BOARD OF CORRECTION

CITY OF NEW YORK

SUICIDE PREVENTION IN CITY JAILS: MARCH 2026 OBSERVATION AIDE ASSESSMENT

JUNE 18, 2026

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Introduction

New York City Charter § 626(e) charges the New York City Board of Correction ("Board" or "BOC") with establishing minimum standards for the care, custody, correction, treatment, supervision, and discipline of all persons held or confined under the jurisdiction of the New York City Department of Correction ("DOC" or "Department").

Section 2-02(d) of Title 40 of the Rules of the City of New York requires the Department to establish an Observation Aide program[1] to monitor individuals identified to be at risk of potential suicide, as well as to recognize warning signals of suicidal behavior in individuals not previously identified. As outlined in DOC Directive #4017R-D,[2] these aides shall be assigned to areas such as new admission housing, mental health housing, protective custody, restrictive housing, and intake, and are required to complete tours of these housing areas every 10 minutes. If no aide is assigned, uniformed staff must conduct tours every 15 minutes.

As the Board requires DOC to establish and maintain a program to monitor individuals housed in these designated areas, Board staff conducted a three-week assessment in March 2026 to evaluate DOC's compliance with these standards and existing policies.

Assessment Tool

To assess compliance with relevant minimum standards and DOC's directive, Board staff developed a structured auditing tool of nine questions focused on capturing

[1] "Observation Aide" is defined as a person in custody with no position of authority who has been trained to identify unusual and/or suicidal behavior and immediately report such behavior to the housing unit officer. New York City Department of Correction, Directive #4521R-A, *Suicide Prevention and Intervention*, Section IV(f) (effective February 2, 2021). The full directive is publicly available here: https://www.nyc.gov/assets/doc/downloads/directives/Directive%204521R-A%20Suicide%20Prevention%20and%20Intervention.pdf

[2] Observation aides must conduct vigilant patrols at irregular intervals not to exceed ten minutes between tours (minimum of six per hour), promptly report any unusual or suicidal behavior to the correction officer on duty, talk with incarcerated individuals to identify their needs and communicate those needs to the officer on duty, and provide assistance to the officer or supervisory staff as directed following a suicide attempt. New York City Department of Correction, Directive #4521R-A, *Suicide Prevention and Intervention*, Section III(E)(1) (effective February 2, 2021).

data about observation aide staffing, equipment made available to observation aides to perform their role, and correctional staff tour compliance in units without an observation aide.

The survey also included open-ended response fields to capture operational challenges, resource gaps, staff and observation aide concerns, and suggestions for improving efficiency and compliance. This enabled both quantitative measurement and qualitative insight (see page 12 for list of survey questions) into recurring issues impacting program performance. For both audits, Board staff visited designated housing areas and collected data through a combination of housing area logbook reviews and structured interviews with observation aides and correctional staff. In housing areas without an assigned observation aide, interviews were conducted with correctional staff. Board staff documented visual observations, including the availability of required equipment, verified logbook entries, and reviewed whether observation aides' names and identification numbers were recorded in the "A" post and observation aide logbooks. All findings and survey responses were recorded using a standardized survey form administered through Microsoft Forms.

Methodology

Board staff conducted two structured audits of the Observation Aide program to establish baseline conditions and assess subsequent improvement. While the audits capture conditions present at the time of the inspection, Board staff visited a broad cross-section of specialized housing areas across multiple facilities, allowing for the identification of recurring operational practices and compliance trends.

The initial baseline survey was conducted from March 1 through March 9, 2026. During this initial period, the team visited 62 housing areas across seven of the eight operational housing facilities at the time. West Facility was excluded from the survey due to its current housing designations, which include general population and the communicable disease unit, a medical therapeutic unit comprised of single cells designed to isolate individuals with a communicable disease. This initial audit identified established practices, operational deficiencies and areas requiring

corrective actions. Observations made were shared with DOC facility staff following the initial audit period.

The second assessment, conducted from March 23 through April 3, 2026, used the same methodology and evaluation criteria to ensure consistency and allow for direct comparisons. The North Infirmary Command ("NIC") was excluded from the follow-up audit because it no longer housed individuals in units eligible for the survey at the time of the assessment, resulting in a reduced sample of 58 units compared to 62 during the baseline audit. To promote comparability between the initial and follow-up assessment, Board staff returned to the same housing areas and conducted the survey during the same tours. The follow-up assessment was designated to measure progress, evaluate the effectiveness of corrective actions, and identity remaining gaps.

