NEW YORK CITY
BOARD OF CORRECTION

November 18, 2013

MEMBERS PRESENT
Gordon Campbell, Esq., Chair
Catherine Abate, Esq.
Greg Berman
Robert L. Cohen, M.D.
Bryanne Hamill
Michael J. Regan
Pamela Silverblatt

Excused absence was noted for Vice-Chair Alexander Rovt, PhD.

DEPARTMENT OF CORRECTION
Dora B. Schriro, Commissioner
Mark Cranston, First Deputy Commissioner
Ari Wax, Sr. Deputy Commissioner
Thomas Bergdall, Esq., Deputy Commissioner and General Counsel
Erik Berliner, Deputy Commissioner
Florence Finkle, Esq., Deputy Commissioner
Sara Taylor, Chief of Staff
Brian Suprenant, Assistant Chief of Security
Eldin L. Villafone, Press Secretary
Carleen McLaughlin, Legislative Affairs Associate

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Amanda Parsons, M.D., Deputy Commissioner
Homer Venters, M.D., Assistant Commissioner, Correctional Health Services
Ross MacDonald, M.D., Medical Director
Zachery Rosner, M.D., Deputy Medical Director
George Axelrod, Chief Risk Officer

OTHERS IN ATTENDANCE
Ana Billingsley
Dahianna Castillo, Office of Management and Budget (OMB)
Megan Crowe-Rothstein, Jails Action Coalition (JAC)
Laurie Davidson, Doctors Council SEIU
Allan Feinblum, JAC
Hadley Fitzgerald, JAC
Leah Gitter, JAC
Vearry Hale, JAC
Barbara Harris, NYCPSP
Sarah Kerr, Legal Aid Society (LAS)
Lucas Koehler, OMB
Suzanne Koneschusky, JAC/CAIC
Neil Leibowitz, M.D., Director, Mental Health, Corizon
Kristin Misner, Deputy Mayor's Office

Five Mualimmak, Campaign to End the New Jim Crow
Luke Nephew, JAC
Jessica Orapallo, The Correctional Association
Jennifer Parish, Urban Justice Center/JAC
Jake Pearson, Associated Press
Daisy Rodriquez, JAC
Nashla Salas, NYC Independent Budget Office
Vivian Velasquez, JAC
Gale Weiner, JAC
Eisha Wright, Finance Division, City Council
Sallina Yung, OMB
Milton Zelermyer, LAS
Michael Zuckerman, MD, Vice President of Operations, Corizon

Chair Gordon Campbell called the meeting to order at 9:15 a.m. A motion to adopt the minutes from the Board's September 9, 2013 meeting was approved without objection. Chair Campbell welcomed the Board's newest member Bryanne Hamill. A former New York State Family Court Judge, now a Judicial Hearing Officer, she served the City as a Bronx prosecutor focusing on domestic violence, and was a psychiatric nurse before attending law school. The Chair added that Ms. Hamill's background and experience will enhance the work of the Board.

Since our last meeting Chair Campbell reported that he has had an opportunity to meet with each of his new colleagues on the Board. One of the issues that several Members raised was that they would like to convene more frequent meetings, as was done in the past, or conduct issue-focused Board tours on Rikers Island. Chair Campbell stated that he and Executive Director Cathy Potler will have more conversations with members about this issue. The Chair also mentioned that Ms. Potler will be polling the Board members to see if another weekday would be preferable for our meetings. Finally, Chair Campbell discussed that he and Ms. Potler will be having conversations with the Board members to identify issues, in addition to rule-making, that they would like to focus on over the next 12 to 18 months.

Chair Campbell stated that he and Ms. Potler have been meeting on a weekly basis and that they will meet with Commissioner Schriro every three to four weeks. The Chair added that the first meeting last week with the Commissioner went very well. He concluded by announcing that time will be set aside at the January Board meeting to give the public an opportunity to address the Board. He requested that Ms. Potler give her report.

Ms. Potler reported on the following matters:

- BOC staff conducted the first of a series of unannounced facility inspections focusing on compliance with the Minimum Standards and other areas of concern. The first inspection was at Rose M. Singer (RMSC). A final draft of the inspection report will be circulated to the Board members in the next weeks. Board staff will discuss the inspection results with RMSC administrators and Chief of Staff Sara Taylor, and any findings regarding the delivery of health care will be provided to Dr. Venters.
- Next week, several Board members and staff will be meeting with the Cardozo Law School's Youth Justice Clinic students who will present their research on the most successful programs nationally for adolescents, alternatives to punitive segregation, and effective staff training programs on how to deal with adolescents. After this exchange, a report will be completed by the clinic students and circulated to all of the Board members to assist in the rule-making process.
- Anna M. Kross Center (AMKC) has needed a tremendous amount of attention from our staff. Our field staff assigned to AMKC and Director of Field Operations have done a terrific job investigating two recent deaths of seriously mentally ill inmates who were housed at AMKC. They have spent countless hours reviewing camera footage, conducting interviews and reviewing records. Days after the first death, Board executive staff decided to add an additional field staff full-time to AMKC for better coverage and to deploy staff on the evening tours. We also assigned staff at GRVC and other facilities to work during the evenings and on weekends. This has proven to be very effective.
- Our field staff at AMKC has been working very closely with the Warden, her staff, and Department of Health and Mental Hygiene and Corizon staff to resolve a number of important Standards issues. Some of these are as follows: (1) ensure that inmates returning from Bellevue Hospital and Kirby are evaluated by medical and mental health staff before being housed; (2) to implement procedures to ensure that new admission, double-detox inmates are evaluated by medical staff before they are housed; (3) to develop a system whereby the paperwork traveling with inmates who are returning from the hospital or specialty clinic or court is delivered in a timely fashion to the medical staff; (4) to ensure that a sufficient number of escort officers are

available so that all inmates on the medical follow-up list are seen; and (5) to update the Inmate Information System (IIS) so that medical and mental health staff are able to locate patients so that treatment and medications can be timely provided.

- Two issues regarding RNDC adolescents raised at the last Board meeting have been resolved: they are getting their clothing laundered in a timely fashion and are being provided an adequate supply of uniforms.

Chair Campbell requested that Board Member Robert Cohen, M.D. report on the issue of rule-making. Dr. Cohen presented the following data to illustrate the serious problem of the mentally ill in the City jail system: about 40% of the 11,500 inmates are diagnosed with a mental illness; 60% of the inmates in punitive segregation are mentally ill; detainees with a mental illness are three times less likely to be bailed out and if they are bailed out, they spend five times more days on Rikers Island than those who are not; and they are more likely to get injured on Rikers Island. The rates of medically-verified injuries related to interactions with DOC staff are much greater when inmates are in segregation. Dr. Cohen reported that 14.8% of medically-verified injuries are DOC-related, but in the Central Punitive Segregation Unit (CPSU), 48% of the injuries involved as a result of an interaction between uniform staff and prisoners, and in MHAUII, it's 57.2%. He added that the positive news is that over the past five months there appears to have been a 12% decrease in the number of people in solitary confinement, and that the Commissioner will discuss what contributed to this reduction. Nonetheless, Dr. Cohen stated that the system is still faced with a serious problem. The Board will continue to identify Mental Health Minimum Standards violations, review jurisdictions that have been able to reduce the use of solitary confinement both nationally and internationally, work with the Departments of Health and Mental Hygiene (DOHMH) and Correction (DOC) to develop fair, humane, and effective standards to decrease the population in segregation, and work with the next administration.

Chair Campbell thanked Dr. Cohen for his report and the members of the rule-making committee. The Chair discussed his preliminary proposal to create two committees: one focusing on prevention and intervention and the other on intermediate sanctions and punitive segregation. Based on conversations with the members, Chair Campbell said that Ms. Potler and he would develop scope and charges for each of the committees, which will be circulated to the Board members for comment. The Chair and Ms. Potler will meet with the two chairs to ensure that both committees are "heading down the path in same direction". The Chair announced that Ms. Hamill has agreed to serve as the chair of one committee, along with Board Members Greg Berman, Pam Silverblatt and Alex Rovt, and that Dr. Cohen will be the chair of the second committee comprised of Board Members Catherine Abate, Michael Regan and him.

DOHMH Assistant Commissioner Homer Venters, MD updated the Board on the Clinical Alternatives to Punitive Segregation or CAPS, a program for people with serious mental illness who have been removed from solitary confinement and placed into a clinical setting. He stated that CAPS was first opened at RMSC for the women and recently opened the cell housing unit for the men at AMKC. Dr. Venters described CAPS as follows:

> It is a very difficult proposition. We're taking people that have been socialized and adapted to . . . dehumanizing conditions, being away from people, being in a tough setting and we're working to engage with them . . . in active programming in an open setting. It's a very tough proposition and both agencies are working very, very hard. The Department of Correction staff has been a fantastic ally and supporter, and the clinical staff is really enthused. Today, we actually opened up the second part of the male CAPS unit, which is a dorm, so that most people will come in first to the cell area . . . and then they'll transition from there into a dorm setting through several levels. It's been a great success and we really appreciate the joint training and coordination with our partners in the Department of Correction.

