



Testimony of

Natalie Fiorenza
Senior Corrections Specialist

New York County Defender Services

Before the New York City Board of Correction

June 9, 2026

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

1. Remembering Our Clients Who Recently Died in DOC Custody

No one should ever lose their life in a New York City jail. Yet, at the end of May, two people represented by our office died within 24 hours of each other while in the Department of Correction's (DOC) custody. This is, and has been for years, a humanitarian crisis, and should be treated as an emergency. DOC cannot be allowed to operate as if everything is normal. Every death in custody is a human life, behind them a family, and a community left grieving. These losses are devastating, and endure as the human cost of the City's shameful failure to address deadly conditions in its jails.

These deaths were not isolated incidents. They are part of a longstanding pattern of preventable harm that continues to unfold on Rikers Island. For years, reports, investigations, and oversight bodies have documented persistent failures to provide timely medical care, adequate mental

health treatment, meaningful supportive programming, and safe living conditions.¹ The urgency required to address these failures has long been absent.

Every death in custody should be treated as a profound systemic failure. Our clients' deaths serve as stark reminders that the conditions that plague Rikers remain unresolved, and prevalent. While we discuss reform and oversight, people remain incarcerated in facilities where their health, safety, and dignity are already compromised.

The City cannot continue to treat deaths in custody as unfortunate occurrences. Every death demands immediate action: accountability, transparency, and elimination of the conditions that made that death possible. We cannot become numb to their occurrence, on the contrary, the fact that a death on Rikers is no longer surprising should be reason enough for alarm. The path forward is clear: we must use all decarceration tools at your disposal, accelerate the closure of Rikers Island, and expand access to health care, mental health treatment, supportive services, and community resources that address people's needs more effectively than incarceration ever can. Anything less is compliance with the present standard.

2. Ongoing Reports of Individualized Lock-Ins and Deadlocking

The Board's June 2025 assessment of lock-in and lock-out procedures documented instances of involuntary lock-ins, including within the mental observation units (MOU), and recommended stronger oversight, reporting, and accountability measures.² Yet, despite these findings and recommendations, our office continues to receive reports suggesting that these lock-ins (also known as deadlocking) remain an ongoing and serious problem. Over the last several months, including as recently as the end of May 2026, we have received multiple complaints alleging that individuals housed in MOU and PACE units were deadlocked. These reports are particularly concerning because they involve some of the most vulnerable people in DOC's custody, those with serious mental illness, for whom it may not be achievable to report this misconduct to their families or legal team.

The Board recommended robust tracking and reporting of deadlocking. We strongly support the recommendations and urge the Department to go further by implementing a system that creates a permanent, auditable record of every instance of deadlocking. Similar to the Department's electronic logbook system, any such record should be time-stamped, preserved, and not subject to alteration without creating a record of the modification. Such a system would provide an

¹ See Rahzeem Gray, *Second Report and Recommendations on 2025 Deaths in New York City Department of Correction Custody*, Board of Correction (Jan. 21, 2026) at <https://www.nyc.gov/assets/boc/downloads/pdf/second-report-and-recommendations-on-2025-deaths-in-doc-custody.pdf>; Nazish Dholakia, *Tracking Deaths in NYC Jails Since 2022*, VERA (May 19, 2026) <https://www.vera.org/news/nyc-jail-deaths>

² Rahzeem Gray, *Assessment of NYC Department of Correction's Lock-in and Lock-Out Procedures*, Board of Correction (June 23, 2025) at https://www.nyc.gov/assets/boc/downloads/pdf/assessment_of_docs_lock_in_and_lock_out_procedures.pdf.

objective record for investigating complaints, identifying patterns, and ensuring that the Department is compliant with its policies and the law.

3. Concerns Regarding the Overly Restrictive Permissible Items List

We are deeply dismayed by the Department's changes to the Permissible Items List. For months, advocates, providers, the Board, and the Department have engaged in discussions regarding how to improve access to items that support the health, well-being, and basic needs of those in custody. There is a gap between the permissible items list posted on the Department's website, and what is actually making it through the mail rooms to our clients. It was divulged by the department that in fact, each mail room on the island was operating under a different set of rules, all diverging from the public facing Permissible Items List posted on their website.

One of the most prominent examples of how this affected our clients in real time arose this winter, when we sought to send thermals to those incarcerated, and they suddenly stopped being allowed in. After weeks of confusion, the Department updated its policy, removing thermals from their Permissible Items List. Their reasoning was that they were distributing thermals themselves, but our clients reported difficulty obtaining them, delays in receiving them, and concerns about their effectiveness in the cold weather. This example illustrates how an item may theoretically be available through DOC, but people in custody still may not be able to access it in practice.