The inspection form captured key data points, including facility, housing area, unit category, census, observation aide staffing levels, logbook compliance (officer and aide), communication practices, equipment availability, and 15-minute tour compliance in units without aide coverage.

Quantitative data were analyzed using frequencies and percentages, with subgroup denominators applied where appropriate. Measures related to documentation and equipment were assessed only in units with assigned observation aides, while 15-minute tour compliance was evaluated only in units without aide coverage. Qualitative findings were used to provide context and highlight recurring themes.

Initial Survey Findings

At the time of inspection, 41 of the 62 housing units had at least one observation aide present and actively assigned to the housing area. The remaining 21 units did not have an observation aide assigned to the unit at the time of the inspection. This indicates that about one in three units lacked coverage. Despite staffing in most units, gaps remained in documentation, equipment, and required practices.

Table 1. Areas visited during initial survey by facility[3]

Facility	Adult/MO	Adult/PC	YA/MO	YA/PC	New Admin	PACE	Intake	Other[4]
EMTC	4	0	0	0	6	0	1	0
GRVC	6	0	0	0	N/A	6	1	2
OBCC	3	2	0	0	N/A	0	1	3
RMSC	2	1	0	0	N/A	1	1	3
RNDC	3	6	1	1	N/A	1	1	0
NIC	0	2	0	0	N/A	0	0	2
RESH Annex	2	0	0	0	N/A	0	0	0

Summary

While most units had observation aide coverage during daytime tours, program and recordkeeping effectiveness was limited by documentation gaps, inconsistent recordkeeping, and equipment shortages. "B" post officers in units without observation aide coverage frequently failed to meet 15-minute tour requirements, weakening a key safeguard in the event an observation aide is not touring or assigned.

Documentation Compliance in Staffed Units

Among 41 units staffed with aides, only 4 (9.8%) had proper "A" post officer documentation reflecting observation aides' names and Book and Case numbers required by Directive #4017R-D,[5] while 37 (90.2%) did not. Observation aide

[3] "MO" refers to mental observation housing, designed for individuals in custody who have significant mental health needs and would benefit from increased patient-provider engagement and enhanced treatment. "PC" refers to protective custody housing. "New Admin" refers to housing for those newly admitted to custody. "PACE" refers to the Program for Accelerated Clinical Effectiveness, which houses individuals diagnosed with a serious mental illness who require a higher level of care.

[4] Other refers to the Special Consideration Unit ("SCU"), Special Management Unit ("SMU"), Centrally Monitored Cases ("CMC") unit, Groups for Addictive Treatment Enhancement ("GATE") unit, and Supportive Transitional Engagement Program ("STEP") unit.

[5] "A" post officers are responsible for: 1) obtaining equipment for observation aides; 2) recording the name and number of observation aides on duty and those who are replaced or relieved in the housing area logbook; 3) notifying a supervisor of any aide who is replaced or relieved; 4)

logbooks were present in 28 units (68.3%) and absent in 13 (31.7%). All 41 units (100%) confirmed aides did not work more than one tour in 24 hours. One aide reported restricted overnight access to water due to the removal of the water container and locked cells.

Compliance in Units Without Observation Aide Coverage

Of 21 units without observation aides, only 7 (33.3%) complied with required 15-minute tours by "B" post officers, while 14 (66.7%) did not. Correctional staff assigned to restrictive housing at the Main Building of the North Infirmary Command reported that *"if there is no suicide watch on the tier, we do not make 15-minute tours."* [6]

Equipment Deficiencies

Only 11 of 41 staffed units (26.8%) had all required equipment. Missing items included flashlights (19), logbooks (17), and working clocks (7). Some aides relied on tablets or televisions to keep track of time to ensure they were meeting touring requirements. Directive 4017R-D, Section F on equipment, states: "while on duty, each Observation Aide shall be assigned the following equipment which must be in working order: hand-held utility light (4x12 and 12x8 tours if applicable) and access to a working clock." Access to tablets or televisions can be limited based on availability, location, and time of day.

Eric M. Taylor Center

immediately notifying a supervisor if an aide is absent or cannot perform their duties to ensure the "B" post officer tours every 15 minutes and a second "B" post officer is assigned; 5) ensuring aides are on post and performing their duties; 6) notifying a supervisor of any aide who cannot perform their duties; 7) notifying a supervisor of any person who has attempted suicide, is displaying suicidal behavior or indicating behavior that requires medical treatment or a mental health evaluation; 8) making appropriate entries in the housing area logbook; and 9) making appropriate referrals to mental health services. New York City Department of Correction, Directive #4017R-D, *Observation Aide Program*, Section III(J) on "A" Post Officer Duties/Responsibilities.