Chair Campbell asked Dr. Venters to share with the Board a conversation that he had had last week with a patient who discussed his concerns about going from MHAUII to the new CAPS program at AMKC. Dr. Venters described a patient with profound serious mental illness who was scared about coming out of solitary confinement after being confined in that setting for two years. The patient simply stated, "When I come out, there are going to be problems." Dr. Venters explained that after patients are expected to accommodate to being in solitary, our agencies set up a new setting – an open dorm with a flooding of stimuli that they are not accustomed to having. Both DOC and DOHMH have a special challenge, which is to how safely take down MHAUII and move the patients into a new setting.

Dr. Cohen asked Dr. Venters to discuss why the Restricted Housing Units (RHUs) have not been expanded. Dr. Venters responded that the RHUs are an alternative model for people who do not have a serious mental illness diagnosis, but have some level of mental illness. He stated that the RHUs have a solitary confinement or punitive setting with clinical resources to address mental health needs and work with patients on behavioral change. Dr. Venters explained that the difficulty in opening these units has been threefold: (1) patients who have been in solitary settings have figured out how to adapt in that setting and have trepidation when told that they will be moved to an area that also has some clinical care; (2) there is only one adult RHU so if patients have problems with each other, there are no other RHUs where they can be transferred; and (3) the need for steady health and security staff who have received a huge amount of training and coordination to properly run the units. Dr. Venters explained that the George Mochen Detention Center (GMDC) RHU will open on December 2, 2013 with the tranfer of patients from MHAUII's Intensive Treatment Unit (ITU), who are accustomed to coming out of their cells and engaging in programming. These individuals should be able to adapt successfully to the RHU. He concluded by stating that "it's a very vexing thing . . . to do some punishment and some clinical care . . . the RHUs in some ways are harder than the CAPS unit, because the CAPS unit . . . is all clinical."

Board Member Abate asked how many MHAUII, CAPS and RHU beds are currently occupied. Dr. Venters replied that MHAUII has about 125, as of Friday, CAPS has a census of 13, with about six patients coming in today, and the adult AMKC RHU has 15 patients, with plans to open several RHUs in the next month, each with a capacity of 30 to 35 beds. Ms. Abate asked if there is sufficient capacity to transition the remaining MHAUII inmates to CAPS or the RHUs. Dr. Venters responded yes.

Commissioner Schriro stated that this have been a "learning curve for everybody." She discussed the transition as follows:

> CAPS will be fully open this week for both men and women, adolescents and adults. And RHU, the last of it, will open in December. One of the lessons that we learned that Homer had pointed out was by trying to get one unit open and do several other things at the same time, we realized a little after the fact that if we had had more than one housing unit for RHU, we could address separation issues or the other things that might come along. And so it's by meeting formally as frequently as every day and talking almost every hour, we continue to make improvements. . . . We also acknowledge that we need to accelerate the closing of MHAUII because it's clear that we're not just telling everybody that it's going away, but that it has gone. . . . And it was both Departments that unilaterally agreed that MHAUII needed to go away and that's what we have been doing ever since. It will close next month and it will close, we believe, forever. . . . I had mentioned to the Board that we . . . have received funding from National Institute of Correction so as to evaluate all of these endeavors. The corrections community nationally is looking at what we're doing. . . . CAPS is the first of its kind in the country where the focus is exclusively on treatment for individuals who are seriously mentally ill…

Chair Campbell requested that DOHMH discuss the consolidation of the mental observation units (MOUs). Dr. Venters explained the future planning: that AMKC, which is the largest jail, also has the greatest concentration of mental health services and would be the site for the consolidation. Dr. Venters stated that the focus of both agencies now is to take down MHAUII, get the CAPS unit open, expand the RHUs, and address some of the systems concerns at AMKC, such as how to track and care for people with mental illness, before consolidating more people in that building.

Dr. Cohen asked whether DOC's practice of requiring inmates to be escorted to medical and mental health services has affected DOHMH's ability to meet the Minimum Standards of timely access to care. Dr. Venters responded that the data has shown a decrease in the number of patients seen for follow-up mental health, sick call and all other care, with the exception of new admissions, has steadily declined by up to a quarter. Dr. Venters added that we have to fix these problems before more mentally ill inmates can be transferred to AMKC. He further explained that lack of escorts is a problem, but there are broken systems on the health side that need to be fixed. He concluded by stating that patients do not have optimal access to care, and that must be addressed.

