NYC Department of Correction
Horizon Juvenile Center Dry Cells Audit Report – December 2018

On July 10, 2018, the NYC Board of Correction granted the NYC Department of Correction (the Department) a six (6) month limited variance from Minimum Standard 1-04(b)(2) for the Horizon Juvenile Center ("Horizon"). This standard states: "*Each single cell shall contain a flush toilet, a wash basin with drinking water*, a single bed and a closable storage container for personal property." (Emphasis added) With two exceptions, the individual cells or rooms for residents at Horizon do not contain "a flush toilet" or "a wash basin with drinking water" and are commonly referred to as "dry cells."

Pursuant to the six (6) month limited variance, allowing residents at Horizon to be housed in single occupancy dry cells, the Department is required to conduct monthly audits on compliance with the following three (3) variance conditions:

1. With respect to youth locked in dry cells, housing unit staff will escort residents of Horizon to the unoccupied housing area bathroom and will provide residents with drinking water within five (5) minutes of the request, absent extenuating circumstances.

2. Housing unit staff will document when a bathroom escort or drinking water is requested. Documentation will include the time of the request and the time escorting begins.

3. Notice of the specific terms and conditions of this variance and the right to notify the Board of any related violations shall be provided to Horizon residents.

Audit Parameter

The audit is conducted through an onsite visit and a manual review of the Overnight Response Logbooks. A manual review of the logbooks was conducted of four (4) randomly selected dates, one (1) day for each week, during the month of December 2018:

- December 2nd
- December 12th
- December 18th
- December 24th

The Overnight Response Logbook[1] was established to document individualized information for each resident request, including the resident's name, book and case number, date, room number, light indicator time, time request was granted, and uniform staff information. To facilitate proper logbook recording, a Programs Memorandum was issued to provide staff with written instruction on the use of the logbook. In addition, the memorandum directed supervisors to conduct daily logbook reviews. The audit review was designed to determine

[1] The Overnight Response Logbook is used to comply with the variance condition requirement that housing unit staff document when a bathroom escort or drinking water is requested and is afforded.

whether residents were provided access to bathrooms and/or drinking water within five (5) minutes of their requests during lock-in hours, between 9pm and 5am, absent extenuating circumstances. The audit covering January 2019 will also include a review of bathroom and water requests made by residents placed on room restriction during lock-out hours.

As indicated above, residents at Horizon reside in dry cells, which are rooms that do not contain a flush toilet or wash basin with drinking water.[2] Residents access bathrooms and drinking water without an escort during lock-out hours. During lock-in hours, from 9pm to 5am, a resident who needs to access the bathroom and/or drinking water pushes a button within his or her room which activates a red light, alerting housing unit staff that the resident has a request. The Overnight Response Logbook is utilized to document the time of the request, based on the indicator light, and the time the request was granted to the resident.

In Horizon, residents reside in halls. For the purpose of this audit the halls are listed from 1 to 10.

Site Visit

In addition to the logbook review, the audit included a site visit during the overnight tour (after 2100 hours) on December 26, 2018. The purpose of the site visit was to observe procedures for the provision of access to the bathrooms and/or drinking water and to assess whether the notices of the variance conditions were properly posted in the halls and/or disseminated to Horizon residents.

During the site visit, officers on post were interviewed during the period when residents were locked in to assess their knowledge and understanding of the relevant variance condition requirements. In addition, the provision of bathroom and drinking water access during lock-in hours was observed.

The site visit also assessed whether:

- each hall had an operable water fountain or a water cooler;
- Officers recorded both the residents' requests to access the bathrooms and/or drinking water and the granting of such requests, and that the logbook entries accurately reflected the times taken to provide residents access to the bathrooms and/or drinking water; and
- the Programs Memorandum, governing the use of the Overnight Response Logbooks, was available in each of the halls for the Officers' reference and instruction.

[2] In the hall for residents with special medical needs, two (2) of the five (5) rooms contain a toilet and sink.

Audit Findings

Site Visit Observations

On December 26, 2018, auditors conducted a site visit during the evening hours when residents were locked in their rooms. During the site visit, entries in the Overnight Response Logbook in each hall for each of the audit dates were photographed for review and analysis, and on-site observations were made relative to the implementation of the variance conditions and the procedures set forth in the Programs Memorandum.

