NEW YORK CITY
BOARD OF CORRECTION

March 10, 2020 PUBLIC MEETING MINUTES

ATTENDEES

MEMBERS PRESENT
Jacqueline Sherman, Interim Chair
Stanley Richards, Vice-Chair
Robert L. Cohen, M.D.
Felipe Franco
James Perrino

Margaret Egan, Executive Director

MEMBERS ABSENT
Florentino Hernandez
Jennifer Jones Austin, Esq.
Michael J. Regan
Steven M. Safyer, M.D.

DEPARTMENT OF CORRECTION
Cynthia Brann, Commissioner
Hazel Jennings, Chief of Department
Brenda Cooke, Chief of Staff
Heidi Grossman, Deputy Commissioner for Legal Matters/General Counsel
Kenneth Stukes, Bureau Chief of Security
Peter Thorne, Deputy Commissioner of Public Information
Steven Kaiser, Executive Director of Policy and Intergovernmental Affairs
Fabrice Armand, Director of Strategic Partnerships & Community Engagement
Richard Bush, Senior Correctional Institutional Administrator
Patrick Rocchio, Press Officer
Al Craig, Correction Officer
Henry Nelson, Correction Officer

NYC HEALTH + HOSPITALS - CORRECTIONAL HEALTH SERVICES
Patsy Yang, DrPH, Senior Vice President
Ross MacDonald, MD, Chief Medical Officer, Sr. Assistant Vice President
Benjamin Farber, Chief of Staff
Carlos Castellanos, Chief Operations Officer/Deputy Executive Director
Nancy Arias, RN, Chief Nursing Officer/Deputy Executive Director
Zachary Rosner, MD, Associate Executive Director

Jennine Ventura, Director of Communications and Public Affairs

OTHERS IN ATTENDANCE
Jennifer Parish, Urban Justice Center
Victoria Phillips, UJC/Jails Action Coalition (JAC)
Lauren Wilfong, JAC
Keiler Beers, JAC
Camron Ruffa, JAC
Anna Meixler, JAC
Bridget McCarthy, JAC
Herbert Murray, JAC
Gregory Williams, JAC
James Abro, JAC
Frances Geteles, Asylum Network of Physicians for Human Rights (PHR) and NY Campaign for Alternatives to Isolated Confinement (CAIC)
Brandon Holmes, Just Leadership USA
Harvey Murphy, Just Leadership USA
Tamika Graham, Just Leadership USA
Sarita Daftary-Steel, Just Leadership USA
Jack Beck, HALT Solitary Campaign
Kayla Simpson, Legal Aid Society Prisoners' Rights Project
Kelsey De Avila, Brooklyn Defender Services (BDS)
Claudia Forrester, BDS
Jasmine Paez, Bronx Defenders
Claudia Forrester, Bronx Defenders
Martha Grieco, Bronx Defenders
Tahanee Dunn, Bronx Defenders
Grace Li, New York Civil Liberties Union
Alana Sivin, NYC Council
Tanya Krupat, The Osborne Association
Scott Corn, New York-Presbyterian Hospital
Darlene Jackson, Bronx CB9
Deanna Paul, Wall Street Journal
Michael Tashji, Juvenile Justice Information Exchange
Nicole Hong, New York Times
Shanel Dawson, Spectrum News NY 1
Courtney Gross, Spectrum News NY 1
Jocelyne Chen, Independent

AGENDA AND PUBLIC VOTES

1. Approval of February 11, 2020 Minutes (March 10, 2020 BOC Public Meeting Transcript ("Transcript"), at page 3)
    - After the item was moved and seconded, the minutes were unanimously approved, 5-0 (Interim Chair Sherman, Vice-Chair Richards, and Members Cohen, Franco, and Perrino).

2. Update on Restrictive Housing Rulemaking (Transcript, p. 3)

3. DOC and CHS Presentation on COVID-19 Preparedness and Planning (Transcript, p. 6)[1]

4. DOC Update on Body Scanner Training Corrective Action Plan (Transcript, p. 25)

5. Public Comment on Variance Request (Transcript, p. 44)

6. Limited Variance Request to BOC Minimum Standard § 1-17(d)(2) (Seven-Day Waiver) (Transcript, p. 79)[2]

    - DOC withdrew its Seven-Day Waiver Variance Request at the public meeting.

7. CHS Update (Transcript, p. 84)[3]

8. Public Comment (Transcript, p. 113)

A video recording of the meeting is available at:
https://www.youtube.com/watch?time_continue=4774&v=n9jKeQz0Nsg&feature=emb_title

[1] DOC and CHS's Presentation re COVID-19 Preparedness Planning is available here:
https://www1.nyc.gov/assets/boc/downloads/pdf/covid_19_doc_preparedness_planning_ppt_final.pdf
[2] DOC's variance request is published here:
https://www1.nyc.gov/assets/boc/downloads/pdf/Meetings/2020/March/March%202020%20Seven-Day%20Waiver%20Variance%20Request.pdf
[3] CHS's Power Point Presentation is available here:
https://www1.nyc.gov/assets/boc/downloads/pdf/chs_boc_presentation_final.pdf

NEW YORK CITY

BOARD OF CORRECTION

BOARD MEETING

ACS Children's Center Auditorium

492 1st Avenue

New York, NY 10016

March 10, 2020

9:00 a.m. - 11:45 a.m.

March 10, 2020

MEMBERS PRESENT:

Jacqueline Sherman, Interim Chair

Stanley Richards, Vice-Chair

Robert L. Cohen, M.D., Member

Felipe Franco, Member

James Perrino, Member

Margaret Egan, Executive Director

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(The public board meeting commenced at 9:00 a.m.)

MS. JACQUELINE SHERMAN: Good morning. We're going to start the meeting, and our scheduled business today will start with a vote on the draft February 11, 2020 Board meeting minutes, which Board members have received. Does a Board member wish to move for a vote to approve the minutes?

MR. JAMES PERRINO: So moved.

MS. SHERMAN: Thank you.

MR. RICHARD STANLEY: Second.

MS. SHERMAN: Are there any edits or questions? Okay, then I'll ask for a vote to approve the February 2020 minutes.

MR. RICHARDS: Approve.

MR. PERRINO: Approve.

MR. FELIPE FRANCO: Approve.

DR. RICHARD COHEN: Approve.

MS. SHERMAN: Okay. By a unanimous vote, the minutes have been approved. We are going to move now to an update on the restrictive housing rulemaking. As many of you know, the

Board's public comment period for the restrictive housing rulemaking ended on January 31, 2020. We received 54 written comments and ov-, and over the two public hearings in December, we received comments from an additional 59 people. The videos and transcripts from those hearings are available on the Board's website. The public comment period raised challenging questions around safety, accountability, health and mental health and the humane treatment of New Yorkers. While there's divers-, still diversity of opinion about the path forward, all parties agree that we need a new discipline model in the Department of Correction. There is broad consensus in this room and across the city that the model of repeated and prolonged isolation does not work to change behavior and make the jails safer. Many commenters told us of the ways the punitive segregation harmed them or their loved ones, both mentally and physically.

While this Board proposed that would have greatly limited the use of punitive segregation, we now understand that this city can

and should do even more to keep people in custody and staff safe in the jails while treating everyone humanely. Considering this shift in our focus, the next step in our process is to further engage with stakeholders for the next six weeks. We will provide a detailed update at the next Board meeting. And now I am going to move to the next item on our agenda. Dr. Cohen?

DR. COHEN: It's a, it is a problem that we are not moving forward at this point. I'm, I'm, I'm hopeful that, that, that we will, but it's not up to the stakeholders to move this process forward at this point. It's up to, it's up to the city of New York to, to, to join actively in, in the process and there are reasons why people are busy at this period of, of, of time, but the, the questions before us are, should be, should be, you know, should have been engaged and I, and I, and I -- we shouldn't come back again in six weeks without having something very well formulated. And in, in the process of, of changing the, the city's policy on solitary confinement, the, the, the leadership is going to

have to come from the, from the city. They, they -- and, and not making decisions to support this process, delays it and, and, and causes harm. So I, I hope that we, that we move forward quickly. It's, it's sad that we have not made the progress that we, that we should have up to this point, thank you.

MS. SHERMAN: Thank you. So we are going to move now to an update from the Department and Correctional Health Service on the coronavirus plans. I'll, I'll just say while there are now a number of confirmed coronavirus cases in the New York City area, there have not been any confirmed cases in the New York City jails. If coronavirus further reaches New York City, the city can expect to see it reach the jails. On March 3rd, the Board sent a detailed letter to CHS and DOC requesting information regarding their plans. We have requested CHS and DOC brief the Board today on their efforts to prevent the transmission of the coronavirus in the jails and maintaining the health and safety of staff and people in custody.

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In 2009 and 2010, during the H1N1 pandemic, the Board received regular public and private briefings from DOC and CHS about their efforts to prevent transmission. We expect to continue this tradition of public dialogue over the coming months as necessary. In 2009 and 2010 CHS and DOC effectively prepared for a severe pandemic. However, the impact was not as serious as feared. At the end of the H1N1 crisis, the Board applauded DOC and CHS's work to prevent transmission in the jails. We look forward to working with and supporting DOC and CHS in their efforts to prevent the spread of the coronavirus. We'll now ask the agencies to present their ongoing work. Thank you.

COMMISSIONER PATRICIA FEENEY: Good morning. I'm Patricia Feeney, the Deputy Commissioner for quality assurance and -- thanks. Okay, I'll start again. I'm Patricia Feeney, the Deputy Commissioner for quality assurance and integrity for DOC and it's my pleasure to meet with you this morning to update you on our preparations and our plan for COVID-19. The

Department has worked very closely with our partners in CHS, DOHMH and other members in city government to walk through various emergency scenarios designed to test our readiness and ability to address the COVID-19 virus.

Part of our plan has been to implement and im- implement training and increase our sanitation in various areas throughout the Department, so all of our housing units, dayrooms and common spaces are cleaned daily, our showers are cleaned three times a day, all of our vehicles will be cleaned daily, the transportation buses and vans to ensure that we're killing any virus that might be present. And the Environmental Health Unit has been doing specific trainings for each of the work details and the institutional aides and our DOC staff to make sure that everybody knows what is expected of them when they are doing the, the daily cleaning and the cleaning of the buses.

In addition to that, we've had a lot of educational communications with both staff and persons in custody. We've used posters, in-

person meetings. I have some of the posters up here that are, that are out there. We have public service announcements that are being made and we're stressing hand washing correctly is the number one way to protect yourself against the COVID-19. We are ensuring that everybody knows our expectation is that the sanitation is going to be done and that anybody who is ill will be referred to be seen by our medical provider, and that any staff members who are ill are expected to stay home and not come to work when you're not feeling well.

We also are in content, constant phone contact with our with our partners and our communication messages also have been posted in our visit house and on our website so the member of the public and the, the staff are aware of the actions that we take, we are taking and what their precautions are. We have a few other posters up here that are being posted, saying if you have flu-like symptoms, fever, coughing, shortness of breath, if you've recently traveled to an area or have been in close contact with

someone who has, go to your doctor and you know if you're, if you're not well just stay home.

We have an appropriate amount of supplies on hand for both personal protective equipment that we expect that anybody who's doing cleaning will wear and we will follow CDC and DOHMH recommendations as to the use of personal protective equipment going forward.

And I think the other message that we're, we're getting out is to keep social distancing, so whenever possible we don't want people standing on top of each other, we don't want folks sitting on each other's beds and, and we're working hard to get that message out as well. So those are the, the highlights of our, of our plan to date.

DR. ROSS MACDONALD: Thanks, Commissioner. Ross MacDonald, CMO for CHS. So CHS, our primary response has been screening at every touch point. So as you know we're live in all the e-pass locations and pre-arraignment, which gives us an opportunity to screen and refer for evaluation before a person would come into

custody, as well in our intake with our electronic health record, we're able to update our screening questions in real time as the recommendations change for what we should be looking for. And we've been in constant communication with our clinical staff, as well as our partners in DOC and DOHMH and our partners at Health and Hospitals. You know, we're lucky to have, to be part of the public, public hospital system of the city, who is among the most expert in the country at dealing with communicable diseases such, such as this. So and we also have implemented different types of screening for, for patients in our healthcare delivery system, including the monitoring of any fever in the system, which will trigger a higher level of review and evaluation for the symptoms underlying that, if there's an alternative explanation.

And as many of you know we're much better positioned than other jails around the country, in terms of the physical plant with our communicable diseases unit, which is an area where people can be isolated for evaluation while

we observe their clinical course and do any appropriate testing that might be needed.

MR. PERRINO: Hello. The normal procedure is the detainee comes in, gets searched, goes in a pen with everybody else, and you know, in a certain amount of time, definitely within 24 hours, he's being seen by medical. And then he's housed, or she's housed. Is it possible before this individual actually goes into a pen with several different people, sometimes hundreds, can a doctor see them before they even engage with other detainees? So I mean right now we're good, but one person sick in a pen of 100 detainees could cause a really serious problem.

DR. MACDONALD: So I think I'll defer to DOC. I mean I think that there has been additional communication to DOC officers to expedite anyone who's experiencing symptoms at any point along the process. As I mentioned, we're seeing everybody in screening at pre-arraignment which would be far upstream of, of that point.

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MR. PERRINO: Right, I understand that and I know DOC is on it and if someone's sniffling, but DOC don't have the experience of a doctor and maybe the symptoms right off the bat. You know what --

DR. MACDONALD: So, I would just point out that, you know, I think there's a general awareness that we all need to have in, in these situations. And it's not necessary for a doctor to be doing that evaluation. I think all people in New York City need to use common sense and, and, and get help and raise a flag and know what to do if they're concerned about someone. So that's been our focus. And I think DOC has communicated that to their staff.

CHIEF HAZEL JENNINGS: So good morning, so one of the things that we've done a little differently is at the courts, because it starts there. We're required to ask a person if they're sick or injured prior to taking custody. And if they are then the agency which is delivering has the obligation to take that person for medical care to the hospital or for the screening. And

when they come in, they come in with what's called a prisoner movement slip and medical documentation if they have been sick and injured.

