NEW YORK CITY
BOARD OF CORRECTION

May 12, 2020 PUBLIC MEETING MINUTES

ATTENDEES

MEMBERS PRESENT
Jennifer Jones Austin, Esq., Chair
Stanley Richards, Vice-Chair
Robert L. Cohen, M.D.
Felipe Franco
James Perrino
Michael J. Regan
Steven M. Safyer, M.D.
Jacqueline Sherman, Esq.

Margaret Egan, Executive Director

DEPARTMENT OF CORRECTION
Cynthia Brann, Commissioner
Hazel Jennings, Chief of Department
Brenda Cooke, Chief of Staff
Dana Wax, Deputy Chief of Staff
Timothy Farrell, Senior Deputy Commissioner
Heidi Grossman, Deputy Commissioner for Legal Matters/General Counsel
Patricia Feeney, Deputy Commissioner for Quality Assurance and Integrity
Peter Thorne, Deputy Commissioner of Public Information
Maureen Danko, Deputy Commissioner of Information Technology
Lawrence P. Dail, Deputy Commissioner of Training & Development
Kenneth Stukes, Bureau Chief of Security
Francis Torres, Assistant Commissioner for Young Adult & Youthful Offender Programming
Steven Kaiser, Executive Director of Policy and Intergovernmental Affairs
Brian Charkowick, Executive Director of Infrastructure & Operations
Richard Bush, Senior Correctional Institutional Administrator
Yanique Calvert, Operations Administrator
James Boyd, Assistant Commissioner of Internal Communications
Kisa Smalls, Warden
Maura McNamara, Senior Policy Advisor
Nancy Li, Policy Analyst
Chelsea Chard, Policy Analyst
Julia Szendro, Policy Analyst
Allie Robertson, Policy Analyst

Andrew Toranzo, Policy Analyst
Beatriz Gil, Strategic Planning Analyst
Jason Kersten, Press Officer
Juan Ramos, Adolescent Ombudsperson

NYC HEALTH + HOSPITALS - CORRECTIONAL HEALTH SERVICES

Patsy Yang, DrPH, Senior Vice President
Ross MacDonald, MD, Chief Medical Officer, Sr. Assistant Vice President
Michele Martelle, MPH, Assistant Vice President for Planning, Evaluation, and Reentry Support Services
Aaron Anderson, MPA, MSEd, Assistant Vice-President for Finance and Risk
Carlos Castellanos, Chief Operations Officer/Deputy Executive Director
Bipin Subedi, MD, Co-Chief of Mental Health
Virginia Barber Rioja, MD, Co-Chief of Mental Health
Benjamin Farber, Chief of Staff
Monica Katyal, Esq., Director, Monitoring and Evaluation
George Axelrod, MD, Director of Health Information & Risk Management
Kelsey Burke, MPH, City Research Scientist, Monitoring & Evaluation
Janet Wiersema, DPH, MPH, City Research Scientist, Research & Evaluation
Zachary Rosner, MD, Associate Executive Director

OTHERS IN ATTENDANCE

Calvin Liu, Cook County (IL)
Jennifer Parish, Urban Justice Center
Victoria Phillips, Jails Action Coalition (JAC)
Elizabeth Meyers, JAC
Nikki Tourigny, JAC
Sarita Daftary-Steel, Just Leadership USA
Dave Ehlke, Just Leadership USA
Akyla Tomlinson, Just Leadership USA
Darlene Jackson, Just Leadership USA
Peggy Herrera, Just Leadership USA
Meghan Kacsmar, Children's Rights
Daniele Gerard, Children's Rights
Charlotte Pope, Children's Defense Fund
Kayla Simpson, Legal Aid Society Prisoners' Rights Project (LAS)
Mary Werlwas, LAS
Veronica Vela, LAS
Redmond Haskins, LAS
Kelsey De Avila, Brooklyn Defender Services (BDS)
Claudia Forrester, BDS
Simone Spirig, BDS
Irene Cedano, BDS
Claudia Forrester, Bronx Defenders
Martha Grieco, Bronx Defenders
Julia Solomons, Bronx Defenders
Tahanee Dunn, Bronx Defenders
Julia Kerbs, New York County Defender Services
Chris Boyle, New York County Defender Services
Brad Maurer, New York County Defender Services
Janet Insardi, NYC Office of Labor Relations

Alana Sivin, NYC Council
Rachel Baker, NYC Council
Kieshorne Dennie, NY Council
Chelsea Davis, NY City Hall
Gladys Arias, NY City Hall
Alyson Silkowski, NYC Comptroller
Steven Goldstein, Office of Special Narcotics Prosecutor
Wendell Walters, The Osborne Association
Lewis Conway, Rikers Debate Project
James Meagher, Safe Horizon
Alex Tereshonkova, The Emergency Release Fund
Ariel Federow, The Emergency Release Fund
Zoe Adel, Brooklyn Bail Fund
Elena Weissmann, The Bronx Freedom Fund
Tanya Pierce, A Little Piece of Light
Liliana Trafficante, A Little Piece of Light
Laura Fettig, FEDCAP Rehabilitation Services, Inc.
Michelle Duhart, The Moss Group
Tina Waldron, The Moss Group
Sonia Moghe, CNN
Jan Ransom, The New York Times
Sydney Pereira, Gothamist
Reuven Blau, The CITY
Ned Parker, Reuters News Agency
Jeff Willett, Extreme Networks
Rosa Palmeri, Free Them All for Public Health
Michael L., NYC-CEC/BJAC
Robert Ellis, GBTC Resource Center
Julia Shaw, STEPS
Patricia Bailey, DANY
Alexis Karpf, Independent
Alexander Shante, Independent
J. Thomas, Independent
Rosie Santiago, Independent
Marlene Aloe, Independent
Martin Kaminer, Independent
Shannon Muphy, Independent
Jean B., Independent

AGENDA AND PUBLIC VOTES

1. Approval of March 10 and April 14, 2020 Meeting Minutes (May 12, 2020 BOC Public Meeting Transcript ("Transcript"), at page 3)
    - After the item was moved and seconded, the minutes were unanimously approved, 6-0 (Chair Jones Austin, Vice-Chair Richards, and Members Cohen, Franco, Regan, and Sherman).[1]

[1] Board Members Safyer and Perrino had not entered the meeting at this time.

2. Updates and Announcements (Transcript, p. 3)

3. Update on Restrictive Housing Rulemaking (Transcript, p. 4)

4. Update on BOC Staff's COVID-19 Oversight Work (Transcript, p. 5)

5. DOC and CHS Updates on COVID-19 Response (Transcript, p. 7)[2]

6. Public Comment on CHS and DOC Variance Requests (Transcript, p. 30)

7. DOC Limited Variance Request to BOC Minimum Standards § 1-05 and § 1-08 (Secure Unit) (Transcript, p. 44)

    - Vote on Variance:
        - After Chair Jones Austin called a roll call vote, the Board unanimously approved the six-month variance, 6-0 (Chair Jones Austin, Vice-Chair Richards, and Members Cohen, Perrino, Regan, and Safyer).[3]
        - The final record of variance is available here: https://www1.nyc.gov/assets/boc/downloads/pdf/Meetings/2020/May/2020.05%20-%20Record%20of%20Variance%20Action%20Secure.pdf

8. CHS Limited Variance Requests to BOC Minimum Standards § 2-04(c)(3) and § 2-05(b)(2)(i-ii) (COVID-19 Emergency Response Variances) (Transcript, p. 49)

    - Vote on Variance:
        - After Chair Jones Austin called a roll call vote, the variance did not pass, with four (4) votes in favor (Chair Jones Austin, Vice-Chair Richards, and Members Regan and Safyer) and two (2) votes in opposition (Members Cohen and Perrino).

    - Vote on Variance:
        - After Chair Jones Austin called a roll call vote, the variance did not pass, with four (4) votes in favor (Chair Jones Austin, Vice-Chair Richards, and Members Regan and Safyer) and two (2) votes in opposition (Members Cohen and Perrino).

9. Public Comment (Transcript, p. 66)

A video recording of the meeting using password "NYCBoardofCorrection1" is available here.

[2] DOC's PPT Presentation is available here: https://www1.nyc.gov/assets/boc/downloads/pdf/Meetings/2020/May/May%202020%20COVID-19%20Preparedness%20and%20Response_5.12.20.pdf

[3] Board Members Sherman and Franco exited the meeting prior to this vote.

NEW YORK CITY

BOARD OF CORRECTION

BOARD MEETING

Virtual Meeting

WebEx Video Conference

May 12, 2020

9:00 a.m. – 12:49 p.m.

MEMBERS PRESENT:

Jennifer Jones Austin, Esq., Chair

Stanley Richards, Vice-Chair

Robert L. Cohen, M.D., Member

Felipe Franco, Member

James Perrino, Member

Michael J. Regan, Member

Steven M. Safyer, M.D., Member

Jacqueline Sherman, Member

Margaret Egan, Executive Director

(The public board meeting commenced at 9:19 a.m.)

BOARD CHAIR JENNIFER JONES AUSTIN: Well, good morning. Everybody and we are going to officially begin May 12, 2020 public meeting of the board, New York City board of correction. I'm calling the meeting to order.

Let me first begin by stating that this meeting, due to COVID, is being held by WebEx and we have a quorum at the meeting. Board member Jackie Sherman may have to leave due to a previous previously scheduled meeting. She may have to leave earlier than when the meeting is done, so just want that to be noted, Jackie, do you want to comment on that at all? --

Okay, good deal. We will begin the meeting. Let us begin with an approval of the March and April 2020 minutes. The board members should have received a minute and I am asking for a board member to --

BOARD MEMBER MICHAEL J. REGAN: Move to approve.

MS. JONES AUSTIN: Good deal -- another board member --

BOARD MEMBER DR. ROBERT L. COHEN: Second.

MS. JONES AUSTIN: Thank you. Any edits to debate? Not hearing any. I call for vote to approve the March 10 and April 14, 2020 minutes -- All right, the minutes are approved.

The agenda this morning includes an update on restrictive housing rule making, we will hear from the Department of correction, and correctional health services concerning the COVID-19 response to date, we will have a public comment on variances, there are three variances that will be presented -- they all are variances that had been previously approved so we will hear from them on that and we'll vote on them.

Let me begin by recognizing the heroic work of so many people during this pandemic -- DOC and CHS staff and leadership have shown incredible commitment, collaboration, creativity and hard work, to minimize COVID transmission in the jails and provide care for people who are ill. We, the board Thank you. We thank the people in custody who make up the jail work details and do much of the jail, sanitation and other important tasks. All the external service providers

should continue to provide a central alternative programming to people in custody, and who continue to support people upon release from jail. Thank you. Thank you to the family and friends of people who are in custody, and their advocates who continue the tireless work of ensuring people continue to be connected to community and supported while inside, thank you to you. And to the lawyers advocates and city staff who work quickly are working quickly to dread drastically reduced the jail population. It's been significant. Thank you. And the board of correction staff and the executive director who quickly, effectively adapted our monitoring strategy to this moment, your hard work, and providing the board in the public critical information on what is happening in the jails. We, thank you.

I wanna recognize that many and staff are like many of the essential workers throughout the nation. They're putting their health at risk in service to the city of New York. Many staff members have gotten sick during the pandemic and sadly, and unfortunately, and tragically some have died. The board sends our condolences to the family members, friends, and colleagues of those who died. Additionally, and our wish is for good health to all the staff who are sick, or who recovered from COVID-19 as well as the people in custody who are sick or have recovered. Also want to make note, mentioned the fact that there are three people in custody -- there were three people who passed away. The board has committed to reporting each death in custody publicly. On April fifth a fifty-three-year-old man, died in custody while, at Bellevue hospital. On April eleventh, a sixty-three-old man died in custody while also at Bellevue hospital and on April twenty third a thirty-year-old man died custody also while at the hospital – all three men died of COVID-19.

Finally, I have one more piece of sad news concerning a board member. Tina Hernandez died in March of this year. Many know Tino because of his work as a true public servant and leader. He was also a very kind and dear individual. The city and the board will miss.

Let us now turn to the business. I will provide an update on restrictive housing rule making. The board’s public

comment period for restrictive housing remaking ended on January thirty first of this year. Comments raised important, challenging and transformative questions around safety, accountability, health and mental health and the humane treatment of New Yorkers, while in custody. While there's some diversity of opinion about the path forward, all parties agree that a new disciplined model at the Department of correction is necessary and must become the goal of the board's rule making work. Anyway forward must focus on safety and violence reduction for staff and people in custody. In the coming months, the Board will approach the work of finalizing these rules with the following principles in mind: safety, support, and accountability.

The New York City system is that a critical juncture, a declining population, and a robust plan to move to a smaller, more humane borough-based jail system provide an opportunity to make the necessary culture change and provide the essential tools to manage the jails and discipline within the jails differently. Tools include a focus on safety, mental health, effective and robust programming, an education investment, training, investment in the wellbeing of the employees, and developing alternative means of accountability to effectively address behavior. Collectively, these can and will improve conditions for people in custody and for staff.

We wanna move to an update from the Department of correction and correctional health services. We've asked the department and correctional health services to provide an update on the response to the COVID crisis. First, I will ask the boards executive director, Margaret Egan, to provide an update on the board's oversight work during the pandemic and I want to, before she talks, applaud her and her staff as well as DOC staff and CHS staff for working very closely together to manage this crisis as we best.

EXECUTIVE DIRECTOR MARGARET EGAN: Thank you. Since the crisis hit New York City in mid-March, the board has approached its oversight with two main goals in mind: 1) monitoring DOC and CHS's evolving response and compliance with the agencies plan and 2) monitoring DOC and CHS's general operations and compliance with the board minimum standards in

the public health crisis. We sought to independently and publicly document the scope of the pandemic in the jails and the criminal justice systems response to understand the successes and challenges and ensure that lessons can be learned quickly. I want to thank the board staff for their quick, thoughtful and effective adaptation to this new normal. I also want to thank DOC and CHS leadership and staff for their partnership as we all work through this together.

All board staff have been working remotely since mid-March from the guidance from the mayor and the Department of health and mental hygiene. This decision was not one made lightly, and we will continue to follow local guidance on agency work conditions and reducing the risk of spreading COVID-19. As we do return to the jails, our oversight work will be guided by the "do no harm" principle, meaning, the board will prioritize the safety of staff and the safety of those who live and work in the jails. Beginning on April 1, 2020 the board is publishing daily COVID-19 updates, which include data on people in custody confirmed or symptomatic for COVID-19, COVID-19 deaths in custody, and jail staff confirmed COVID-19, and likely exposed but asymptomatic people in custody and an analysis of the full population in the jails. These reports are critical to understanding the scope of the crisis. And we are encouraged to see that the census in COVID designated housing decreasing and hope to see that trend continue.

The board has issued several public calls for the jail population to be reduced as one tool protecting staff and people in custody. We've been working closely with all stakeholders, advocates, defender organizations, providers, city, hall and state Docs. to assist in achieving this goal. Since March 16, over two thousand and six hundred and fifty people have been released from custody and the number of new admissions to the jails has increased significantly in recent weeks out of the week. As of May 3, there were two hundred and thirty-four new admissions to the jail compared with only one hundred and three admissions to the jail the week of March 29. We will continue to work with all stakeholders to ensure the population remains as low as the safely possible, despite

not being physically in the jails board staff has continued to monitor conditions in the jails through a variety of sources, including Genetech surveillance camera review, sanitation audits, grievance system audits and complaints received by the board. We began publicly releasing our early finding and are working closely with DOC and CHS to address any immediate concerns. The board published a report presenting data collected by board staff, using remote access to the Genetech security video footage system to monitor social distancing, use of PPE among staff, use of masks among people in custody, phone access and cleaning, and rounding practices in units. Board staff observed housing areas for confirmed COVID-19 patients, symptomatic individuals, and likely exposed but asymptomatic individuals. A couple of key findings include of the nine hundred and forty-three staff board staff observed over the two weeks, eighty-six percent were wearing masks correctly, meaning the mask covered the staff member's nose and mouth [inaudible] and sixteen percent of visible people in custody were correctly wearing masks, in forty nine percent some visible people in custody were correctly wearing masks, and then thirty five percent of the visible people in custody were correctly wearing masks. While we have no reason to believe that there are mask availability issues, we have recommended DOC and CHS identify and address barriers to the use of PPE for staff and people in custody and renew its efforts to educate on the importance of proper use. As in the community, it as a public health challenge for trusted messengers to continue to deliver critical information on how people can protect themselves and the people around them. Jail setting creates unique and increase barriers to this work and we'll take creative and an intensive report. Additionally, as of May ninth the board has begun targeted in jail inspections to strategically supplemental remote oversight work that I described above. Each visit is going to be carefully planned to be responsive to the ongoing and exceptional health risks as well as the public oversight need.