On the day of the site visit, the total resident count in each hall was:

Hall 1 – twelve (12) residents
Hall 2 – six (6) residents
Hall 3 – four (4) residents
Hall 4 – eight (8) residents
Hall 5 – eleven (11) residents
Hall 6 – zero (0) resident
Hall 7 – nine (9) residents
Hall 8 – six (6) residents
Hall 9 – one (1) resident
Hall 10 – ten (10) residents

Note: Hall 6, which was a female only hall, was closed on December 21, 2018 and was reopened on December 27, 2018, at which point it began to house male residents.

Through the site visit, the following issues were identified:

Availability of Drinking Water

- Drinking water, either from water fountains or water coolers, was available in the halls with the following exceptions.
- Residents in Hall 3 used a plastic water dispenser, but the dispenser was empty and was located on the housing area floor. In Hall 10, residents used a water fountain, but the water fountain drain was clogged and water had pooled on the top of the water fountain. Hall staff had submitted a work order for the repair of the water fountain on December 6, 2018.

Notice to Residents

- The “Notice to Residents” posters, notifying residents of the procedures for access to bathrooms and drinking water during lock-in, were not posted or available in Hall 2, Hall 3, Hall 8 and Hall 9.

- The "Notice to Residents" posters, notifying residents of the procedures for access to bathrooms and drinking water during lock-in, were posted in Hall 1, Hall 4, Hall 5, Hall 6, Hall 7, and Hall 10.

Programs Memorandum entitled "Overnight Response Logbook"

- No hall in the facility had the most up-to-date version of the Programs Memorandum entitled "Overnight Response Logbook," which provides instructions to staff on how to use the logbook. Hall 9 had an outdated Programs Memorandum. The other halls had no Programs Memorandum addressing the use of the Overnight Response Logbook.

Use of Overnight Response Logbook

- During the site visit, the following observations and concerns were noted:
    - In several halls, staff did not consistently record the time under the column entitled "Light indicator Time." Instead of the time, some hall staff drew a line under this column heading or wrote the word "knock," indicating that the resident had made known his request for bathroom access or water by knocking on his room door[3]. Without recording the time, auditors could not determine whether staff afforded each resident access to bathrooms and/or drinking water within five (5) minutes of the request being made, in accordance with the terms of the variance.
    - A resident in Hall 2 was using the bathroom when auditors arrived in the area. Staff had not recorded this resident's request for or use of, the bathroom in the Overnight Response Logbook.

Unauthorized Use of Showers

In Hall 2, a resident in the bathroom was using the shower rather than the toilet. Hall staff stated that residents sometimes use the showers instead of, or in addition to, the toilets when provided access to the bathrooms during the overnight tour. Hall staff stated that they are unable to turn off the showers in the residents' bathrooms. On subsequent audits, auditors will attempt to assess whether the residents' use of the showers during the overnight tour is delaying other residents' access to the bathrooms.

[3] In the case that an indicator light is malfunctioning, residents are able to indicate a request to use the bathroom and/or drinking water by knocking on the unit door or speaking through the door to the officer on duty. Officers respond to knocks or verbal requests in the same manner that they respond to indicator lights.

Red and Green Lights over Room Doors

- In Hall 7, the following problems with the door indicator lights located over the room doors were observed:

    - In room #G205, the red indicator would not illuminate, preventing the resident from using the red indicator light to request access to the bathroom and/or drinking water. The room was occupied.
    - In room #G215, the red indicator light would not turn off, preventing the resident from using the red indicator light to request access to the bathroom and/or drinking water. The room was occupied.

Overnight Response Logbooks – Manual Review

Part of the audit was conducted through a manual review of the Overnight Response Logbooks located in the halls on the four (4) audit dates. Listed below are the audit findings based on a manual review of the Overnight Response Logbooks on each of the dates audited.

December 2nd

On this audit date, in four (4) of the halls, Hall 2, Hall 6, Hall 7, and Hall 9, staff properly recorded all the required Overnight Response Logbook information, and based on the logbooks, residents were consistently afforded access to the bathrooms and/or drinking water within five (5) minutes, in compliance with the variance conditions.

