



Testimony of

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## **I. Power Outage**

On January 23, 2026, one of our attorneys received an email from the “P.M.A / T.E.A.M.S. unit” in the Department of Correction indicating that video conferencing services were unavailable because Rikers Island was “experiencing an island wide power outage.” This power emergency coincided with the record-breaking winter storm that beset our city days later.

This notification prompted immediate concern and a flurry of activity among defender offices to determine the scope and consequences of the power outage, particularly with respect to heat. Some defender offices were informed that blankets and thermal clothing were being distributed to mitigate a loss of heat, while others were told that these items were being provided merely as a precautionary measure related to the storm. An NYCDS corrections specialist who was on Rikers Island on January 23rd observed officers bringing in boxes of flashlights for distribution in the facility, suggesting a possible lighting failure as well. Defender offices attempted to communicate with one another to gain clarity, but ultimately received conflicting and incomplete information from the Department of Correction and other public safety officials.

This incident underscores the extreme vulnerability of those in the custody of New York City’s Department of Corrections. Physically isolated from the rest of the city, and relying on archaic, analog systems and infrastructure, those incarcerated on Rikers are in constant danger of suffering in silence when the city faces extreme circumstances. With phone and videoconferencing services unavailable, there was no way to know what our clients were

experiencing on this day, and no way to corroborate any limited information that came from the Department. It is no secret that the Department likes to conceal the worst of what occurs in their facilities, and on this day this was eerily apparent when an officer on the island told staff from our office who were visiting “we like it quiet”.

This incident highlights the urgent need for a formal notification procedure to public defender offices whenever an emergency affects persons in custody. Such a procedure must include clear and timely information regarding the nature and cause of the emergency, the remediation plan and anticipated timeline, and most critically, which housing units are impacted. When information is communicated by the Department of Correction, it is often described in overly broad terms, such as affecting the entire island or an entire building. But our clients individualized needs vary significantly from housing unit to housing unit, depending on physical and mental health vulnerabilities and assigned levels of supervision. More specificity regarding the facilities impacted would allow our staff to better triage and deliver support to the individuals who are affected.

In addition to posting information about the nature of an emergency on the Department’s website in the interest of transparency, the Department of Correction should designate an individual liaison responsible for communicating directly with a point of contact at each defender office, and for responding promptly to all relevant inquiries.

## **II. Chronic heat failures**

This winter has been marked by sustained, severe cold across New York City, with temperatures remaining far below seasonal norms for weeks on end. This enduring cold front has laid bare the fundamentally faulty, inadequate heating system that people in custody and advocates have complained about for years. City agencies have issued repeated advisories to the public warning them that extreme cold can be life-threatening and urging people to seek warmth and shelter.<sup>1</sup> For people in custody, who cannot control or regulate their environment or take basic steps to protect themselves from the cold, the failures in heating systems and building conditions have immediate and serious health consequences.

Throughout this period, our office has received a continuous stream of reports of heating failures at nearly every facility on Rikers Island. The frequency and consistency of these reports indicate systemic problems with immediate health implications. Not dissimilar to DOC’s failure at

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<sup>1</sup> As of February 9, 2026, 18 people have died in New York City from the extreme cold. This demonstrates the need for appropriate heat to be provided for our clients. Erica Brosnan, *Outdoor death toll in NYC rises to 18 amid extreme cold*, Spectrum News NY 1 (Feb. 9 2026) at <https://ny1.com/nyc/all-boroughs/news/2026/02/09/death-toll-in-new-york-city-rises-to-18-after-extreme-cold#:~:text=Outdoor%20death%20toll%20in%20New%20York%20City%20rises%20to%2018%20amid%20extreme%20cold&text=Another%20person%20was%20found%20dead,Seymour%20Avenue%20in%20the%20Bronx>

temperature regulation every summer, the absence of reliable and effective heat constitutes a serious threat to the health and well-being of people in custody.

At the North Infirmery Command (NIC), a client reported that there was *no heat at all* in the housing area and that he was freezing. NIC is designed to house individuals with significant medical needs, including those receiving treatment, recovering from illness or injury, or requiring heightened medical supervision for long-term conditions, and this client was no exception. For this vulnerable population, prolonged exposure to cold temperatures is particularly dangerous and can exacerbate existing medical issues, interfere with recovery, and pose a serious and possibly fatal threat to health and safety.

At the Robert N. Davoren Center (RNDC), a client reported a different but equally troubling pattern: when individuals complain about the cold, corrections officers turn the heat on temporarily, but then turn it back off shortly thereafter. Another client observed that even when the heat is on in their housing area, the wind coming in through the poorly insulated windows leaves cells frigid. These risks are compounded by an inexplicable recent restriction on sending thermal garments to people in custody, an issue discussed in greater detail below.

These failures are not isolated or resolved incidents, but part of a persistent and ongoing problem that persists today. Yesterday, Monday, February 9, our organization received reports that the West Facility was lacking heat. This morning, we reported complaints that OBCC's windows were broken, leading to freezing temperatures in the 3 upper housing area.

We have raised these concerns directly with DOC's legal department, the Office of Constituent and Grievance Services, facility leadership, and Board staff, yet the reports of inadequate heat continue pouring in. The continued receipt of such reports after DOC has been notified raises serious concerns about the adequacy of corrective measures and the ability of existing systems to ensure safe housing conditions during extreme cold.