COMMISSIONER CYNTHIA BRANN: Good morning Executive Director Egan, Chair Jones Austin, and members of the Board. Thank you for the opportunity today to speak to you about how

the Department has been handling the unprecedented COVID-19 crisis, and the steps we are taking to keep everyone who works and lives in our facilities safe. Before I begin, I would like to take a moment to publicly thank the hard-working men and women of the Department of Correction and Correctional Health Services for their incredible work during this crisis. Despite experiencing the same uncertainty and loss so many New Yorkers now face, DOC and CHS staff have remained committed to protecting the safety and wellbeing of those entrusted to their care. As Commissioner, I am proud to work beside you and thank each and every one of you for your service to New York City during this unprecedented time. Your efforts have been nothing short of heroic and have not gone unnoticed.

As America marches through the coronavirus pandemic, no small amount of attention has been paid to how the outbreak is playing out in our correctional institutions. The New York City Department of Correction operates the nation's fifth largest jail system. Even before the first case appeared in New York City, the Department and CHS were preparing in accordance with guidelines from the CDC, the city's Department of Health and Mental Hygiene, and with knowledge and experience gained through past epidemics. Screening, housing, sanitation, and health protocols have followed all these guidelines. The Department's pandemic response plan that was presented to the Board and the public on March 10, nearly two weeks before the city and state ordered its shutdown, provided a strategic roadmap for the limitation of the spread of COVID-19 within our facilities that we continue to follow today, two months later.

DOC took early and unprecedented measures, including reopening a closed facility – the Eric M. Taylor Center – on March 22, to house those who are symptomatic or confirmed to have COVID-19. At the same time, we centralized the intake and housing of asymptomatic new admissions at the Manhattan Detention Center. Finally, at the direction of CHS, people in housing areas that may have been exposed to coronavirus are quarantined. As a result of our preparation leading up to this crisis, and the swift and decisive action we have taken to address instances of COVID-19 in our facilities, we are seeing success. There has been a steady decline in the number

of “quarantined” housing units across the facility, a clear indication our containment strategies are working. Throughout this pandemic, we have endeavored to be as transparent as possible. We have provided daily updates to media on the numbers of confirmed cases among both people in custody and staff, and the numbers of those who have died from coronavirus. We provide detailed data, down to the facility level, to the Board of Correction which posts data daily for all to see on their website. We are in regular communication with elected officials, defender organizations, and other advocacy groups. When I reflect back at the whirlwind that was the past two months, I am struck by the fact that we amassed a mountain of accomplishments in a matter of days and weeks in March. You will hear shortly from dedicated DOC leadership about how quickly we created systems and operations from the ground up – asymptomatic/ symptomatic New Admissions, staff health screening, family video visits, a law library request and delivery service, and a daily all-staff newsletter – and how we are now carrying out these operations at frequencies in the thousands, as if we had been doing this for years. Acknowledgment of our remarkable work during this crisis has not been limited to local interest; we have fielded inquiries from correction systems around the country that are looking to learn from our successes and modify their operations to mirror ours.

Controlling a highly contagious disease within a jail facility is a challenge, and it is understandable that questions and concerns have been voiced about sanitation procedures, the availability of soap, and the provision of PPE. Let me be clear: The Department first acted to require masks for staff and people in custody on March 11. Over the next days and weeks, we added additional areas/units/posts where staff and people in custody were required to wear masks. The Department took these actions almost a month before a “recommendation” was issued by health authorities that masks be worn by people when in public. On April 3, the Department required masks be worn by all staff and people in custody. This was almost two weeks before the Governor’s Executive Order that all New Yorkers must wear a face covering when social distancing was not possible. At every stage, the Department has supplied everyone with ample PPE to meet these requirements. No staff member and no person in custody is being required to reuse masks. Staff have been instructed to

procure PPE from their control room at the start of their shifts and people in custody have replacement masks readily available to them in their housing unit. Soap and cleaning supplies are provided to all people in custody free of charge. Housing units, dayrooms, and other congregate spaces are sanitized on a daily basis, high touch areas are sanitized every two hours, and showers are sanitized three times per day. Since mid-March, supervisors have conducted, nine times a day, detailed coronavirus sanitization audits of all of our facilities, and we have provided the results of those audits to BOC daily. Since early March, DOC transport vehicles have been sanitized daily, unless they have transported a person who is symptomatic, at which point they are immediately sanitized.

For the past few years, New York City has had the lowest jail incarceration rate and the lowest crime rate of all large cities in the nation. In the face of the current public health emergency, the number of New Yorkers held in NYC jails has plummeted, shrinking by about 30 percent in just over one month — a steeper population decline than in all of last year. At the same time, we faced an unprecedented rate of staff out sick with coronavirus-like symptoms. In response to these things, we did not consolidate the number of open housing units, though that would have been the best practice for operational and fiscal efficiency. Instead, in close coordination with CHS and in support of the housing unit strategies that we jointly agreed were necessary in order to protect the health and safety of those in our custody, we have maintained the same volume of open units and limited unnecessary housing reassignments for people in custody. Nevertheless, there has been considerable, repeated, public attention and concern voiced regarding the purported "density" of our housing units and our ability to support social distancing practices in the jails. Here are the facts: The Department is currently operating at an overall occupancy rate of 49 percent. This means that more than half of the beds in units which are open, are empty. Dormitory style housing units – which by design do not afford individuals their own rooms in which they can self-isolate from others – are occupied at a rate of approximately 37 percent. The overwhelming majority (70 percent) of dorms are less than half full. For the dorms that are more than half full, almost all of them (84 percent) are medically quarantined. This means

that the individuals who live in the unit are asymptomatic but were previously exposed to a person who was symptomatic and tests positive for coronavirus. In partnership with CHS we have agreed to limit any housing unit reassignments for the people in those units unless absolutely necessary for a period of weeks or longer in order to minimize the potential spread of coronavirus among our jails.

As of today, there are four dorms that are not quarantined and exceed 50 percent capacity, but the people in them are healthy and safely living together. And all but one of them are program houses (e.g., detox). Therefore, at this time, we have elected not to make housing reassignments solely for the purpose of achieving an arbitrary housing capacity threshold. We have been in constant communication with staff and people in custody to raise awareness and educate them on safe social distancing and handwashing practices, including painting cues on chairs and benches that support appropriate social distancing. Despite this unprecedented crisis and its many challenges, the Department remains committed to protecting all those working and living within our facilities. We will continue to collaborate with our partners to develop creative practices and policies to effectively manage this public health emergency, and we will come out stronger and bolder as a result. Thank you again for the opportunity to briefly highlight our efforts to maintain the health and safety of those in our custody and care. I will now turn it over to CHS and DOC staff for a more detailed presentation on our joint COVID-19 response.

MS. JONES AUSTIN: Thank you Commission Brann. Before we go right -- I just want to make sure board member Steve Safyer has joined us and I just wanna make sure that he can hear us.

BOARD MEMBER DR. STEVEN M. SAFYER: I can hear you.

MS. JONES AUSTIN: Good deal. Thank you. Okay. Let's see. CHS is presenting with us on the phone call.

BOARD STAFF BENNETT STEIN: I think CHS is having trouble with them and I'm the calling number.

MS JONES AUSTIN: Okay. Alright. Thank you.

MR. STEIN: CHS are you here?

CHS SENIOR VICE-PRESIDENT PATSY YANG: Can you hear us?

MR. STEIN: Yes. We can hear you.

MS. YANG: Okay. Thank you. Sorry about this, we don't know what the technical difficulty was. We wanted to thank the board for a publicly posting the data that we submit. It shines some light into the accomplishments that we've achieved um, want to definitely thank Chair Jones Austin, for her May 10 laudatory words about our work during last week's national correctional workers week. I regret that the focus continues to remain on the negative, rather than the tremendous undertaking that we and our partner DOC have achieved in the face of this devastating pandemic. For example, in the material that the board posted this morning, it notes that the percentage population of individual's telephone Pretrial has increased from seventy five percent to eighty eight percent during this pandemic. Although that's a mathematically correct calculation, what it fails to highlight is that there's actually hundreds and hundreds of people who are no longer in pre-trial custody. This also includes half of our population of patients who are fifty years of age and older are most vulnerable. The work of releasing people in custody before, and also during this current pandemic, requires tireless actions and not merely words. It relies on relationships with courts, with the vendors, with prosecutors, and with state agencies that have been built over months and years.

Similarly, in its housing report, we were chastened for not having formalized policies the crisis we faced was not a stable and static situation requiring formal policy, but it required constant daily work, which we did together with DOC to devise and implement protective housing strategy involving almost two hundred housing and thousands of beds. Personally, I am so proud and privileged to be working alongside over a thousand dedicated front line, healthcare professionals as well as thousands of frontline DOC staff. Every day each of them risk their own lives and help to protect that of the individuals who are incarcerated in our joint care and custody. Their dedication and the aggressive and strategic measures that DOC and CHS together implemented, allowed us to

confront head on this fast moving and shape shifting lethal virus.

Initiatives that CHS had been undertaking since it's transition in 2016 were put into hyperdrive during this pandemic. Just some examples of these include our re-entry support services, our compassionate release program, our establishment with the of housing units that are defined by clinical conditions and needs, our creative use of telehealth and telephonic equipment to maintain, or increased contact with our patients. Most tragically three people in custody succumbed to this plague, but I do believe that it was because CHS and DOC strove to lock arms and stay in lock step that we were also able to save so many lives.

Every evening at precisely seven PM in every neighborhood throughout the city people stop in the streets, open their windows and go out on the roof. They whistle, they applaud they shout they bang, pots and pans. They sound their car horns. They do this gratitude for the health care workers as well as other frontline workers who put their patients and their mission before themselves and their families. We hope that, as you participate in each evening tribute, you will give special thought to both our staff who, among even central workers faces unique set of challenges and have done so unflinchingly with professionalism and dedication. I'm gonna ask Dr. MacDonald and Mr. Castellanos to update you on the current status of our work.

CHS CHIEF MEDICAL OFFICER DR. ROSS MACDONALD: Hi, this is Ross McDonald, chief medical officer for CHS, Bennett are you able to share the slide?

MR. STEIN: Yes, it's on.

DR. MACDONALD: Great Thank you. So, I just wanted to give you a little context about where we are now. So, in the months leading up to the advent of COVID-19 in New York City, CHS as you all know, was planning diligently, and we have drawn on a long history of infection control in correctional health, which has been one of the key focuses of the field. But also a particular focus in New York City, and we were particularly well positioned with our communicable disease unit, which was

built in the 1990s for the control of tuberculosis. And we really drew on that tradition and those resources that we have, that we know from collaborating with our partners around the country, many people are not fortunate to have. But, of course, the virus that we faced was new to our society and severe in its scale, this is a more deadly virus than the ones we're used to and it spreads with rapidity, unlike a disease like tuberculosis, which though deadly in its own right, grows slowly and responds to our infection control procedures.

So our response was one clearly following the plans that we had laid out but it's important to recognize that things move very quickly and that no amount of planning could prepare us for the spread of a virus that no one in our society had yet seen. The curve that you're looking at represents daily fevers as recorded in our electronic health record. That's the blue bar as well as daily positive test results for COVID -- and you can see our baseline fevers in our system, which we had tracked for years, tended to run around zero to five outside of flu season and a COVID hit really once flu season had just resolved in New York City. So we're about back down to a baseline of zero to five fevers per day in our system, and very quickly in a matter of days that increased up to over thirty fevers on certain days and -- of those harrowing days, those fevers all represented COVID. The symptomatic testing doing at that time, returned positivity rates of approximately 90 percent, which is probably the limits of the sensitivity of the test such that all those patients that we were identifying, had COVID.

I'm happy to say that through our efforts and through the efforts of the city and our collaboration with DOC that the situation that we face today is quite different. So, you see the curve very rapidly increasing towards the end of March, but you also see a decline to the point where our daily fevers have returned, mostly to their baseline and the majority of new positive tests that we're seeing now do not come from the jail population, but from new admissions, coming into the system. To give you a little bit of sense of that scale, if you look at the week of March 23 we had one hundred

and sixty-nine COVID test returned positive. If you look at the last week we had, when excluding new admissions, we had only four tests, return positive.

So, we've seen a dramatic change and what happened in between was really close fidelity to the plans that we had laid out, but also nimbleness to change those plans really every day in collaboration with our partners at DOC we built new systems, new workflows and new ways of doing our work. Really hinged on the history of infection control in correctional health, and [inaudible] very closely to the CDC guidelines for correctional facilities, which, you know, interesting to point out, were not even released until March 23. So, that guidance only was issued when we were in the midst of this crisis in New York City. But I'm heartened by the fact that our plans were for the most part identical to the recommendations of that body.

Patsy mentioned some of the strategies and strategies that we used, and I won't go into the details of those but I just wanna mention the key goals of our effort were to minimize the harm to our patients, to our staff, and to our colleagues in DOC and I also want to acknowledge that perhaps the most important intervention was a concerted effort at de-population, which allowed us, I think, to do much better than many systems around the country [inaudible] we continue to collaborate with and to talk with weekly, despite as we all know having a broader epidemic in New York City that was more severe than anywhere else in the country.

So then, if you could just go to the next slide. Thanks so, this gives a little bit of context as well. So this is an alignment charts activity rate for our tests. There's the cumulative positivity rate and it shows that that curve is starting to bend under fifty percent. Part of the reason that it never went over fifty percent, even though the symptomatic positivity rate among our patients at times was as high as ninety percent, is our very aggressive testing strategy. So, I believe we were the first correctional facility in the country to be testing on site, and we implemented a large-scale testing as soon as it was available to us. And, as I mentioned, we've continued to see a rapid decline in the rate

of positivity. Such that our most recent tests, only nine of those were positive. So we've gone down to approximately ten percent. And the final side, just shows a graphical representation of the different types of housing that we set up. The top chart shows, the total capacity of our isolation that we collaborative with our partners at DOC to build and as you can see, we did not come close to needing the total capacity and we see a continued decline in the census of those housing units designated for people who are experiencing confirmed COVID disease. Similarly, we set up an enormous new infrastructure for their surveillance of people who may have been exposed as, you know, these are the houses that we call AE houses – asymptomatic expose. And then the chart at the bottom that shows as well that we've been able to remove the status of AE from those houses, progressively, as a number of cases have declined across the system.

So, I'm extremely proud of the work that CHS has done and DOC and the collaboration that we've had, and I just want to point out that, you know, my clinical staff has acted heroically, but it's also true that we're a team and there are so many staff that support the work that we do and we would not be able to have come through this as we did without those staff. And so I'm gonna pass it over to Carlos, our chief operational officer.

CHS CHIEF OPERATIONS OFFICER CARLOS CASTELLANOS: Hi, good morning. Thank you, board members, and thank you DOC for your support. You know, it's been an incredible nine weeks of hard work. Thank you to my colleague at CHS. I mean, their work is so critical, and you know, I can’t describe the kind work they do just to make sure that patient and COs are safe. CHS primary focus in response to COVID-19 crisis has been to minimize transmission in the jails, to enhance access to health services, and the safety of our staff and patients across all the jails. So, in order to accomplish this effort, CHS and DOC have worked closely through logistics, physical planning, there was a lot of challenges in the physical planning in infrastructure of the jails but we able to establish housing plans where we are able to separate patients safely in accordance with health status and other risk

factors. We also developed new workflows and tracking systems to ensure that patient movement was done appropriately and in [inaudible] manner, and we also established several phone lines to allow patients to get in contact with CHS staff and reporting [inaudible] and any COVID-19 related symptoms. We also established a phone line to allow patients to get in contact with mental health services, if they wish to. We also continue to screen patients of various points throughout the system process at the [inaudible] courts and at the discharge. We also joined DOC on the screening of all staff at the jails, specifically are Rosie's and NIC. Again, one thing that I really want to acknowledge is the success of our taxi and commission branding and goes, you know, once the details and data demonstrated that we've been successful, what we try to do around minimizing the transmission of COVID-19. But I think the success has to be due to commitment from all staff in the jails on the DOC side and CHS side and has been incredible the staff so committed and so mission driven. They come every day and just do the best they can to, to, to make sure all patients are safe. Most recently we started this in patients [inaudible] at Rosie's and MDC, and that's just another step forward to accomplish what we want to accomplish around minimizing transmission route patient throughout the systems. Now, I'll pass it on to DOC.