Incomplete Logbook Recording

Through the audit process, incomplete logbook recordings were noted in five (5) halls' Overnight Response Logbooks. In Hall 1's logbook, on one (1) occasion, in Hall 3's logbook, on five (5) occasions, in Hall 5's logbook, on two (2) occasions, in Hall 8's logbook, on eight (8) occasions, and in Hall 10's logbook, on one (1) occasion, the "Light Indicator Time," which represents the time the resident made the request, was not recorded. In Hall 4's logbook, on one (1) occasion, the "Time Afforded," which represents the time the resident's request was granted, was not recorded. In the case of Hall 8 and Hall 10, the word "knock" was recorded instead of the "Light Indicator Time" in the logbook. As a result, it could not be determined for the above occasions whether the residents' requests for bathroom access and drinking water were met within five (5) minutes.

While not violations of the variance conditions, on one (1) occasion in Hall 4's logbook, the logbook entry did not record the "Staff Member/Shield #," and in Hall 5's logbook, on one (1) occasion the logbook entry did not record the "Room #."

Access Afforded Exceeded Five (5) Minutes

As part of the logbook review, the audit identified the number of requests for access to the bathroom and/or drinking water for which the time in which the request was granted exceeded five (5) minutes. On this audit date, based on a review of Hall 1's Overnight Response Logbook, on one (1) occasion a request for bathroom access and drinking water exceeded five (5) minutes and was granted in less than ten (10) minutes. In Hall 8's Overnight Response Logbook, on one (1) occasion a request for bathroom access and drinking water exceeded five (5) minutes and was granted in less than ten (10) minutes. For this request, "Resident Out" was recorded in the "Remarks" section of the logbook, denoting that another resident was using the bathroom and/or accessing drinking water at the time the request was made. In the case of Hall 1, due to incomplete logbook recording, no entries were recorded in the "Remarks" column; therefore the circumstances that resulted in the delayed response time could not be determined.

December 12th

On this audit date, in four (4) of the halls, Hall 1, Hall 3, Hall 6, and Hall 9, staff properly recorded all the required Overnight Response Logbook information, and based on these hall logbooks, residents were consistently granted access to the bathrooms and/or drinking water within five (5) minutes in compliance with the variance conditions.

Incomplete Logbook Recording

Through the audit process, incomplete logbook recordings were noted in a number of hall's Overnight Response Logbooks. In Hall 2's logbook, on seven (7) occasions, in Hall 4's logbook, on one (1) occasion, in Hall 5's logbook, on six (6) occasions, in Hall 7's logbook, on eight (8) occasions, in Hall 8's logbook, on five (5) occasions, and in Hall 10's logbook, on two (2) occasions, the "Light Indicator Time," which represents the time the resident made the request, was not recorded. In the case of Hall 8, on two (2) occasions, "knock" was recorded instead of the "Light Indicator Time" in the logbook. As a result, it could not be determined whether access to the bathrooms and/or drinking water was provided within five (5) minutes on the above occasions.

While not a violation of the variance conditions, on one (1) occasion in Hall 7's logbook, the logbook entry did not record the "Book and Case #."

Access Afforded Exceeded Five (5) Minutes

As part of the logbook review, the audit identified the number of requests for access to the bathroom and/or drinking water where the time in which the request was granted exceeded five (5) minutes. On this audit date, based on a review of Hall 5's Overnight Response Logbook, on one (1) occasion a request for bathroom access and drinking water exceeded five (5)

minutes and was granted in twenty-five (25) minutes. In the above instance, due to incomplete logbook recording, no entry was recorded in the "Remarks" column; therefore the circumstances that resulted in the delayed response time could not be determined.

December 18th

On this audit date, in one (1) of the halls, Hall 10, staff properly recorded all the required Overnight Response Logbook information, and based on this hall's logbook, residents were consistently granted access to the bathrooms and/or drinking water within five (5) minutes, in compliance with the variance conditions.

Incomplete Recordings and/or No Logbook Entry

Through the audit process, incomplete logbook recordings were noted in a number of hall's Overnight Response Logbooks. In Hall 1's logbook, on two (2) occasions, in Hall 2's logbook, on three (3) occasions, in Hall 3's logbook, on four (4) occasions, in Hall 5's logbook, on two (2) occasions, in Hall 7's logbook, on three (3) occasions, in Hall 8's logbook, on two (2) occasions, and in Hall 9's logbook, on three (3) occasions, the "Light Indicator Time," which represents the time the resident made the request, was not recorded. In Hall 2's logbook, on one (1) occasion, and in Hall 5's logbook, on one (1) occasion, the "Time Afforded," which represents the time the resident's request was granted, was not recorded. In the case of Hall 5, on one (1) occasion, "knock" was recorded instead of the "Light Indicator Time" in the logbook. In the case of Hall 8, on two (2) occasions, "knock" was recorded instead of the "Light Indicator Time" in the logbook. In the case of Hall 9, on three (3) occasions, "knock" was recorded instead of the "Light Indicator Time" in the logbook. As a result, it could not be determined for the above occasions whether access to the bathrooms and/or drinking water were provided within five (5) minutes.