[6] Observation aides shall be assigned to all special housing areas where the incarcerated population has been placed under observation, including mental health housing areas, restrictive housing, protective custody housing areas, intake areas, and new admission housing areas.

The Eric M. Taylor Center ("EMTC") serves as an intake facility that houses newly-admitted male people in custody prior their transfer to their designated facilities, as well as City sentenced individuals. Due to high turnover driven by frequent reassignment and movement between housing units and facilities on Rikers Island, EMTC experiences constant population fluctuation. Based on observations from prior observation aide surveys and direct field observations, the frequent movement of staff appears to increase the number of qualified observation aides available across facilities; however, it also contributes to inconsistent staffing coverage and observable gaps in the implementation of the Observation Aide program. This pattern was further supported through conversations with EMTC Job Assignment staff, who noted a high rate of aide turnover in new admission housing areas due to frequent and ongoing staff transfers across assignments.

Follow-up Findings

Overall Observation Aide Coverage

During the baseline audit, Board staff identified and flagged concerns directly with officers within each facility. Following the completion of the initial audit, the findings were relayed to job assignment officers and, in some instances, the tour commander within each facility in real time, allowing for immediate awareness, transparency and clarification where necessary. Facility staff were receptive to feedback, and open lines of communication were established to discuss identified issues and potential corrective actions.

A three-week interval between assessments was intentionally scheduled to ensure that findings reflected conditions over a broader timeframe rather than a single day. This approach allowed for a more representative evaluation of practices withing the program. At the conclusion of this period, a follow-up audit was conducted using the same mythology and survey as the initial assessment. The second assessment was designed to reassess conditions, determine whether previously identified issued persisted across time, and assess whether frontline staff demonstrated awareness of concerns raised in the initial audit.

Of 58 housing units included in the follow-up review, 48 were staffed with observation aides and ten were not. As previously noted, NIC was excluded from

the follow-up audit because it no longer housed individuals in units subject to observation aide requirements at the time of the second assessment, resulting in a reduced and non-comparable sample between the two periods.[7]

Documentation Compliance in Staffed Units

Board staff's review of the housing area logbooks noted that officer documentation improved slightly in 6 units (12.5%) from 9.8%. Observation aide logbook use increased to 79.2% from 68.3%. No aides worked more than one tour in 24 hours. Observation aide touring issues persisted due to clocks being inoperable or not available for use.

Compliance in Units Without Observation Aide Coverage

Of 10 units without observation aides,[8] only 20% complied with 15-minute tours by "B" post officers, down from 33.3%. DOC staff continued to report they were not aware they were required to conduct 15-minute tours when an observation aide was not on shift. These findings reflect units that, consistent with DOC's directive, require observation aide coverage, and were specifically reviewed during the assessment for compliance with those staffing and tour requirements.

Equipment Availability

Units equipped with all required equipment increased to 22 of 48 staffed units (45.8%), up from 26.8%. However, 54.2% still lacked at least one required item (flashlights, logbooks, or clocks).

Comparative Summary

Observation aide coverage improved (66.1% to 82.8%), as did logbook use (68.3% to 79.2%), and equipment availability (26.8% to 45.8%). However, officer

[7] New York City Department of Correction, Teletype Order HQ-00659-0, *Bellevue Hospital Outpost Therapeutic Housing Unit / Update on North Infirmary Command* (dated April 7, 2026).

[8] The procedures defined in Directive 4017R-D, entitled "Inmate Observation Aide Program," state: "In the event an Observation Aide is absent or unable to perform assigned duties, the Correction Officer assigned to the "A" Post shall immediately notify the housing area supervisor. The supervisor shall direct the Security Post Officer to conduct fifteen (15) minute tours of inspection and make corresponding logbook entries. The Correction Officer shall remain assigned to the housing area until a qualified Observation Aide reports for duty."

documentation as required by DOC policy remained low (9.8% to 12.5%), and 15-minute tour compliance in areas without an observation aide declined (33.3% to 20%). Overall, improvements were observed but key compliance gaps persist.