DOC DEPUTY COMMISSIONER FOR QUALITY ASSURANCE AND INTEGRITY PATRICA FEENEY: Good morning. This is Patricia Feeney, the deputy commissioner for quality assurance and integrity. DOC and CHS, especially those that are conducting the audits and inspections to ensure that our COVID plan is in place. These folks have been going into the jails every day, putting themselves at risk to make sure that we are monitoring and ensuring that our plans is working and in action And I'm really proud of my staff, they did an outstanding job. We've all heard some misinformation that DOC is not providing soap and cleaning and sanitizing supplies, and I would like to tell you what the facts are regarding this. The department implemented an enhanced sanitation program that included changing our schedules for cleaning, for training the incarcerated individuals who are our workers and do the cleaning and our staff that supervise

them and to put the other plan together within a very short amount of time. And we have been updating our plan as the guidance changes from the CDC and DOHMH. So all of the work that we're gonna discuss with you today was developed and implemented within a very, very short timeframe and has been modified as necessary since then.

So, for our preventive sanitation and cleaning protocols, we clean all housing areas, including the day rooms, the common spaces once per day, shower areas are cleaned and sanitized three times per day, common touch surfaces, including doors, bars, phones, are clean numerous times throughout the day, and cleaning and sanitizing materials are accessible during all lockout times. And I think that is probably one of the most important parts of our plan, because any incarcerated individual at any time, or a staff member for that matter, can take the cleaning and sanitizing products and clean and sanitized any area that they are about to touch whenever they want to do so- so they can sanitize the sink the tables and the phones because we have those products out and to facilitate that we have a bucket of the virex 256 and sponges available near the phones at all time. And that solution is changed at least once per tour and more often as necessary. The sanitizing product virex 256 is effective against COVID, but we did have to slightly change our common protocols. So the product that we normally use, but for COVID the surface needs to remain wet for ten minutes. Therefore, the environmental health unit has been conducting training in every facility and between January 1 and April 29, we trained three hundred and forty staff members and three hundred and fifty-four individuals in custody. The department has distributed thousands of masks, and gloves, eye protection, and N95 masks are provided for those who work in COVID positive or symptomatic housing areas. We started distributing PPE to particular areas in the middle of March and chief Jennings will give you more specifics about that in a few minutes. Our supplies of our disinfectant, our cleaning supplies, the soap is offered free of charge to the folks who live in our facilities. And, as I said, the satisfactory solution is effective against COVID-19. Every incarcerated individual will be given a bar of soap as needed and those

are available inside the housing areas. And in order to ensure that all of these supplies are, where they're supposed to be, the department has a three-tiered audit system in place. So the first is the area captains, during their three tour inspections during their eight hour tours, hey look to ensure that all of the sinks in the area are operable, that there's soap available at those sinks, that all of the individual sanitation supplies are available, they speak to the incarcerated people to see if they have any complaints or if the staff has any complaints, they look back in the log book and find out when was the last time that sanitation was performed and they are expected to address any deficiencies by the end of their tour. In addition to that, my staff in quality assurance and integrity and the bureau chief of facility operation staff conduct daily audits in every facility, including Saturdays and Sundays. And in those jails they look at the intake and a rotating schedule of housing areas to verify that what the captains are finding is indeed accurate. We're making sure soap dispenses are available, that the chemicals are available, the sinks are functioning, there are adequate cleaning supplies and that there are masks available for staff and incarcerated people. And finally, when the compliance and safety center is doing their regularly assigned video monitoring they are documenting whatever sanitizing steps are being taken during the time that they're watching the video for their regularly assigned task, and they are documenting whether staff and incarcerated people are wearing the masks. If they're not, phone calls are being placed to the housing area as a reminder that that should be done. There's kind of another misconception out there – that we are not providing our information regarding COVID to the population and to the staff, and that it's not publicly available – and that also is not quite accurate. On March 17 the department began sending daily updates regarding COVID-19 to report our COVID preparation plan and was available on our website on March 18 and as we have updated that plan throughout the outbreak, we have updated the plan on the website. There's a recorded presentation of the plan and the response to the questions from the March board meeting. We've been in close communication with our criminal justice

partners, our partners with the city, of course CHS and on March 24, the deputy commissioner for public information started issuing an end of the day report to all staff, which is a compilation of any new information regarding COVID, regarding our policies, we have acknowledged particular work done by particular staff members and their messages from leadership in the end of the day report. Our educational information regarding COVID and how it is spread is distributed on informational posters in all of the facilities, and the housing areas, and the visitor areas, and the core commands. Informational handouts were given in English and Spanish; one pager of program information was distributed by the inmate Council. We have public service announcements that are on our DOC TV in the facilities – it's also in headquarters and on our Internet. We have daily role call updates where Teletypes are read and information that needs to be stressed is disseminated to the staff. And again, they can distribute the end of the day report.

DOC CHIEF OF DEPARTMENT HAZEL JENNINGS: Okay, hi, good morning. This is chief Jennings. I just would like to start out by given my sincere thanks to so many people who have worked tirelessly alongside of me during this pandemic Commission Brann, Brenda Cooke, DC Feeney, Judy Bill and Phil Terwiel and their staff at programs who have worked well into the night between discharges, there were days when we didn't go home, to make sure that we got people out of our custody in a timely manner. To Tim Farrell and his captains at custody management for making all of these discharges happen at the time, because there was so much paperwork that has to be going through and, you know, phone calls to jurisdictions to make sure. And Carol James and the staff and [inaudible] at CJB and Brian and Maureen from I.T. and all of their staff for bringing all of these tech solutions that made it so real for us and my maintenance staff for helping out, because we could not have done it without them. And my front-line staff who came in day in and day out, when times are so hard and I think that, you know, it's just been a prayer and all of the external partners to helping us out, CHS for all of the daily phone calls and the collaboration that went on. And I think that we just also have to thank our men and women in custody

who were cooperative and volunteering for these work details to make sure that all of our sanitation has been conducted. And so, you know, I'm thankful for all of our staff and our doctors who showed up when there was, you know, the world of so uncertain as to what was going on.

And so I, I just want to start the housing. Since March 16, we discharged well over one hundred persons in custody. As of May 7, the department overall housing unit capacity was at approximately forty-nine percent. The dorm department wide at thirty-seven percent. Among non COVID housing dorms are approximately thirty-six percent capacity. And the COVID dorms are at forty percent capacity. Some of the things that we did, we opened up EMTC on March 22 to provide symptomatic, exposed, and confirmed positive housing. Symptomatic and COVID confirmed individuals were also housed at CDU at West Facility as well as Rose M Singer and NIC. Some of the additional things that we did with housing, CHS provided vulnerable persons so that we were able to a bubble wrap NIC and also open up housing units where we house vulnerable populations together so that we can protect those persons in custody. From April 20 to April 24, the number of COVID housing areas reduced by twenty percent from one hundred four to eighty-three. And then April 24 – May 1 the number of quarantine houses decreased by twenty percent, from eighty-three to sixty-six. And then, as of May first, there were approximately twelve hundred fewer people designated as a systematic expose for the two weeks prior. Keeping in touch from April 2 to April 30, we distributed over seven thousand, eight hundred and sixty-seven free stamps and thirteen thousand four hundred and ninety-four pre-stamped envelopes to people in custody. From the period of March 1 to May 30, we provided one million, five hundred and sixty-five thousand, nine hundred and forty-three free phone calls. May 1 to May 6 We facilitated one thousand, seven hundred and thirty-five video conferences and this is something that we kinda designed on the dime with the systems to do it where we installed a, these kiosks so that people in custody could actually one – well the seventeen, thirty-five was the video conferences for people company with their legal representation, where we install Skype and Skype kiosks in

all of our counsel visit areas in other areas of the facility. Our incoming and outgoing mail boxes have not been impacted as people have called up to inquire about. At no time did we stop any of our mail services doing this time.

We also instituted department wide telecom visiting, which came about on April 1, which allow families connect to their loved ones from the home devices. We initiated this program just two weeks from suspension of in person visits. We facilitated a three thousand, four hundred and seven televisits between April 1 - April 28 and we currently have ninety-three tele visiting devices across visit areas exclusively from family visits and we're looking to expand. We also have forty-nine teleconference and booths across all facilities updated with Skype to expand connectivity of access to courts, attorney visits, and other criminal justice stakeholders. In regard to personal protection equipment, on March 11 we instituted a protocol for our N9 masks distribution to staff at court command and transportation division. Symptomatic persons in custody were issued masks on March 18, which expanded areas posts requiring masks and provided masks to staff working in close contact with medically isolated housing areas. On March 22, we opened up our emergency operations center and staffed that so around the clock if any of the facilities were in need of any items or assistance, someone could be dispatched to that facility or either get in contact with maintenance staff, so that we could streamline that. I'm sorry also back on March 6, we also started an electronic health management division sick rate tracking system so that we were able to track our sick rate department wide. And then on April 3 all of our staff issued a required to wear masks and masks were provided for all people in custody available in the housing areas and available as a on need basis in the intake and we also provided masks in all of our controls areas for all staff who are entering into the facility. And just know we took this action ten days prior to the April 13 New York state guidance, regarding safe covering and public. And these are some of the posters that we put up in response to recommendations made by the mayor to everyone requiring them to wear a face covering the commanding officers also made sure that staff where aware

as to where masks were being distributed and that they were available. And we also began multiple times during the week with facility operations, doing audit of the facilities to make sure that none of the facilities, the units, ran out of their protective personal equipment. In regards to our enhanced social distancing and protecting the vulnerable population, on March 13 began our preliminary social distancing guidelines released and on April 14 our social distancing guidelines released where we allow no more than four individuals in the shower or bathrooms at any given time. No more than ten individuals in the day room or intakes at any time and social distancing cues were painted in the day rooms in the intake areas. Almost thousand enhanced social distressing guideline posters were put up throughout the facilities in all of the housing areas. And I just want to be clear that no one infractions were generated for violating the guidelines and the officers were also encouraged that we would not be using force to enforce these guidelines but just trying to get an active and willing participation by all persons in custody. We also limited all of our inter-facility transfers and making inter facility transfers between housing areas so that we could slow down the rest of the spread to movement. And also, I just wanna again make sure that everyone understands that people have been living in these housing areas together and they are healthy. This is again, some of the COVID-19 health advisory posters, and the stock that people have to have masks beyond the point and while entering and going throughout all of the facility. We had dedicated housing units for cohorted individuals at higher risk - like I explained earlier - where we bubble wrapped NIC housing areas, which allowed increase levels of separation from the general population. And it also allows for increased access to clinical attention. Eric M. Taylor center is housing newly admitted individually showing symptoms, COVID-19 positive individuals. Rosen M. Singer has been housing areas for the same purpose, dedicated for female individual's and MDC on March 24 was dedicated as an intake facility for individuals without symptoms.

Screening and healthcare consisted of on April 7, a telephonic sick call triage, which allow patients direct

access to CHS nursing staff daily from five am to ten am, medical screening for people in custody consistent with federal state and local guidelines, we allowed persons in custody rather to utilize the telephones in the housing areas in the intake areas to do discharge pre-screening and CHS screenings at pre-arraignment and upon admission. We work collaboratively with CHS partners or COVID related housing determination and all movement into and out of such how units on the individual level. The asymptomatic exposed housing areas were quarantine for fourteen days. The symptomatic exposed test pending housing areas, or COVID-like undergoing assessments, testing, and monitoring until the COVID status was confirmed and our COVID-19 confirm tested positive. Our medically vulnerable populations designated by CHS or housed in dedicated housing units again, the patients that require an activation and monitoring without being confirmed positive were prioritize for housing in a cell environments to mitigate the risk of infections spread and patient showing complication or who became symptomatic were produced for immediate medical attention. For our staff screening we created with our EMT and other training staff a unit where all staff were screened prior to entering the facility, and we also work with CHS with their assistance and two of our facilities and they answered, we have yes, no questions answered no touch temperature screening. Our staff access to COVID-19, we partnered with northwell health care sites, and they provided to symptomatic staff adults or those who had been exposed to symptomatic individual's testing.

We currently have a new initiative going where we are doing testing at one of our facilities, NIC, which launched on April 24, for a new temperature taking with the, the direction of supervision of Chief Barnes and ADW Mitt and with temperatures will be checked with this new equipment and so we are looking to actually do this initiative and evaluation for 30 days before rolling it out at all facilities. Announcement updates, again northwell health go health urgent care is proud to partner with staff to offer this COVID-19 testing to symptomatic and potential exposures. We also offer this on our Intranet so that staff would know where they could go and what were the hours. Okay, staff

wellness between March first and May first our chaplains and psychologists and social work is in a stack from here they did sixty-six hospital calls and forty-one hospital visits. Twenty-three members of service receive care from the care unit. We had seventy-one of staff has been seen for bereavement support and fourteen desks attended by the wellness staffed I support staff. We also had our chaplains, the psychologists and social workers, uniformed, peer counselors who are available a wellness staff, continued to monitor and check in with uniform and non-uniform. And they also collaborate with training and public information staff to provide supportive measuring and coping strategies for all staff. And last but not least we currently have the working with our Chaplin and the IT install to large screen televisions in all of the chapels so that we will be able to provide additional support for people in custody.

DOC GENERAL COUNSEL HIEDI GROSSMAN: This is Heidi Grossman. And I'm here to talk about the relief program as, you know, you've heard from the commissioner, from CHS, from the chief, the historic number of individuals released in such a very short period of time has contributed in large part to a lot of the good work that we've been able to accomplish, and we could not have accomplished all of this without assistance and help from external stakeholders and internal stakeholders, including the state, the court and, and many others. So, as you can see our census on March 16, as has been referenced was about fifty, four hundred and forty-seven and then on April 29, we went down to thirty-eight hundred and eleven. There were also as you can see a number of new admissions are almost up to a thousand, which gets to our total about twenty-six hundred and thirty-nine total releases from March 16. So it's important to note that the department does not have control over the reasons why a person is going to be released, that really is something that we need to depend on the courts for and other agencies. And that's where the DAs offices, and state parole, state Docs, come into play and the collaboration that has occurred over this period of time has been very instrumental in these releases. We can go to the next slide.

So we will, when it comes to technical parole violators, that requires, as I mentioned some work with the state Docs, to see if they're willing to lift the warrants. And if that decision is made to lift the warrants, and the department will execute - will initiate the discharge and make sure that that happens and comply with any lifting of the warrant. What what's interesting and what has happened that's new, where we have sentenced individuals for under a year, the state law authorizes the commission of correction to allow that individual to serve the remainder of their sentence in the community and under supervision. So, we have about three hundred plus individuals who are in that program. Other individuals who remain in our custody for over a year, and are waiting for state prison a transfer, if they're held on warrants and held on court orders, we, we're not authorized to release those individuals - that is something that can only have a judge issuing an order. Next slide please. I think that's about all we have to say about the releases as in terms of these particular details. Thank you.