While not violations of the variance conditions, in Hall 2's logbook, on one (1) occasion, the logbook entry did not record the "Room #." In Hall 4's logbook, on two (2) occasions, the logbook entry did not record the "Staff Member/Shield #." In addition, in Hall 5's logbook, on one (1) occasion, the logbook entry did not record the "Date" and "Room #."

While an Overnight Response Logbook was located in Hall 6, on this audit date no entries related to requests for access to bathrooms and/or drinking water were recorded and, as a result, it could not be determined through a logbook review whether any requests for access to the bathrooms and/or drinking water were made in this hall. Entries related to change of tours were recorded in the logbook on this audit date.

Access Afforded Exceeded Five (5) Minutes

As part of the logbook review, the audit identified the number of requests for access to the bathrooms and/or drinking water where the time in which the request was granted exceeded

five (5) minutes. On this audit date, based on a review of Hall 1's Overnight Response Logbook, on one (1) occasion fulfilling the request to access the bathroom exceeded five (5) minutes, and was granted in less than twenty (20) minutes. For this request, in the "Remarks" column of the logbook, "One Resident Out" was recorded, denoting that another resident was using the bathroom and/or accessing drinking water at the time the request was made. In addition, in Hall 8's Overnight Response Logbook, on one (1) occasion fulfilling the request to access the bathroom exceeded (5) minutes, and was granted in twenty-one (21) minutes. For this request, in the "Remarks" column of the logbook, "One Resident Out Already" was recorded, denoting that another resident was using the bathroom and/or accessing drinking water at the time the request was made. "Refused to Lock in" was also recorded in the "Remarks" section of the logbook for the previous resident's request.

December 24th

On this audit date, in three (3) of the halls, Hall 2, Hall 4 and Hall 10, staff properly recorded all the Overnight Response Logbook information, and based on these hall logbooks, residents were afforded access to the bathrooms and/or drinking water within five (5) minutes, in compliance with the variance conditions.

Incomplete Logbook Recording and/or No Logbook Entry

Through the audit process, incomplete logbook recordings were noted in a number of hall's Overnight Response Logbooks. In Hall 5's logbook, on five (5) occasions, in Hall 7's logbook, on six (6) occasions, in Hall 8's logbook, on four (4) occasions, and in Hall 9's logbook, on one (1) occasion, the "Light Indicator Time," which represents the time the resident made the request, was not recorded. In the case of Hall 5, on five (5) occasions, "knock" was recorded instead of the "Light Indicator Time" in the logbook. In the case of Hall 8, on four (4) occasions, "knock" was recorded instead of the "Light Indicator Time" in the logbook. In the case of Hall 9, on one (1) occasion, "knock" was recorded instead of the "Light Indicator Time" in the logbook. As a result, it could not be determined for the above occasions whether access to the bathrooms and/or drinking water were provided within five (5) minutes.

While an Overnight Response Logbook was located in Hall 3 on this audit date, no entries related to requests for access to bathrooms and/or drinking water were recorded and, as a result, it could not be determined through a logbook review whether any requests for access to the bathrooms and/or drinking water were made in this hall. Entries related to change of tour were recorded in the logbook on this audit date.

Access Afforded Exceeded Five (5) Minutes

As part of the logbook review, the audit identified the number of requests for access to the bathroom and/or drinking water where the time in which the request was granted exceeded five (5) minutes. On this audit date, based on a review of Hall 1's Overnight Response Logbook,

on two (2) occasions fulfillment of a request to access the bathroom exceeded five (5) minutes; these two (2) requests were granted in less than ten (10) minutes. For each of these requests, "Other Resident Out Already" was recorded in the "Remarks" section of the logbook. In the same hall's logbook, on one (1) occasion fulfillment of a request by one resident to access both the bathroom and drinking water exceeded five (5) minutes and was granted in thrity-five (35) minutes. In this case, "resident refused to lock-in" was recorded in the "Remarks" section of the logbook.