Given these discussions, the Department was expected to meaningfully consider ways to expand access and streamline processes related to permissible items. Instead, they unilaterally changed the Permissible Items List to prohibit the sending of almost all clothing items - a move that completely contradicts our collaborative efforts. Restricting items that can improve a person's daily life in custody should not be the default position. The rationale cannot simply be administrative convenience or a vague "security concern".

The Department providing an item should not, standing alone, be sufficient grounds to prohibit family members, loved ones, advocates, or community organizations from sending that same item. There is an inherent dignity in allowing people to receive packages, specifically clothing. Access to personal belongings that reflect an individual's preferences, needs, and sense of self can provide an immeasurable level of comfort and autonomy in an environment where nearly every aspect of daily life is controlled. And on an even more basic level, as the department fails to provide adequate laundry services across the island, it gives individuals in custody the ability to have more than one pair of socks, underwear, etc - something that is shamefully all too common. Policies that unnecessarily restrict these connections not only limit access to desperately needed clothing but also further erode the humanity and personal agency of those in custody.

4. Protecting the Right to Counsel for People in Restrictive Housing

We are concerned about people in restrictive housing being limited to six-minute phone calls, including calls between a person in custody and their legal team. Access to counsel is a fundamental right, and individuals in restrictive housing often have an even greater need to communicate with their legal team due to the inhumane conditions of their confinement. Our office has received reports suggesting that attorney-client communications have been improperly subjected to six-minute limits due to unknown issues with the Department's Do-Not-Record list. In some cases we have also not been able to determine whether our clients in restrictive housing are even able to contact counsel in the first place.

We are additionally troubled by reports that non-restrictive housing units may be subject to 6-minute call restrictions as a form of punishment for the actions of one individual in a unit. An example of this occurred in GRVC, where someone was late to court, and as punishment his entire housing area was restricted to one 6-minute call a day for multiple days. Access to counsel is a constitutional right, not a privilege. If the Department is not able to ensure the efficacy of Do-Not-Record list, then it is unconscionable to limit any housing area to 6-minute calls. And on a basic human level, this is unconscionable regardless of the access to counsel violations.

The Closure of NIC and Conditions at Bellevue Therapeutic Unit

We support the closure of the North Infirmery Command (NIC), and the long awaited opening of the Bellevue Hospital Outposted Therapeutic Unit. NIC's closure is a necessary step towards closing Rikers Island once and for all. However, the transition has not been without significant challenges. We fear that in its haste to close the notoriously dilapidated NIC, the Department transferred their most medically vulnerable individuals into facilities that were unprepared to meet their needs, creating significant disruptions and hardship.

We have received a number of complaints from clients in the Bellevue Hospital Therapeutic Unit, West Facility, and RESH-annex. Those placed in Rosie's Medical Cohorted Housing are reporting feeling unsafe, those placed in West Facility are reporting unbearable isolation, and clients housed at BHTU report alarming barriers to every day needs.

Many of the issues we hear about impose substantial discomfort and inconvenience on our clients, yet would require minimal accommodation to correct. First, the new BHTU units are not currently equipped with cambros, or another source of communal drinking water. Instead, those in custody are instructed to drink the lukewarm water from the communal bathroom sinks. In addition, the BHTUs lack hot plates which are commonly used to boil water, make instant ramen, and cook many of the other foods available on commissary. Over and over we've heard, "All I want is a hot cup of coffee, and a cold cup of water". Providing these simple kitchen amenities, which are readily afforded to all other jail facilities, would go far to improve the conditions and morale at BHTU.

On a more disconcerting front, we have heard that clients housed at BHTU are subject to unnecessary strip searches in order to travel within or outside of the facility, including to counsel visits and daily medical appointments. Not only is the new strip-search policy egregiously intrusive, because it is applied inconsistently and because it is out of step with standard operating movement protocols, it has caused undue stress and confusion to those detained in BHTU. We urge the Department and the Board to investigate and cease this practice.

We have also heard complaints about laundry, the property vouchering system, and clinical staffing, which we hope will be sorted out in the coming weeks as the unit becomes more operational. We will continue to flag these matters to DOC and BOC, and hope this channel of communication will allow these matters to be addressed swiftly without further escalation.

This is a critical moment for our city jail system, and the closure of NIC marks an important milestone in the long march to close Rikers Island. We also know that closing Rikers will only be successful if it is accompanied by a fundamental change in the longstanding culture of operational dysfunction that has plagued Rikers for decades. In order to achieve this necessary shift, the Board must rigorously monitor, oversee and scrutinize DOC operations and conditions during these periods of transition. Thus, we implore the board to look into these complaints, check in on the patients housed at BHTU, and rectify these issues.

Thank you for holding this meeting and listening to our concerns. If you have questions about this testimony, please contact me at nfiorenzo@nycds.org