Heat is a basic necessity, not a discretionary comfort. The continued failure to provide consistent, adequate heating across Rikers facilities, whether due to outright system failure or structural deficiencies, reflects a systemic problem that demands immediate and sustained intervention.

### **III. Continued chaos in package rules**

In January, the Department updated its online list of "permissible items." This list narrowed what families and organizations are allowed to send to people in custody and, as discussed above, now prevents the sending of thermal clothing. In practice, these policy shifts have been accompanied by widespread confusion and inconsistent implementation across facilities. DOC's new package policy, and its conflicting implementation have completely undermined the ability of families and service providers to meet even basic needs.

One area of concern with the new permissible items list is footwear. The updated policy lists two specific styles of name-brand Vans as the only permissible shoe option. These shoes are expensive and cost-prohibitive for many families and organizations providing these items. Notably, they are not available for purchase on Amazon, adding to the difficulties of mailing compliant shoes. Despite repeated efforts, we have not received clear guidance on whether generic or equivalent shoes in the same style are permissible, and some facilities do not even seem aware that the policy has been changed to Vans only.

This specific change has had direct and harmful consequences for individual clients. In one instance, an individual injured his foot months ago and was placed in a medical boot. His injury has since healed, but DOC has inexplicably not given him a second shoe, despite requests from our office and the client himself. We cannot remedy the situation ourselves, due to our packages being rejected. As a result, he has been forced to keep the medical boot on continuously, not because it is medically required but because he has no other footwear available.

In another case, a client reported that he has only sandals and has been unable to attend recreation for months because his footwear is inadequate for colder weather. We have also not been able to send him a replacement pair of shoes due to the new policy. In both instances, the inability to access basic, permissible footwear has resulted in prolonged discomfort and basic human indignity.

Notably, since the updated permissible items list was published, our office has observed that items have consistently been rejected in nearly every package we have attempted to send, often without any discernible explanation or citation to the posted policy. The shoes our clients need are only one example of the types of packages being rejected. These rejections vary widely across facilities or even within the same facility, depending on who is working, suggesting that the package rules are not being uniformly understood or consistently applied in practice.

The consequences of these rejections are significant. Rejected items are not automatically returned to our organization, or to whomever sent the package, as DOC requires that people in custody use their commissary funds to pay for return shipping. Many of our clients lack sufficient commissary funds to do so, and our office does not have the budget to continually replace lost items. As a result, essential items are effectively destroyed or permanently withheld, further depriving people in custody of basic necessities.

In response to this uncertainty, our correction specialists have spent hours contacting individual facilities to determine which items can and cannot be sent. We have documented these efforts, which reveal stark inconsistencies not only between facilities, but also between the guidance provided by staff and DOC's own posted policy. This information has been sent to the Board for your awareness. This lack of uniformity has created delays, wasted resources, and preventable hardships for people in custody and those attempting to support them.

#### **IV. Response to Deaths in Custody Report**

The Board's Second Deaths in Custody Report reveals the unacceptable care provided to vulnerable populations at Rikers Island. We hope this harrowing report, which documents an unconscionable number of preventable deaths of people suffering from acute mental health and substance use challenges, prompts a reckoning within the Department. There must be a serious assessment of how much oversight in custody settings is exercised by correction officers as opposed to clinicians, and whether there is sufficient capacity for clinicians to be onsite more consistently. The report reflects a troubling reluctance to transfer individuals to the PACE unit, where access to clinical care is significantly greater. Instead, people with mental health challenges often experience repeated interactions with correction officers rather than medical professionals, even when there is a well documented history of severe and intractable mental illness and multiple prior incidents.

The case of Mr. Benjamin Kelly is disturbingly illustrative of this failure. While in custody, he experienced what was clearly a severe mental health episode that resulted in a use of force response. Although the Department has invested in specialized training programs such as Integrating Communications, Assessment, and Tactics (ICAT) and Crisis Intervention Teams (CIT) to better equip officers to respond to mental health crises, officers should be a last resort when dealing with individuals with mental health challenges. Experience both inside and outside of jails consistently demonstrates that the fewer interactions between correction officers and people experiencing mental health crises, the better the outcomes. Yet, of the five individuals with mental health issues identified in the deaths in custody report, only one was housed in a PACE unit.

The report also reveals systemic failures in required touring and staffing practices. Not only were tours frequently not conducted as required, but when they did occur, they were often cursory and superficial. In one alarming instance, officers repeatedly passed by an individual without realizing he was deceased. Meaningful touring would have prevented the majority of the seven deaths listed in this report. Officers must be required to visually confirm breathing and movement and to engage in brief verbal interaction to assess an individual's condition, particularly when staff are already on notice that the person has mental health challenges. Officers must also be properly trained to recognize warning signs and should err on the side of caution by escalating to a medical professional. Instead, the report documents repeated failures to report concerns when red flags were present.

BOC places significant reliance on the Video Monitoring Unit (VMU) as an oversight mechanism to compensate for negligent staff practices. The Board notes that real time

monitoring can be “a crucial tool in identifying poor touring practices, deficient supervision, unsecured and covered cell doors, as well as other incidents that pose a risk to individuals in custody and staff alike.” But this assumes that the VMU teams are not impacted by the pervasive culture of indifference and lax accountability among corrections staff.

There must be a systemic evaluation of what drives this persistent failure to perform the most basic responsibilities of a correction officer’s job, and what must be done to change it. The failure to conduct tours, to secure cell doors, and to maintain accurate logbooks has resulted in an unconscionable number of deaths, and continues to put lives at risk at this very moment.