Chair Campbell asked Commissioner Schriro to update the Board on the interim centralized new admissions facility. The Commissioner stated that the Central Intake Facility (CINT) enables a more consistent intake process in one physical plant. She explained that on November 6, 2013, VCBC was the first facility to cease intake and switch to the central intake process, which now takes about eight to 12 hours to complete. Next week AMKC will redirect new admissions to CINT. She added that the transition will be completed in December, however, Manhattan cases will continue to be processed at the Manhattan Detention Center (MDC), male adolescent intake will remain at RNDC and the women will be processed at RMSC. The Commissioner encouraged the Board members to visit CINT.

Chair Campbell asked DOHMH to describe the new medical intake operations at CINT. Dr. Venters responded that the new intake procedure has started well, and there are many benefits to centralizing the intake. He described an important challenge facing DOC and DOHMH: the need to develop a very good system by which they can expedite and guarantee that somebody who is found to have a real pressing concern – such as the need for ongoing detox medication during the central intake process – will be immediately presented to the medical clinic wherever they go. Dr. Cohen asked where people who need stabilization will be sent. Dr. Venters clarified that people who are very sick in need of hospitalization will be sent to hospitals, and added that urgicare is located at the same facility as CINT. When people come in with an immediate need, like a life preserving medication, they should be seen right away in the facility clinic where they are sent. Dr. Venters described a transfer notification form has been developed, along with DOC, which the receiving facilities must sign off on to ensure that the new admission inmate gets whatever special services are needed. DOHMH has a secondary system to track instances should any mistakes be made.

Chair Campbell asked Commissioner Schriro if she would give her PowerPoint presentation on the issue of sentencing reform. Commissioner Schriro reported on the following matters:

- The Department made efforts to reduce the amount of time individuals spend in punitive segregation, and to divert people to alternative forms of punishment. The backlog of individuals who don't have mental health issues has been abated. It is down 17 percent.

- Based upon our sentencing guidelines, the Department has decreased the average penalty by 36 percent, from 22 to 14 days. Adolescents' penalties have been cut in half, and there has been a reduction for people with mental illness. Sentences now run concurrently. Concurrent sentencing was made mandatory, except for several rule violations where there is still discretion on the part

of the adjudication captains.

- Expunging owed time has also decreased time spent in punitive segregation. This was a long-standing practice at DOC that has now been reversed. DOC now expunges virtually all of the historical time accrued. Expungement does not occur with very serious rule violations where there is injury to inmates or to staff. Conditional discharge had been a dormant practice, and DOC has revived it.

- By the end of calendar year 2013, MHAUII will be completely closed. By the end of this fiscal year, DOC will reduce punitive segregation capacity below 5 percent of the average daily population, which is consistent with other systems.

Ms. Silverblatt commended DOC for the multifaceted approach and focus on reducing punitive segregation. She asked if by the spring or summer the Department would be able to show a juxtaposition of what the reduction in punitive segregation looks like as compared to the incidents of violence. Commissioner Schriro responded that it is possible to give the Board some partial reports.

Commissioner Schriro requested renewal of all existing variances, and the Board unanimously approved. The Commissioner requested a Thanksgiving Day variance, which provides visits on a daytime schedule on Thanksgiving Day, rather than during the evening schedule. Chair Campbell explained that for years, the Board has granted this variance to enable visitors to attend visits during daytime hours on this holiday and to enable DOC staff assigned to visit-related posts to enjoy the holiday. This was unanimously approved.

Chair Campbell described a new request for a variance from the DOHMH, and a thoughtful letter commenting on the request from the Legal Aid Society. After thanking the Legal Aid Society, the Chair asked Dr. Venters to explain the request. Dr. Venters also thanked everyone for their comments and stated that DOHMH and Corizon take care of patients who are injured and one of the things they do is fill out an injury to inmate form, which is used by both correctional and medical staff. He reported as follows:

> This form is essential for the correctional authorities both to look into it on a jail base level and also for Deputy Commissioner Finkle and the staff with the Department of Correction, who do formal investigations of these matters. And so the existing language of the Board Standards specifically precludes us from sharing a diagnosis with the Department of Correction. . . . In the instance where a patient has been injured while in jail, when we fill out this injury form, we would like to be able to share any diagnosis that's related to that injury only. So we do not seek to share any background medical information, other diagnoses, but for instance a skull fracture or a jaw fracture or an orbit fracture is a diagnosis. And it is important for us to be able to share that with the Department of Correction in order that they may . . . rigorously and robustly investigate these matters. . . . If we were seeking an amendment, which we're not, but we certainly would follow the guidance of the Legal Aid Society who gave very good thoughtful comments about how we would do an amendment. But we believe . . . that the existing language we have proposed in the variance is sufficient and that this will allow both us to report the very limited scope of information and for the Department of Correction to investigate these matters in a rigorous fashion.

The variance was unanimously approved.