However, on our paperwork when we are interviewing a person, there is a, a space or one of the boxes which talks about flu-like symptoms. And so the plan will be if that person says yes, that they will be issued a mask, they will be isolated from all the persons. And then there's notification that will happen to H+H operations, the facility in which the person is going to and special trans, where that person will be transported separate and apart from all others so that when they arrive into the facility, the medical staff will already be alerted that the person is coming so that they can go in to see a swift medical attention, so that is our plan.

MR. PERRINO: So, so, chief, so if someone does say yes, medical's ready at the door and they're going --

CHIEF JENNINGS: So this is why the notification has to be done prior to, that we do have a person that will be coming in with flu-

like symptoms, so that they can be sep-, they'll be transported separate and apart and at the arrival of the facility, the medical staff will be ready to see that person.

MR. RICHARDS: A couple of questions. What's the capacity for the isolation? How many how many cells do we have with the negative air or negative pressure for containment?

CHIEF JENNINGS: So we have approximately 28 cells for negative pressure. However we have 88 cells at the CDU unit.

MR. RICHARDS: Those are the, they're the same? Is it --

CHIEF JENNINGS: So there is some different, but we have the ability to isolate a person and where they're contained.

MR. RICHARDS: So, 88. How, how are you handling officers, you're telling people if they're not feeling well to stay home. How is the Department handling officers who stay home and don't have sick time and --

CHIEF JENNINGS: So, so, currently our staff has unlimited sick time and that when

they're out over a certain amount of days, they have to report to HMD and they have to be cleared by their medical doctor and HMD prior to returning to work.

MR. RICHARDS: Great.

MS. HEIDI GROSSMAN: I, I, I just also add, I would just also add that we've been receiving guidance from the Law Department and from our partners on how to handle individuals who are in need of staying home, if there is a diagnosed case, whether people might, they would not need to necessarily use their accumulated leave to stay out. But there, there are all sorts of guidance that we've received them we're going to be following that guidance.

MR. RICHARDS: Great. And the final question is Chief Perrino talked about the courts. I know the pens, 50 people in the pens. Are you doing, increasing the number of transportation buses available so you have smaller numbers of people in pens? How are you handling that kind of issue?

CHIEF JENNINGS: So we have increased

our sanitation, but effective January 1, with all of the reforms that we have been doing our new admission processing in itself has decreased significantly.

MR. RICHARDS: But I'm talking about courts.

CHIEF JENNINGS: So, so we're talking about courts. So we went from an average of anywhere from nine to 1,200 people going to court to now we're only averaging anywhere from four to five persons going to court on a daily basis.

MR. RICHARDS: Wow, that's great. Thank you.

MS. SHERMAN: I have a cou-, a cou-, --

CHIEF JENNINGS: You need me back?

MR. PERRINO: No, Chief, this is for Commissioner Feeney. I know cleanliness, disinfecting over and over again, I'd just like to say just a comment. Working for you for many years, the Department and the city couldn't have a better person in place. You've kept me up many nights as a warden, just trying to get my kit place clean and you taught me a lot of stuff, and

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I feel very confident with you being behind the wheel, so I just want to make a comment.

COMMISSIONER FEENEY: Oh, thank you very much I appreciate it.

MS. SHERMAN: I ha-, I have a couple of questions, starting with steps that are being taken to screen or provide information to visitors to the jails.

MS. GROSSMAN: Yes, we just recently received some guidance from the State Commission of Correction that requires all jails and prisons to do screening of visitors, and so we've been working around the clock to make sure we are able to implement. It could be implemented as soon as tomorrow. I think the overriding principles that we saw from the slides are if people are feeling flu-like symptoms, if they are experiencing coughs, fever, shortness of breath they should be thoughtful about whether they should be coming for a visit. If people are symptomatic, the plan is to have people, we would not allow entry for a visit. But we are working around the clock to make sure that we get this plan implemented and

we will keep the public apprised as we have our final plans.

MS. SHERMAN: So thank you and that relates to a second question that I have, which is could you speak a little bit more to steps that have already been taken to apprise the public of DOC and CHS's plans and plans for future steps to ensure that the public stays informed?

MS. GROSSMAN: Sure, I think that I'll, I'll pass it on to DC Feeney, but we do have information and notifications on our website about our visits and we expect to update those websites as information comes in. And it's a very fluid situation, so as information comes in and we have to update, we will work with our IT division and make sure that we're able to get the best information out to the public.

COMMISSIONER FEENEY: I don't know that I have much to add to that, but that's exactly what we're doing. We're in constant contact with our Deputy Commissioner for Public Information. As we get new information and new decisions are

made, it's going out on the website and social media. Internally, we're issuing teletypes, having in-person meetings with staff, using the, the DOC intranet to get information out. So we're, we're -- you can't over communicate this issue enough.

MS. GROSSMAN: I, I would also add that we also rely on our partners at DOHMH. There are also guiding principles from CDC and State Department of Health, so we're all working together as a city in a unified way to make sure that we are communicating in the best way that we can.

MR. RICHARDS: And I would just like to request that when visiting screening policy goes into effect that we be kept informed and that we monitor how many people get turned away. I wouldn't want to see visits getting canceled based on the recommendation of one person with no ability to have that decision checked, and just want to make sure that you know people aren't being turned away because of the, the fear, but in fact this is based on some sound medical

approaches.

MS. GROSSMAN: We understand. We agree.

DR. COHEN: Yeah. I, I'm going to second that, Stanley's last point. It's, you're going, you haven't had visits for the past two days. Tomorrow there, there will be and it's critically important that your staff understand what the criteria for screening are and that people coming -- obviously people shouldn't come if they're sick, you know, that will be a tough thing for people when they want to see their, to see their family. But on the other hand, the screening mechanism should, should be, should, should be reasonable. I have two other questions. How is the health -- there's a, there's a health education aspect to this, this crisis that we're, that we're in, which is very important. So how is the, how is CHS going to provide medical information to the persons living in, in, in the jail so they will understand this situation as it evolves because it's, it's not a poster situation because it's changing, changing day, day-by-day. And another question

specifically for, for, for health is are there people who are in the facilities who shouldn't be there given, given the, the scope of this epidemic? Are there, are there people above a certain age, or with a certain illness, who are pregnant or who because of the, of the, the knowledge of the difficulty of controlling -- everybody's going to work very hard, but knowing what we know about this, you know and such people are advised not to go into large, into spaces with other people, is CHS -- has CHS or does it plan to make any recommendation to identify people, as you do, when there are people who are dying of cancer, you, you work very hard with the Department and with all, with all parties to get them out, because there's no point and them being incarcerated. Do you have a plan for this as, as well?

DR. MACDONALD: So to your first question, we have adapted some of the DOHMH recommendations for the general public to our setting. So we have specific information for patients which is being disseminated that's

sensitive to the way things work. So where it says call your doctor, it, it explains how you would seek care in our system.

DR. COHEN: Something like speaking to --

DR. MACDONALD: Yes, and so beyond that I appreciate, as you said it's not just about posters. You know, I think our staff are there in the facilities with our patients and it's a constant conversation. I mean obviously, the concern for panic is, is real and we need to be there present with our patients and engaging in that conversation. And also, it speaks to our communication with our own staff, so our staff need to feel comfortable, need to feel like they have a clear plan, need to feel like we've done this before, which we have and that we are being transparent, that we're, that we're being open about the situation and that we have plans that are, are going to keep people safe.

To your second question, you know, I think the when you look at the epidemiology of the virus, absolutely there are patient

populations that are more at risk. And we have a particular sensitivity to that. With our electronic health record, we do a lot of reporting and we have particular plans in place to try to protect the most vulnerable populations. But certainly, to look at the jail population by age, for example, I think would be an important thing to do.

DR. COHEN: I have one more question. It's my understanding, I mean I know that you are not performing intake evaluations in the, in the clinics from I think 11:00 p.m. to 6:00 a.m., so that during that that seven or so hour period, no one, anybody who is in the intake facility will have to remain there, in a pretty miserable setting.

DR. MACDONALD: We, we have --

DR. COHEN: In the context of identifying people, does, does it make sense to close down intake at, at night, as you, as you're doing in the facilities?

DR. MACDONALD: So, as we discussed when we met with you on this topic, the, the overall

efficiency of the intake process has improved based on the data that we have related to that specific change. And it's not the case that we're not available 24/7. CHS is available in the jails 24/7 to respond to any concern. And as we discussed, there has been communication to the officers to raise those concerns as quickly as possible. And we have staff present to deal with that, whether it's an emergency or whether it's just a question that somebody wants to raise. And we have systems in place to deal with that 24/7, absolutely.

MS. SHERMAN: Thank you very much for the update. I think I will underscore what other members have said, that we want to continue to support you in your efforts throughout the jails and over time as this situation develops, and we look forward to continued briefings consistent with past practice, as the situation develops and your planning and implementation unfolds over time. So thank you very much.

MS. MARGARET EGAN: The Board's January 2020 public report on body scanners and

separation status found a significant number of untrained staff oper- operating body scanners, reviewing scan images and initiating, reviewing and approving separation status placements and re- removals. In advance of the February meeting, Board staff conducted a new audit of training completion for staff conducting and supervising body scans across all facilities from January 18th to the 24th of 2020, which found that DOC staff who have not been, who have not completed all required training continue to operate scanners and approve separation status placements and re- removals.

The Department immediately issued a teletype requiring tour commanders to take a more active role in supervising any use of the, of a body scanner. The Department also reported that they were beginning weekly audits to assess whether staff using body scanners have completed the required training. The Department did provide those audits, and while training is improving, they still found that members of staff who are not, have not been trained are making

determinations. The Board has requested the Department provide an update on this issue today.

MR. KENNETH STUKES: Good morning, Kenneth Stukes, Bureau Chief. I would just like to state that we have taken this seriously with regards to the issues brought to our attention by the Board. Instances where improperly trained staff members utilize the body scanner, it's wholly unacceptable. We have taken several steps to address the concerns and to ensure that only properly trained staff members are operating the body scanners. So, I'll give some comparative dates and data of staff who have operated body scanner who have been trained in both radiation online safety and body scanner operations training. So with regards to supervisors, which is the rank of captain, on January 24th there were 48. When we go to February 29th we had a total of 60 which is a 12 percent, 12 persons, with a 25 percent increase with the captain's training. As it pertains to correction officers, as of the January 24, 2020 date, there were 248. As of February 29, 2020, 308, an increase of 60

with a 24 percent increase totaling 296 persons for that period, between correction officers and captains, total captains and the addition of staff training, a total of 368, 72 new persons with a 24 percent increase.

Moving on to our staff trained with the image evaluations, assistant deputy wardens as of January 24th, 11, as of February 29th, we increased to 18 a total of seven with a 64 percent increase. Captains, as of January 24th, 22, as of February 29th, 25 totaling three persons with a 14 percent increase. Correction offices, 110 as of January 24th, February 29th date, 123, or a total 13 additional persons with a 12 percent increase, totaling between the two, three ranks, 173 persons totaling 23 new additional with a 15 percent increase.

As I previously stated at our Board, Board meetings, the Department issued a teletype issued on February 4th by the chief of the Department which is read at 28 roll calls. The teletype reiterated the requirements that our scan operators must use their own login

credentials. In addition, they must be properly trained in both the radiation safety online training and the body scanner operations training.

What was new to this teletype that the tour commander must ensure that an adequate staff are properly trained, are assigned to areas that have the body scanner at all times. In addition, the tour commander must authorize the use of the correction officer to operate the body scanner.

And as previously stated, any identified failure to comply with the teletype orders and any authorized use of the body scanners would result in staff being appropriately disciplined. Any staff who have been found to operate the body scanner without being properly trained or use other person's login credentials was referred to our Investigation Division for further investigations.

Multiple signage has been posted in the body scanner areas, so that staff are knowledgeable by with only information pertaining to the training and the requirements of the body

scanner operator. In addition, the Department issued talking points to the management teams at the facilities that they may utilize at both our roll call with a frontline staff and at their internal meetings. The weekly training audits continue to be in process and the body scanners credentials of any persons who are not authorized and using by another person are deactivated making that person's access to operate the body scanner unusable.

The training and development academy has delivered 150 body scanner informational booklets and the information that is contained in those booklets is how the body scanner works and why they are important, how much radiation a person is exposed to during each scan and lastly what the Department is doing to ensure that that health and safety of those person being scanned.

So I'll move on to the audits that we have conducted regarding, pertaining to persons who have receive authorized training to operate the body scanners and the second part of the audit will consists of supervisors who are

reviewing images either for placement or removal. I would just like to note that prior to our Board's meeting on February 11th, and our existing policy, it did not require that the supervisor who reviewed the image was required to have been trained in both the radiation safety training and image evaluations.

So I'll just walk through some data as it pertains to audits that were conducted weekly. So the Department conducted audits of the weekly body scanner logbooks across seven body scanners which in use at our facilities. There were twelve days selected at random and the Department, the three days were chosen at random for each week and all scans were evaluated on the chosen days. The audit eva-, the audit evaluates whether the Department's body scanners were operated and supervised by appropriately trained staff and whether separation status placements and removal paperwork following a scan was approved by a trained staff member.

So week one, the dates were February 4th, 6th, and 7th. Week two, the dates were

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February the 11th, 13th, and the, 11th and 13th, 11th, 12th, and 13th. Week three, the days were February 18th, the 20th and 21st. Week four was February 25th, 26th and the 27th, all random dates. So when we speak about staff authorized to operate the body scanners, we refer to staff who've been trained both in the radiation safety and the body scanner operations training.

So as a note, VCBC which is one of our campuses that's online with the use of body scanners were placed online latter part of the month of February.

So, during this audit period there were total 1,048 eligible entry scans conducted across the audit dates. Of this number, 1,034, one percent scans were operated by in- inefficiently trained staff members. So let me correct that. Of the 1,048, 1,034 which is 99 percent, scans were operated by properly trained staff members. Fourteen, one percent, scans were operated by inefficiently trained staff members. There were a total of 1,030 eligible entry scans supervised across the audit dates, to refer to supervised,

that is the rank of a corrections captain who's supervising the scan after it has been done by a correction officer who operates the body scanner.

So 764 which is 74 percent, scans were supervised by properly trained staff members, 266, which is 24, 26 percent, scans were supervised by inefficiently trained staff members. I would like to take note that of all the placements for a positive scan that were reviewed by an assistant deputy warden who have completed all the training as it pertains to image evaluations. In addition, as we mentioned at other Board members, all of the members who are assigned to the operations and security intelligence has been trained in image evaluations trainings.