Audit Recommendations

The Department commenced the audit process in November 2018. By October 1, 2018, residents had been transferred from facilities on Rikers Island to Horizon. During this transitionary period, procedures to facilitate compliance with the variance conditions were being operationalized and continue to be updated and optimized. Through this second audit, several issues were identified related to operationalizing the Overnight Response Logbooks, such as making complete and consistent logbook recordings and providing access to the bathrooms and/or drinking water within five (5) minutes.

After the completion of the audit covering November 2018, the facility administration indicated that the following recommendations for corrective action had been implemented:

Notice to Residents

- "Notice to Residents" posters have been posted in each hall.

Documenting requests for access to the bathrooms and/or drinking water

- The Programs Memorandum instructing staff on the use of the Overnight Response Logbook has been revised and a copy has been placed on each post within the Overnight Response Logbook for staff to review and reference. The revisions include the following:
    - Staff are to record complete and consistent information for each request for access to the bathrooms and/or drinking water during lock-in periods and all other periods of room confinement.
    - In the event that a resident makes a request for access to the bathrooms and/or drinking water when another resident is already out accessing the bathrooms and/or drinking water, which causes a delay, staff shall indicate the reason for exceeding five (5) minutes in the "Remarks" column of the Overnight Response Logbook.[4]
    - A logbook entry must be recorded when no residents request access to the bathrooms and/or drinking water during a particular overnight period.

[4] Only one resident is permitted out of the room to access the bathrooms and/or drinking water at a time.

  - Staff are to record the time record the time that a resident has made a request to access the bathroom and/or drinking water, whether the resident activated the indicator light or knocked on his unit door.
- The Programs Memorandum has been read at roll call on a recurring basis in order to provide staff with instruction on how to complete proper logbook entries, and to emphasize that a logbook entry must be recorded when no requests to access the bathrooms and/or drinking water during a particular overnight period are made.
- All supervisory staff have been instructed to ensure they review the Overnight Response Logbooks daily in order to verify that hall Officers consistently and accurately record requests for access to the bathrooms and/or drinking water. When deficiencies in logbook entries are noted, supervisors are to implement corrective action to address and rectify these deficiencies in a timely manner. In addition, if the deficiency is related to an Officer's failure to record a residents' requests for access to the bathrooms and/or drinking water, supervisors are to direct the assigned Officer to prepare and submit a written explanatory report. Supervisory duties in ensuring the complete and consistent recording of logbook entries are reiterated at weekly supervisory staff meetings.

The facility administration should implement the following corrective actions:

Posting of Notice to Residents

- To ensure the posting of the notice related to the variance conditions, the facility shall direct supervisory staff assigned to the housing areas/halls to verify daily that the required "Notice to Residents" posters are posted in each hall, or have been issued to each resident.
- If a hall has been identified as not having the notice posted, or its residents were not issued copies of the notice, the facility administration should ensure that the notice is posted in a timely manner, or that copies of the notice are issued to residents.

Availability of Programs Memorandum

- Supervisory staff shall verify daily on each tour that the Programs Memorandum, governing the use of the Overnight Response Logbook, is on post in each housing area hall for the Officers' instruction and reference.

Availability of Drinking Water

- Supervisory staff shall verify daily on each tour that drinking water is available, either from water fountains or water coolers. Supervisory staff shall identify any water fountains that are inoperable or have clogged drains, and water coolers that are empty or stored on the floor, and document and take the necessary corrective actions.

Unauthorized Use of Showers

- The facility administration shall create operational protocols to address the use of showers during the overnight tours.

Indicator Lights over Room Doors

- The facility administration shall ensure that the green and red lights over room #'s G205 and G215 in Hall 7 have been repaired.

Properly Recording the Time of a Resident's Request in the Logbook

- Train staff that the word "knock" is not an appropriate form of documentation and should not be substituted for recording the "time" that the inmate requested access to the bathroom and/or drinking water. Staff can record "knock" under the "Light Indicator Time," but must also record the time that the resident made his request for bathroom and/or drinking water access known to staff, whether the resident activated the light indicator or knocked on his room door.

Documenting when Residents Do Not Request Use of the Bathrooms or Drinking Water

- Supervisory staff shall verify daily on each tour that hall staff make a logbook entry whenever no residents request access to bathrooms and/or drinking water during any particular overnight period.