DOC DEPUTY COMMISSIONER FOR PROGRAMS AND COMMUNITY PARTNERSHIPS, JUDY BEALE: Good morning executive director, Egan members of the board. My turn. My name is Judy Beale and this is my first time speaking to this board since assuming my role as deputy commissioner for the division of programs and community partnerships. The division established very quickly after the outbreak of COVID a written request and delivery system, which allows the population in custody to write to staff and explain what they need regarding social services and law library services. And staff complete those request slips in writing and return them to the population within one to three days, depending on the level of research that's required. This new system became operational on April 16, and during the full week of service being in place, the library staff completed over one thousand requests. Additionally, counselors are picking up and distributing written request for services and those working remotely are spending their time completing responses for the requests that are being made by the population. The system ensures that those in our custody continue to connect with essential resources and services, in all of our facilities and upon

discharge. Additionally, I'd like to note that we've established within the division of the cqf process where we're conducting random audits of the services being provided to ensure that the needs are being met. On March 20, congregate religious services are temporarily suspended in all facility chapels. However, limited one to one chat services continue to be provided in their housing areas in accordance with social distancing guidelines. On March 27, a hotline was opened, allowing individuals to reach Chaplain for spiritual services and care. A Chaplain can be reached through the hotline during hours when phone calls are regularly permitted and information on how to dial the hotline has been placed in all facilities. Program staff is providing self-directed material to interested individuals, packets consist of the same evidence -based books and worksheets the counselors use during their in-person sessions. Materials include interactive journaling, books, anger management, goal, setting and coping skills, reading materials and worksheets as well as creative arts activities. Materials are replenished and distributed a weekly basis. Community re-entry providers established a discharge planning hotline, which allow people in custody to connect essential services in preparation for their release outline. Information is posted in each housing area. To encourage the social distancing and minimize idle time, the department has provided entertain and materials to those in custody. And these includes four thousand handheld, gaming devices, radios puzzles, fifteen thousand reading books, movies and D. V. D. players. These materials are being distributed on an ongoing basis, as new orders are fulfilled. The division has also work hard over the past couple of months to redeploy our existing stock with tablet. This process has required an I assessment of housing areas for the Wi-Fi and cellular connectivity as well, as the development of a command level order, outlining a new protocol and policies surrounding use of tablets. The last two weeks of April, the department worked to make tablets available to all individuals in custody at both RNDC and GRVC in total, approximately one thousand tablets were deployed between these facilities. Staff distribute tablets each morning and collect them in the

evening for charging. The department's tablets include hours of supplemental educational and programming instruction across a variety of subjects, one thousand five hundred publications covering all reading levels, law library, services, religious texts, [inaudible] programs and movies. Regarding educational services, there was a suspension of educational services in all NYC public schools, and the East River Academy suspended in person services that our facilities on March 14. On March 19, the department received individualized packages for enrolled students across the island. The DC distributed the packets to all students between March 21- March 24. Individual learning packages, prepared by DOE instructor, varied as each package targeted students' specific needs. Each package contained learning materials for eighteen days along with personalized notes from teachers to their assigned students. The DOE was on a spring break from April 9 through April 17, 2020 and the department has offered to continue distributing additional educational packages to ERA students.

CHIEF JENNINGS: Thank you. Steven if you could remove the slide at this time please. And that concludes our presentation.

CHAIR JONES AUSTIN: Well, I want to on behalf of the board thank you DOC and CHS for a very thorough report, presenting the work that you all have done in managing COVID as well as addressing several of the questions, the concerns the comments, that the board has received from advocates, from persons in custody from other interested parties. As I stated at the beginning of this public meeting, the board is deeply appreciative of the Department of correction and correctional health services for all that you've done to manage and contain the spread of COVID-19 while also caring for many persons who are in custody as well as tending to, you know, the issues presented with many staff who've tested positive for COVID-19 or been exposed and, you know, we appreciate the significant planning that's gone underway, and the impact that you've had thus far. That does not mean that we do not have questions and that we will not present them to you when issues are raise that are of concern to us, but that

does not at all minimize our appreciation for all that you've done to manage and contain the spread of this disease and we believe, I believe that you've done a significant job. You've been very responsive to questions and concerns that have been raised and while they always is a request for greater transparency we appreciate, we truly appreciate the work of the leadership and staff throughout this pandemic. The board may have comments, but we do not at this particular moment have the time to hear them. We will if possible, put them at the end of the public hearing.

We want to now turn to the variances that have been put forward by correctional health services and by the Department of correction. We're going to first have public comment on them and then the board will entertain the variances. And so what we will now do, is just walk you through, summarize what these variances are and the comments that we'll hear and then give you some guidance concerning list of speakers who signed up to be heard, concerning these variances. We'll give you the instructions for how to give you a public comment.

Correctional health services has again requested variances from two minimum standards in order to respond to the COVID-19 emergency. CHS requests variances from Mental Health Standard 2-04(c)(3), which requires among other things an individualized written treatment plan based upon the evaluation of a treatment team be developed for each person in custody placed in special housing for mental observation and for all people in custody is medication for mental or emotional disorders is prescribed, and then a review of the plan be documented in the patient's chart every two weeks; and mental health minimum standard 2-05(b)(2)(i-ii) which require that no prescription for psychotropic medication shall be valid for longer two weeks and the person in custody receiving psychotropic medication shall be seen and evaluated by the prescribing psychiatrist or in cases of emergency when a physician other than a psychologist prescribed medication at least once a week until stabilized, and thereafter at least every two weeks by medical personnel.

The Department of correction has requested a variance for the continued use of the secure unit for young adults,

including reduced out of cell time and an in-unit law library alternative. The board first granted this request in 2016, and as it has renewed every six months since then. The boards proposed rule would eliminate the need for this variance.

I have a list of speakers who I'm going to call each person's name individually. When you hear your name, please raise your hand, using the hand icon below the participants list on your WebEx screen. When you hear your name, please raise your hand using the hand icon, below the participants list on your WebEx. If you don't see the participants list, click on this silhouette, on the menu at the bottom of your screen, once you open the participants list, you should see the hand icon in order to raise your hand when you raise your hand, we will unmute you and you will be able to turn on your video, you can then begin your public comment. I will tell you when your three minutes to speak has expired and we'll move to the next speaker. You can also submit your comments by emailing your comments to boc@boc.nyc.gov or mailing your written comment to 1 Centre street, Room 2213, New York, NY 10007. Okay, we shall begin the public comment with Martha Grieco.

MARTHA GRIECO: Thank you. I'm an attorney at the Bronx defenders with our prisoners' rights unit, and I'm also a criminal defense attorney. Before the board votes to approve the extension of the two mental health related variance requests from CHS, we at the Bronx defenders want to remind the board that right now, more so than ever, CHS patients, our clients are dangerously isolated. All in person visits are suspended, family tele visits require a level of technology that many households don't have access to, attorney video conference time slots are backed up weeks for some facilities [inaudible] in competition with court appearance time slots, and the attorney visit window has been cut by several hours, not to mention the elimination of weekends. What's more is attorneys are ordering video conferences very sparingly because of the risks movement entails. Similarly, our clients risk their lives every time they pick up a phone that has been used by ten people before them. So the facts that CHS states in its letter to the board

that they're not aware that the granting of the variance has cause anyone harm is not entirely reassuring without more data and public information. We at the Bronx defenders have received an alarming number of complaints of neglect since the pandemic began to spread. We want to bring one example to the board's attention. We were made aware that CHS had suspended its medication assisted treatment program for opioid use users and the way the defender community found this out was after a client reported lying on the floor of an intake pen for two weeks in the agony of detox. What could possibly be the reason for the department failing to notify defense attorneys of this new policy? We understand that medical providers throughout the city are making difficult policy changes to cope with COVID-19, but there's no excuse for keeping anyone in the dark about those changes. Knowing what types of medical treatment are not available to a person that we arraign is a factor that could help us convince a judge not to put them in jail. So given how critical this information is to our advocacy, we are concerned that CHS and the board, both of which represented in public statements the importance of decarceration for public health, would not inform those of us on the front lines, trying to keep people off Rikers of policies that would help us keep them off Rikers. So, to relate to the variance requests, we urge the board to investigate further, we ask what other changes and policies CHS is implementing that there have not been variance requests for, and what if anything, the board is doing to monitor the effects have on CHS’s patients. Given the advocates have extremely limited contact with our clients right now, we are relying on the board to monitor the actual implementation of the policies that CHS has testified to and that the department is starting to testify to today. In reference to the report that was published last night long after my comments were prepared, it is now confirmed that the board has no one in the jails right now --

CHAIR JONES AUSTIN: Your three minutes expired and we have to keep moving. I apologize to you. Thank you. Daniele Gerard. Okay Daniele has raised her hand. Can you hear us?

DANIELE GERARD: Yes, I can hear you. Good morning Chair Jones Austin and board members, I'm Danielle Gerard, a staff attorney at children's rights. We have been a national advocate for twenty-five years for youth in state systems, we're also a member of the Department of correction's former adolescent and young adult advisory board and the New York City jails action coalition. Our experience with adolescents and young adults in foster care and juvenile justice systems -- contact with young adults and use corrections policy as our clients are disproportionately represented in young adult and juvenile correction facilities. We're concerned about the welfare of young adults and youth at Rikers and Horizon. We remain concerned that young adults are spending too much time in their cells on the secure unit. We note that the March 2020 audit of the secure unit shows that the department has not even kept track of lock in and lockout times on the secure unit and that the majority of young adults in phase three were on lock out for more than ten hours without incident. Therefore, it is unclear on what basis the department is seeking to keep young adults in their cells for longer periods of time by requesting a variance for a minimum of ten hours a day out of cell time within the unit. As we have frequently testified, notably in our December 2019 public comment opposing restrictive housing rulemaking, we urged the board to establish a fourteen-hour minimum of daily out of cell time for all young adults incarcerated in the city's jails. As the board is aware excessive isolation particularly at this time is incompatible with current research and policy for older youth. In addition, by not allowing the young adults in the secure unit to leave the unit to go to the law library, the department confined them to the unit itself. Even when they are on lockout use of kiosks, and allegedly temporary solution seems to have become permanent with the requested variances recurring for four years now. We urge the board to require the department to devise a plan for young adults on the security unit to use a law library, and to set a date by which this will occur. Neither of today's variance requests is actually limited. We request the board deny them and set firm dates for the department to comply with the minimum standards. Regarding CHS, we thank CHS for its work regarding

the requested variances. We join with the concerns expressed by the jails action coalition and add that as the population on Rikers has diminished significantly since the public health crisis began, we urge that the board deny the variance request. Every incarcerated person with mental and emotional disorders, particularly at this time, which the daily snapshot indicates is over half the population, should receive medical attention and compliance with minimum standards. Finally, we thank you for your update on restrictive housing rulemaking. gain, we urge the board to reinstate the young adult plan in its entirety, and to abolish solitary confinement outright. Thank you for the opportunity to testify.

CHAIR JONES AUSTIN: Thank you. Thank you very much. We will now move to Alex [inaudible]. Are you present? If so, please raise your hand? Oh, okay. Doesn't appear that you're with us. We'll move on Mr. five. Mr. five are you with us? Okay, we will move onto Rosa Palmeri.

ROSA PALMERI: Hi, I'm with free them all for public health and I'm an organizer with no new jails. I was at the last hearing and I'm here to testify again on behalf of my incarcerated friends and community new members. I urge the city to immediately release incarcerated people from city jails and deny the request to renew these variances. Even before this pandemic began, existing medical care in city jails was already dangerously inadequate. For example, in 2018, incarcerated people missed nearly a quarter of all medical and mental health appointments. And a dozen people have died in city jails over the past few years alone. City jails failed to deliver healthcare to incarcerated people under normal conditions since the variance request was issued last month, the already inadequate healthcare available to incarcerated people has rapidly worsened. People have been told to call 311 for seizures, crippling back pain, and acute leg infection while being denied the surgery, medication, or other care that they need. Our friends in city jails have reported that they're being crammed into close quarters and that people who have symptoms of COVID-19 or other health issues are not receiving medical care. They've also been

denied food, water, cleaning supplies and hygiene products and access to their mail, which we have confirmed by multiple Cos. Most recently corrections officers at Rikers denied clean plates to incarcerated people and demand that they clean their plates with dirty water. Clearly there is a gap or obstruction of information here. I see it when I'm talking to my friends inside, and I see it when I read the letters of other advocates prior to [inaudible] including public defenders. I'd also like to add that without adequate data as to how many deaths have occurred after release, especially since those release have been some of the most vulnerable to infection. You can't really report on how many deaths have occurred as a result of COVID-19 in jails. People, that fellow organizers, and I've aided in release have died and are not among your count. It is reprehensible to extend the variance and continue to provide less healthcare then the already inadequate healthcare provided in city jail. We also adamantly opposed the proposed variance to restrict for young people's access to time outside the cells into law library. The public health evidence is clear, while incarceration exacerbate ill health and contributes to the disproportionate vulnerability of black, immigrant, transgender, nonconforming, disabled, and working class people to sickness and premature 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 our communities is the only viable solution. I asked the board to deny these variances and to use all the political power you have to push judges and Das to release everyone in city jail and provide them with vital services. Thank you.

SIMONE SPIRIG: Good morning. My name is Simone Spirig and I’m the jail services social worker at Brooklyn Defender services. The board should deny the variance from CHS as it pertains to restricting mental health services for people in general population. For two months, as COVID-19 continues spreading throughout New York City jails, the jail services team has fielded over two hundred individual calls from people in custody. This morning our team will be sharing stories from our clients. My comments today were formed by the

experiences of people currently in DOC custody and will describe more broadly the difficulties accessing CHS and how these continued challenges only heighten the need for mental health services, especially for those in general population, where rounding and accessibility is growing increasingly difficult. During a recent phone call, a person in custody stated mental health gives you the run around, the only way to get mental health is if you see them in passing, like in the corridors or if they're seeing someone else so they have no choice but to help you. As routine, when our office receives a complaint about inability to access healthcare or interest in receiving services, we encourage them to sign up for sick call in their housing unit and we also send a referral email to CHS only to receive an automated response from staff that our message will be forwarded to the facility. In one particular case, it took over a week for our client to access mental health care with no reason provided for the delay and even more severe cases we're aware of medication lapse and inconsistency for people on custody to access staff despite numerous request made by people on custody in our office to CHS. Furthermore, CHS just rolled out a hotline for people in the jails to contact CHS directly. Though we support additional means of communication, we are deeply concerned and the efficiency of the new protocol. Several people have shared that they have tried the new hotline, but are only met with a voicemail machine and have no confirmation that their grievances are being heard or that they will be followed up on. Those that do on the line, they have had to wait over a week to be seen including one man, who reported increased difficulty breathing due to his asthma, despite repeated call to the hotline. So, we support the hotline with needed improvements, it's our understanding, the hotlines for the purposes of contacting medical staff, and not mental health staff. If this board is going to approve limiting mental health care for people in general population, CHS, DOC and BOC and must provide additional means of communication for people to access mental health, if they so choose. People in general population, though, they may not have a diagnosis of serious mental illness, are being locked in for twenty-three plus hours a day, depending on their unit. They are already

isolated from their families have limited or no inside support and are now learning to survive during the pandemic. We all know the dangers that isolation can have on an individual and the likelihood of decompensation during these times. All morning we've heard deception and inaccuracy regarding protocol, this narrative is challenged by the people I've been speaking with directly from inside the jails. CHS has not provided enough evidence why this variance is necessary and what specific steps will be taken to ensure the mental health safety of people –

CHAIR JONES AUSTIN: Ms. Spirig you time has elapsed. You can submit the remainder of your testimony via email. Thank you. Let's move to Irene. Okay, can you hear us.

IRENE CEDANO: Hi. My name is Irene Cedano and I'm a jail services advocate at Brooklyn defender services. As Simone mentioned, our team has received hundreds of calls from people in custody describing conditions in need of help, accessing care, and asking questions on how they can best keep themselves safe. We hear their pleas for help and when you vote today on variances, you should take into account their stories implemented a hotline that is meant to allow people to easily discuss their health concerns during COVID-19. However, most people report that the hotline has been unsuccessful. Typically, people are kept on hold for the entirety of the call. They're unable to connect to any medical staff, and if they're finally able to share their medical concern, they often receive no follow up. We feel that this has created a backlog of requests, and that people in custody who need immediate attention are falling through the cracks. Even more alarming, some people that request staff to escort them directly to the clinic report that some staff members don't want to escort them due to fear of potential exposure to the virus. One clients in particular demonstrates the challenges people in custody are facing regarding access to medical care during these difficult times. I received the call from our client who recently tested positive COVID-19 and is considered high risk by the CHS. Despite also having two fractured feet and serious mobility concerns, our client was transferred to a general population housing unit that

requires them to take the stairs when being escorted throughout the facility. Our client previously had access to a wheelchair. However, once he was transferred, he was given crutches, which he reports do not provide him enough stability to walk. As a result, our client has had to have his meals, brought to him by other incarcerated individuals to his unit. Our client attempted to request medical attention through the hotline multiple times, however, even after talking to an operator about his concerns, he received no follow up by medical staff. After our office's second referral to CHS, BOC and DOC, our client met with the captain, and had to be carried to the clinic by two individuals due to his inability to walk on his own, unfortunately, this isn't an isolated case. Other clients are unsure of the hotlines operating hours, whether it could be used for both medical or mental health needs or what the hotline is at all. We're extremely concerned about our client's well-being in addition to the hundreds of others that may be going unnoticed. Similarly, while DOC reports that it has implemented the containment and control transmission guidelines, individuals in custody are saying that there is a lack of cleaning supplies, face mask, and an inability to practice social distancing in jail. Clients support using the same face mask for over two weeks at a time, having to wash your hands with shampoo due to a lack of soap, and sleeping in dorms with beds far less than six feet apart. I fear for individuals whose voices are not being heard at this time and whose lives and safety remains at risk. We understand that the board published a report and updates late last night and we appreciate the boards efforts to bring transparency into these discussions.