The percentage of scans operated by properly trained staff members increased by three percent from week one to week four of the audit period. The percentage of scans supervised by properly trained staff members increased by three percent from week two to week four of the audit period. Week four had a total of 240 supervised

scans. Out of 60 which were supervised by inefficiently trained staff, within that 60 number, one captain accounted for 16, then there was another captain that accounted for 30. The two captains constituted 46 out of the 60, which is 77 percent. Again, I would just like to place emphasis on the point that any finding that an insufficient trained staff member operated or supervised a use of a body scanner is in violation of our policy and will be referred to the investigation division.

So I'd just like to walk through some data as it pertains to our efforts to ensure compliance with the policy regarding the use of body scanners. So I will speak to week one and I'll break it down into two parts. Staff members operating the body scanner who have been appropriately trained and staff supervising the image after the body scanner has been done by a correction officer.

So for the first three random dates in week one, which I initially stated February the 4th, 6th and the 7th, so I'll just go into some

of our facilities that have the body scanners that is online. So the Anna M. Kross Center, 59 entries, staff members who have completed training 59, 100 percent. GRVC, 29 entries during the audit dates, staff who operated the scanner who have completed training 29, 100 percent. Otis Bantham Correctional Center, the number of eligible entries 73, the number of staff members who have completed their training that operate the scanner, 73, 100 percent. OBCC, which operates two scanners, the segregation area 10 completed training, 10 at 100 percent. I'll move on into week two. Yes?

MR. STEVEN KAISER: I think we've sent the audit findings. I think the main findings that we wanted to reiterate are that 99 percent of the scans operated were operated by trained staff received both the operator and the radiation safety training during the audit period. We're still working on the captain supervisor training, but any and all placement or removal paperwork related to separation status were reviewed by an ADW, image evaluation

training. And, you know, as we mentioned prior to the last meeting, we're going to be working with our external vendor to schedule these trainings for our supervising captains as quickly as possible. Over the month of February, we had some cancellations from those ext- external vendors that we're currently working with them on and we're, you know, prioritizing those trainings.

So we think we have a gra-, a grasp on the issue. We're going to keep working on it. But we've spent a lot of work into it and we think we're in a good place and on the right, on the right track with this.

MS. SHERMAN: No questions? Questions?

MR. RICHARDS: Yes, a couple of questions. Thank you for the presentation and the data and your diligence on not only watching this issue but moving it, moving it forward. Congratulations on that.

MR. STUKES: Thank you.

MR. RICHARDS: The question I have is on the placements and removals. According to your,

what it seems like, of the seven placements, all of those placements were done by officers that were not trained. Am I reading this report right?

MR. STUKES: I'm not certain where you're at on the report, sir.

MR. RICHARDS: It's on page seven of your report, it's on operating staff. It says placements, seven completed training, seven, no. Removals, six completed training, yes. And then supervising staff, it says placements, seven, completed training, two, no. Removals, eight, completed training, seven, no. So it looks like, it looks like y'all are doing a great job on making sure that tests are being, scans are being done by trained officers and, and it's being reviewed by trained supervisors. It looks like there were two captains in RNDC and the OBCC that sort of were doing random, you know, doing tests on their own and they weren't trained. They accounted for 46 of the 60 tests, something that you easily can pinpoint. But when I looked at the placements and the removals, that was a

little alarming that the tests that resulted in a placement were done by somebody that wasn't trained. Am I reading it wrong?

MR. KAISER: Yeah.

MR. STUKES: Yes, you are.

MR. KAISER: So, just to clarify, for the operating staff of the 13 eligible either placements or removals, all of them were conducted, the actual scans were conducted by properly trained staff. Like we said before, we're still working with the supervisor training with the vendor to schedule those trainings and get those captains supervised. But the, there's an extra layer to this. We're actually doing three layers of review for any placement or removal. There's an ADW in the OSIU unit who's trained on image evaluation specifically, so any scan whether it's a positive or negative scan that leads to a placement or a removal is reviewed by a, an ADW at the minimum, also an operator who has trained in image evaluation through those trainings who is approving or denying that reading of the scan. So there is,

for all of those placements or removals, there was a minimum of two layers of staff with image evaluation training and all of the staff that conducted those scans were properly trained.

MR. RICHARDS: So this is saying that one of those three steps, seven officers were not trained?

MR. KAISER: That's correct, related to the supervisors, that's what we had explained to Board staff prior to the last meeting that we're going to need some time to work on that portion.

MR. RICHARDS: To do the supervisors? So this is all about supervisors?

MR. STUKES: So yes. The operating staff usually lies with a correction officer, so when you look at the data here but it says seven placements --

MR. RICHARDS: Right.

MR. STUKES: -- all those seven placements were done by correction officers who had completed all the training and were authorized to operate the scanner.

MR. RICHARDS: So, so, who are the seven

that were not trained?

MR. STUKES: So, when we talk about the supervising staff that is a correction in the rank of captain who supervised the image, who had not received the image evaluation training. However as mentioned, there is an assistant deputy warden as a third layer, who works in operation security intelligence --

MR. RICHARDS: Okay, good.

MR. STUKES: -- who has received evaluation training and is responsible for reviewing the, either the placements or removal from separation status.

MR. RICHARDS: And it speaks to the 99 percent that you got perfect?

MR. STUKES: That is correct, so as we mentioned, the supervisor part of the image evaluation wasn't an initial part of our policy but we are working with the vendor to ensure that we get as many supervisors appropriately trained as possible. This will require some time.

MR. RICHARDS: No this is, I mean you did a great job in making sure people are, are

trained up. The supervisors are the next level. All the ADWs have all already been trained, right? It's really that middle band of captains and supervisors that you have to train up.

MR. STUKES: Yes.

MR. RICHARDS: A, a second question, of the 1,000 some odd tests that were conducted during this audit period was it only 15 people that went to separation housing? Am I, am I reading that right?

MR. KAISER: So, so it's a little different. I don't have the total placement numbers for the month with us, but this would be looking at only placements that were precipitated by a positive scan reading.

MR. RICHARDS: Got it.

MR. KAISER: In terms of that level of looking at placements and removals, if it's a negative, if it's based on a refusal, you don't need someone trained in image evaluation, there's no image.

MR. RICHARDS: Right.

MR. KAISER: But just to, just because

it might help you with the report, I think you were looking at the N number

MR. RICHARDS: Yeah.

MR. KAISER: -- and that N stands for number, not no in terms of training. So that thirteen that were either a placement or a removal, that 100 percent is to say that they were all done by and operated by staff that were properly trained and they were also all reviewed by staff who were properly trained in image evaluations specifically.

MR. RICHARDS: Got it, got it. And final question, do they do more tests but you are unable to determine the result or out- outcome of that test when you say legible?

MR. KAISER: That refers, that just refers to the recording in the actual logbook at the scanner, so if a staff name gets smudged in the logbook for example, it would be recorded as an illeg- illegible logbook entry, so you know there are going to be that cases of those. We're reiterating the staff that needed to make sure there are legible entries in logbooks. And then

we're also recording information electronically through the scanner machines as backup, so we use both that information. If we find a discrepancy, we refer it to the investigation division to investigate.

MR. RICHARDS: Good work, good work.

MR. KAISER: Thank you.

MR. RICHARDS: Thank you.

MS. SHERMAN: Any other questions? Thank you very much we look forward to staying informed about your efforts, particularly with respect to ensuring that all of the supervisors obtain the training as soon as you are able to do so and very much appreciate the hard work that has gone into your efforts to date. Thank you.

MR. STUKES: Thank you.

MR. PERRINO: Yeah, I'd just like to say also, I notice there's a difference in leadership, this problem has become really at hand. And this sense of urgency has like, you know, doubled and tripled, so it seems like your credit is going way up in my book, okay. And I appreciate it, because when we see problems and

we work together to get resolved, I really feel like things are happening, and great job.

MR. STUKES: Thank you.

DR. COHEN: I'd like to support that. Thank, thank you.

MR. STUKES: Thank you.

MS. SHERMAN: Okay, we are now going to move to hear comment on the Department's variance requests. The Department requested a variance that would allow the Department in highly exceptional circumstances presenting safety and security concerns to waive the requirement that people be immediately released from punitive segregation for seven days after they have been held in punitive segregation for 30 consecutive days. The Department has not granted a seven-day waiver since October of 2018. The Board renewed this variance in January for three months expiring on April 16th. Since the Board does not have an April public meeting the Board must consider the request today. The Board approved the variance for three months in order to allow for the Board to consider this policy in

restrictive housing rulemaking, rather than via variance. The Board's proposed rule on restrictive housing incorporates the variance and its condition. The rule's enactment would eliminate the need for this variance. As discussed earlier, this section of the proposed rule is a point of active discussion.

So now I will call on members of the public who have signed up to comment on the variance request. We ask that you limit your comments to the proposed variance. Albert Craig.

MR. ALBERT CRAIG: Good morning.

MS. SHERMAN: Good morning.

MR. CRAIG: I know we supposed to talk about the variance, but you had this thing about the coronavirus, which I think this is, I wanted it before I forget this, this morning I went to RNDC and the president of COBA, Elias Husamudeen, told all the officers that a civilian had contracted, a family member had contracted coronavirus, so and they wind up going, there was a, a whole bunch of text messages and e-mails to everybody telling everybody last night, but he

confirmed it this morning about 7:00 o'clock that a civilian had, a family member had contracted corona.

So I want to just talk about that for one second. I know this -- we're not supposed to, but what I'm asking for, they said if you ask the question that nobody be disciplined for being sick contracted, considering that we work in close proximity and got to pat inmates down consistently, also that we have gloves right, search gloves, on the ready. Also that an inmate who spits be placed in a spit mask, placed into isolation until it's determined whether or not he has coronavirus, being that we, we are touching elbows and washing hands. I think spitting in your mouth, that you know, we should show some concern about the spitters who you know, might give a officer this, this virus. Also he said about notification, nobody notified anybody. There should be somebody from the, from this department who speaks to the officers personally about what to do, right. Let's say I'm searching an inmate and the inmate is sneezing and

coughing, and I'm still being ordered to search him. Should that inmate may not be searched and placed into isolation and then you know, until he receives medical treatment? In addition to that, gloves, immediate notification, yeah that's basically it in terms of like the corona thing.

Nobody told anybody about it, right. You have officers who work down in the basement with this individual, right. Right now, we don't know whether these officers have, if it is true, contracted it or not. We don't know and they had no, they didn't mention that. And I'm, I'm -- if Elias Husamudeen is aware of it, that means they are aware of it, so when he stood up here and talked about it they didn't mention that. You know, I'm, I'm really concerned with these spitters. I know it's a pandemic, it's a state of emergency and to spit on someone and like I said the last time, spit in someone's mouth, I think we ought to be a little more concerned about that now that it's a pandemic and the mayor is making more videos than Jay-Z or every time you turn around somebody, you know, he's on the

news creating a panic in the city so either it's something we should be concerned about, or it's something we shouldn't. Because he's telling everybody not, if a crowded train, don't get on it wait for the next one if you can.

So I'm asking you to please ask them what are they going to do in terms of notification and, and in terms of making sure there are gloves there, assuring that sanitizer in these areas, hand sanitizer is there, that these inmates are placed into masks if they spit and taken to the isolating -- I'm sorry I think this is important.

MS. SHERMAN: Please, I understand and please try to wrap up. We are going to --

MR. CRAIG: Oh, I am wrapping up but they're taking notes, so at least somebody's showing some concern that this is a real issue that we could contaminate those visitors that you're concerned with and, and the inmates. Thank you, I know, I'm wrapping it up it's not important.

MS. SHERMAN: Thank you, Mr. Craig. Mr.

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Nel-, Henry Nelson.

MR. HENRY NELSON: Good morning, everyone. I know everyone is here pretty much with the best of intentions, but I want to talk a little bit about the officers, which right now they have, they have a, they have a hell of a job to do. But they also have many tools to fail. There's still, there are inmates still housed in gang affiliation instead of classification. There's too many. The concept of one or two officers controlling multiple inmates was on the basis that it's not a gang affiliated house. If I tell one person that they can't do one thing, I'm following the rules, I'm telling one person you cannot do this or that, the chance of me gang, being ganged up on is high. This is a situation that keeps -- that's continuing to go on. Until we get that clear, I wonder should we even look at the levels directive, because the longer we take to respond to a, a situation, the more likelihood of someone being seriously hurt, whether it be an inmate, officer or any other staff member. We have to understand that. A

level A might not -- it might escalate quicker because they're gang affiliated. I've dealt with that situation on a daily basis, in which we're talking to someone and being that I'm talking to him, I said, no you can't go in this area. Four or five more come running over. This is a situation that we could avoid, because the only ones that's going to get hurt is the officers and the non-affiliated inmates, with no gang affiliation whatsoever. That's the issue that we need to address. We can make it safer. It can happen. We just have to listen to one another. We really can get there. But until we keep letting it go on and on, it's going to be a problem.

And before I leave, I have one other issue. I'm still trying to figure out the concept of, I understand the disciplinary process. I understand if you do wrong, fine, you can be disciplined for it. However I don't understand the concept of being suspended pending an investigation or the probability of you being suspended. That makes zero percent sense.

Remove that staff member or officer from any contact whatever, until the investigation is complete. Then whatever disciplinary action comes out of it, should come out of it. Then, now you're going to have officers hesitating, you're going to have people hesitating. We got this spray, the chemical agents, we're going back and forth with that.

I'm trying to be reasonable with everyone. If you constantly tell me that if two, two people are fighting, two inmates are fighting and I spray with my intention of no one getting hurt. If you say it's closer than three feet and you want to hit me with a charge, it's not -- people are misreading the language of the directive itself. It's a guide so you won't have to have physical contact, but so much. You can wash your face, but if the two people are engaging in a fight which could cause serious bodily harm and you use your chemical agents with the best of intentions, you should not be disciplined because it's so called closer than three feet. It doesn't make sense. Hesitation

kills in corrections. Thank you very much.

MS. SHERMAN: Thank You. Brandon H. Good morning.

MR. BRANDON HOLMES: Good morning. My name is Brandon Holmes I'm the New York campaigns coordinator for Just Leadership USA. And today, with several members of the Jails Action Coalition, we will uplift the voices and concerns of directly impacted New Yorkers and share proven alternatives to solitary confinement that can and must be implemented with your oversight.