Chair Campbell asked the Commissioner to report on two recent suicides, one at GMDC, and the other at AMKC. The Chair added that he visited AMKC with Ms. Potler and Mr. Martinez, who took him to the areas where two of the recent deaths occurred and walked him through the details.

Commissioner Schriro said, "Every death, wherever possible, should be prevented and avoided and that continues to be our commitment to do so." She briefed the Board on Mr. Gilbert Pagan's death as follows:

> This death occurred on September 30, 2013. The Department's Investigation Division is currently investigating this case and so it's still in process and we will continue to brief you as additional information comes forward. Mr. Pagan . . . died at the age of 26. He was admitted to DOC custody on July 27, 2012, which would suggest that his charges were serious. And he was transferred at his request at the end of September to protective custody housing unit due to difficulties that he was having with several other inmates. Late in the day of September 29, he locked in, and the Captain making a routine tour, observed him hanging in his cell. He had lifted the metal bed up onto its end and had tied ligature around his neck and, I regret to say, successfully hung himself. The staff responded and they cut him down and attempted resuscitation but he was pronounced dead shortly after midnight. The ME [Medical Examiner] has preliminarily determined that the cause of death is suicide. We don't have any final information yet from the ME's office. . . .

Ms. Abate recalled a similar incident not so long ago when an inmate used the bed and in order to prevent it from happening again, the Department was going to look into bolting the beds so they could not be lifted. The Commissioner responded that the majority of the beds have been bolted; however, an asbestos problem delayed the completion of the last beds.

The Commissioner continued her account as follows:

> The account from other inmates and staff is that he did not appear to be despondent that evening. He stayed up and there was a sports game on and when the curfew came and he was locked in, there didn't appear to be any obvious signs of distress.
>
> This is really an unfortunate situation. Mr. Moore passed on October 14th of this year. He actually expired at East Elmhurst Prison Ward and here again, the Department's Investigation Division is investigating this matter. Mr. Moore was 35 years of age. He was admitted to DOC October 11th of this year. And so he expired within three days of his admission. He was brought in on a violation of parole. On the evening of October 14th . . . was actually early morning of the 14th, he was in the new admission area in an intake pen and he was found hanging from a shower, part of the shower, in that area. He had taken a piece of clothing and tied it around his neck and had successfully taken his life. Officers responded, cut him down, attempted to resuscitate him. He was taken, as I mentioned, to East Elmhurst Hospital and he was pronounced dead at approximately 4:00 in the morning. Again, a preliminary result from the ME is that the cause of death was suicide.

Dr. Cohen noted that Mr. Moore was incarcerated on a technical parole violation and thought it was important to recognize that.

Commissioner Schriro described the death of Bradley Ballard as follows:

> Mr. Ballard expired on September 11th of this year, and here again, it's the Department's Investigation Division that is currently investigating this case. Mr. Ballard was 39 years of age and he was admitted to DOC custody on June 13th. So just several months before, again, to Dr. Cohen's point, this was a violation of parole as well, and he was assigned to mental observation housing, and it was from this area where this situation occurred. It was September 10th that evening that, that officers observed him in distress, and they summoned medical staff. And he was taken from his cell and then transported immediately to East Elmhurst, where he expired in the emergency room. . . . We don't have an autopsy report yet, but we have preliminary finding of diabetic shock.

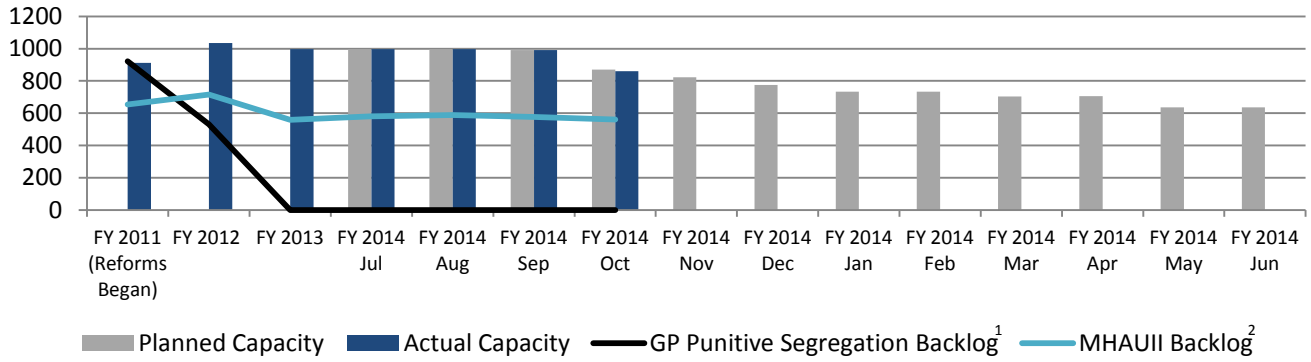
Chair Campbell asked for a brief status report of the two in-custody homicides, a number of use of force cases which had been subject of concern, and the August disturbance at GRVC. The Commissioner responded that her understanding was that these would be discussed in Executive Session. The Chair asked if any of the investigations that the Board has inquired about were completed, in which case we could have a discussion in the open meeting. The Commissioner answered that there is no closure on any of the previous cases and requested to discuss them in Executive Session. The Board voted to go into executive session.

