



Testimony of

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I am Natalie Fiorenza, Senior Corrections Specialist at New York County Defender Services (NYCDS). NYCDS is an indigent defense office that every year represents tens of thousands of New Yorkers in Manhattan's Criminal, Family, and Supreme Courts. The NYCDS Corrections Specialist Team provides a direct channel of communication with and advocacy for our clients who are incarcerated. Thank you for this opportunity to provide testimony.

1. Response to BOC's Third Report on 2025 Deaths in Custody

Thank you as always for producing these reports on the tragic loss of life of people in custody, using your access to video footage to get to the truth of what caused such horrific events. Unfortunately, your findings present a tale as old as time.

a. Logbook Falsification

This report documents what we must name plainly: *the falsification of official records*. In the case of Mr. Randall's death, logbook entries reflect consistent 30-minute tours that video footage directly proves to be a lie. In Mr. Furse's case, the B post officer recorded "nothing to report" during a period when individuals were out of their cells, accessing unauthorized areas, and passing contraband.

These are not isolated errors, these are intentional actions rooted in a steeped culture of perceived limitless immunity. It would be foolish to assume the problem ends there. The examples in this report are of officers who *happened* to get caught because fatalities triggered investigations.

Falsified logbooks are a systemic integrity failure, and the department's preliminary finding of no wrongdoing in the case of Mr. Ramos' death does not inspire confidence that the issue is being treated with appropriate seriousness.

We understand that new technology with automated timestamping is being considered to make logbook entries harder to falsify. We ask the Board to formally inquire into the status and timeline of that deployment in each facility, and reporting on its success. The deaths documented in this report, and all reports that came before it, make plain that this cannot be an open-ended commitment.

b. Post Abandonment and Touring Failures

In both the Furse and Randall cases, B post officers repeatedly abandoned their assigned posts or simply did not pay attention. In Mr. Randall's case, the B officer left the unit unsupervised for nearly three hours between 5:58 am and 8:42 am, and when that officer finally returned, they did not conduct a tour! Mr. Randall's medical emergency was discovered over an hour later at 10:08am by CHS personnel, not the B officer. In Mr. Furse's case, the B officer conducted what appear to be very cursory check-ins on Mr. Furse until finally persons in custody alerted officers to his condition.

It is in precisely these unmonitored intervals that people are lost. Naloxone is most effective when administered immediately after an overdose. By the time CHS staff reached Mr. Furse, they found him with vomit and water on his bed and the floor, no signs of breathing, no pulse, and pupils that were fixed and dilated. At that point he had been in crisis for an extended period. The B officer should have been touring. The A officer should have been tracking the B officer's movements. Both failed.

c. Mr. Randall and the Limits of PACE

The case of Kyron Randall demands a direct answer to a question the report does not fully ask: does Rikers Island have the capacity to manage people with this level of need?

Mr. Randall had diagnoses of schizophrenia, bipolar disorder, PTSD, and manic disorder, alongside documented polysubstance use and a medication compliance rate of zero to fourteen percent. He had been placed on suicide watch multiple times, referred to Bellevue Hospital eight times, rendered unfit to stand trial, and committed to Mid-Hudson Forensic Psychiatric Center for restoration before returning to DOC custody. He was housed in the PACE unit, which is designed for individuals with serious mental illness requiring a higher level of care, yet CHS's own records state that his psychiatric condition could not be safely managed within DOC custody.

From the facts as described, it is impossible to determine with certainty what Mr. Randall died of. ***What is certain is that the setting failed him long before that morning.*** PACE does not have the clinical capacity to manage the complexity Mr. Randall presented. We need the Department and CHS to seriously evaluate diversion pathways for individuals whose needs exceed what any correctional setting can effectively provide. Continuing to cycle people like Mr. Randall through Rikers, Bellevue, and state forensic facilities without a stable alternative is not a treatment plan. It is a recurring deadly tragedy.

2. Attorney Visit Scheduling Pilot

On April 13, DOC launched a pilot program for online attorney visit scheduling at Rikers Island, allowing attorneys and their agents to book one- to two-hour meetings up to 48 hours in advance. We are pleased to report that our office's experience, along with that of peer organizations, has been uniformly positive. DOC's implementation has been smooth, and clients have been produced promptly for visits, a meaningful improvement in attorney-client access at Rikers. This should, in the long-run, assist with reducing the length of case processing, and foster more positive attorney client relationships.

We offer one recommendation for refinement: DOC should make 30-minute increments available. Corrections specialists and social workers who visit multiple clients in a single day, often for brief check-ins or to obtain signatures, are currently required to book a full hour, creating unnecessary inefficiency. This is already an option on the video teleconferencing scheduler, so it should not provide significant logistical hurdles.

Finally, wait times at RNDC unfortunately remain hours-long, an issue that warrants DOC's and your focused attention.

3. Heat Mitigation Plan

As we consider heat mitigation, it is important to note that temperature regulation at Rikers Island is both counterintuitive and mismanaged. While adherence to the 2026 Heat Action Plan is absolutely necessary, and overheating remains a serious concern that can cause illness and exacerbate symptoms of mental illness, Rikers Island often blasts air conditioning to such an extreme that people in custody report freezing conditions and needing additional layers to stay warm. The core issue is one of balance: Rikers must monitor and regulate temperature to maintain a livable, safe environment for those in its custody. Air conditioning is a genuine advantage, but it should not be deployed so excessively that our clients are shivering in the summertime.

Additionally, “heat sensitive housing” can reach up to 80° without being considered out of compliance. It goes without saying that 80° is ***very*** hot, and not an adequate temperature cap for the population heat-sensitive housing is meant to care for.

4. Closure of North Infirmery Command (NIC)

The closure of the North Infirmery Command is in theory, welcome news. But in reality, it stokes an intense anxiety that we will begin to hear stories from our clients similar to when ESH was moved to the Rose M. Singer Center, or when men were moved into the 800bed tower in that same facility.

When the Department decided to move ESH from GRVC to what became RESH, they removed the ability for any of those clients to meet with their attorneys, they did not create a fully staffed front gate, and infrastructure wise, it looked more like someone's back yard DIY project than a city facility. When the department decided to house men in Rosie's, the women were made second class citizens without missing a beat. They lost their library, their rec yard, they were moved farther away from the clinic, and their movement was deprioritized. Now the department is opening a new housing area for men on the second floor of RMSC, even though they are calling it the RESH annex. Although their new commissioner seems to champion a "people first" approach, the bleak history of how these processes typically unfold is overwhelming, and thus will require very close monitoring.

Conclusion

Thank you for holding this hearing and providing the opportunity for the public to provide testimony. If you have questions about this testimony, please do not hesitate to reach out to me at nfiorenzo@nycds.org.