Crisis Negotiations Team Leader discuss the status of current negotiations, and ensure command decisions that may affect negotiations are discussed with both CNT and tactical teams before taking action
42. Reinforce the requirement for all SORT/CERT members to wear mission specific protective equipment (i.e., helmets, ballistic vests, eye protection) before entering the hot zone.
43. Announce facility-wide the designation (name, time, location) of the Incident Commander.
44. Reinforce the expectation that the Incident Commander manages the incident, and needs to delegate the authority to another position to manage facility operations.
45. Implement training on first response actions, including isolation and containment as the first priority.
46. Conduct drills and exercises with mutual aid partners to ensure seamless response and integration with local law enforcement, fire, medical, and media during an incident.
47. Create staff incident report expectations and provide training relative to writing clear, concise, legible incident reports.
48. Emphasize the importance of including dates and times in all incident related reports
49. Implement training on first response actions, including isolation and containment as the first priority.
50. Consider revising weapons qualification training for tower officers to ensure firing from an elevated position is covered and trained.
51. Revise training and protocol to ensure the consistent use of arrest teams for SORT/CERT missions, including staff/hostage rescue.
52. Revise training and protocol to ensure tactical plans contain rules of engagement for the specific mission at hand, and the rules of engagement are approved.
53. Evaluate SORT/CERT disturbance control training based on modern correctional disturbance control practices, including force options and equipment.
54. Ensure staff making notification of incidents or requests for assistance first notify Central Control.
55. Ensure only the Shift Commander directs available staff to provide assistance.
56. Consider more specific, team oriented training for quick response teams, including additional equipment, and designated a sergeant as the team leader/on-site supervisor.
57. Consider implementing the Incident Command System (ICS) as the standard incident management process for all incidents and significant events.

Administrative

58. Consider establishing response and movement posts (16/7) to provide inmate movement coverage and an immediate quick response strike team.
59. As an alternative to establishing response and movement posts, review and revise the posts identified as ERT so critical post coverage remains (i.e., gym, living units) until areas are secure.
60. Review and implement a system of phased response (Phase 1, Phase 2, and Phase 3).
61. Consider the use of force multipliers (ample quantities of OC, less-lethal options, etc.) for Phase 2 responders.
62. Increase the strength of the on-person carry OC spray to 1.3% law enforcement duty aerosol.
63. Consider, in conjunction with establishing response and movement posts (or revised ERT posts) issuing OC spray in larger crowd control quantities (i.e., Mark 9, 1.3% duty aerosol).
64. Consider discussing with stakeholders the possibility of integrating external mutual aid resources into the incident command structure (i.e., Unified Command or resources integration)
65. Once sufficient incident management team members arrive at the facility, ensure the Incident Commander relocates (time and circumstances permitting) to the same location (i.e., leave control and reestablish command in the main command post).
66. Reinforce the expectation that only one person, the Incident Commander, is in charge of the situation. If necessary, transfer command to a higher level authority.
67. Meet with mutual aid agencies to discuss strategies for resources sharing and integration.
68. During major incidents or significant events, create a facility operations position (i.e., deputy incident commander, branch director) to manage the unaffected parts of the facility allowing the Incident Commander to focus on managing the incident
69. Add less-lethal options (i.e., 40mm launcher, 12 gauge drag stabilized, OC grenade, etc.) to the tower.
70. Ensure staff required to work in hazardous areas are provided appropriate personal protective equipment for the conditions/environment and provide more frequent, ample breaks that offer the opportunity to seek fresh air and water.
71. Review the living unit staffing model to ensure sufficient number of staff are available in the right areas.
72. Consider adding another officer post (16/7) to the tower during open movement times (i.e., 0600 – 2200).
73. Following a critical, traumatic incident, rescued staff should be offered the opportunity to meet with medical, mental health and victim services representative, the opportunity to clean up, and make quick family notification before being debriefed by incident management team members.
74. Ensure inmates and staff interviewed as part of the any investigation are kept separate.