CHAIR JONES AUSTIN: Thank you very much. Claudia Forrester is the next person to speak. Can you hear us? Please begin.

CLAUDIA FORRESTER: Good morning. My name is Claudia Forrester, and I'm a jail services advocate at Brooklyn defender services and, like my colleagues Simone and Irene, every day I am on the phone listening to people inside our jails. I want to share their stories with you this morning. The most common pattern in my phone calls is the astounding

lack of access to the supplies needed to keep oneself safe during this pandemic. Today, the department has stated that all people in custody had been provided with masks and replacement masks are available upon request. We hear a very different story. One person housed in VCBC described a complete lack of disinfectant spray, meaning, there's no way to clean the phones between use. Moreover, only eight out of the twenty-five people in his unit had masks, all of which were one time use and should've been discarded after eight hours. Another client stated at the captain who regularly comes through his unit never wears a mask and when asked why, she responded that she was waiting to receive a pink mask, because she didn't like the blue ones. While DOC and CHS reportedly instituted new protocols communication with those inside the walls makes it obvious these procedures are not the lived reality. We are deeply concerned that DOC and CHS are understaffed and ill equipped to actually enforce their own procedures in the face of this crisis. Our clients also voice a dangerous lack of essential care for issues unrelated to coded. One client suffers from a severe autoimmune disease for which he takes medication twice a day. Yet, he has not received his medication for over six weeks. The result is crippling pain, which leaves him unable to move sleep or eat. He requests medical attention every day by phone and through the COs but is told that the clinic is only taking COVID related issues. Another individual shared that recently her PTSD and anxiety have been intensifying, she's been having extreme nightmares and intrusive thoughts and panic attacks multiple times a day. One recent panic attack with so intense that she seriously injured her knee and now uses crutches. Despite requesting care for the last three months, she is yet to see mental health staff. Our incarcerated clients are terrified by what they're being forced to experience and not knowing with the long-term consequences of loss of access care and treatment will mean for them in the future. The calls I receive every day are dominated by fear and desperation. In one voicemail, one individual shared “I'm not sentenced to death, but by being incarcerated right now I'm being sentenced to death due to the coronavirus.” We recognize the difficulties we're all under and the work necessary to protect

people in our jails, including staff, but transparency is essential – not deception of policy that fails to prove successful implementation or accountability. We must not gloss over the struggles many people are actively dealing with in our jails. Just this morning, the chief of the department declared that everyone in DOC staff is required to wear a mask, while simultaneously not wearing a mask herself. Nothing could more perfectly symbolize the way these policies are not actually being followed behind the walls. It's crucial for this board to continue --

CHAIR JONES AUSTIN: Your time has expired, thank you so much for your testimony. We have to move on, Veronica Villa - Vela Please raise your hand. Please, forgive me for the pronunciation of your name. Let's see. It does not appear that she. Is with us anymore, so we're gonna move on to the next person. Jennifer parish.

MR. STEIN: I think that Veronica is here just she raised.

CHAIR JONES AUSTIN: Okay. Alright I did not see that on my screen. Okay. I apologize. Are you there? Veronica?

VERONICA VELA: I'm here. Hi, the Prisoners' Rights Project of the Legal Aid Society remains concerned with efforts to reduce engagement with detained persons who need mental health care when people in custody are experiencing unprecedented levels of trauma and stress. CHS received the flexibility to go up to eight weeks between appointments after very little notice to the public after limited time for public comment for the board. CHS now asks the variance be renewed, stating that it is not aware that the granting of the variances has resulted in harm to the patient, but given their limited presence in the effected of housing units, and a reduction in regular appointments, can CHS accurately say that there's no harm in such that the board can rely on the statement. The Prisoners' Rights Project spring from clients in distress over their abandonment by mental health staff that they have come to rely on. One person with multiple diagnoses, including PTSD and bipolar disorder was experiencing increased anxiety because he had multiple health conditions making him vulnerable to the virus, but he had

been making a request for two weeks to see mental health staff without response. We heard from another individual in punitive segregation who was harming himself, he was passing notes to correctional staff saying he needed mental health care and he was hearing voices. Those requests were ignored. Another individual has called us repeatedly to report that he used to speak to mental health staff weekly for thirty minutes but now he speaking to them every other week for only five minutes each time. The variance request says individuals are given clear guidance about how to seek care if their situation changes but that is not what we're hearing. Since its inception, we've heard reports to sick calls not working, individual's call the sick line and 311 [inaudible] lead report need for mental health attention, or interrupts with the medication that are not receiving any follow up. They can't get through to a staff person or the line rings and rings re just changes up on them and keep in mind that individuals have to use communal phones to call for help, in many cases phones that we repeatedly here they cannot clean them. Individuals are avoiding the phones, because it's one of the only ways they have to control their exposure in the jail. CHS rightly highlights their efforts to support the release from custody of vulnerable persons. Yet, individuals with mental illness are increasingly over represented in this population and at the time, when there are fewer people in the jails, that those people have a greater need, we should be providing more frequent care - not less, and we should be proactively safeguarding patient needs. When individuals cannot rely on the phone line or DOC line staff to contact mental health staff, prescheduled regular appointments are essential. We are aware that resources are strained across all the institutions during this emergency that some shifts and priorities are unavoidable but reducing individual's access to mental health care during this crisis is misguided and harmful.

CHAIR JONES AUSTIN: Thank you very much. We will now move onto Jennifer perish. Okay, she's raised your hand Jennifer has been unmuted.

JENNIFER PARISH: Thank you for this opportunity to comment on the requested variances. First, we oppose the Department of Correction's variance request related to the secure unit. Urban justice center along with more than sixty organizations and twenty individuals, including the public advocate, York City controller, and city council speaker and other council members support implementing the blueprint for ending solitary confinement in New York City jails. We believe that the department can pursue the objectives of the secure unit without limiting out of cell time. Young adults in the secure unit are regularly denied the out of cell time permitted by the current variance. According to DOC's audit report for March, lock in lockout times were not necessarily recorded on two of the four audited dates and the data DOC collected shows that on the audit dates, only thirteen percent of young adults in phase one received the full ten hours of lockout time. The board should deny this variance request and complete this restrictive housing rule making, by adopting rules that require all housing areas to be provided the full fourteen hours out of cell. Regarding the correctional health services variance requests, we urge you to deny CHS variance request from mental health minimum standard 2-05(b)(2). We are deeply concerned that people with mental health needs are not receiving adequate services during this pandemic. We appreciate the vital work that CHS staff and leadership are doing to care for their patients during the COVID-19 crisis and we recognize that the current crisis is draining their resources. However, restricting access to care for people with mental health needs is not an acceptable solution. At this critical time people in the jails need comprehensive mental health treatment. Along with their existing mental health needs people in jail are experiencing additional stressors created by this crisis. People who are prescribed psychotropic medication should not be left to languish for eight weeks without seeing a psychiatrist. Regularly scheduled appointments are critical to ensuring that people receive the treatment they need, especially given the difficulty of access and care without an appointment. People in general populations are not able to connect with CHS when needed. If this variance is granted, problems with their

medication could go unaddressed for almost two months. We receive complaints from people inside describing their lack of access to mental health care. One man at AMKC described needing to have his medication adjusted but was not able to access mental health staff. He complained that the correction officers were making it impossible for him to meet with CHS. A man at OBCC with serious mental illness described suffering from flashbacks and uncontrollable crying he reported repeated attempts to access mental health treatment, including contacting 311 and complaining to a captain. His concern was not only the need to have his medication adjusted, but to have more frequent sessions with a therapist. Although the percentage of people receiving mental health treatment in the jails has increased to fifty one percent of the population, the number of people on the mental health caseload has decreased by three hundred. An issue with CHS resources --

CHAIR JONES AUSTIN: I have to end your testimony but thank you very much. Let's proceed to Lewis Conway Junior. Please raise your hand if you are here. Bennett I'm not seeing Louis Conway. Jr. So, I'm going to move on to minister Dr Victoria Phillips, Ms. V. She's raised her hand.

VICTORIA PHILLIPS: I have a question before I begin, I'm still going to get public comment, right? Okay, so I just want to say, deny the variance 2-05 and everyone else is telling you why but I want you to hear directly from the inside -- Speaker one: I’m here in the facility and the staff to management issues is all complete BS. Um, the communications plan failed miserably you know, they trying to posters put up in April, which is way late, you know they saying they communicating with us like with guidance and updates and protocols - which is total false. You know staff is coming into work sick and not told to stay home which most of us believe that the staff is who got us sick, way more staff are sick than intimates. Like I said we have twenty or twenty two people in our unit and within a week our count went up to forty eight people, and it's impossible to have social distancing - our beds are literally two and a half feet from each other.

[inaudible] Mental health staff - do you feel like the board should give them that extension or require them to see more or keep it as it is?

It’s harder to get down there and get treatment – one guy was asking for mental health for like a week, asking for a whole week, just finally got to go speak with somebody like yesterday and they, you know, they push you to a break where you’re ready to snap and then they come and be like, oh, what can we do for you? Right now we haven’t had library I gave them my paperwork for legal documents, talking mail it out Friday gave it to them Thursday morning. It’s Sunday I still haven't got my paperwork back, we haven't got law library since then. Things like that really stress – people can't work with your legal matters, can’t work on your case. Everything is just bad -some of us would literally have to buy off of other guys who work in linen and our clothes and like, bleach to clean the house by ourselves because we have lack of adequate supply. So we have to [inaudible] just to get proper cleaning stuff just to clean.

So there’s no confusion when the public hears that, what did you just say please?

I said we had to -- we didn't have a lot of cleaning supplies or adequate supply to sanitize or clean our housing unit we would have to literally buy cleaner stuff off of other inmates who’s working, like, linen clothes box, like its drugs or something just to get cleaning supplies like bleach or things to clean our own house to try to keep this virus down.

Can you tell us like, how do you make it through the day? Like how do you keep your mental.

I really don’t and that's another thing that I haven't been able to see a psychiatrist. For the past three months that I've been here they haven't provided me with a psychiatrist. I've seen a [inaudible] put a little worse scenario than anybody else because I actually went to medical and I was complaining about my medication not being at the window and they put me in for having the coronavirus and sent me to another building. And I was sitting in the intake area for about maybe twenty-four hours waiting to be seen by a

doctor, they swab me, tested me, and kept me in quarantine for 16 days. We had no T.V.s there, uh the phone weren't working for the first couple of days, it was bad like there was there was no circulation of the air. There was no recreation, no television, the doctors didn't even come on the unit for three or four days –

I tried to cut it so I could fit it into the time limit. I'll talk to you more during public comment.

CHAIR JONES AUSTIN: Thank you MS. V Thank you very much, appreciate your sharing that with us. That concludes the public comment on the variances that have been requested and we will now turn to correctional health services to present to variances. The board will then discuss and vote and then we will turn to DOC to present its variance concerning the secure unit. CHS please begin and perhaps in your presentation you can speak to the issue that has been presented by just about every person who's given public comment concerning the lack of access we've been told is a lack of access or responsiveness to request for mental health counseling and support. Please begin. Is CHS there to present on the variances? Would you please -- I can see -- the camera. I can see the camera. Can you hear us? We cannot hear you. Is your system muted? Okay, perhaps, if we tried to -- can you hear us?

MR. STEIN: Jennifer I think that there's an issue with the audio on their end.

CHAIR JONES AUSTIN: Okay. So what we will do as you try to clear that up is, Meg we're going to turn to the DOC variance in the interest of time. That alright?

ED EGAN: Yes can you please present the secure variance?

DOC BUREAU CHIEF STUKES: Good morning. This is Chief Stukes speaking. I would just like to start by saying, thanks to the men and women that's uniform and non-uniform who shows up every day to do this essential work in out New York City jails. As mentioned, I'll be presenting on behalf of the department, the request for the secure unit, so pursuant to section one through fifteen of the New York City board of

correction, the New York City department of correction requests a six month limit various renewal from standards section 1-05(d) lockout and section 1-08(f) access to courts and legal services, for the purpose of maintaining the use of the secure unit. The department seeks the variance to take effect on May 24, 2020, the day upon which the current variance is set to expire. I would just like to give one highlight for the department. The department led the nation on the path forward, progressive, restrictive housing practices to their historic elimination of punitive segregation for young adults in 2016. The department subsequently developed a continuum of safe housing options to address both the immediate security concerns, and the behavioral health need for the young adults who commit violent acts while in departments custody. Addressing the behavioral health needs of violent young adults is an imperative for the departments vision of care and integral component of any meaningful housing intervention for this age cohort. Simultaneously, Department requires safe housing options to ensure security following a valid act in order to mitigate the potential for retaliatory acts of violence. With consideration for these dual priorities, the secure unit was created in 2016 and has evolved over the time to ensure the least restrictive means are achieving positive behavior and safety outcomes.

I would just like to give some more context on a unit as of today, to date. May be a little different from what was supplied to you as of the fifth. The census this morning in the secure unit of those three persons in phase one, who is entitled to ten hours of lock out; phase two there's three people, twelve hours; and phase three, there's eight people who is allowed fifteen hours of lockout for a total census in a unit of fifteen.

CHAIR JONES AUSTIN: Thank you very much. I ask for a board member to move to vote on the six-month variance request to allow DOC to [inaudible] out of cell time to a minimum of ten hours per day in the secure unit and to allow for alternative access to legal services and materials in that unit.

BOARD MEMBER JAMES PERRINO: James Perrino, I'll move the item.

CHAIR JONES AUSTIN: Thank you may I have a board member second.

VICE-CHAIR STANLEY RICHARDS: Stanley [inaudible].

CHAIR JONES AUSTIN: Thank you very much. I will now ask the board. Are there any request or conditions anybody wishing to debate for discussion or propose a condition?

VICE-CHAIR RICHARDS: I wanna just ask the department about the number of people who are accessing out of cell time. It looks like from our audit the folks who are in the various phases are not accessing the full amount of time. Is that because it's not available to them, or is it because they don't wanna participate?

CHIEF STUKES: No, that is not correct. It is not because it's not available. The unit is set up in structure so that each phase have the amount of time out that corresponds with the phase. It is a young adult's own ability not to come out of this cell for entire lockout time.

MEMBER PERRINO: I had a few phone calls that - and this was maybe a month ago, I'm not sure what's going on now that - in the secure unit there was more people like, you know, initially they want I believe eight people in each area, which has been way too much. So the department has gone to a lot of, you know, a lot of a thought to keep that number always low. And I was being told that more people going in and the numbers were a little higher. What's your average per unit, there's four units in there, has that number been getting higher? Or do you have a number that you'd like to stick to?

DOC ASSISTANT COMMISSIONER FRANCIS TORRES: For the most part, the average has been five in recent times, but as of today, we have two quads that have three young adults in each of those quads. While two other quads have five - sorry four young adults, and then one quad has five young adults.

MEMBER PERRINO: Okay, so my concern Ms. Torres is like, five is a little high I think - actually being one of the

ones who actually started it and always pushed for a lower number. So, I would encourage the department to take a look at that and keep that number lower based on the structure of it that number being high, I don't think it's good business and with social distancing also, it's really not too much room to go in that little - I'm gonna call it area - but that's something to look at. Yeah, I, I think it's five is high. I think that makes me concerned, but once again, you know, that's something for the department to look at, but I'm definitely concerned.

AC TORRES: we appreciate the feedback. We certainly will take a closer look internally and discuss further, but thank you so much.

MEMBER PERRINO: Ok thank you Ms. Torres, thank you Chief Stukes.