Rose M. Singer Enhanced Supervision Housing ("RESH")[9]

RESH does not operate pursuant to DOC Directive #4017R-D, as officers do not allow individuals in RESH to participate in the Observation Aide program. A DOC area supervisor informed the Board that, based on the infraction history of individuals placed in RESH, they are considered a "security risk" and are therefore not permitted to serve as observation aides. The DOC area supervisor further stated that individuals in RESH are frequently moved between housing areas, which creates challenges in maintaining consistent observation aide coverage. Furthermore, DOC does not permit individuals not assigned to RESH to enter the unit, limiting options for observation aides. However, according to DOC's Enhanced Supervision Housing ("ESH") directive, individuals housed in RESH Level II are eligible to fulfill observation aide roles.[10]

Per DOC supervisory staff, required tours of the unit are electronically recorded at 30-minute intervals with a touring wand,[11] and any tours conducted outside of the scheduled timeframe may be flagged as anomalies within the system. However, this explanation contradicts the touring policy, as RESH is considered specialized housing warranting 15-minute tours in the absence of an observation aide.[12]

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[9] § 1-16(b) of the Board's Minimum Standards (previously repealed but reinstated by mayoral emergency executive order) states that a person in custody may be confined in Enhanced Supervision Housing if they present a significant threat to the safety and security of the facility if housed elsewhere.

[10] Directive #4491, Enhanced Supervision Housing (ESH), on work assignments within housing units Level II only.

[11] New York City Department of Correction, *Operations Order No. 1/23: Guard 1 Plus Patrol System (PIPE)*, § V(A)(2), (E)(1) (effective March 7, 2023).

[12] Directive #4017R-D, Observation Aide Program, states that in the event an observation aide is absent or cannot perform the prescribed duties, the correction officer assigned to the "A" post shall make immediate notification to the housing area supervisor. The area supervisor shall instruct the security post officer to commence making 15-minute tours of inspection and logbook entries. The correction officer shall ensure that they are touring the housing area and observing

Conclusion

A follow-up assessment of the Observation Aide program conducted from March 23 through April 3, 2026 across DOC facilities showed improvement in observation aide staffing, communication, and equipment availability since the initial survey. However, significant gaps persist in documentation by correction officers, compliance with 15-minute tours in areas lacking an observation aide, and consistent access to required equipment.

Recommendations

Recommendations are categorized to address operational improvements through policy enforcement, enhanced coordination, strengthened oversight, and improved reporting:

Policy:

1. Area supervisors must ensure 15-minute tours are conducted by "B" post officers in specialized units without observation aide coverage, per Directive #4017R-D.
2. RESH should transition to employing observation aides on a modified alternating schedule aligned with tier lockdowns, per Directive #4009-R on lock-in/lockout.

Review:

1. Correctional staff should seek feedback from observation aides and housing area staff to identify barriers and improve operations.

Coordination:

1. Facility programs or job assignment staff should distribute updated observation aide rosters weekly to ensure all stakeholders are informed of current coverage.

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signs of life of all individuals housed in the area. A second correction officer shall be assigned to the housing area until a qualified observation aide has reported for duty.

2. EMTC should train and assign qualified City sentenced candidates as observation aides to address high turnover in intake areas.

Reporting:

1. “A” post officers must document the name of the observation aide on duty in the “A” post logbook.
2. Leadership should implement a centralized inventory system with routine audits to ensure observation aides have required equipment, such as flashlights, logbooks, vests, and clocks.

Addendum

Survey:

1. Is the area staffed with an observation aide? If yes, how many?
   (Enter number here)
2. If yes, did the "A" post officer[13] note the name and Book and Case number[14] of the observation aide in the logbook?
   (Yes or No)
3. Does the observation aide have a logbook to record their observations?
   (Yes or No)
4. Does the observation aide communicate their observations to the housing area officer?
   (Yes or No)
5. Is the observation aide required or expected to work more than one tour within 24 hours?
   (Yes or No)
6. Does the observation aide have the necessary equipment such as a flashlight, a working clock, logbook, or vest to perform their role?
   (Yes or No)
7. If they do not have the necessary equipment, what is missing?
   (Check choice of item missing: Flashlight, Logbook, Working Clock)
8. Is there anything the observation aide would like us to know or want to add that can improve the efficiency of their work?
   (Enter comments here)
9. In the absence of an observation aide, are "B" post officers[15] assigned to restrictive housing, new admission, mental health, protective custody, and the intake on post, touring every 15 minutes as required by DOC policy?
   (Yes or No)

[13] "A" post officers remain inside the "A" station, colloquially known as the "bubble." The "A" station is the housing area's secured control room and cannot be accessed by people in custody.
[14] Internal Department identifier for people in custody.
[15] DOC uses the term "B" post when referring to a correction officer assigned to a housing area floor post. "B" post officers interact with and directly supervise people in custody inside the living area.