The meeting adjourned for Executive Session at 10:30.

NYC DEPARTMENT OF CORRECTION
OCTOBER 2013 REPORT TO BOC

The punitive segregation capacity was reduced by 14 percent during October. **On October 31, 2013, the combined punitive segregation capacity had decreased by 17 percent from 1,035 to 860.** Thus far this month, another 49 beds have been taken off line, lowering the current capacity further to 811.

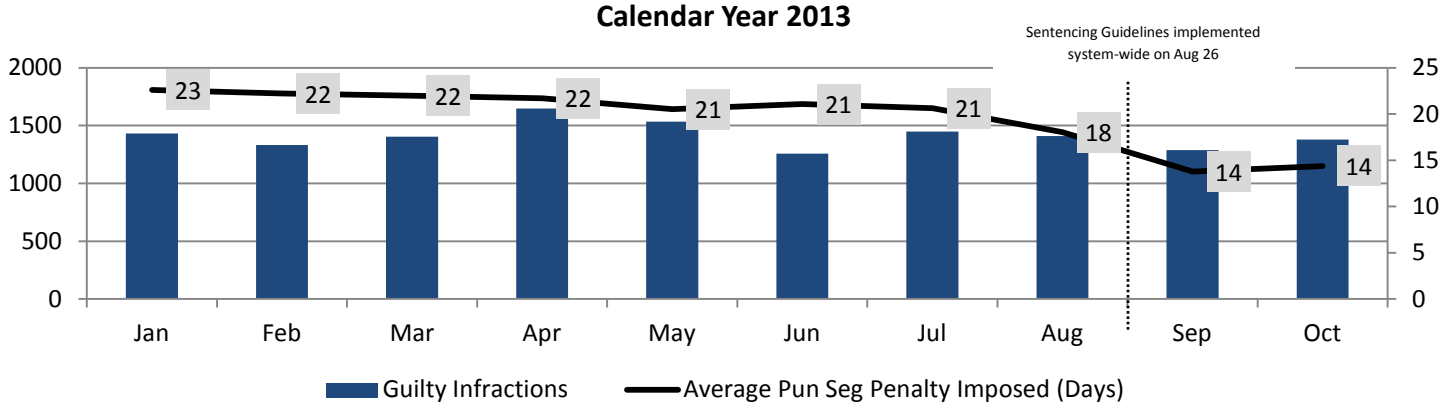
Punitive Segregation Capacity and Backlog
Fiscal Year 2011-2014



The reduction in both the capacity and census in punitive segregation is attributed in large measure to sentencing reforms that DOC instituted over the past several years. These reforms feature the adoption of sentencing guidelines, expunging historical time owed, imposing penalties for more than one violations concurrently and not consecutively, and awarding conditional discharges for good institutional conduct and program participation (after serving 50 percent in RHU and after serving 66 percent of the penalty imposed in general population punitive segregation or MHAUII).

DOC first piloted sentencing guidelines at RMSC beginning May 1, 2013, and then added RNDC on June 24, 2013. On August 26, 2013, the guidelines were instituted department-wide. **Since the sentencing guidelines were instituted department-wide, the average punitive segregation sentence imposed has decreased by 36 percent from 22 to 14 days.**

Guilty Infractions and Average Days Imposed in Punitive Segregation
Calendar Year 2013