DR. COHEN: The, the population has really grown up a lot. The population has, you know, in 2018 and 2017 was seven or eight a day and now it's averaging fourteen or fifteen or sixteen and you're right to be concerned about the characterizing, I mean, these are ages -- I have a question which is related to my concern about secure, which is, what is the Department's plan to create -- if it's growing like this did you plan to create additional secure units and what would they look like architecturally? And what are your plans for the new borough facilities in terms of the secure units? And then I have another questionnaire after that.

CHIEF STUKES: This is Chief Stukes speaking. As it pertains to the secure unit, we have not discussed any plans to add any additional units.

DR. COHEN: And my next question is a question we've asked before in terms of ESH young adult, and here as well, very low participation in recreation twenty ninety percent of the young adults only participated in recreation. What has the department done? And that's the question we've asked previously to -- what are you doing to increase the access to encourage people to make it, you know, an important health experience for them while they're locked up in secure. We

hear that they’re spending a lot of time in their cells and we also know they're not spending a lot of time in recreation.

DOC CHIEF OF STAFF BRENDA COOKE: Are you asking about secure or ESH, Dr. Cohen?

DR. COHEN: I’m asking about secure. Our data on secure is that -- I mentioned twenty nine percent -- we've asked about ESH –

COS COOKE: [inaudible] ESH is rec, so, that's why we're a little confused, but so we can answer about recreation in secure.

CHIEF STUKES: As it pertains to recreation in the secure unit, each individual has the ability to participate. It is afforded, it is a person’s own will not to participate, but through the steady assign offices and the captains the programming staff and the counselors, they do encourage the a young man that's assigned to those units to participate with the recreation when it is afforded. It is their choice if they do not go and looking at the data, it would a seemingly report that is a low participation rate, but it is just the young man's ability to not participate at their own will.

DR. COHEN: Thank you.

CHAIR JONES AUSTIN: Are there any other questions comments or concerns board members would like to make at this time? Hearing none and hearing no conditions, so I'm going to ask if one of the board members would move to vote on this variance.

MEMBER REGAN: So moved.

CHAIR JONES AUSTIN: Do I have a second?

MEMBER PERRINO: Second.

CHAIR JONES AUSTIN: I will call for a vote, beginning first with James Perrino.

MEMBER PERRINO: Yes.

CHAIR JONES AUSTIN: Michael Regan?

MEMBER REGAN: Yes.

CHAIR JONES AUSTIN: Steve Safyer?

DR. SAFYER: In support.

CHAIR JONES AUSTIN: Stanley Richards?

VICE-CHAIR RICHARDS: Yes.

CHAIR JONES AUSTIN: Bobby Cohen?

DR. COHEN: Yes.

CHAIR JONES AUSTIN: Felipe is no longer with us due to an appointment that he had to make - a medical appointment - and Jacqueline Sherman has left as well due to a meeting. So I'm the only one remaining, Jennifer Jones, I vote in support so the variance passes. Okay.

We will now return to the variance request of correctional health services. And again, I asked that you present the variances and in presenting, speak to the issues that have been raised by several persons concerning the responsiveness, or the lack thereof to request for mental health support or medical support.

DR. MACDONALD: This is Ross MacDonald, CMO for correctional health. So, I, you know, in listening to the public comment, I am concerned that there's a misperception fundamentally of what these variances are requesting. Of course, we understood as we prepared for this crisis that there would be mental health consequences for our patients and that there would be increased stress for the people who were living in the jail. These variances speak to parts of our service that are extremely peripheral to the core of what we do. One of them is a variance from a requirement for documentation in the medical record - so, it's what we write in a patient's note and has nothing to do with what we actually do in interacting with our patients and caring for them. The other is to give us leeway to focus on the people who need our help most in the middle of a crisis. So it is not to deny care to anyone who wants it. It is to allow us to avoid a bureaucratic timeframe for follow up for those subset of our patients who tell us that they would prefer not to and where we agree from a clinical standpoint, that we could

forego that appointment in a time of crisis. And there are many reasons why people may not want to come down to the clinic. During these days to have an encounter when they feel that they're doing well, and we've built additional systems for those patients to be able to access us at any time. So, these variances are not at all about, with holding care. They're about allowing CHS to focus our resources on the people who need us the most and that's what our staff has been doing and to suggest that we're trying to get out of doing our job is a mischaracterization of this. It's really so that we can focus on the core things that we built the PACE units, the CAPS unit, the mental observation units, and build new systems to communicate with people who are in new situations that didn't even exist before, like, people who are in isolation because they have confirmed COVID. So really, these variances are -- like any healthcare delivery system -- we have to change the way we do things, but the change is not the with healthcare, the change is to focus care for the people who need it most. Of course, the complaints and concerns raised by our patients to outside advocates and to their attorneys are critically important to us. And we do take those very seriously and we follow up on every single one of them. They I would argue, though, are not the entirety of how to assess the quality of a healthcare delivery system and, and there's complexity behind that uh but I just wanna reiterate, that people who request care through any channel CHS follows up. And that is a priority, that's one of the clinical priorities that I'm talking about, so these variances are in the service of allowing us to reach those patients. I'm just going to pass it over to our mental health leadership for additional comment before I read the text of the variance.

CHS CO-CHIEF OF MENTAL HEALTH DR. BIPIN SUBEDI: I’m Dr. Subedi and I am one of the co-chiefs of mental health and I’ll specifically address the GP variance, and then pass it over to Dr. Barbara to speak about PACE and CAPS. So, just to reiterate Dr. MacDonald, the purpose of these variances was really to provide flexibility to both the patients and the clinical staff to make decisions that were in accordance and appropriate for someone’s clinical needs and the patient's

wishes. It is not to restrict or limit care. I think that's very important to reiterate. And, you know, through the months of March and April, our staff have put in extreme amount of effort to have in person evaluations with all patients. They work closely with our partners at DOC to prioritize production for individuals at higher risk. In some cases we've actually been going to the housing areas to have inpatient visits when there's been limitations to how patients produce. During these visits we are performing a routine clinical work, but also providing additional education around COVID-19 as well as providing and reinforcing information on how to access mental health care during this time. And the decisions for follow ups again, as Dr. MacDonald said, were collaborative in nature. We engage the patient in the conversation on how they're doing, kinda the future risks associated with being in the housing areas and being exposed to stress and together made determinations about what was appropriate in terms of follow up. And what we've seen is that some individuals were seen at an increased frequency, seen within one or two weeks, and some individuals may have been seen a little later again, based on their clinical risk and needs. And in general, from looking at the data, the majority of individuals were still seeing within a one month. I also want to reiterate that this variance specifically applies to non SMI individuals in GP, and so these are individuals who, as a cohort in general tend to be on lower risk medications, and in general, the medication changes that we do take place, take a longer time to show effect. So, I think this is not only clinically appropriate and sound, but again, these variances are kind of trying to respect patient needs during this very complicated time. And generally, speaking are kind of aligned with community standards of how we all want to be treated and make decisions with our physicians and healthcare staff. So, with that being said, I'll kick it over to Dr. Barbara to talk about the specialty mental health units.

CHS CO-CHIEF OF MENTAL HEALTH DR. VIRGINA BARBER RIOJA: Good morning, I’m Dr. Barber, co-chief of mental health. I just wanted to briefly mention or talk a little bit about the care in the mental health units, PACE and CAPS units, which are, as you know, where we have several multiple vulnerable

populations, so most of the patients who are housed on those units have a serious mental illness. Some of them also have a developmental or intellectual disability and I just wanted to again reinforce that we're not restricting access to care on those units, that very little has changed on those units and our stuff continues to go in and out of those units. We have psychologists, clinicians, social work, reentry services, discharge planners, creative art therapists, going into units and providing services on that. Although we have to change how we document some of the notes, the number of encounters have not changed and we have been tracking the data, again, confirm that we keep meeting with people at the same frequency done as before and that in some situations, we actually meet with them on an increased frequency - this is just the encounters that are documented. But, of course, when you have mental health treatment aides and clinicians on those units every day, they are entering in contact with their patients several times throughout the day just that we obviously do not document every single encounter. So I wanted to just reiterate today what we said last month during the board meeting, that very little has changed on those units. I would say probably the main change is that we're not running as many groups as we were, for obvious reasons, the patients do not want to participate in groups, it’s hard to social distance when you are running groups. We are starting to do some groups now, the creative art therapies are, you know, getting creative about this time when we have another space now, fewer numbers of patients, we are doing some group activities, but that is the main change that has occurred on those units. Thank you.

CHAIR JONES AUSTIN: Thank you. Is there anything else that you'd like to present in this variance?

DR. MACDONALD: No, I'd be happy to read the text. The first variance request is for a variance from section 2-04(c)(3), variance first granted on April 14, 2020, allows correctional health services to waive the requirement that an individualized written treatment plan, based upon the evaluation of a treatment team, be developed for each inmate placed in special housing for mental observation and for all

inmates to whom medication for mental or emotional disorders is prescribed, and that a review of the plan be documented in the patient's chart every two weeks. Instead correctional health services may complete limited, initial treatment plans and have patient encounters for treatment plans documented in progress notes in the electronic health record.

CHAIR JONES AUSTIN: Very good. We will take action on the first variance. I ask a board member to move to vote on the requested variance.

MEMBER REGAN: Move the item.

CHAIR JONES AUSTIN: Is there a board member who will second the item?

VICE-CHAIR RICHARDS: Second.

CHAIR JONES AUSTIN: Thank you very much. The floor is now open for debate, questions, comments.

MEMBER REGAN: Just to -- Dr. Macdonald, you know, and to the chiefs to0, you're doing an extraordinary job as the Chairperson started this meeting by pointing that out. Dr. Macdonald, you know that you have our trust and our admiration. What you're doing -- the data is overwhelming and inspiring. Keep it up, pay attention to this hotline thing, just make sure there's enough staff, make sure that there's enough people. I look forward to this, but thank you all for everything that you are doing.

VICE-CHAIR RICHARDS: I second what Michael said and that goes for the Department of corrections and correctional health. I think exploration of how the response to COVID has been is not an reflection of our lack of understanding or lack of support for the amazing work that has been done to allow people to stay home and you all still going out there and doing what needs to get done. So I just wanna start by thanking you all. So the question I have Ross is twofold, one, why do we still need this variance being the population has significantly been reduced while simultaneously your staff hasn't been reduced. So have we gotten to the point where we could implement, go back to the regs as it is stipulated, being that the population has went down, but your

stuff hasn't. The second part to that is that -- it was just expressed -- that you are all still meeting with the majority of people. So, do you have specific numbers of how many people are being impacted by this variance? Is it ten? Is it thirty, is it fifty? How many people are actually being impacted by this variance? Would like to know that if you have it.

DR. MACDONALD: Thank you sure. Thanks, Stanley. So I think we're moving into a phase where every day we're putting back normal operations as much as possible, and we've been doing that for many weeks. You know, you may notice that of the variances we asked for in the last meeting, two of them have dropped off from here. So I think it's a constant evaluation of where we are, you know, and we've presented good news about the reduction in cases in the jail system, but we still do have cases. And we still do have people being transferred to isolation every day for testing and we still have a lot of stress among patients and among staff. So I don't want to give the impression that things are back to normal - they're not. And I don't think they will be for some time. So I think it's really part of a, an attempt to be as thoughtful as possible as we get back to a normal life, just like, we're trying to do in society. As far as who is being affected by this, we have looked at the data, as Dr. Subedi mentioned, the majority of patients are still being scheduled within these timeframes and so we think it's a small proportion of the population and about what we would expect clinically at the far ends of pathology, meaning, that the people with the least severe disease who oftentimes are getting the marginal benefit from their interaction with the mental health service to begin with, who are sort of, along with their clinician choosing to stretch out those timeframes.

VICE-CHAIR RICHARDS: Thank you.

CHAIR JONES AUSTIN: Are there other board members with questions comments?

DR. COHEN: I would like to comment. You know, for the past many years, CHS has come to us with a variation on this variance, which asks for four weeks, rather than two weeks,

and then last month you asked for eight weeks. So we've heard from the chief that you don't really need it because on average you're seeing patients for psychiatric evaluation every four weeks. And in your defense of the variance you just wrote you don't know that there's any difference - previously you've given us more expansive documentation about why four weeks was adequate. I don't think the board needs to the support this variance at this time. I will say as everyone else has said, that I am amazed and I'm in great admiration for the staff at CHS and for DOC for what you have done and what you've accomplished and what needs more to be accomplished. Although we've not had comments, except for these kinds of comments from my perspective in my apartment, we're not towards the end of this thing, there will be more waves, which will affect corrections and we do need a going forward when you ask us for variances like this, we need data as to why it's important and we need the same kind of data and information that everybody else in New York City and New York state gets about a positivity and other things - we'll talk about that in many different forums - but although the numbers are great within the jail rights now, there's only reason to think that we are in a multi-year pandemic, which is not gonna be over this week. So, I'm gonna vote against both of these variances, one, because there's no demonstrated a need for it and, secondly, is that the initial comprehensive evaluation for someone who has a serious mental illness and is getting medications should just be completed in total, there's no reason not to completed beyond that. I would certainly vote for it if you wanted to have the follow up one just be the note during this critical time and reevaluate that on a regular basis, but as scheduled, I don't think the board should endorse not having the mental health staff complete as required a comprehensive evaluation of someone the first time they come into the service.

CHAIR JONES AUSTIN: Thank you. Bobby I just want to clarify. I am hearing bobby's point, I now have a question. As I've understood this, this is flexibility not in completing the initial treatment plan, but rather with respect to documentation in the progress notes, is that correct?

DR. BARBER RIOJA: Yes, the initial treatment plan is completed, but not all of the fields are filled out and then subsequent treatment plans are substituted by personnel.

CHAIR JONES AUSTIN: Okay, but the treatment itself --

DR. COHEN: Well, she said it's except for certain cells are not completed --

CHAIR JONES AUSTIN: So, what does that mean? When you say certain cells --

DR. BARBER RIOJA: Yeah, so the initial treatment plan has different sections. The most -- what we consider to be essential sections are completed, like, the mental status exam, suicide risk assessment, summary of the session with the patient, violence risk assessment. The part that is not completed, that we call problem domains, where we identified different problems that we will be addressing with treatment and then in subsequent treatment plans, you basically comment on the progress that the patient has done, you know, for that specific objective - that part is not filled out in the initial treatment plan –

CHAIR JONES AUSTIN: Because it is something that is done in the follow up?

DR. BARBER RIOJA: Well, because right now, what we are finding with our patients is that a lot of the focus on the sessions is around the stress that they are experiencing with COVID and that gets documented in the initial treatment plan in the summary of the session. But right now, we don't believe that it's essential for us to be documenting the different problem domains.

DR. COHEN: As I understand it is, what, from what you just said that those individual problem domains will be the basis for follow up care. I still have not heard an argument as to why you can't just finish this form. I believe this is actually has nothing to do with the board of correction, but has to do with Brad H. and it's not something we should be endorsing at this time.

DR. MACDONALD: Bobby, I just want to speak to one point. I mean, of course, could we do it? Yes, we can do it. The point is, it's a prioritization of documentation over patient care and is that the best thing for our patients right now. The reason we're bringing this to you is because we don't believe that it is the best thing for our patients, for our staff to be focusing on this versus support of our patients in what is, as you rightly pointed out an ongoing crisis. And that theme will extend to the experience that we discussed. It's a question of prioritizing a bureaucratic requirement over our clinical assessment of what kind of care is needed in this moment.

CHAIR JONES AUSTIN: Okay, again, I'm doing my best to follow this conversation, but I keep hearing -- Is this a documentation request? Or you actually not addressing certain elements of the evaluation, the initial evaluation? I'm hearing two things.