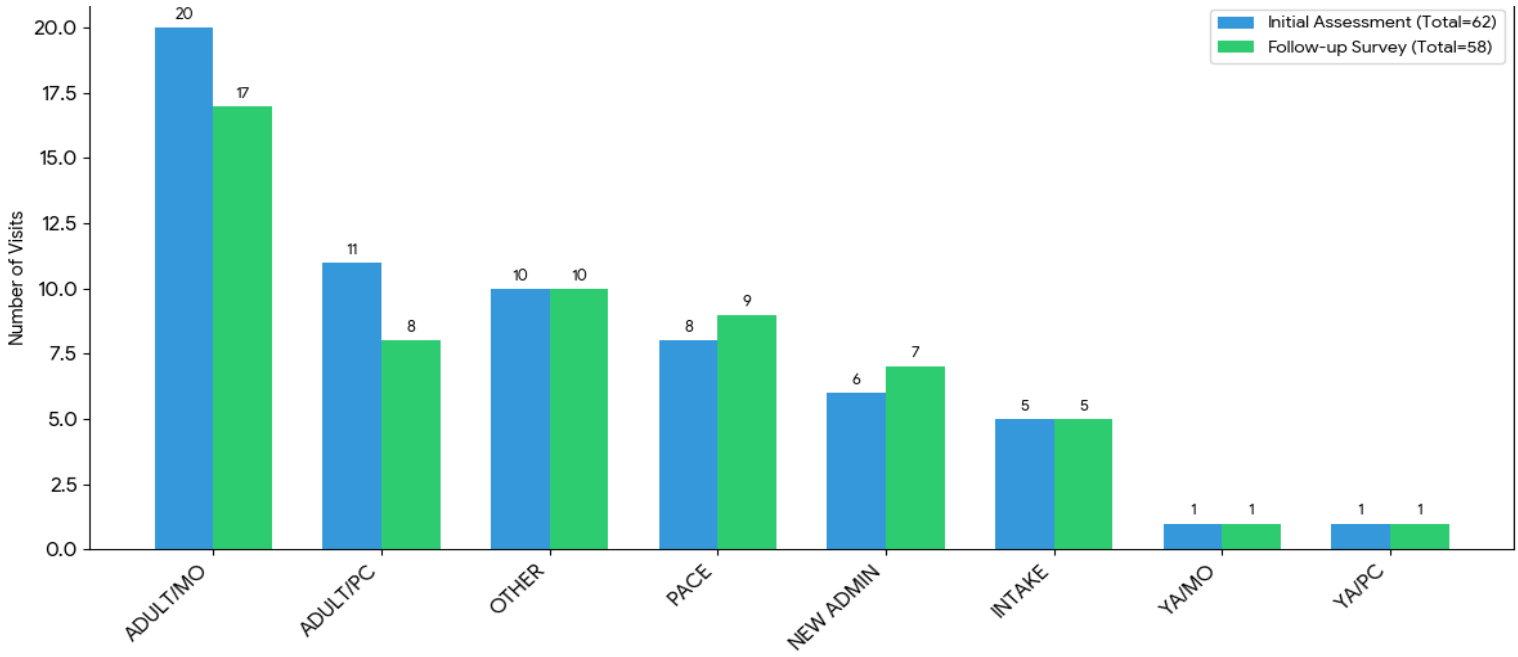
Table 2. Areas visited during follow-up survey by facility[16]

Facility	Adult/ MO	Adult/ PC	YA/MO	YA/PC	New Admin	PACE	Intake	Other
EMTC	4	0	0	0	6	0	1	1
GRVC	3	0	0	0	0	6	1	3
OBCC	3	1	0	0	0	0	1	2
RMSC	2	1	0	0	1	1	1	2
RNDC	3	6	1	1	0	2	1	1
NIC[17]	0	0	0	0	0	0	0	0
RESH Annex	2	0	0	0	0	0	0	1

[16] NIC was excluded from the follow-up audit because it no longer housed individuals in units eligible for the survey at the time of the assessment, resulting in a reduced sample of 58 units compared to 62 during the baseline audit.