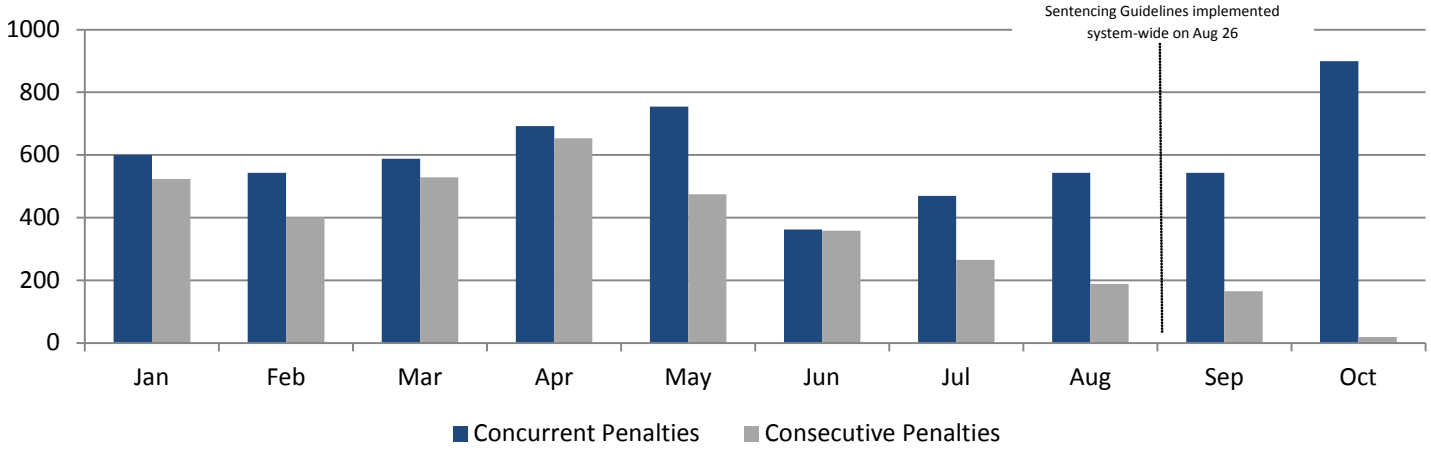


We have seen even more appreciable decreases in sentences for special populations. The average sentence imposed for adolescents has decreased by 50 percent (from 26 to 13 days) and the average sentence for the mentally ill has decreased from 35 to 22 days, a 37 percent decrease.

[1] Since there was neither an expansion of MHAUII beds nor an appreciable increase in M-inmates cleared by DOHMH for placement in general population punitive segregation, the backlog of approximately 600 M-inmates was not eliminated.

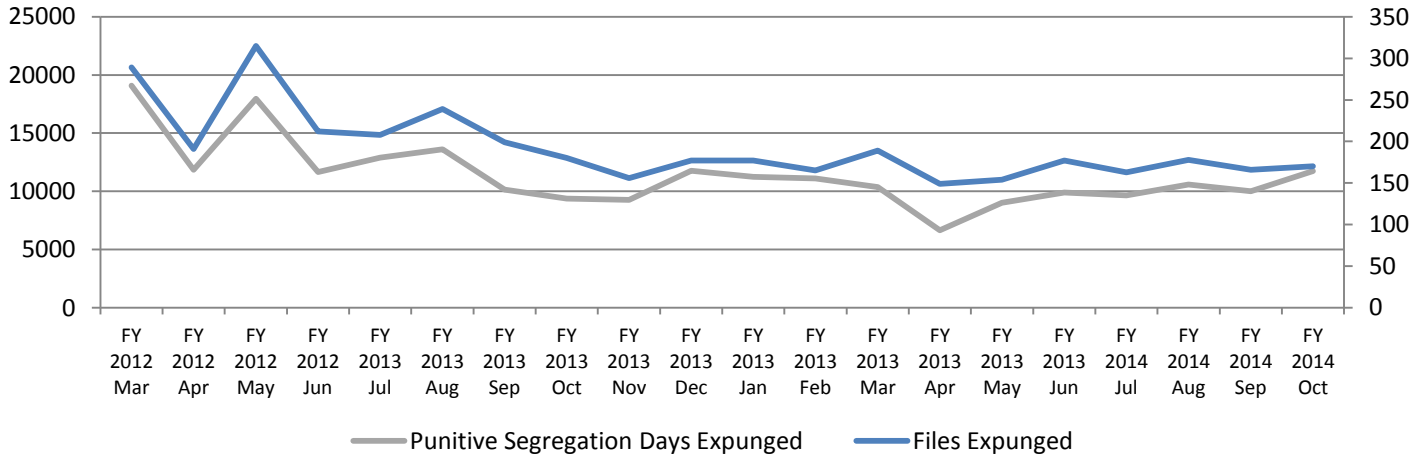
In February 2012, DOC reversed the longstanding practice of routinely imposing penalties consecutively, by delineating instances under which adjudication captains were to impose concurrent sentences. Now, punitive segregation penalties for non-violent infractions with multiple offenses must run concurrently. **With the Department-wide implementation of the sentencing guidelines in August 2013 including the mandate to run penalties consecutively, the fewest number of consecutive sentences was imposed (since the Department began collecting this data) in October 2013 (N=19), an 88 percent decrease from September 2013 (N=165).**[2]