DR. BARBER RIOJA: Yeah, so we are doing the encounter, we are having the clinical encounter for the patient for the initial treatment plan. Typically what we do when that happens -- that happens after we've done the initial intake and that has not changed. Our intake process has not changed. So, during the initial assessment is when we actually collect all of the psycho-social history from the patient and that has not changed at all. The next encounter with that patient is what we call the initial treatment plan. During that initial treatment plan. We do a number of things, we assess the patient’s mental status exam, we do a suicide risk assessment, we talk to the patient and provide counseling and in addition, we document what we think are the objectives for treatment. These things can be things like treatment compliance and medication compliance is maybe something that we're going to work together in treatment or reduction of the symptoms of depression or improvement of interpersonal skills. So then we will list all of those problems so that in subsequent encounters we can note what's the progress. That requires a lot of time, it requires a lot of documentation and right now, we really want to focus on the acute stress that the patients are experiencing related to COVID. So we are filling

out things like the mental status exam, which is crucial, the suicide risk assessment we are documenting, what are the concerns that the patients are bringing to us, but we are not filling out the problem domains. In subsequent meetings, typically, for example, if you're housed in a mental observation unit, one week you will do a progress note and then the week after you do a treatment plan. So, what we are doing is that instead of doing the treatment plan, we're documenting a session, so, we're having a clinical session with the patient. We're still doing a mental status exam, we're still making sure that they're not having suicidality, we are still providing counseling, but we are not again attending to those problem domains. So, we are really just focusing on the very acute problems and not thinking much about things that we will be taking care in the future. And I absolutely agree. I mean, treatment plan are an essential part of clinical care under normal circumstances, but as we've said before, right now we are prioritizing the time that our clinicians spend with the patient from the time that they spend in documentation.

CHAIR JONES AUSTIN: Thank you. Alright. Are there any other questions or comments there?

MEMBER PERRINO: On like a normal operating thing, which I left the department maybe four or five years ago, there was eleven thousand, twelve thousand, thirteen thousand a day. Now, if those population was the same, then I would say, we definitely need to really oh. my God no, you've got to do something But we're talking about three thousand eight hundred I believe, the last time I heard - that's the less than half. And I think if we're gonna cut down on something, it should not be mental health. I understand the procedure. I understand they’re getting it, but we should be putting more I mean, these people are in a middle of a pandemic and they can't move, they haven't seen families and if anything, we should be putting more mental health in, because that must be a horrible situation we live in both staff and detainees. So, I’m with Bobby, you know, I don't think I'm going to endorse this because I think taking away should be the last thing we're doing and we are in the middle of a pandemic, I

get that, but the populations are lower -- it's never gonna be normal number one but even when it does get normal, we're talking about four thousand detainees the department at one point, had twenty three thousand, but it's been averaging out eleven thousand. You know, maybe if your staffing had been reduced to a critical amount since that deduction then maybe it's a different conversation. But I don't believe that's what the case was. So, my concern is we gotta look at the population. We gotta look what's going on and we gotta look for the need. So, no, I probably won't be in support of this, this one.

DR. MACDONALD: I appreciate that chief, you know, I think that many things have changed since that time, and the level of care that we're providing on CAPS and PACE units is not comparable to those days and the severity of patient pathology is. So, we still have the sickest patients, we still have the most challenging patients in the system, and what we're talking about again, just to clarify this misperception, we're not talking about withholding care, we're talking about prioritizing care for the sickest people.

MEMBER PERRINO: I know. But when I left, those units were in effect and doing very well. I mean, so stuff for people all over the nation to see, and, you know, it's something that you guys should be very proud of. So you were doing it and the population was a lot higher again, haven't been there for four years so, I'm sure that a lot has changed.

DR. MACDONALD: So we've built of those units since you left. We have more those units.

DR. SAFYER: How much how much longer do you think you will need to have this variance?

DR. MACDONALD: I think that, you know, as I mentioned, that's kind of a day by day discussion and there are a range of things that are not covered by the minimum standards that we are also in the process of returning to normal operation. But, you know, I, I will say the data that I presented -- things are much different now than they were, but they're not back to normal. So, I'm hopeful that we can reach a new normal, all the data that we have suggests that our focus

needs to shift to new admissions to the system where we're seeing the bulk of the of the positivity. And so, I think, you know, as two of the variances that we asked for last meeting have dropped off, I think that I would expect these to be temporary. So I can't say exactly when, but I'm hopeful that we can be back to normal operation soon.

CHAIR JONES AUSTIN: Alright. Are there any other questions or comments?

VICE-CHAIR RICHARDS: Just, I just have one. Ross could you speak to what are your quality assurance practices with the hotline? Because a number of speakers raised concerns about people calling and not getting access to somebody. What's your quality assurance and the outcome of your quality assurance practices?

DR. MACDONALD: Yeah, thank you Stanley. That's a great question. So, there we set up multiple different lines and different systems for remote care through the course of our response And, you know, I think it's a constant learning process for us as well as for our patients of how to use those lines, the different lines. I think because we had so many different needs for that, that we may have confused some of our patients and things were confused in general during those, those wild days. And so, we have a daily tracking of the number of calls that we're getting, the purpose of those calls, and our follow up. And one of the key benefits of this is that we can be able to track those metrics and have a closed loop from the person who calls us to us addressing concern. And that goes also for voicemails that are left outside of those hours.

VICE-CHAIR RICHARDS: It would be helpful if we could see at the next meeting some data related to those activities, how many people called that sort of thing. It would also be helpful based on these two requests, how many people are not seen who would have normally been seen as a result of this standard 2-04(c)(3) and 2-05(b)(1) and (2), how many people would have normally been seen underneath those standards that weren’t, just so we have a sense of what happening. I appreciate that.

CHAIR JONES AUSTIN: Alright, any other questions comments? So not hearing anymore and not hearing any conditions. We are going to take a roll call vote on this variance. This is the variance tied to allowing flexibility to focus primarily on patient acuity and complete limited, initial treatment plans and to have patient encounters that are documented in progress notes, rather than in treatment plan reviews, reducing the amount of time clinicians spend on paperwork. Beginning with Michael --

MEMBER REGAN: Yes.

DR. SAFYER: Support.

MEMBER PERRINO: No.

VICE-CHAIR RICHARDS: Yes.

DR. COHEN: No.

CHAIR JONES AUSTIN: And I support, the variance carries. Okay, the last variance that we --

DR. COHEN: What was that -- four?

CHAIR JONES AUSTIN: Four – two.

DR. COHEN: Don’t you need to have five votes to pass a variance?

ED EGAN: We do, Bennett correct? We need five votes?

CHAIR JONES AUSTIN: That's right. Thank you, I apologize for that. So the variances does not carry. Thank you Bobby. Okay, that variance was not approved. Let's move to the next variance, please CHS present it, it’s related to non-seriously mentally ill adults -- I’m sorry, mental observation.

DR. MACDONALD: I'm sorry I just didn't understand what happened with the last vote. Is that related to the board members who are absent?

CHAIR JONES AUSTIN: So, five votes are required to pass a variance. We had a vote among six members (two members are no longer in the board meeting) and of that six, four voted

in favor and two opposed and so the voting did not carry – the variance did not pass.

DR. MACDONALD: Okay, the second variance request is for a variance from section 2-05(b)(1)-(2). Variance first granted on April 14, 2020 allows correctional health services to see non seriously mentally ill adults in general population during the period of up to every eight weeks, and to see patients in mental observation units within two weeks after medication change.

CHAIR JONES AUSTIN: May I have a motion from a member of the board?

VICE-CHAIR RICHARDS: Motion.

CHAIR JONES AUSTIN: Okay. Do I have a second? I'm requesting that a board member vote and move to second the motion to vote on the requested variance.

MEMBER REGAN: Second.

CHAIR JONES AUSTIN: Alrighty, the floor is now open for questions comments.

DR. COHEN: I have a question and then a comment. The first question is, could CHS comment on the increase in incidences of self-harm and give us some idea of how they are addressing this and what the volume of self-harm acts are.

DR. MADONALD: So, as we're discussing here, part of our response to this crisis is to prioritize the clinical need that we feel will be associated with the stress of COVID. In that context, an increase in self harm was one of the things that we were concerned about and preparing for. That's why things, like, bureaucratic rules about how often we see patients who are not ill and don't want to be seen and about documentation are important, so that we can prioritize the treatment of patients who are struggling with the stress of this pandemic while they're incarcerated. So, it was not unexpected that we would see an increase and that's part of the work that we've been doing and prioritizing during this crisis. To put those numbers in context though, I think you've compared February to March and February was a historical low,

as far as self-harm is concerned in our system. So, the increase we saw in March was not particularly pronounced and with the reduction in population of those numbers in April have come back down to below the numbers that we saw on February.

DR. COHEN: Thank you. Basically, questions for CHS about this variance and a way to address it. As I mentioned earlier for many, many years, we have been approving a six month variance to increase it from two weeks to four weeks because it's an issue in the rule that you've come to us repeatedly with documentation saying this is not necessary. Why don't you just put up the four week variance, which we've had for forever rather than the two week thing given that you said you don't need it you don't really need it because you have enough staff on average and you're doing it. Anyway, it just seems that there is not a need given the volume, you know, to to eliminate -- to go up to eight weeks that -- whether this is perceived as a diminishing of care, and we hear from the people who you're serving that they are receiving a diminishment of care. So, would the CHS be open to just asking us the traditional variance that you have every six months since I think I've been on the board, for a four week up from the from the two weeks from this for non-MO patients.

DR. MACDONALD: So Bobby, I don't know how many times I can explain it, so I think again it's about prioritization of care and this is not affecting patients who are in distress because they're not able to access mental healthcare. This would only apply to patients who agree to a later appointment date and for who that's clinically appropriate. So, I don't know how many times I can say the same thing.

DR. SUBEDI: I also want to clarify something I said earlier. It is true that the majority of patients were scheduled for an appointment within four weeks. But there are a proportion of individuals who scheduled later than four weeks, and I think it is important to kind of maintain and respect the wishes of those patients who don't want to be coming down right now. So I think, like we said earlier, this doesn't limit our ability to see individual's sooner, but it does allow the flexibility to schedule patients later who

want to be seen later. And I think that is also something to keep in mind that this part of the stress recently, for everyone, whether you're incarcerated or not, is a loss of control over our lives. And I do think it's important to try to maintain that control for patients and staff out of respect. And also, you know, thinking that they're appropriate, given the situation clinically and then on an individual basis.

DR. COHEN: I would just respond that, so a number of these issues, the suicide rate in February was higher than in previous months --

DR. MACDONALD: There were no suicides in February.

DR. COHEN: Self-harm, the self-harm rates were higher -

DR. MACDONALD: No they weren’t, that's not true.

DR. COHEN: We'll discussion it with you afterwards, but our data says yeah -- and can you please tell me the number of cases that were deferred and how much because of the system.

DR. SUBEDI: Yeah so, for, I guess overall we're looking at mental health clinician and psych provider visits --

DR. COHEN: Now we're just looking at psychiatry data right?

DR. SUBEDI: Sure. So sixty three percent of individuals were seeing within four weeks. Approximately six percent were seen between four and six weeks And about thirty percent were seen from six to eight weeks.

DR. COHEN: How many people is that?

DR. SUBEDI: That's about three hundred and eighty-eight individuals.

DR. COHEN: Of the hundred percentage three eight-eight?

DR. SUBEDI: Correct.

DR. COHEN: And so the numbers that were more than four weeks were how many?

DR. SUBEDI: The numbers that were more than four weeks were about one hundred, thirteen plus twenty-five -- so about one hundred and forty, roughly – so about a third.

DR. COHEN: And you could not handle that capacity.

DR. MACDONALD: It's really more about an appropriate standard of care of Bobby. I mean, I don't know how many times we can say that we're prioritizing, but you have knowledge of what community standards of care are and these are bureaucratic requirements that are much in excess of that. And the patients we're talking about are those who have the most mild mental illness who again, don't wanna come to the clinic and have pathways to reach us if that changes and for who we think that's clinically appropriate. So, I, I, we, we should probably proceed with the vote.

DR. COHEN: You don't have to answer it again Ross. But what we've heard from many, many people is that they feel they have difficulty in accessing right now. So that's why I'm concerned about limiting the formal requirements for access, which this variance calls for.

DR. MACDONALD: Again, this would not affect anyone who wanted care, in fact, is for us to focus on those people. That's the point.

CHAIR JONES AUSTIN: Are there other comments, question? Not hearing any additional questions or comments. We're going to move to have a roll call beginning with Dr. Safyer.

DR. SAFYER: Support.

CHAIR JONES AUSTIN: Michael Reagan?

MEMBER REGAN: Yes.

CHAIR JONES AUSTIN: James Perrino?

MEMBER PERRINO: No.

CHAIR JONES AUSTIN: Bobby Cohen?

DR. COHEN: NO.

CHAIR JONES AUSTIN: Stanley Richards?

VICE-CHAIR RICHARDS: Yes.

CHAIR JONES AUSTIN: I support, but there being only four votes in the infirmative, this variance does not carry.

DR. MACDONALD: Can I just understand -- so, that was a vote of four to two? Just to clarify?

CHAIR JONES AUSTIN: Yes, a vote of four to two.

DR. MACDONALD: Thank you.

CHAIR JONES AUSTIN: Alright, we have completed the variance voting at this time. all that remains as a board matter is public comment. And so I actually have a my own organizations is board meeting that I now have to turn to. I had asked a vice chair Stanley Richard to now take over the board meeting. Thank you all and I appreciate all those who have participated on this video conference board meeting, those people who have signed up for public comment. I appreciate the work of everybody DOC, CHS, the board, correctional staff, board members, all of the advocates and, and even, you know, clients I should say, detained person's coming forward and letting their issues and their concerns be heard. Thank you all, have a good afternoon and thank you vice chair Stanley Richard for taking over.

VICE-CHAIR RICHARDS: So, I have a list of speakers signed up. I'm going to call the person's name when you hear your name, please raise your hand. The same process we used earlier, you could locate the participants at the bottom, and then just click the icon to raise your hand. Once you are acknowledged, you can begin speaking, you have three minutes to speak and we will begin. The first caller is Martha Grieco.

MARTHA GRIECO: Thank you. Once again, my name is Martha Grieco, I'm an attorney, and I'm speaking on behalf of Bronx defenders. Related to our first comment about the lack of transparency about what actually happens on the ground in the city jails, as opposed to the policies. We urge the board to implement access to counsel and disciplinary proceedings as part of the overhauled restrictive housing plan. At Bronx defenders we regularly check in with all of our clients in the punitive segregation unit, and since COVID-19, not one

client has reported receiving a hearing before being placed in solitary confinement. All of our clients report that they did not refuse their hearing. If a person in custody's advocate is notified whenever they receive a ticket and given a chance to negotiate with DOC to investigate the circumstances of the incident and potentially even represent them at the hearing, if needed, disciplinary sanctions would be utilized far less often and conflict would be resolved without resorting to the torture of solitary confinement. We implore the board to review the Bronx defenders' comment on the restricted housing rule, it contains many more details about access to counsel and disciplinary proceedings. And if is interested, we can facilitate meetings with advocates in other jurisdictions, where this is the norm. Access to council would be a big step forward in the jails. But as you can see, today, the department praises itself before the board for such progressive policies, like the elimination of solitary for young people, that they actually fought tooth and nail. It's the advocates you hear from, in the public comment period of these hearings, who push for the end to solitary for young people, for free phone calls. We advocates should be at the jails mediating and advocating for our clients whenever conflict occurs. New York City is well behind the curve on this crucial issue, and I respectfully request that as the board reconsider the restrictive housing rule in the next few months, that they review our comments on this issue. Thank you.

VICE-CHAIR RICHARDS: Thank you the next speaker is Brandon Holmes. Is Brandon raising his hand? Is Brandon on Bennett?

MR. STEIN: No.

VICE-CHAIR RICHARDS: Ariel Federow? Okay, I see Ariel.

ARIEL FEDEROW: Okay, so I'm second year law student and part of the emergency relief fund, which is in part of the COVID-19 bail out effort that some people have already mentioned earlier in the comment period. And what we wanted to say, a little bit more broadly than some of the other comments from people in the defense and bail out community,

is that please continue to be pessimistic? Like we're there -- I'm very glad to see that these requests for variances were refused, because your willingness to be optimistic when making policy to lay out things that are best possible scenarios means that people get stuck in and I wanted to lift something up in particular that maybe isn't clear right. So we're seeing multiple cases where judges considering medical release look at DOC policy and how the DOC is implementing that policy as presented to the public and say, everything's fine, so we don't need to keep anyone out, this person's gonna be fine. We have clients in their fifties, sixties, seventies, with COPD, with asthma who are denied medical release because they see these sort of best case projections and they say, oh, it's gonna be okay, so we don't need to let this person out no matter how high risk they are medically. Just like all of my colleagues have said, and the people who are in right now said, the reports that we're hearing from the people we're talking to in are so far from the DOC and CHS reports, that it's a different planet. And we're trying to get people out, which you all have identified as an incredibly important part of reducing infection, and if that's gonna happen, we need a realism. We don't need protocol that assumes everything goes well - we need a protocol that assumes it doesn't go well, because I think everyone here knows so often, the situation on the ground is never ideal, let alone in a global pandemic. Our clients are telling us, they don't have masks and our clients are telling us phones aren't cleaned. I hear the DOC saying something different is happening. I hope that in addition to the reports that you're viewing, you've getting people back on the ground. I know there's safety concerns, but this is a moment of truth, right? One thing I've learned, there's never anything that happens in the best case scenario where jailing people is concerned, it's the worst and these violations, and the ways in which people are kept in relate directly to the willing say, oh, we'll just give everyone masks. And that when the DOC says, well, we've given everyone masks, it doesn't matter how often our clients don't get masked because when we take those reports to court, the judges really are just saying, well, there's a plan in place so, we don't see the problem. So, in some, I'm just asking to

continue being pessimistic in your oversight. Not optimistic [inaudible] be for the worst-case scenario, not the best. Thank you so much.