I would also like to start just saying I find it difficult to believe we would still be in a rulemaking process these many months later. If more members of this Board had reviewed the blueprint and enacted these recommendations, I would never dare wish ill on any of your families or loved ones, but I hope that you recognize that many of us here have loved ones who are still behind that wall who have experienced solitary. We are taking care of loved ones who have come home and come out of isolation and our communities are reeling. If your family was

behind those walls, I believe if they were in a dark cage deprived of light, air or compassion, you would share the same sense of urgency that we have and you would hold all of your other Board members just as accountable as we try to do with each of you every month.

We oppose the current variance request and urge the Board to reject it. Instead, we recommend that the blueprint be adopted by the Board with the recommendations that we've introduced six months ago. Jails Action Coalition and the Halt Solitaire Campaign released the blueprint, a document that outlines how New York City can and must end solitary confinement in all its forms throughout New York City jails in 2019. The blueprint reflects the experiences and expertise of people who have endured solitary confinement; the family members of incarcerated people; mental health, legal and human rights experts; and many members of our campaigns.

It is written in the context of growing calls to fully ban solitary confinement,

including from the Progressive Caucus and Women's Caucus of the New York City Council, as well as leading presidential candidates. Additionally, our blueprint has been endorsed by over 70 elected officials, organizations, faith communities and their leaders, some of whom you all know very well.

The overall purpose of this blueprint is to provide key mechanisms for how New York City, the mayor, City Council, Board of Correction and Department of Corrections can completely eliminate solitary confinement together in city jails and instead promote alternatives that take an opposite approach to the isolation and deprivation of solitary and are actually effective for promoting safety and reducing violence both inside jails and when people return to their outside communities. In recognition of Leyleen Polanco, Bradley Ballard, Kalief Browder, Nicholas Feliciano and countless other people who have either lost their lives or suffered devastating psychological and physical harm, New York City must take immediate action to finally

and fully end solitary confinement. The blueprint shows the way to reach that goal, drawing on proven evidence-based approaches that are more humane, effective and safe.

And lastly, I would just say if there is anything that if you need more information or anything you need to better understand from this blueprint please reach out to the formerly incarcerated leaders and advocates who have crafted this, because there are proven solutions in there. Thank you.

MS. SHERMAN: Thank you. Sarita D. Good morning

MS. SARITA DAFTARY-STEEL: Good morning my name is Sarita Daftary. I'm an organizer with Just Leadership USA and I will pick up where Brandon finished, with continuing with the blueprint. We're doing this on the record out loud. You can also share it with your colleagues who have not read the blueprint themselves. So to start, solitary confinement is torture. The sensory deprivation, lack of normal human interaction and extreme idleness causes

devastating physical, psychological and emotional harm.

Research proves that people in solitary are nearly seven times more likely to harm themselves and over six times more likely to commit potentially fatal self-harm. People who have spent time in solitary are significantly more likely to both die, including by suicide homicide and overdose, and to be reincarnated after release, with the risks increasing as the time in solitary increased. As we learned from the unconscionable torture and neglect experienced by Bradley Ballard during his six days in solitary, for some people even a short solitary sentence can lead to tragic consequences and even death, so seven more days is far too many.

It's been nearly ten years since the United Nations called for the complete abolition of solitary as a means a punishment or discipline and the complete abolition of solitary for, among others, all people in pretrial detention as the vast majority of people in New York City jails

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are held.

I'm going take a pause from the blueprint itself to note the irony of a representative from the union suggesting that he doesn't understand the concept of being suspended pending an investigation when they oversee thousands of people who are being locked up pending their trial.

Going back to the blueprint, solitary is disproportionately inflicted on black, Latinx and Native-American, American Indian people, as well as on young people and people with mental health needs. As DOHMH study found, that black and Latinx people incarcerated in NYC jails were less likely than their white counterparts to receive appropriate mental health diagnoses and more likely to experience solitary confinement.

Solitary is also disproportionately inflicted on queer, transgender and gender non-conforming people. A national survey of 1,200 incarcerated LGB- BTQ+ people found that 85 percent of respondents had been in solitary confinement. Solitary is counterproductive to

the purported safety justifications sometimes given for its use, as it can cause violence and make prisons, jails and outside communities less safe. Moreover, replacing solitary with more effective alternatives will ultimately save money, while importantly saving human lives and human potential.

After struggling to treat patients who are suffering the torture of solitary confinement, Dr. Homer Venters, the former head of Correctional Health Services for New York City jails has said solitary units should never have been built. This blueprint presents New York City with a way to unbuild these torture chambers.

MS. SHERMAN: Thank you. Herbert?

MR. HERBERT MURRAY: Yes.

MS. SHERMAN: Good morning.

MR. MURRAY: Good morning. How y'all doing today? My name is Herbert Murray and I've been incarcerated for 29 years. Of those 29 years, I did approximately ten years in solitary confinement. I too will continue with where

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Sarita left off with. The first recommendation of the blueprint, of the blueprint is to ensure that the Board of Correction minimum standards for out of cell time applied to all people in city jails, other than emergency, but remove an exception to those standards punitive segregation and SHU units.

Other than an emergency situation, the Board of Correction minimum standards for out of cell should apply to all people in city jail. Section 1/05 of the board of current standard requires that no person should be voluntarily locked up other than eight hours at a night and two hours during the day. The common standards allowed exception to those required for people in punitive segregation and enhanced supervision housing, ESH units. Those exceptions should be removed and the basic minimum standard generally should apply to everyone in city jail so that all people in city in the jails have a mandatory allowance of 14 hours out of their cell per day. The minimal exception is contagious disease unit can remain.

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The reason for eliminating these exception in both that solitary confinement is torture that cause devastating harm, that limited out of cell time does not in any way contribute to greater safety or reduction in violence. As we will discuss in more detail, unit that allows separation, separation from the general pop-, jail population without any restriction out of their cell have proven more effective at reducing violence and promoting safety. The clinical alternative for punitive segregation units on Rikers Island and the former Merle Cooper program, New York State prisons are two positive successful examples of unit designed to separate people from general pop- population without restricting the amount of cell, out of their cells. Thank you.

MS. SHERMAN: Thank you. J.J. Parish. Good morning.

MS. JENNIFER J. PARISH: Good morning. I'm Jennifer Parish with the Urban Justice Center Mental Health Project and the Jails Action Coalition. The second recommendation of the

blueprint is to create minimum standards for emergency individual lock-ins and emergency lockdowns. To address emergency situations that may arise, there should be the allowance, if necessary for emergency, short-term mandatory lock-in for individuals and emergency short-term lockdowns for targeted portions of the jails.

These emergency policies should have the following specific and limited ways in which they can be implemented. First regarding emergency individual lock-in. Drawing from the rooms, drawing from the rules for room confinement in New York City's secure detention youth facilities and from other models of youth secure detention policies, such as those adopted in Colorado, individuals can be involuntary locked, involuntarily locked in for immediate de-escalation purposes in emergency situations when absolutely necessary as a last resort and when other mechanisms have failed for the shortest duration possible, measured in hours rather than days, weeks or months.

The purposes, the purposes of these

lock-ins are never to be used as punishment or isolation, but instead to immediately and temporarily separate people to prevent physical harm; to provide br-, a brief time and space for de-escalation and cooling down; and quickly restore people back to the general jail population, or if necessary to move them to another housing area to avoid further harm or conflict or to ESH to address underlying issues that are resulting in negative conduct. The presumption should be that such lock-ins should end within two hours, with extensions available only when absolutely necessary. If the lock-in time spent is approaching four hours, the chief of department should be required to be involved to work toward ending the emergency lock-in. For young people and elderly people who are particularly vulnerable to the risk and harm of isolation, there should be a maximum lock-in time of six hours. For all other people there should be a maximum lock-in time of eight hours.

In addition, to ensure that people are not repeatedly locked in day after day, thereby

subjected to extended solitary confinement, there should be a total time limit of eight hours in any two day period or a total limit of 20 hours in any seven day period. In extreme circumstances, where the Department believes it absolutely necessary to exceed the multiple day time periods, the Department should be required to obtain a court order permitting a lock-in that exceeds the limit. For each day that the Department seeks to extend the lock-in it should obtain a new court order. To deescalate the situation as soon as possible and to avoid people decompensating further or even harming themselves while isolated, staffs should check on any person who's locked in at least every 15 minutes, a mental health staff in particularly should check in on a person within the first hour and at least once every additional hour the person's locked-in.

And just in case it's not clear to you why we are presenting the blueprint during this comment period, it's because the Department is asking you for permission to extend the use of

solitary in certain circumstances. We believe the blueprint is an alternative to that and while the fundamental point of the blueprint ending solitary confinement has been well communicated, the fact that it includes our vision for alternatives to solitary seems to have been lost. So we are presenting the details of those alternatives today in hopes you will adopt it, rather than approve the variance.

MS. SHERMAN: Thank you. Ms. V. Good morning.

MS. VICTORIA PHILLIPS: Good morning. My name is Minister Dr. Victoria Phillips and I'm standing here today as a person from the Mental Health Project Urban Justice Center and a member of the Jails Action Coalition. I'll pick up.

Emergency lockdown, in situations where it's absolutely necessary to either investigate or deescalate an emergency situation, the city jail should only be able to utilize lockdown procedures in strategic, limited ways and areas. Currently, the Department utilizes lockdowns far too frequently, thousands of lockdowns per year

averaging over five lockdowns per day with an average length of time of 11 hours, but sometimes encompassing multiple days. Lockdowns should never be used as punishment, but as a last resort in response to clear acts of violence or imminent threats of violence when more limited interventions, including in- individual lockdown would not address the need.

Lockdowns should be limited to as few people and as few jail areas as necessary and limited to the minimum time necessary. Lockdowns should also not be allowed to be a substitute for lock-ins, thereby holding more people in isolated conditions than necessary as a loophole to the time limits for lock-ins as another form of punitive segregation or solitary confinement, nor as a way around the Board's other minimum standards.

The emergency lockdown procedures should also be regulated to ensure they are not used for punishment, administrative ease or other reasons that are not intended to prevent imminent and serious harm. As such, the time limits on

lockdowns in particular and other conditions should mirror the limits on lock-ins. The presumption should be that such lockdowns should end within two hours with a two hour extension available only when absolutely necessary. If the lockdown time is approaching four hours, the chief of the department should be alerted to works was ending the emergency lockdown.

Lockdowns should be limited to a maximum time of six hours in a single day, eight hours totaling over two days and 20 hours totaling over seven days unless a court order is obtained in any instance in which the Department determines it is absolutely nec- necessary to exceed those limits. Lockdown should only be allowed in extremely serious situations, particularly instances where people cause or attempt to cause such serious physical injury or death or an imminent substantiated threat of such violence or death, compiled or attempted to compel sexual acts by force or threats of force, led, organized, incited or attempted to cause a riot or violent insurrections, procedures, deadly

weapons or other comparably dangerous contraband that pose a threat, escaped or attempted escape or any other conduct of the same magnitude of harm. The scope of lockdown, including which people in physical areas of the jail are affected, should be limited to what is absolutely necessary to, for the purpose of the lockdown.

During lockdowns, the Department must ensure timely medical and mental health care, especially emergency care, and must provide for delayed or missed services as quickly as possible following a lockdown.

Last part, the Department must publicly and promptly report all lockdowns, including any restrictions on visits or phone calls, the reason for any lockdown, which areas are affected and why, what medical and mental health services are affected, what programs are affected, actions taken during the lockdown to resolve or address the reasons for the lockdown and the number of staff diverted it for the lockdown. Have a blessed day.

MS. SHERMAN: Thank you. Jack B. Good

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morning.

MR. JACK BECK: Good morning. My name is Jack Beck and I work on the Halt Solitaire Campaign. I'm going continue the blueprint. And this is actually the core piece of it, which is there are alternatives.

The third recommendation of the blueprint is to end punitive segregation and make ESH and any other alternative unit actually about safety, rehabilitation and prevention of violence. New York City should A) end punitive segregation entirely and B) ensure that enhanced supervision housing, ESH, and any other alternative unit in the jails are actually about safety, rehabilitation and prevention of violence.

Punitive segregation causes devastating harm and actually increases violence rather than reducing violence and promoting safety. As the renowned mental health jail administrator and expert, Dr. James Gilligan has written, far from preventing violence, punishment is the most powerful stimulus, stimulus to violent behavior

that we have yet discovered. And you've used him as your expert.

As recommendations one and two suggest, if people are engaged in conduct that poses a real and serious threat to others, then they can be separated from the general population. But if the city is truly serious about safety and violence reduction and prevention, then separation should be the opposite of isolation and punishment. Instead, it involves the opportunities for more intensive human engagement and programs to address the reasons for separation and prevention and to prevent future violence or harm.

The City and the Board have many powerful examples to draw from in creating effective programs that are the opposite of isolation and actually are effective at promoting safety and reducing harm. New York City's Clinical Alternatives to Punitive Segregation, CAPS, which I'm sure all of you have seen, unit is a much more program intensive treatment supported and empowerment based alternatives to

solitary confinement that does not restrict the amount of out of cell time provided, utilize, utilizes de-escalation of a difficult situation and has greatly reduced the amount of violence and self-harm.

The Merle Cooper program, which formerly existed in New York State prisons also provided a successful program intensive empowerment based unit that involves complete separation from the rest of the prison population, but no isolation of individual people. For people deemed at high risk of recidivism, the Merle Cooper program provided group sessions, intensive programming, peer led initiatives, increased autonomy and responsibility, most of the day out of cell and the oppurt- opportunity to earn unlocked cells.

Even though Clinton Correctional Facility is considered one of the most violent prisons in New York during its implementation from 1977 to 2013, its Merle Cooper's unit reported high levels of safety and near universal praise from correctional officers, participants and administrators. The issue is not separation,

but engagement. And the issue is not punishment, but treatment.

MS. SHERMAN: Thank you. Tamika? Good morning.

MS. TAMKIA GRAHAM: Good morning. My name is Tamika Graham. I'm formerly incarcerated and the placement of solitary confinement at the age of 16 still impacts me today at the age of 40. I'm going to pick off where Jack left off.