Concurrent and Consecutive Penalties Imposed by Month
Calendar Year 2013



In March 2012, DOC began expunging historical time owed for infractions committed during a previous incarceration after one year in all but three exceptional instances – assaults on staff, inmate-on-inmate assaults that resulted in serious injury and incidents involving weapons – in which three cases, time owed is expunged after two years. **In CY 2013 through October 31, 1,650 inmate files were expunged, purging a total of 107,179 punitive segregation days imposed and not yet served. In October alone, 170 files were expunged eliminating 11,752 punitive segregation days pending.**

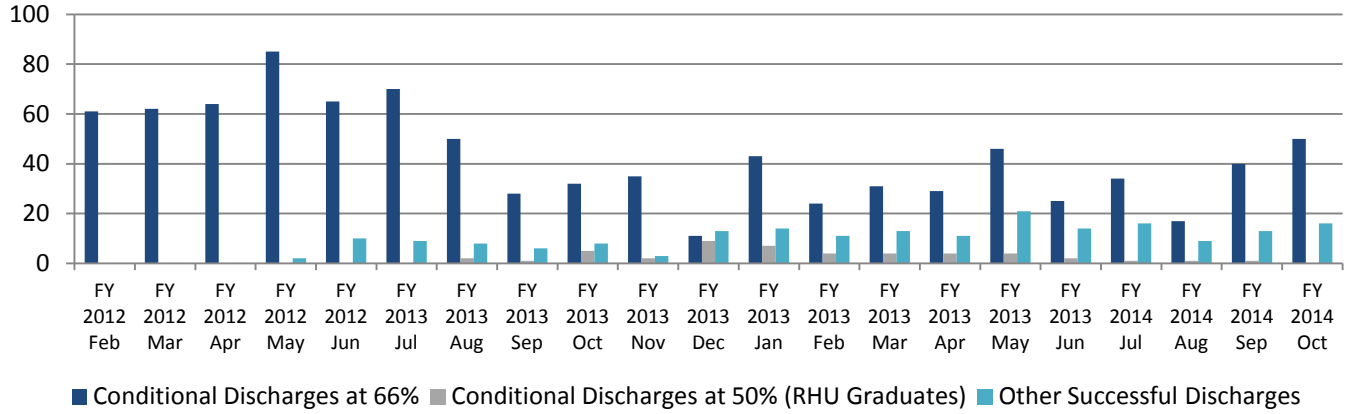
Total Disciplinary Files Reviewed and Punitive Segregation Days Expunged by Month
March 2012-October 2013



[2] With the implementation of the sentencing guidelines, DOC changed the policy shifted from discretionary to mandatory in all but limited circumstances.

In February 2012, DOC reactivated a long dormant policy of conditional discharge, suspending the remaining portion of time imposed on inmates who committed non-violent rule violations and remained violation-free while in punitive segregation. Inmates in RHU are eligible for a conditional discharge after serving 50 percent of their penalty; general population inmates in punitive segregation are eligible at 66 percent. **In Fiscal Year 2013, the DOC released 508 inmates early on conditional discharges from general population punitive segregation and another 44 from RHU; an additional 108 individuals were assigned to and satisfactorily participated in the RHU during this time period but were discharged prior to completing the program because they had satisfied the penalty that had been imposed, were released from custody, or aged out of the program.**

Conditional Discharges from PSEG and RHU, Other Successful Discharges
February 2012-October 2013



Of the 860 punitive segregation beds on line today, 593 are general population punitive segregation beds occupied by inmates with no mental illness or those with a mental illness who have been cleared by DOHMH for placement in punitive segregation units, MHAUII or RHU (69%). The remaining 267 beds for mentally ill inmates not cleared by DOHMH consist of 76 RHU and 191 MHAUII beds (31%). **By July 2014, DOC will have reduced the total capacity for punitive segregation by 38 percent to 638 beds.** These 636 beds are the equivalent of approximately five percent of the average daily population, the national standard for punitive segregation. At this point, there will be 466 beds[3] in punitive for inmates who have been cleared by DOHMH for placement and 172 beds in RHU for inmates with infractions who are determined by DOHMH not to be suitable for placement in punitive segregation. There will be no MHAUII beds as DOC will have eliminated MHAUII.

[3] Initially, DOC plans to allocate approximately 50 punitive segregation beds as "Limited Punitive Segregation" or LPS housing, a form of punitive segregation with appreciably more out-of-cell time for inmates serving penalties for lesser rule violations. Going forward, the number of LPS beds will be adjusted to reflect demand.

Punitive Segregation Capacity by Unit Type and Census (GP and M)
Fiscal Year 2011-2014