75. Until facility security features are restored to full operation, ensure inmate security and movement is highly controlled, especially when moving through areas that contain contractors, tools, equipment, and staff armed with force options.
76. Reevaluate the continued use of pepper ball weapons as they were ineffective in gaining compliance in the multiple situations in which they were used throughout the incident.
77. Consider the expanded use of chemical agents for SORT/CERT, whether dispersed from the tower, from observers on rooftops, or from gunners to increase compliance, create stand-off distance, and provide concealment.
78. Evaluate the total number of SORT team members needed, factoring in a 75% recall rate due to leave, injury, and/or on duty status.
79. Continue to explore ways to increase the amount of programming and idleness reducing activities available.
80. Conduct a classification review that considers how best to establish the custody and security level of TSCI.
81. Consider developing and implementing an electronic inmate file management system.
82. Evaluate the storage location and process for issuing SORT equipment.
83. Compare existing Emergency Response Team (ERT) structure, staffing, equipment, and training to widely accepted practices for maximum/close security institutions.

Acknowledgements

While this report does not express the many examples of bravery, professionalism, and attention to detail exhibited by several of the TSCI staff throughout the incident, it is important that these are not lost in the review presented in this report.

Shift Commander Sergeant Ulrich, serving as an acting Lieutenant and with only five years of NDCS experience, quickly assumed the role of Initial Incident Commander and remained in command for nearly six hours. Although the incident escalated quickly, large portions of the facility were overrun by inmates, and multiple staff were trapped, Sergeant Ulrich continued to issue clear directives, notified appropriate staff and responders, and remained committed to ensuring staff were safe. Further, Sergeant Ulrich took responsibility for his actions, even under extremely difficult situations. Sergeant Ulrich was required to make decisions under great pressure, many of which had no clear precedence, and his actions no doubt prevented further staff injuries or possible hostages.

Sergeant Remple, working a voluntary overtime shift and serving as the Yard Supervisor for the first time, after calling medical line immediately noticed something was out of the ordinary. Sergeant Remple recognized that inmate Washington #73519 was out of bounds, identified him as a leader of the crowd, and immediately called for staff to respond. Further, Sergeant Remple kept the Shift Commander informed, and called for additional responders for assistance. Although responders were unable to overcome the resistance of such a large group of inmates, had Sergeant Remple not immediately noticed something unusual and made notification, the number of inmates unsecured in the courtyard and living units could have been substantial greater.

The Special Operations Response Team, Correctional Emergency Response Teams, and Crisis Negotiations Teams, who placed themselves into harm's way to conduct multiple staff rescue operations. Although there are lessons to be learned from their operations, it is important to highlight that all TSCI staff were rescued by Specialty Team members, and excluding the initial staff assaults in the courtyard, no additional staff were physically injured by inmates during the disturbance.

Lastly, the staff that were trapped for hours in offices, tower, gym, food service, and religious services, who endured actual and perceived violent threats posed by inmates, witnessed the events unfolding right before them, and who had to be rescued to safety, their dedication to public safety does not go unnoticed. Although all correctional professionals understand the inherent danger and risks to personal safety that come from working in our business, no correctional worker imagines it would manifest into such a personal reality. They endured situations that one cannot always prepare for, yet continued to stay alert and aware, maintained both a facility and personal safety and security mindset, and provided invaluable information to both incident management and response teams throughout the ordeal.

It is important to recognize that the staff from Tecumseh State Correctional Institution, many of whom not only endured this incident from the onset and remained on duty for a countless number of hours, continue to arrive for each and every shift to manage the recovery and return to new normal. It was evident to the review team that TSCI staff are dedicated, hardworking, professional individuals who are committed to making TSCI better than it was before.

In closing, the review team sincerely appreciates Warden Gage and all TSCI staff who seemed to welcome the opportunity to determine the facts surrounding this incident, and collectively seek ways to improve operations. The review team was met with professionalism, pleasure, and an attitude of assistance throughout our time at the facility.