One of the strongest examples which the blueprint draws from is a resolve to Stop the Violence Project, RSVP in San Francisco jails. This well studied and documented project immerses residents in an intensive program including group discussions, classes, counseling and meetings with victims of violence, which occur out of cell for most of the day. Research found that RSVP resulted in a 25-fold reduction in violent incidents, five-fold reduction and re-arrests for violent crimes, a six-fold reduction in jail time and significant cost savings.

If NYC, excuse me, if New York City is serious about increasing safety and reducing

violence, the Board of Corrections and Department should replace solitary confinement with the program akin to RSVP in the city jails. Based on these successful models, we suggest that ESH and any other unit should have comparable congregate human incarceration, excuse me, interaction, comparable amenities, TVs et cetera, and comparable congregate programming as in the general jails' population in settings that are conducive to congregate interactions and congregate programming with at least several people.

In total, people in ESH, in ESH or any other unit, should have access to at least 14 hours of out of time, of out of cell time on including at least seven hours of out of cell congregate programing per day. These units should also have additional high quality alternative programming aimed at addressing the reasons for separation, including therapeutic antiviolence programming, restorative justice and cure violence health programs, which the Board has previously recommended.

The RSVP program mentioned above should serve as a model. The Department must also ensure opportunities for mental health and a substance use treatment as recommended by the Board. These should be additional, meaningful, substantial and repeated training for staff working at ESH and other alternative units on topics including conflict resolution, mediation, de-escalation, restorative justice and use of force as recommended by the Board. De-escalation and meaningful use of positive incentives rather than the use of disciplinary sanctions must be the primary methods for addressing issues that arise in the general jail population in alternative units. Thank you.

MS. SHERMAN: Thank you. Gregory. Good morning.

MR. GREGORY WILLIAMS: Good morning. My name is Greg Williams, and not only have I been formally incarcerated for approximately 30 years but I'm directly impacted by isolation. And I'd like to continue with my sister left off. If this thing will turn on.

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Alright, the existing criteria for placement in the ESH should be narrowed. Currently, the Department can justify placement based on conduct that occurred five years prior if they occurred while the person was incarcerated anywhere. The Department should no longer be able to utilize past conduct to justify placement in ESH or other alternative units. People should only be separated if actually necessary to address current serious harm or threats of harm.

Before someone is placed in ESH or any other alternative unit, there should be a hearing with a neutral decision maker and access to legal representation by lawyers, paralegals or other incarcerated persons to increase the burden of proof on the Department. And the opportunities to appeal any placement decisions to the Board with similar procedures as used for appeals to the Board or other contexts. The Board's minimum standards should specify that there should be no other restrictive housing units apart from ESH.

The fourth group recommendation is to

adopt specific mechanisms and time limits for get, getting out of ESH and any other alternative units. There must be clear mechanisms and processes for people to be discharged from ESH and other restrictive housing units including completing programming, release at periodic review and mandatory time limits. The mechanisms outlined in the Halt Solitary Confinement Act can serve as a basic framework to draw from and apply in the context of jail settings, where people are held for short periods, are primarily held for pretrial and are presumed innocent.

Upon entering ESH or any other alternative unit, this should be both an individual needs assessment and a realistic, appropriate plan established, including a plan for discharge from the unit. If the person completes the plan, they should be discharged.

The periodic review process needs to be strengthened, take place, taking place at least every 15 days rather than the current 45 days. A multidisciplinary team, including program staff and treatment staff, should carry out this review

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and should discharge a person if deemed appropriate. The person should be told what they need to do to be discharged.

There should be a total maximum time limit of four months in ESH or alternative unit. There should also be a Board appeals process, like other Board's appeals, where for decisions related to the placement in ESH or other alternative units and denial of discharge. Thank you.

MS. SHERMAN: Thank you. Fran. Good morning.

DR. FRANCES GETELES: Good morning. I'm Dr. Frances Geteles and I'm with the Halt Solitary Campaign. And thus far, most of what has been discussed has been the issue of solitary as put forth in our blueprint, but I'm going to address a related issue, which is the question of constraints. And our recommendations regarding that are drawn from the standards of the ABA and the Mandela Rules.

There should be a strong presumption against the use of restraints, particularly

during congregate activities and programming, with limited exceptions based only on individualized determinations of imminent risk of harm. The default should be that people are not placed in restraints and that they are only used as a last resort if there is an individualized determination that they are absolutely necessary to prevent imminent and serious harm.

The Department must use only the least restrictive restraints necessary. If restraints are going to be used on more than one immediate occasion, then there needs to be at least a due process hearing with procedural protections and the possibility to appeal to the Board. Any decision to continue to use restraints should be renewed at least daily. Work should be done to de-escalate, to move towards removing restraints and a new full due process hearing should be held at least weekly.

In order to avoid incidents where a restrained person could potentially be attacked or harmed by an unrestrained person, there should generally be a prohibition on co- comingling

people in restraints and people not in restraints, which in practice could mean that congregate programming could take place among unrestrained people and separately among restrained people. Thank you.

MS. SHERMAN: Thank you. James.

MR. JAMES ABRO: Good morning. Hi, my name is James Abro. I'm here as a concerned citizen and a New Yorker. I'm a professional working writer, who has a hard time keeping up with New York City rent so I've experienced our wonderful homeless shelter system. Now, one of the most shocking parts of being in the shelter is to see how many young New Yorkers have spent most of their lives incarcerated one way or another, from juvenile detention to rehab programs that are mandatory, to the prison system and then they quite frankly get dumped into the shelters.

And I got to know a lot of them and after a while, I could tell right away who had been in solitary. They're withdrawn, they're confrontational, they have very little cognitive

ability. They're damaged. And outside of all the changes in rules and regulations, I think we have to go back to what Brandon was talking about, how would you feel, how -- would any of you allow your own children to be treated like this? Because, you know, they not only lose years of their lives they -- psychologically how do you, how do you, how do you overcome that damage? I don't know if these kids I met in there will ever overcome that. How are they going be productive members of our society if, if they're coming out that way, right?

So I'm supporting the blueprint and well to stop solitary confinement. We shouldn't be doing that anymore, you know. Thank you.

MS. SHERMAN: Thank you. That concludes the public comment period on the proposed variance. At this time, I will ask the Department to present the variance.

MR. STUKES: Good morning.

MS. SHERMAN: Good morning.

MR. STUKES: So at this time, the Department wish to withdraw the seven-day waiver

as it pertains to the variance request.

MS. SHERMAN: Thank you.

[APPLAUSE]

MS. SHERMAN: Dr. Cohen.

DR. COHEN: We should just be clear. The reason this has been withdrawn, is because the vote would not have passed. And --

[APPLAUSE]

DR. COHEN: And I just want to comment on discussions we've had from up on this podium before, it's good that we're not extending the, the possibility of keeping people in solitary for 70 days in a row by, by, by not approving this, this variance, because the Department doesn't need it. It doesn't take away a critical tool that they have, it's not something they, they, they need.

And additionally, last, last, last month, we passed a, we, we, we passed an extension of, of, of a, of restraint desks in, in, in juvenile ESH. So we're, we're, we are working here at the, at the Board and it's, it's -- since rulemaking is not progressing at, at a,

at a satisfactory rate at this point, we should not say, as has been said before we're not going to engage in issues around solitary confinement because we have to wait for rulemaking to happen. When they come before us, we should take appropriate action and I think today the effective defeat of this, of this request is, is the right direction for us to go forward.

MR. PERRINO: You know, I'd just like to add it's been like a year-and-a-half since the Department actually utilized it, so I, I've got to say that the restraint that the Department used it's -- everybody's going in the same direction and they should be commended because they could have used it for those 18 months, but they chose not to. And I think because of all the discussion in this room really made the difference. And, but I would like to say that, you know, like a lot of you are saying this.

There's got to be a system in place to separate these violent individuals from people just trying to do their time and it's such a small amount that's actually causing the

violence, such a small amount, but it's hurting people that's just trying to do their time. So, a lot of the blueprints that you're talking about, we, we need that and we need the separation desperately, because I don't want to see nobody get hurt. You know, punitive segregation, even though it don't work, okay, it did provide that separation. So, we need to find something to separate these individuals to keep our community safe. So, I just want to add that the Department had a huge amount of restraint. Even though they had the tool they did not use it for 18 months.

MR. FRANCO: I want to make a comment to, to your point. I think what I heard loud and clear from the blueprint, as I met with them before, it's not just about separation. It's actually about making sure that people actually get the skills and the support they need to be able to regulate their emotions and behavior. I think that's I would like to commend the Department, I mean that's the direction to move. It's our obligation at the Board and the

Department of Corrections to help the people that they serve be better, to work in society, not just to separate them, yeah.

MR. RICHARDS: Yeah, and I want to acknowledge the Department still could have put the variance through and you made the decision not to and I think that's an acknowledgment, as you said, of the comments that were made today, but has been ongoing conversation. And it's the Department's desire truly, I think, this is an example of the Department saying how do we work together we want everybody to be safe. We don't want to have isolation be the tool that is used. And I think we're on the cusp of really being able to do something that is powerful in terms of making sure people who are incarcerated are safe and do it in a humane fashion.

So, I just want to acknowledge the Department, I look forward to the ongoing conversation, thank the advocates for your hard work in thinking this through and sticking it through with us and I look forward to the next phase of our work together.

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MS. SHERMAN: Thank you.

MS. EGAN: The Correctional Health Services has requested an opportunity to present an overview of their re-envisioning of its service and staffing models. So, I will invite CHS up.

DR. PATSY YANG: Right. Good morning. Do I have a PowerPoint? I don't know how to do this, so just -- great. Okay, so we are entering our fifth year since the transition over to York City Health and Hospitals. And so we thought it was a good time to update the Board on what we accomplished last year and what we're heading towards at least initially this year. Sorry. Okay.

So, we actually migrated from our electronic health record system, which had been a legacy system from the DOHMH days. The vendor was less than responsive and, and it was getting a little bit unstable and not particularly responsive to our needs from the beginning. We purchased and adapted a, a records system, which we call CHAR, Correctional Health Electronic

Record, and migrated completely beginning in April at Rosie's and Horizon. And in July, all the rest of the, the facilities, our target date had been December of '19 and we, we beat that target.

We launched our point of reentry and transition practices in July. These are, there's a couple of elements related to the PORT pro-, the PORT program. One is very notably, two outpatient clinics that we have at Bellevue and at Kings County, where our providers rotate through side-by-side with the hospital primary care providers, offering care to people who are released. We make appointments for people and referrals prior to discharge from jail, so there's that continuity of provider care, where the person whom you might have seen inside is the same provider who can take care of you outside.

We have community health workers who are both in the jails and in the hospitals, so there is that warm handoff and when you actually arrive at the hospital for your appointment you can just text our community health worker, who will meet

you at the door walk you through the registration process and into clinic. You can stay in clinic, in our PORT clinic practices as long as you wish, although the goal there is really in the four months immediately post discharge that you can begin to migrate over to the primary care setting in a managed care setting in, in the right, in the hospital outpatient departments.

We also have a PORT line, which is staffed by community health workers. All our community health workers have lived experience and they're available to answer any calls, make referrals, connect you to care assistance of any kind.

Last October, we opened our fourth and last enhanced pre-arraignment screening service and there's about 33 percent of emergency department runs have been avoided since we, we've started this process. The borough-based jails, we have been an integral part since the beginning for the planning of what the borough-based jails will look like. We're really excited about the opportunity to create more normalized, dignified

settings for people who do need to be in detention. We have continued to increase the number of jail-based therapeutic housing units that we have in the physical plants that currently exist in the jails. There are limitations in terms of HVAC and, and, and natural light, but we have been working with the Department of Correction very well to, to, to expand the number, both of medical substance use and mental health therapeutic units, the latter being the more famous, the PACE units. And we are actually on ta-, on target to open all 12, get up to twelve PACE units by the end of this year.

These, these jail-based therapeutic housing units have really been remarkably successful in terms of creating a better environment where our, the correctional health staff are actually embedded in those units. There is a better access, there's more continuous integral interactions and therapy. In the mental health units, for example, we've seen medication adherence, voluntary medication adherence up by

50 percent and self-harm down by 25. Oh, I went the wrong way, sorry, that was not good.

Our outposted, you might have read about this, but we were really excited last year to be able to get approval to create outposts to therapeutic housing units. This has not been done anywhere else. While we have the therapeutic housing units inside the jails that I just talked about, we did recognize that there are some, some patients with complex medical, mental health, substance use or co-morbidity needs who need regular and frequent access to specialty services and subspecialty services in the hospitals. They're not sufficiently acute enough to, to merit inpatient acute hospitalization, but the lengthy transportation that's required to get to a hospital for a 15-minute consult or, or procedure is a deterrent, can be a deterrent to patients accepting and consenting to receive life-saving or life improving, health improving services.

So, what we're doing is through a process we -- Correctional Health Services

contracted with Lothra [phonetic] to look at all Health and Hospitals facilities that have unused or underutilized space. As a result of that, Woodhull and Bellevue are identified as being the most appropriate for placement of these, these units. They're going to be operated by Correctional House Services, not by the hospitals and DOC will be managing the cus- custody there.

They are locked units. Decisions to admit people to these outposted units or discharge them will be based on that individual patient's clinical needs as determined by us. We are in the middle of procurement and on track with beginning the, the design of these units beginning June 1st, and we are hoping to fit maybe 250, maybe 27- 275, 74 beds between the two facilities.

The other the other piece that we started this year, so that was in last year and we're really excited all that work. One of the things that we launched this year was, was after much planning over the course of 2018 and 2019, recognizing that not only our staffing matrices

but the way we're delivering core services had been legacy from Prison Health Services, Corizon and not been changed over decades. And where, where the jail environment can sometimes seem to be random, we thought that what we could do is restructure what our core services, which is intake, how sick call is handled and medical follow-up so that there are more structured and focused expectations on the part of patients, DOC and ourselves, have of each other and of ourselves.