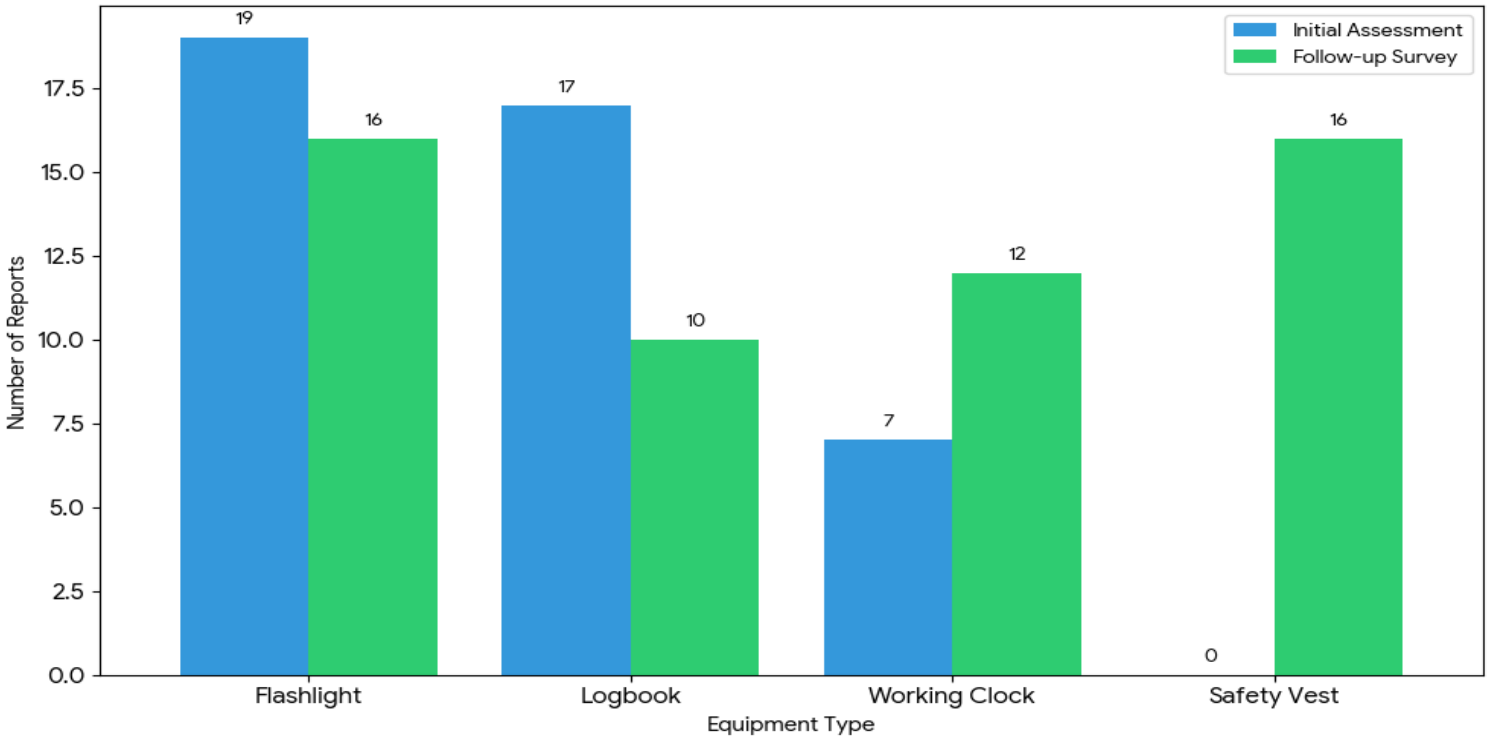
[17] NIC stopped housing individuals prior to the follow-up survey.

Figure 1. Initial and follow-up survey by housing area category [18]



[18] Other refers to the Special Consideration Unit ("SCU"), Special Management Unit ("SMU"), Centrally Monitored Cases ("CMC") unit, Groups for Addictive Treatment Enhancement ("GATE") unit, and Supportive Transitional Engagement Program ("STEP") unit.

Figure 2. Follow-up survey question documenting missing observation aide equipment, amended to include vests[19]



[19]New York City Department of Correction, *Chief of Security, Security Memorandum No. 01/26*, issued February 3, 2026 on SPA Identification Vest (Pinnies): "SPAs will be required to have the following equipment in accordance with Directive 4017R-D _INMATE OBSERVATION AIDE PROGRAM" while performing their duties: Fluorescent SPA Vest, DOC issued Flashlight, Access to a clock, and SPA Logbook." Vests were formally introduced on February 3, 2026; however, distribution did not occur until approximately one month later. This figure reflects compliance with newly issued vests at the time of the follow-up survey.

Figure 3. Overall improvement comparison