VICE-CHAIR RICHARDS: Thank you. Sarita Daftary?

SARITA DAFTARY: Thank you members of the board I'm testifying today on behalf of just leadership USA and as a member of the jails action coalition I want to thank you all for your work early on in urging all decision makers to use their power to urgently release people from city jails and for your daily reports to improve some measures of transparency during this critical time. Today I'm asking for the board's attention to [inaudible] response that continues to be insufficient. I want to urge the board to use all appropriate measures, including video and unannounced in-person visits to observe, document, and report on actual compliance with DOC and CHS COVID-19 response plans within the jail. We continue to hear a great discrepancy between what DOC says is being done and what people in the jails are reporting to us and their family members. A couple of recent examples, I heard separately from two different people who had no communication with each other that their loved ones in jail were given three masks one month ago and given no masks since then - so in direct contradiction to what the department has said about the availability of masks. I also heard the same report that was named earlier about people being told to wash their dishes in a mop sink. So again, two separate reports from people who do not know each other confirming the exact same thing. Very clear that what the department is reporting is not actual conditions. In concert with what was just mentioned, the reports about the actual conditions are incredibly important because they are either supporting or denying people released as they're influencing how judges determine that in response to lawsuits from public defenders, DOC consistently argues that they are taking adequate measures to stop the spread of COVID just based on their stated policies but the board has the ability and responsibility to document the conditions, assess if DOC's policies are actually being implemented, and it has been well-documented that this is a department that's consistently

violating minimum standards for responsible treatment of people in their custody. Secondly, I urge the board to investigate the city's failure to immediately implement the guidelines outlined by commissioner barbell in her March 25 order. This order was sent to FEMA to notify them of the city's plans consistent with FEMA public assistance eligibility criteria to use non-congregate shelter options for a number of groups of people, including people in DOC's custody. This directive clearly would apply to people in DOC custody. None of the jails even if they're forty nine percent empty would qualify as non-congregate sheltering and it's clear that this was not immediately implemented and that lives were lost in the process, both people in custody and staff. And so, I want to urge the board to investigate the response to that directive. Thank you.

VICE-CHAIR RICHARDS: Thank you. Mr. five are you on? Okay let's go to Kayla Simpson. I see Kayla's hand. Good afternoon Kayla you can begin.

KAYLA SIMPSON: Good to see everybody. I just wanna thank you first of all for your daily reporting and for the first report on monitoring work that the board's staff have been doing. I want to emphasize that reporting is the most trustworthy, regular source of public reporting that we have about what's happening in the jails - it's essential because I don't have to tell you how reliable information is important in this moment. It's not only a public health necessity, but it's a public service. And in that vein, you know, it's been sixty-three days since the March 10 board meeting when we first heard about the department and correctional health action plan for COVID and of course, we welcome all updates from the department and correctional health about their policies and whatever data they have to share. Because I think in this moment, we really have to reflect on what is working and what isn't working, how those things can be effective when monitored. And I wanna echo everything that my colleagues have said about the gap. And that is one reason that your role is essential here, but the other reason that I think hasn't been touched on as much is that, there's going to be additional pressure on these systems. You're seeing new

admissions start to rise as executive director Egan pointed out, public health authorities warn about the potential of additional wave of the virus. And so we need to both be clear about the gap between what we heard today and what we as advocates, hear from people every single day. But also it's important going forward to understand how these things have changed over time and what we can learn from them. And that's why we need more information. So I want to give you a couple of specific examples. We need to understand the real spread of the virus in department facilities. We need the cumulative number of incarcerated people who've been diagnosed, the number of people who've been tested, who've received results, we need to know how many have been hospitalized and placed on ventilators because we need to understand how sick this vulnerable population is getting in comparison to the community. Basic health data. We also need more information desperately about the telehealth system. We hear frequent reports that the phones are not sanitized, that phones ring and that people are not able to speak with clinicians or staff and Dr. McDonald said that they're tracking data about these [inaudible] well they should be, we're glad to hear that. The public should see that data. But, moreover, what about the calls that don't go through that so many people report to us? Are they tracking that information so they have the ability to understand why that is happening? Are there enough CHS staff manning the hotline? Are people able to leave messages? Who's responsible for follow up on those messages? How many missed appointments have there been? Also, we need to understand more about social distancing measures and populations density. It's a helpful snapshot to have, what we heard today, but as new admission continues to come, we need to understand how that affects the population density. Thank you so much.

VICE-CHAIR RICHARDS: Thank you Kayla. Peggy Herrera? Is Peggy on? Okay, I see Peggy.

PEGGY HERRERA: Hi how are you? Thank you for this opportunity to testify today. Again, my name is Peggy Herrera, and I am a member and also leader of just leadership USA and today I want to let you know, my son, he struggles with mental

health concerns and in the past, he ended up in the criminal justice system and was sent to the rikers island barges in the Bronx where he spent three nights sleeping on the floor with roaches climbing on him. He wasn't given a bed, an opportunity to bath or phone call. When I spoke to him, he told me felt trapped and he had no one to talk. At that moment, he needed services not isolation. People with mental health issues need engagement, not separation. People with mental health issues are put in solitary confinement at higher rates because guards are looking at behavior and overlooking the root of the behavior. [Inaudible] see mental health as a burden and use solitary confinement as punishment. Unfortunately, people in solitary confinement start to exhibit the very problem that you're trying to prevent. It can create aggression, depression, suicidal thoughts, a range of mental health issues that may not have been there or it can worsen than preexisting ones. We have failed by using jails as mental health facilities. Correction officers are not social workers or counselors. Mental illness has been made a crime in this country. There's something terribly wrong with a system that is willing to spend more money to confine a person with mental illness than to treat them. Untreated mental illness is a community problem that requires community solutions. As a mother, I'm concerned for those who have mental health illnesses, especially now in light of COVID. I urge the board of corrections to move forward with the rule making process to restrictive housing and to implement the blueprint to end solitary confinement. I thank you for giving me the time to speak. Thanks.

VICE-CHAIR RICHARDS: Thank you Peggy, thank you for sharing. We have a Rosa Paul Malmeri.

ROSA PALMERI: So I'm very thankful that these variances were not passed. I believe that New York City must develop plans and protocols to release everyone, beginning with people at greatest risk of serious illness and or death from COVID-19, and provide them with adequate care and accelerated release. And this should go beyond just people age fifty and older, it should include pregnant people, people with hepatitis C, HIV, diabetes, hypertension, and or cardiac

disease, chronic lung conditions such as COPD, immunocompromised people and trans people. DOC can address this pandemic by releasing people from confinement, not reducing healthcare services. And while I recognize this isn't necessarily the purview of the BOC, I urge all city and state leaders to take steps and to use your political power to lower jail churn by reducing arrest, dropping charges and declining prosecutions and releasing people on their own recognizance when arranged. Because jail term increases the risk of COVID-19 spreading through vulnerable populations. It's very painful for me to read Mayor de Blasio's austerity budget, which includes more than eight hundred million in cuts to education alone and the total elimination of the city's summer youth employment program. Meanwhile, as you've mentioned, billions will continue to go to new burrow based jails into the two city departments that came out of the revised budget process not only unscathed, but with a budget increase and guaranteed capital growth, the NYPD and Department of corrections. We must pursue a strategy to free them all and prevent people from entering jail and releasing people already detained. New York city can divest from the jails that are making our community sick and at risk for premature death and we can invest in providing community based humane and dignified healthcare for all in the face of COVID-19 and beyond. So I urge you to user political power to pressure electeds to release people and invest in community services. Thank you.

VICE-CHAIR RICHARDS: Thank you. Rosa. Is Brad Mower on? Okay, I see. Brad.

BRAD MOWER: My name is Brad Mower, and I'm an attorney in the DNA and forensics unit at New York County defender services. I'm here to comment on the urgent need for true COVID-19 data transparency in the New York City jails. At the outset of this pandemic, all the stakeholders in New York city's criminal justice system agreed the reducing the jail population would be critically important. But how much do we need to reduce the jail population to truly stem the tide of infections? How can we tell if what's being done is actually enough. From today's presentations one might be tempted to

assume that it's all under control now, the jail population, is at a seventy-four year low after all. But that fact alone tells us absolutely nothing about whether we're doing enough to contain the spread of the virus in our jails in trying to answer this difficult question, every public health agency, every municipality, every country is focusing on the same data. Some of these data include how many new cases are being diagnosed each day? How many people are getting sick enough to need ventilators or ICU beds? What proportion of tests are coming back positive? Are we testing all the people we should? And how accurate is our test? The board of correction has been putting together its daily updates from the data that's apparently available to it. While this is better than nothing the plain truth is that we are not getting the data we need from DOC and CHS to evaluate any of the most crucial data milestones. Regarding daily new cases is reporting how many current inmates ever tested positive, regardless of when they were diagnosed. This number is not particularly useful. What we need to know is whether more or fewer prisoners are testing positive over time, and we know that DOC is capable of reporting this exact data because they are reporting new cases with respect to CHS and DOC and workers. Today's presentation by CHS made clear that this daily new case data is being collected for inmates, why is it not being reported? Regarding hospitalizations, DOC is reporting the total number of prisoners currently a Bellevue, but they are obscuring how many are there specifically because of the virus? Meanwhile, this exact data city wide is readily available. Regarding testing, DOC has refused to report the proportion of positive versus negative tests. Other jurisdictions are readily reporting this information and some have tested everyone in their jails with results so staggering that they demand action. Meanwhile, we are covering our eyes to avoid having to confront the truth in our jails. Again, this data is being collected and my understanding is that the board has thought this data for its public updates. Why is it not being reported? We also have so little information about the test that's being used, the criteria governing who is tested, the availability of tests. Why aren't we testing asymptomatic prisoners?

If the issue was testing capacity that reality should be acknowledged, and the data regarding new admissions is quite alarming, especially since new admissions are on the rise again. We demand that all necessary steps to be taken to compile and record the kind of data that would actually allow the public to determine if what's being done in our jails is working, otherwise we'll be forced to conclude that those with the power to inform us, have prioritized hiding information over the health and indeed the lives of incarcerated persons, health workers, correctional staff and the public at large. Thank you very much.

VICE-CHAIR RICHARDS: Thank you. Our next speaker is Marlene. Is she with us? Okay, Akyla Tomlinson?

AKYLA TOMLINSON: Hi, my name is Akyla Tomlinson and I'm a member of the close rikers campaign with just leadership. I urge the board of corrections to move forward with the rule making process on restrictive housing and to implement the blueprint to end solitary confinement. I'm here to speak on behalf of those formally, and currently incarcerated, we have spent time in solitary confinement. Right now, on any given day in this country, at least sixty-one thousand people are in solitary confinement. Being held in a small and confined space for a long period of time can cause anxiety, paranoia, and in some cases lead to suicide. We have already seen tragic deaths and solitary confinement and New York City jails and afterwards, also, as people struggle with the ongoing trauma, of that particular form of torture. Subjecting a human being to long-term isolation, is just means of punishment and not an effective method of rehabilitation. Therefore, it cannot, and does not make jails safer, because it does not address the root cause of a person's behavior. A high percentage of people who serve time in solitary confinement suffer from serious mental health issues. Ending solitary confinement is necessary for the safety of our community, considering studies show that when people who have been in solitary return to our community they suffer ongoing effect of that trauma, and can be more likely to commit crime. My uncle is currently being held in a super max facility where he spends twenty-three hours a day in his cell by himself, he has no contact

with the other incarcerated people and minimal contact with the prison guards. These conditions my uncle has been living under for the past fifteen years, has led to depression. Solitary confinement is torture and I support putting an end to it. New York city can set an important precedent by moving forward to end solitary confinement in its jails and this board can lead the way. That was it, thank you.

VICE-CHAIR RICHARDS: Thank you. Thank you for testifying. Thank you. Our next speaker is MS. V. Dr. Victoria, Minister Dr. Victoria.

DR. VICTORIA PHILLIPS: It's Ms. V from jails action coalition and I'm just speaking for myself. So I really believe -- I had a couple of things I wanted to touch on but I'm not. So I really believe that everyone deserves a round of applause you know CHS, DOC and even the board of corrections everyone, and more importantly, us advocates who actually are out on the ground, boots running doing the work. I say that so often so many times people in position of power come to these meetings with their ego on their shoulder expecting a bow or courtesy because they signed up for their career to do their job, and I say that having worked in ER, ICU and psych units for over a decade, so I know what it is to do nursing in crisis situations and pandemics and major issues. I know what it is to do nursing behind the walls. That's why I've advocated not only for the incarcerated, but for DOC staff and CHS staff to have to have proper PPE. So I'm pretty appalled that one of the board members today actually to CHS you have our trust and admiration. And I'm so appalled because how can you trust people that tell you everything is a okay when just five days ago, there was nurses rallying, protesting outside of rikers for lack of PPE – lack of PPE – use your Internet access that you logged on today to look it up. And so is very disturbing to me the board is slapping people on the back and telling them everything's a okay and it's not a okay. You're supposed to be in a position to hold people accountable. So, please do the job and I'm, I could say, so many other things, but I'll just finish up by letting someone behind the wall speak. You see nothing, I didn’t hear nothing. Like excuse me, you can hear everything

from the noise like where we are you know what I mean it's very frustrating [inaudible] and every time I go to sick call, I just call and go to sick call, wait two meetings to get to sick call I get kicked out of sick call. This will be my third visit, third time being kicked out of sick call. What do you mean get kicked out of sick call? And even the captain see me coughing, see me sweating in bed, he grabbed my and said you need to go to the clinic, like you have to go to the clinic, you're coughing you're sweating, he takes me to the clinic, it's only in this jails and two hours later they say there's no doctors to see you, go back to your housing unit. I'm like excuse me? You know what I mean? It's – there's a lot of things and the main thing I think I wanna say is think of [inaudible] will act like an inmate, come here as law enforcement and to record everything that's really going on here just to act like he's [inaudible] and see what's really gonna happen [inaudible].

VICE-CHAIR RICHARDS: Thank you Ms. V. And I would encourage you if you can to submit those recordings and if you could identify what facility that came in, that'll give us an ability to be able to follow up and pull the thread on that, on both of the recordings that you have.

DR. PHILLIPS: Okay.

VICE-CHAIR RICHARDS: Thank you. The next step is Phillips on behalf of Ms. V … it says Philips, I think it might be … is this another recording Ms. V?

DR. PHILLIPS: No, I didn't know I could sign up again.

VICE-CHAIR RICHARDS: No it looks like somebody signed up on your behalf.

ED EGAN: Stanley I think the name is going to the second line.

VICE-CHAIR RICHARDS: Got it got it yeah.

DR. PHILLIPS: I sure [inaudible] getting ready to play another recording --

VICE-CHAIR RICHARDS: But all those recording Ms. V, if you could submit them to us and let us know what facility

they came out of that would allow us to look into those particular situations and the date if you have it, we appreciate that.

VICE-CHAIR RICHARDS: So that includes public comment and it concludes our public meeting. I offer the board any last reflections, comments. Okay --

ED EGAN: Stanley just before we go, the next scheduled meeting is June 9 at nine AM and we will announce the details whether it is by WebEx or by some miracle in-person in the coming weeks. And so people should stay tuned to the website.

VICE-CHAIR RICHARDS: Yeah, and thanks everybody for participating. It looks like we had over a hundred and twenty-five participants at the peak of this meeting. Wanna thank everybody for participating. Stay safe, stay healthy and take care everybody have a great day.