So this is all to improve continuity and access and quality of care and as well as provider and patient satisfaction. On January 6th, we initiated a change in our intake hours going from two blocks of time from 6:00 a.m. to 11:00 a.m. and 4:00 p.m. to 8:00 p.m. in three intake buildings, while in Rosie's and AMKC, we continue to offer that around the clock. The sick call, we're launching targeting is March 31st to roll out at AMKC and April 6th, the following Tuesday at the rest of the facilities is introducing a new supplemental way of, of, for

patients to reach us directly. Right now, there is no way except to be asked to be brought to clinic. So with DOC's assistance and support, we have identified, we've established a confidential line directly to Correctional Health Services from each of the housing units where patients can call and speak directly with our nurses and ask questions about their medication, ask, you know, say they want a dental appointment rather than waiting to be brought to clinic to say I need a replacement pair of my eyeglasses or a renewal prescription. That can be handled over the phone as well as some, you know, discussion to the extent that they feel comfortable about what their concerns or questions or ailments might be.

So the, our nurses can handle that either administratively such as making an appointment at dental clinic for you, telephonically explaining what, what side effects, what to expect, what the next step in your treatment plan might be, to adding, adding on a visit in person in clinic as a sick visit.

That leads to the third piece that we're

doing, which is a medical follow-up. We are setting set hours, so that like everyone else, you sort of know when your doctor's hours are so you can plan your life a little bit better, you don't have to worry about having a conflict with your commissary or a visitation, or law library. You'll know that you'll be brought to clinic 10:00 to 10:00. We're also assigning people, we're moving to a team-based approach for medical follow-up care, so that rather than a patient seeing any provider who happens to be there for that one complaint at that point in time or any provider seeing whoever for that patient is in front of him or her, you'll be assigned to a team of providers who will get to know you. You'll have a relationship with your provider, a provider patient relationship over time and holistically, not just the presenting complaint. And we're really excited about, about that. And the visits that I talked about earlier would be pulled into those medical follow-ups with your team. And particularly if you have repeated, you know, presentations about the same complaint,

obviously we need, we need a continuum of care and, and a provider who knows you and understands and can really get at the root of your question, because we're, we're not doing it well this way. And, and that's it. Thank you.

MS. SHERMAN: Thank you. Questions?

MR. RICHARDS: Thank you for this presentation.

DR. YANG: Sure.

MR. RICHARDS: As you was going through some of the points, I was just envisioning how tied is this with the borough based facilities, right, when you get to a vertical facility, the ability to have this kind of technology play into the delivery of services and to have this rolled out is, is really good. You said you, you piloted the intake. Could you share some of the results between what you found in terms of the way you are envisioning doing intake medical screening in the new way versus how it's has been happening around the clock before? Have you seen differences between the two models?

DR. YANG: One of the, the more

remarkable, not surprising, but, but notable resul-, changes has been how well collaboratively and cooperatively DOC and CHS are working for orderly and timely throughput, you know, patients process, through the intake process. It had been a little bit less structured before, but now with the chief's support and the commissioner's support, it's very much you know first arrival in is first, first brought to us and first housed so people are the intake less.

MR. RICHARDS: And chief, have we seen, have we seen, have we seen people get into their assigned housing units faster? I remember it used to take us days to get to a housing unit, to go see medical and get cleared. Are we, as a result of this, seeing people get seen faster, getting placed in housing faster?

CHIEF JENNINGS: So the ideal is to have medical treatment initially to see someone if they're sick and then for the new admission processing, as expeditiously as possible and to be housed. Because the design is not to keep anyone in the intake process for prolonged

periods of time. So that's one of the things that we've worked at. And then with just the sheer numbers of persons who are being intaked has reduced significantly, which really gave us the flexibility to look outside and, and come outside of that box to do some things so differently.

MR. FRANCO: This is fantastic. Can you talk a little bit about young adults and adolescent services? I mean are we doing anything specifically to kind of meet the science in terms of healthcare and mental health needs for those up to age 24?

DR. YANG: Yeah, do you want to talk about that? Yeah, I don't know.

DR. MACDONALD: So I think one of the things that is so critical about this effort is really to have a more concise team full of people who are specially trained. And sensitivity to different populations is absolutely part of that. So we were really able to build a team of intake physicians with special qualifications. It was a new position within CHS that we hired separately

for and interviewed for. And we have a, a touch point with that group, that much smaller group, where we can go through protocol changes as well as really the range of, of teaching and best practices for what we want our staff to be doing.

So young adults is a, is an example of a special population that req-, has special needs and where we can work with those intake providers to understand exactly what we want out of the intake process.

MR. FRANCO: My question comes from the context of knowing that actually everyone is talking more and more about the importance of adolescent pediatricians and I didn't realize actually until recently that New York City has three of those programs and we, I cannot [unintelligible] [01:50:48] everyone else, so is there any search or intent to actually bring those like expertise into your fold?

DR. MACDONALD: So, we do have adolescent trained staff on the, on the psych side --

MR. FRANCO: Okay.

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DR. MACDONALD: -- and at Horizon, as you know pediatric staff. Separate, because it wasn't a new initiative this year, but we have our young adult service --

MR. FRANCO: Okay.

DR. MACDONALD: -- which is a team specifically tailored to relationship building with that group. And they do a lot of in-jail support. And really the goal of that team is to, to support people through the stress of incarceration, which can often be mis-assigned as mental illness but may be a normal reaction to trauma and to stress, and also to leverage the relationships that they build to lend credibility to our health service, so that we can treat their mental illness effectively or their medical illness.

MR. FRANCO: Yeah, I mean, I'd love to talk more. I mean it seems that actually there's a lot of new research and evidence-based practices that actually take advantage of the plasticity of the brain at that age and that actually are really good at helping young people

reduce the likelihood of violent behavior, and so we should be looking at that together.

DR. MACDONALD: And one other point related to what Patsy presented, you know I think the, our involvement in the development of the therapeutic housing units for the borough-based facilities absolutely plans for a footprint that doesn't necessarily cast young adult services in a mental observation unit model, but understands that therapeutic environments specific for that group are critical.

MR. FRANCO: Thank you.

MR. RICHARDS: And could you just walk through I'm sorry, Bobby, just could you walk through on the telehealth, someone comes in what does that process look like? How does the person get engaged if the person is detoxing or on new medication? How does that whole process work?

DR. MACDONALD: Yeah, so it's a nursing driven process, which is not new. So, if you know anything about the way our intakes have worked for many years, the first touch point is nursing and there a range of things that the

nurse does. You know we, over the years have piled a lot of public health interventions into the intake, so it can be a lengthy process. Nursing starts doing some of the essential screenings, offering rapid HIV, rapid Hep C testing, EKGs for cer- certain populations and asking the initial screening questions as well as anything special like the coronavirus screening that we've talked about today.

So that part of the process is very similar to what people are used to. The change is that instead of now going back to another waiting area or back to the pen to wait to see the doctor or the PA, that nurse will bring up the, the, the doctor on the telehealth monitor. So, it's a collaborative process between the nurse who's with there, there with the patient, it happens in real time and the, the doctor will go through their part of the process. That is quicker or longer depending on the complexity of the, of the issues that we need to deal with. But we think that this really allows us to have the most specialized people on the doctor end

doing that very critical task of, of intake, because it really sets the tone for how we're going to care for that person for the duration of their incarceration while still preserving the human contact with the, the nurse.

MR. RICHARDS: And that will speed up, thank you.

DR. COHEN: You know, I'd like to comment on this process. The, to -- another way of describing is that in facilities, right now I think this would be RNCD, the barge, MDC where there is significant intake, there will be no -- as well as in R- RNDC AMKC from 10:00 a.m. until 8:00 a.m., I'm sorry, 10:00 or 11:00 a.m. to 6:00 a.m., I think it's 10:00 to 6:00, for that for that period of time there will be no intake going on so that people who come into the receiving room during that period will not be seen by, by, by anyone, because the routine intake process is closed down.

I, I found that sad, objectionable, inappropriate. I'm not sure that that's a violation of, of, of our standards, that

particular issue. But I'm surprised that the, that CHS would decide the best thing to do at this moment in history is to, is to say we're going to leave people in receiving rooms for extended periods of time, closing them down at night.

Now to be clear, it could be understood, it could be under-, there will be a doctor because that's required by our standards in the clinic during that period. There will be correctional staff in the receiving room during that period and they just won't be doing anything relative to -- the medical staff won't be doing anything relative to intake. They won't be doing sick call, they won't do be doing intake, they won't be doing follow-up. They will just be there. And I think particularly, at any time the goal would be to, if someone is in intake to get them out of there as quickly as possible. So that is a, is a problem with this procedure.

Secondly, our standards require that there be a physical examination of the patient when someone enters this facility, by a medical

professional. A medical professional is, is defined as a physician, a physician assistant or a nurse practitioner. It's not a, it's not a computer screen. And I am disappointed that Correctional Health Services would think that it is an improvement in our system to take someone who has been arrested usually, has been arrested, has been in a police lockup, has made it to arraignments, has been, has been -- their only contact up to that point was they've been people who have been, not on their side and to come to the medical service, where I came many years ago to, to work as a doctor, to be the person who could be there when someone is, gets their intake into the facility, rather than a computer screen.

Now, our standard is very clear that it requires a physical examination and our counsel has, has reviewed the subject and, and said that it is a violation of our standard to have a, to not have a physical examination. CHS should be asking us for a variance to, to allow this or for us to consider it. But they, but they're, they're taking the position as I understand it,

that that they don't have to do that, that they are going to ignore our, our, our standards.

I think there's lots to talk about here. There are ways to do things differently over, over, over time, but I hope that we will very quickly get a, get a request for a variance from you, that you will stop closing down intake during a substantial part of the day and, and, and have your goal to be no person spending any more time than is, than is necessary in intake. And that cannot be done if you're closing down the intake to, to, for ten hours a day. And, and that should be done right away.

There's some other elements of the re-envisioning which might, which might be, which might be excellent and I look, I look forward to them. But right now, you are in violation of our standards and therefore you should ask for a, for a variance, which we can consider. Thank you.

MR. RICHARDS: What was the basis for the timeframe?

DR. MACDONALD: So, the basis for the timeframe was really to try to normalize, as

Patsy explained. You know, to be doing this critical relationship building and initial intake into our health care delivery service, you know, there's no other medical setting that exists where you try to have a relationship and an interaction like that in the middle of the night.

So we're trying to normalize, we're trying to standardize, we're trying to control the process, which also allows us to work with our partners in DOC to make sure that the process happens orderly and quickly and timely and that's a critical element of it. Just because we were available to be there overnight doesn't mean that those were happening timely throughout history going all the way back. I, just say to Bobby's points, you know we have deep areas of disagreement on this, clearly.

We at CHS are not doing this because it's easier for us, we're not doing it to save money. We're doing it because it's the best way to do the work that we care about that we need to do for our patients. So, we can talk about your concerns about it, but I just want to be clear

that for the people who are passionate about this work and do this work every day, this is our strategy to do it right.

MR. RICHARDS: So, I mean do we, have you asked the Department like in terms of just understanding the impact when you shut off intake at 8:00 p.m., like how many people will that impact? Like because I know, you know, people who come in on after arraignment in the evenings or a late night will get to the facility early in the morning, which means they would be around for at least five or six hours waiting to 6:00 o'clock. Like, have we thought about like what's the impact of how many people by changing this? Does the Department know how many people it might impact? I know the numbers have been coming down.

CHIEF JENNINGS: Yes, so prior to taking on this pilot, there was an analysis done with the numbers to see if that was something that could be done. But to Bobby's, the point that he was making, during the new admission processing there is no one sawn, or seen by telehealth.

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This is a feature thereafter, that the first time that they are seen by medical, it is in person. The telehealth was something totally different than new admission processing, which they were speaking to.

DR. COHEN: The standards require a, a medical professional, a physician or nurse practitioner or PA to examine the patient. And that's --

CHIEF JENNINGS: So, for new admission processing that is happening. They --

DR. COHEN: It's not happening.

CHIEF JENNINGS: Uh, yeah.

DR. COHEN: No, they're using televisions instead.

CHIEF JENNINGS: No.

DR. MACDONALD: So, I, I really think we can have this discussion, which we initiated with you, which I appreciated you coming to talk with us about it. And I'd like the opportunity to talk more about it. We believe this complies with the standards. And we carefully considered that before we initiated it. And so, I, I just

think there's a lot for us to discuss, but my fundamental point remains. This, the notion that the status quo of what we've done, which is more than any other system in the country, just assumed that putting more staff in every corner of the jail system at all hours of the night is going to lead to quality. It wasn't the case.

MS. SHERMAN: I actually, I have a question sort of off that point, which is sort of two-part. Both how is CHS and/or the Department obtaining and reviewing feedback from folks who are served by this process? And overall, what criteria are being applied to evaluate the success of the initiative?

DR. MACDONALD: So, we have a very robust --

[PHONE RECORDING]

MS. SHERMAN: Excuse me.

DR. MACDONALD: I caught it, I caught it, you don't have to repeat that. So, we have a very robust quality improvement and quality assurance department at CHS, which is part of the structure of Health and Hospitals. So just like

hospitals have teams that help the clinical staff evaluate what they do, evaluate new initiatives and improve the quality of care, we have a team of experts who, who helps us with that. So, we have looked at a range of quality metrics around each element of what we're describing here. And, and the critical elements of intake that I mentioned to you, you know, there are things that need to be done right every time when people come into jail. So, for example, screening for acute suicidality and escalating that to mental health appropriately, the evaluation of withdrawal and the appropriate treatment of withdrawal, the standard screenings that we do, the evaluation of chronic diseases when present. So many times people will need urgent treatment.

The intake process has pathways to address all of these and really what we're looking for is reliability and consistency. And the strategy to do that is with this team of doctors who are really specialized in doing this work. It's not something that you would know how to do if you were a doctor coming from a clinic.

It really requires specific training and you know I think that's, that's really the key of this initiative. There are a variety of quality metrics that apply to all the elements of re-envisioning what Patsy described. I just also would like our chief nursing officer to speak to the process.

MS. NANCY ARIAS: Hi, how are you? I'm Nancy Arias. In speaking of the process, I've been intricately involved in training the staff and being present in the process with our patients. And also I've been here historically for 18 years, and I've seen the process from the beginning of our patients sitting in intake areas, us unbeknownst to the timeframes that they've been sitting in those areas.

And in learning this new process, the patients are having the human contact, they're expressing that this is a collaborative process where the nurses are able to interact with them, get an assessment with them as they're sitting with them and being able to project that with their providers that are sitting across the

screen, and is a positive interaction. And the nursing staff is helping to facilitate that. Where nurses are not MPs or PAs or MDs, nurses have a license, they can work at a higher level of their license and they do have rights to assess a patient, so that collaboration of their assessment sitting with the patient is easy to facilitate with the provider that's on the screen. And it's a joint collaborative effort. And our patients are having a better, more proactive positive experience through the intake process with that collaboration.

MS. SHERMAN: Thank you.

MR. RICHARDS: Well, I can tell you, if, if it's -- if you're eliminating someone going to the clinic seeing the nurse going back in the bullpen and waiting to be called on a doctor, if you're eliminating that process that they get to see the doctor in that one setting that is a huge change. It used to be hours between seeing the nurse and then finally being called to see the doctor. And you're not getting to your housing area until you get to see the doctor. So, if

you're saying that that is all happening that at one time that is a huge elimination of a process that wasn't working very well.

MS. ARIAS: Another thing that Dr. Yang spoke about was about the collaboration with DOC and that has been an integral part of making this a success as well. We know when our patients are coming, we get a list early in the morning, we get a list before the next timeframe. And to be clear we do have crossed out timeframes that were saying that the staff can get a list and these are the patients that they're to expect for the day to be evaluated through the process. So, we're not saying okay, it's beyond the block and we're not going to see those patients. We're getting a block of time that we're seeing those patients in, but that's the list of the timeframe that we're going to take the patients that DOC is advising us that they have available for us to see for the tour. So, we're not negating the fact that they're sitting in the pen and waiting for the next tour. We know who they are and we know the timeframes and we know who expect. And

they support us in providing all our patients in a timely manner.

MR. RICHARDS: And so, I'd like to have, be part of this conversation that we're going to have ongoing because I think there might be some opportunities for some fine tuning, like developing a standard that nobody should be in a bull pen for X number of hours, that that automatically triggers being that you already have 24-hour medical care on-site, that that triggers a visit, so that they're not sitting in a bullpen for five hours. I think there are things we can do to, as you have just done, implementing some, some procedures that's going to enhance the process. I think there are some things that we can do together. And I would love to see the analysis, chief that y'all did to see how many people actually fall out of the, this timeframe of 8:00 p.m., how many people actually come into the facility for intake between 8:00 p.m. and 6:00 a.m., so we can see what we're talking about.

MS. SHERMAN: Thank you.

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DR. YANG: We're happy to, happy to talk to you about it.

MR. RICHARDS: Okay. Thank you, Patsy.

MS. SHERMAN: Thank you for the update. I think you can hear from the members of the Board, they are engaged, they are very interested. We want, wish to remain involved and engaged and informed as you continue the rollout of this initiative. We look forward to speaking with you and continuing to monitor and have input on the rollout of this initiative. Thank you very much.

The next item on the agenda is public comment. The public comment will be limited to three minutes per speaker, and as you can hear we have a timer right up here. The timer will sound at the end of your three minutes. So, I'll fir- first call on James Abro. Albert Craig. Henry Nelson. Lauren Wilfong. Good morning.

MS. LAUREN WILFONG: Good morning, my name is Lauren I'm here with my colleagues, Keiler, Cameron and Anna. We're all going to be reading jointly a testimony from someone that

we've been working with through the Urban Justice Center Mental Health Project who's currently incarcerated at Rikers. And this is their testimony that they would like to share with the Board today and we've also brought a complete written copy. We're only going to be reading some excerpts into the record, so I'd like to also provide you a copy.

MS. SHERMAN: Thank you.

MS. WILFONG: Okay. Life was good before I got locked up but at Rikers, it's horrible. I've been here since spring 2019. Before that, I was in the Brooklyn Detention Complex, since 2018. Before I was arrested, I worked as a super in the Bronx, managing buildings. I'm a handy guy with lots of experience, not just with the work, plumbing and electric, but as a people person. I worked seven days a week to take care of my daughter.

Before I was locked up, I was very active. I loved to ride dirt bikes and to snowboard. I'm a New Yorker through and through, born in raised in Brooklyn and then moved to the

Bronx. I also come from an over policed neighborhood. In minority communities there are a lot of police, too many. I'm very family-oriented. I talked to my family every day on the phone. My family used to come visit but they don't much anymore. Some of the guards would make comments to some of my women family members that made them uncomfortable. Plus, the searches are horrible. They really rob you of your dignity. My daughter still visits though every week. She's five now, and going to be six soon. She's everything to me and I love seeing her.

I wish that Rikers would do more for those of us with children visiting. They don't have snacks or games during regular visits, only through CHIP. There are no activities, just a bare room. I feel like an ant in an ant farm. We can't relax during visits because we're being watched by guards the whole time. There's nothing to do, no activities for the kids. They can sit on your lap and you talk. That's it. My daughter's five. She wants to play. I wish there were board games or something for us to

make it more like regular family time. Even just a small change could do a lot for a parent.

I do everything I can to stay out of trouble here. I mostly stay in my cell in order to avoid fights and stay safe. I meditate and I read and I write a lot. I think they should, they should have everyone with similar charges in the same place. It's confusing to have everyone together, people with all different kinds of cases, people who are back here with parole violations, people waiting for trial. It creates unnecessary issues and sometimes violence.

The gangs run Rikers but I'm neutral. I stay out of it. Sometimes that can be dangerous. Everyone wants you to pick a side. The officers put in my file that I'm a Crip even though I'm not. But then they put me in a house that's all Bloods. I'm not a Crip, but that perception alone is dangerous. If officers think I'm a Crip like they say, they're not supposed to put me in a house with Bloods. It's dangerous for me. I filed a grievance to get that gang designation removed from my file because it's not true but

they have not removed it.

MR. KEILER BEERS: There are a lot of problems here. The, the food is terrible and half the time, it's skimped. It's a hassle trying to get all the nutrients you need. There are cockroaches everywhere, there's no AC and there are people who are heat sensitive. We have to fight for basic things like clean blankets. They never bring boxers or socks or things like that. I have to rely on my family for that. Half the time, I don't get my mail or if I get it, sometimes I can tell it's been opened. The letters always take forever to arrive. I had one letter that I didn't receive until a month after its marked as sent. The commissary is overpriced and half the time you don't get what you paid for. They'll say oh, we're actually out of that, but then you don't get your money back.

It's also hard to get medical here, care here. Last month, I broke my glasses and I can't see without them. I put in a request to get my glasses fixed, but it's been almost a month and no response. I also have asthma and it can be

hard to get refills for my inhaler.

I just went to solitary confinement for the first time. During the heat wave last summer, me and some other guys from my house started playing around, splashing water on each other, just something to refresh us and to pass the time. We were just distressing a little, but we got written up for that. We each got 10 days in the box and the $25 fine just for playing around with water. They didn't call me to serve it though until six months later, just a week before my court date. So instead of spending that time leading up to my court date in the law library preparing, I was stuck in a room the size of a closet for eight days straight.

I take medication for my mental health and they're supposed to send someone around to check on you when you're in solitary. But the checks are more like a drive-through. Somebody came by once or twice, just a quick knock on the door. You okay, thinking of killing yourself? And that's it.

I put in a request every day to get

access law library, but they ignored me. I asked every day for a shower but was only able to get one the entire time I was there. And I had to practically beg for that shower.

MS. CAMERON RUFFA: Good morning. Even in solitary, you're supposed to get some rec time out of the box but I didn't get any. I was in there 24/7. They only let me out for a few minutes to take my meds each day. All I could do was sit there and stare at the wall. The first day, I didn't even have a mattress. I had to kick the door for 30 minutes just to get them to bring me something to sleep on.

I was only allowed one phone call a week. My family was so worried about me because they usually hear from me daily. The morning of my court date, they took me out of solitary and brought me to court. I asked to shower and to change my clothes, but they wouldn't let me. They brought me to court in the orange jumpsuit, which indicates some kind of wrongdoing, not having showered in days.

I don't know why they waited six months

to put me in the box after my infraction and then picks a week before my court date to do it. I was embarrassed to go to court like that, without a shower or the opportunity to change my clothes. They're trying to throw people in the box before their pre-hearing detention. It's happened to three or four people in my house just for minor fights. I washed up as best I could in the little sink in the room, but it wasn't the same. Eight days in the closet without anyone to speak to or any chance to move my body took a toll on my mental and physical health.

Mentally, if you're not fit, solitary would destroy you. I've only been in solitary once but I've been deadlocked several times. That's when they totally shut you down, no rec time, no phone calls, no nothing. One of the times was right before an earlier court date. Deadlock is inhumane. It's the box outside of the box. But unlike the box, there's no hearing, no process. That's because it doesn't officially exist. If you go in certain houses you'll see a red tag that says deadlock, but it's not in any

books. It's an unsanctioned and undocumented punishment.

When you're deadlocked you're stuck until they decide to let you out there's a guy in my house has been in deadlock for two months straight. He hasn't showered in two months. The worst part is because there aren't phone calls on deadlock, you can't call 3-1-1 to complain or call your family to get them to advocate for you. You have to rely on other inmates to call for you, but they're not going to do that. They have their own family to call.

MS. SHERMAN: Can I ask that you please identify yourselves before you speak?

MS. ANNA MEIXLER: Yeah, hi I'm Anna from NYU Law and I'll be continuing the testimony.

I haven't had too many problems with the guards here but I've witnessed a lot. The worst is when they use MK9 pepper spray. It's lethal. If they spray in one house, you'll feel it in the next house. They use bear spray and it's just too strong. It's especially bad for me because

of my asthma. I've never been the target of the spray, but I've been affected just from being in the same place or even within a couple hundred feet of it.

The spray feels like a handful of needles just continuously poking you all at the same time. You don't even have to be directly sprayed to feel it. And it sticks. The next day you'll still be feeling it. And they, and after they spray, they don't come in and clean up they don't decontaminate a space after they spray. You have to be careful because there can be spray residue everywhere.

I've been at Rikers for almost a year now. A lot of people come in and out but I'm like an elder. I've seen a lot. I think they should cut the max days for solitary and shouldn't give it for little things like playing with water. I only served eight days in the end in solitary and that was bad enough. Another eight days and my mental health would have been really questionable.

Right now, they can give you thirty days

or more, easy. It's just too much. I don't think they should be able to wait until whenever they want to make you serve it either. I got my infraction in the summer, but didn't serve it until late January. It interfered with my court date and my trial prep. They shouldn't be able to hold it over people and drag it out like that. Any time spent in the box should count towards your sentence there too. Sometimes they put you in the box while waiting for your hearing. You could be in there for 15 days before you even get a hearing. Then, at the hearing they sentence you to 15 days in the box and you start all over. None of the time you spent in there before your hearing counts, so you end up serving twice the time that you were supposed to. That's not right.

I also think that the officers should take mental-health issues more seriously. If you're not on the brink of suicide, they tell you you're fine. Mental health checks are just a quick knock on the door, nothing more. Jail life can be very difficult and if you have mental

health issues on top of that, it's even harder. We're taken out of a natural environment and put in a cage. It's hard to fight your case from the inside. The system takes advantage of that. It's a lucrative business, modern-day slavery. All this stuff is just contracts we are robbed of our dignity.

Before I was okay, but being here has made me depressed. Officers should take depression more seriously. Finally, I hope you'll close Rikers a little earlier. This place is truly horrible. there's no justice here.

MS. SHERMAN: Thank you. Cameron Ruffa.

MS. RUFFA: That was me.

MS. SHERMAN: Okay. Thank you. Bridget McCarthy. Good morning.

MS. RACHEL: Hi, my name is actually Rachel [unintelligible] [02:20:49]. I'm here with Bridget McCarthy.

MS. BRIDGET MCCARTHY: I'm Bridget McCarthy.

MS. RACHEL: And we are also here with Urban Justice Center's Mental Health Initiative

and sharing testimony from another incarcerated individual on Rikers. And I hope that this testimony demonstrates lack of meaningful choice that's available to people incarcerated.

I'm 25 years old I'm from the Bronx and I've been locked up for 20 months, a total of 60 months over my life. I've been in almost every building on Rikers and also the tombs in Brooklyn House. But I'm trying to get my life together. I never want to come back. I have a five-year-old daughter at home and I want to be there for her.

In jail life is on standstill. I missed my grandfather's funeral last October, because I was here. He raised me, he was my best friend and like a father to me. While I was in foster care when I was younger, I was diagnosed with anxiety, PTSD and bipolar disorder. I took medication for a while but I stopped because it was messing with me. I couldn't stand straight.

The jails need more housing for people with mental health problems and they need to take people's mental health illnesses seriously.

People who are having issues need to be able to be housed separately instead of being together with everyone else in general population. Right now, for you to be sent to mental health housing, they have to feel like you're going through psychosis and they have to have bed space, because even if you're having an episode, if they don't have bed space you can't go. But if you've got a problem they need to send you there ASAP, not next week.

It feels like jail is turning into Bellevue's men's shelter in Bellevue Hospital. People are arguing over really minute issues dealing with mental health problems. If they're going to have these types of services, then they should have more caring and attentive staff.

The last time I was in solitary was three months ago and I'm hoping I can go back. Sometimes it could be a good thing if you're not accepted into mental health housing. I want to go back to solitary because sometimes dealing with my own issues in this type of environment can be a struggle. In the dorms there are people

all around, all around all the time. There are less problems in solitary. In jail, problems come from all over the place. People use other people's problems to get out of their own problems.

In solitary, there are urine fights, feces fights and lots of verbal fights. People tell the guards you have to have your light turned on in the middle of the night, so then you can't sleep. One time, someone was taunting the CO. The CO couldn't tell who it was, but he decided not to give breakfast to the guy he thought it was the next day to get back at him. For the camera, the CO made it look like he was offering food and that the guy said he didn't want it, even though he said yes. The CO walked away without giving him food.

Also in solitary, the only thing you can get in commissary is toiletries. Even if you don't need mental health housing, you should at least be able to talk to someone. The counselors aren't always available, probably fifty-fifty they can see me when I want to talk. Sometimes

the counselor has, the counselor has people there already. Sometimes they don't have time, sometimes there's no clearance. I don't always see it the same person when I go it's usually different people. I mostly feel comfortable opening up but I get frustrated that they feel like they can't actually empathize or share their experiences and they act like they're doing something wrong when they open up. I'm not a kid and I don't want them to treat me like one. They check their watches and often sometimes I feel like they're there for a paycheck. When you need help, you need real help.

In jail, it's like your soul is getting shut down, like when your little cousin is trying to talk to you and you yell at him to stop, you shut him down. That's what happens to your soul here. Thank you.

MS. SHERMAN: Thank you. Kayla Simpson. Good morning.

MS. KAYLA SIMPSON: Good morning. My name is Kayla Simpson. I'm a staff attorney at the Legal Aid Society's Prisoners' Rights

Project. Thank you very much for putting COVID-19 on the agenda today. I want to focus on that for a moment. And I think it's really important that when we talk about plans to address this crisis that we center it in the experience of what it's like for people who are incarcerated.

And people confined in jails, I don't have to tell you this, during outbreaks of infectious disease are particularly vulnerable not only because, of course, chronic illnesses and suppressed immune systems are over represented in the population, and not only because of the physical environment, which includes obviously poor ventilation and very close proximity. But people in custody are vulnerable, because of the profound constraints on the ability to help yourself, that the coercive power of incarceration affects on them.

Many of the actions that the CDC tells us to do in the community to protect ourselves and each other, like thoroughly and frequently washing our hands with soap, seeking physical distance from other people, finding medical care

if we're symptomatic are available to incarcerated people only with the permission and often overt assistance of the people who are jailing them. And I think it's impossible for us as we go to bodega to bodega to search for hand sanitizer, to imagine what it would be like to not have the agency to get soap when you don't have it.

And I think it's really important that as we think about what questions we should be asking and what preparedness looks like that we remember what it would be like to be robbed of that agency to protect yourself.

And of course, I want to say we're very glad to hear that Correctional Health and DOC leadership are aware of the critical importance of many of the things that they expressed and we appreciate that. I don't mean to minimize it. It is important. But I think it's important to be concerned about what we didn't hear today, particularly a swift and reliable quality control program for making sure that hand-washing is actually available to people who are in custody

and staff. I didn't hear anything about that. How many sinks are down? How many are operational? How many housing units have soap? What's the extent of that supply? What cells are empty or broken? How many people are going to be forced into closer custody than the, the plan indicates?

And I think DOC needs to provide an audit to you of all of that relevant information so that we can know the extent of actual preparedness. I think it's a cornerstone of Public Health. It's measurable, it's quantifiable, it's important. And also, when will people be allowed the opportunity to wash their hands? In intake when they've been transported? Who's tasked with ensuring that it happens? And I just want to imagine riding the subway in your morning commute and being placed in a tiny room with a dozen other people, someone coughs, you hear them cough. And then you're not allowed to wash your hands for hours and you're at the mercy of someone who's keeping you in custody to do that. I just think that keeps

nobody safe.

What are the city's plans if all beds and hospital wards in the CDU are full? What do they do with people in the interim? I think we, we've seen how quickly, if Italy has taught us anything, this can spiral and we need to be prepared for that. And just a few more things.

We're gravely concerned about the health of people who may be con- confined in movement restricted places, about the ability to access medical care. I think it's important to consider cell side rounding. And lastly, we would just say that implementation is critical here. I think if Nunez teaches us anything, it's the cost of implementation failure. And we implore the Board to be vigilant in its oversight and to not allow issue fatigue, which plagues so many things, which plagues public health crises is in general. People are prepared for the first couple of weeks and then it kind of lapses. We cannot allow that to happen with people who are in this vulnerable position. And we look forward to continuing to talk to you about that. Thank

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you very much.

MS. SHERMAN: Thank you. Grace Li. Good morning.

MS. GRACE LI: Good morning. My name is Grace Li. I'm from the New York Civil Liberties Union, the ACLU of New York. And thank you, Board and thank you DOC for addressing coronavirus again. We are asking DOC to publicly share your plans for the prevention and manage- management of coronavirus beyond what is already being shared about visitors. Share the full plans. And we're also asking the Board to urge the DOC to share those plans and also for the Board to share data about the spread of the disease within the jails. It's only that way that the friends and families and communities of people in the jails can be up-to-date on the information and can have some of their worries alleviated about the health and safety of their loved ones.

We also are asking that the Board evaluate the plans and make sure that the DOC is able to implement the plans. So that means that

we're asking you to inspect the jails to ensure the plans are being implemented and that your staff is safe and prepared in order to do regular inspections. We heed the warning of former commissioner Martin Horn, who said that contagious disease is a most dangerous foe and the least, and the least amenable to structured control in a setting where social isolation is difficult due to open dormitory housing, court pens that are incubators and accelerators of contagion and staff coming to work not aware that their child is a carrier.

We also want to address the DOC plans where we again commend the DOC for sharing an overview of some of their plans, but we hope that their plans address the following questions. Housing of people who are exposed to the virus, what are the DOC's plans for how and where people will be housed if they're exposed, if they're at high-risk or if they become sick? This should not result in prolonged widespread lockdowns, prolonged use of isolation or indiscriminate bans severely impeding contact with attorneys or

visitors.

Vulnerable populations, in addition to pregnant women and elderly people, people with chronic illnesses, compromised immune systems, disabilities, people whose housing placements make it hard for them to access medical care and limit the staff's ability to help them immediately.

Data collection, what are DOC's plans for collecting data in sync with the rest of the city? And having plans that address these questions can prevent the need for isolated confinement and constricting the use of visits and attorney cl-, at- attorney client visits and family visits. So please publish the plans on the DOC's website, please publish the plans on your website and keep the public informed.

MS. SHERMAN: Thank you. Sarita Daftary. Good afternoon.

MS. DAFTARY-STEEL: Good afternoon. Thank you. My name is Sarita Daftary. I work for Just Leadership USA and am a member of the Jails Action Coalition. During this comment

period, I want to return to a question that has been raised repeatedly in these hearings, what can the Board do about the Department's continued and documented failures that cause harm to the people in their custody. We must acknowledge that this is a department that is consistently violating minimum standards, which is designed to be the minimum requirements for responsible treatment of people in their custody.

Specifically, I want to talk about use of force. It's been repeatedly acknowledged by the Nunez Independent Moni- Monitor, including in their most recent report, and we're probably just a few weeks away from their next report, that the Department of Corrections has not fully institutionalized the use of force reforms required by the consent judgment. The report states that the Department remains in non-compliance with four, with the four most consequential provisions of the consent judgment, implementation of the use of force policy, timely and quality investigations, meaningful and adequate discipline and reducing violence among

young people. It also reports that use of force rate has increased 98% since 2016.

In the January Board meeting, Dr. Cohen noted that they are often uses of force by correction officers, which the Independent Monitor identifies as inappropriate, but which the Department identifies as appropriate through their internal reviews. Dr. Cohen requested the opportunity for Coard members to review those videos along with Department leadership and the Independent Monitor. This seems like a crucial way for the Board to gain insight into how the Department views use of force. Commissioner Brann offered in that meeting to bring up this idea to the Monitor and to get back to the Board regarding this request. We'd like to ask the Board either today or the next meeting to report on if this review has happened and what the results were. Thank you for your work.

MS. SHERMAN: Thank you. Ms. V. Good afternoon.

MS. PHILLIPS: Is it afternoon already?

MS. SHERMAN: It is.

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MS. PHILLIPS: Good afternoon. My name is Ms. V. I'm speaking from the Jails, well as a member of the Jails Action Coalition. I just want to address some things that was brought up today. Thank you for actually having to update on the coronavirus. I finally, I waited so many years and he has left now, but Chief Perrino, he mentioned finally DOC stats actually mentioned on the record, that DOC is not medical staff. And I've said that so many times in so many different ways around so many issues regarding what occurs in DOC custody.

So, today it took the coronavirus for DOC staff to actually put that on the record. So I wanted to take that sentence and point out to you when we talk about, when DOC talks about the staff in arraignment actually calling ahead of time to speak about someone who may or may not be exhibiting flu-like symptoms, it should not be on DOC staff. It should be on CHS, CHS staff if anything, because once you enter into the criminal legal system you become a responsibility of DOC. DOC has a responsibility to get you

medical attention, right. So CHS is, because we removed Corizon several years ago, and CHS took over that spot. So CHS is the medical providers for anyone in the Department of Corrections concern, right.

So, it should be on their staff to actually say whether or not someone should be isolated, someone needs to have further care or whatever it is. Because DOC can't even follow minimum standards that you give them on a daily basis, let alone around a crisis, an outbreak.

And just to be clear, to follow up on what I just said, DOC reported to y'all today that 1,048 scans have been done through a certain period of time, date, and then they try to trip you up with the numbers they give you. But they also said that out of that 1,048, 1,030 scans were supervised by a supervisor, like a captain and observed. But they also said that 764 of those scans were supervised by a captain who had been trained correctly and that 266 were supervised by an ineffective staff member.

But actually, when you divide, when you

take away 764 from 1,048 it's actually 284 scans that were not supervised by someone trained correctly. And even in those numbers that DOC came up here today and spoke to you, it clearly shows that they're not still capable of actually implementing any type of program to keep their population safe.

So do not leave it in the hands of DOC to say whether or not someone is exhibiting symptoms and should be seen by further medical staff. Make it a mandate, make it whatever you have to do to push the rule forward, that CHS has to be responsible for observing those people before they enter into to a larger population area. The bottom line, people that are waiting for their fair day in court should not be opened up to all these other diseases. And I'm going to say it again as a brain surgery survivor, these people who have not been scanned properly by people who are not trained properly, you're doing a damage to them, you're doing a disservice to them and you are the oversight of that Board. Please step up and do your job correctly. Have a

blessed day.

MS. SHERMAN: Thank You. Jocelyn Chen. Good afternoon.

MR. JOCELYN CHEN: Good afternoon. Thanks. My name is Jocelyn Chen and I'm here to testify on behalf of my incarcerated friends and community members. I urge the city to preemptively release incarcerated people from city jails to prevent the devastating spread of COVID-19 through a highly vulnerable population, made more vulnerable by lack of access to adequate basic medical care.

The spread of coronavirus has made abundantly clear the inadequacy of our public health infrastructure, nationally and within New York City. Across the country, local and federal jails, prisons and immigration detention facilities are lacking basic hygiene supplies like soap and sanitizer, do not have COVID-19 tests and are relying on protocols developed for the normal flu to address this novel health crisis.

While Governor Cuomo has already

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announced a state of emergency due to the spread of coronavirus through New York State, is not surprising, but highly alarming. The specific vulnerability of incarcerated people to deadly infection has yet to be addressed.

I would also like to note that the depravity and cruelty of using incarcerated peoples hyper-exploit and forced labor to produce hand sanitizer, which incarcerated people themselves are prohibited from possessing and visitors aren't able to use because hand sanitizer triggers for false positives on ion drug scans. This only goes to show how much the current conversation of COVID-19 ignores the specific risks and barriers to help, faced by incarcerated people.

People in jails and prisons are more likely to be sicker, poorer and without health care, in other words, especially vulnerable to infection. The communities who are hyper policed and hyper incarcerated, black and brown working-class people, people who use drugs, homeless people, trans and gender non-conforming people,

people with disabilities and people with mental illness are also are the communities most impacted by lack of access to medical care prior to be incarcerated.

On top of this, jails expose people to incarceration specific health risks, exacerbating existing health conditions and provoking new ones. In other words, jails make already sick people sicker and make healthy people less healthy under now and pandemic conditions.

Existing health medical care in city jails is already dangerously inadequate. For example, in 2018 incarcerated people missed nearly a quarter of all medical and mental health appointments and dozens of people have died in city jails over the past few years alone. City jails fail to deliver health care to incarcerated people under normal conditions. We cannot now expect them do better in the face of pandemic.

And proposed reforms to jail healthcare like placing locked jail wings overseen by the DOC in existing public hospitals, merely expands carceral control and commingles punishment with

spaces of purported care. Expanding DOC and police presence in our public hospitals would inevitably prevent the most vulnerable among us from accessing health care, increasing the vulnerability to COVID-19, that criminalized and policed people already face. Criminalization is a threat to public health.

Failing adequate healthcare provisions, New York City jails are likely to do what incarcerated people across the country are already reporting, using key block facility wide lockdowns and curtailing family visits to quarantine possibly sick incarcerated people and ostensibly prevent the spread of illness. But restricting the movement incarcerated people and preventing them from accessing programs through recreation, family visits and sunlight exacerbate the strain and violence of incarceration producing more vulnerability to illness. Lockdowns are not healthcare.

Fortunately, the health, health, the public health evidence is clear. While incarceration exacerbates ill health and

contributes to disproportionate vulnerability of black, immigrant, transgender non-conforming, disabled and working-class people to sickness and death, preventing people from entering jail in the first place and freeing people who are already detained are always good for the public health, the health of incarcerated people and the health of the communities.

I urge the Board of Correction to recommend the City Council and NYC DOC follow examples set by Iran, which recently released 54,000 incarcerated people to slow the spread of COVID-19. And while I recognize this isn't necessarily a purview of the DOC, I urge all city and state leaders to take steps to lower jail churn by reducing arrests, dropping charges and declining prosecutions and releasing people on their own recognizance when arraigned, because jail churn increases the risk of COVID-19 spreading through vulnerable populations locked in institutions inadequately and drastically unprepared for the health and welfare. By pursuing a strategy of radical decarceration,

preventing people from entering jail and releasing people already detained, New York City can divest from the jail [unintelligible] [02:42:51] making a community sicker and sicker and invest in providing community-based humane and dignified healthcare for all in the face of COVID-19 and beyond.

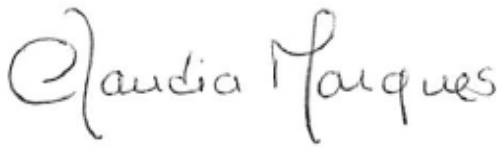
MS. SHERMAN: Thank you. Tehani Dunn. All right, I believe that concludes the public comment period, and that also concludes our agenda for today. Before we adjourn I'd just like to remind you that the Board's next scheduled meeting is on May 12th at 9:00 a.m. That meeting will be located at 125 Worth Street in the second floor auditorium. Thank you very much and the meeting is adjourned.

(The public board meeting concluded at 11:45 a.m.)

CERTIFICATE OF ACCURACY

I, Claudia Marques, certify that the foregoing transcript of NYC Board of Corrections Board Meeting on March 10, 2020 was prepared using the required transcription equipment and is a true and accurate record of the proceedings.

Certified By



Date: March 31, 2020

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