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

On July 10, 2018, the NYC Board of Correction granted the NYC Department of Correction ("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 Parameters

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 for five (5) randomly selected dates, one (1) day for each week, during the month of October 2018:

- October 3rd
- October 13th
- October 18th
- October 22nd
- October 31st

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 afforded, 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. Additionally, the memorandum directed supervisors to conduct daily logbook reviews. The audit review was to determine whether

[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.

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. Commencing with the audit covering December 2018, the audits will also include a review of bathroom and water requests made by any resident 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. 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 afforded to the resident.

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

In addition to the logbook review, the audit included a site visit during the overnight tour (after 2100 hours) on October 24, 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 notice 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 request to access the bathroom and/or drinking water and the affording of such requests and that the logbook entries accurately reflected the times taken to provide residents access; 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 October 24, 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 Logbooks in each hall for each of the audit dates were photographed for review and analysis, on-site observations were made relative to the implementation of the variance conditions and the procedures set forth in the Programs Memorandum.

Through the site visit, the following issues were identified:

Availability of Drinking Water

- Drinking water, either from water fountains or water coolers, were available in all halls.

Notice to Residents

- The "Notice to Residents" posters, notifying residents of the procedures for access to the bathrooms and drinking water, were not posted in the intake area or any of the halls.
    - Intake staff informed auditors that the "Notice to Residents" posters were not available in the intake area and as a result were not issued in this area to new admission residents.
- Based on auditors' interviews of staff assigned to the halls, the residents were not in possession of the "Notice to Residents" posters.

Use of Overnight Response Logbook and related written instruction

- During the site visit, the following observations and concerns were noted:

    - The memorandum that provides housing unit staff with written instruction on the use of the Overnight Response Logbook, was not found in any of the hall areas for staff to reference.
    - One (1) of the ten (10) resident halls did not have an Overnight Response Logbook needed to properly document resident requests in that hall.
    - The Overnight Response Logbook located in Hall 10, did not contain any logbook entries prior to October 21, 2018. The auditor's inquired further with the Officer assigned to the hall, to determine whether entries had been made regarding access to the bathrooms and/or drinking water in another logbook within the hall. The Officer indicated that no entries had been recorded for either type of request.

- In four (4) of the Halls: Hall 4, Hall 7, Hall 8 and Hall 10, auditors observed the assigned hall officers providing residents with access to the bathrooms and drinking water from their individual rooms. The Officers, however, did not record access provided in the logbook.
- In one (1) of the halls, the rooms were not numbered/labeled in Hall 9. As a result, the assigned Hall officers were not able to record information in the column entitled "Room #" in the Overnight Response Logbook.

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 five (5) audit dates.

Listed below are the audit findings based on a manual review of the Overnight Response Logbooks on each of the dates audited.

October 3rd

Logbooks Not Operationalized

On this audit date, seven (7) resident halls: Hall 2, Hall 4, Hall 5, Hall 6, Hall 7, Hall 8 and Hall 10 had not begun the use of the Overnight Response Logbooks and, as a result, an audit to assess compliance with the variance condition that residents be escorted to unoccupied housing area bathrooms or drinking water within five (5) minutes of the request, absent extenuating circumstances, could not be conducted based on a logbook review. Additionally, an Overnight Response Logbook was not located in Hall 9. Based on the above, on this audit date, these hall areas were not in compliance with the variance condition requirement that documentation be maintained relative to all bathroom and drinking water requests.

Incomplete Logbook Recording and/or No Logbook Entry

On this audit date, issues were also identified relative to incomplete recording of logbook information. Based on a review of available Overnight Response Logbooks, on two (2) occasions, in Hall 3 logbook entries did not record the time that the request was afforded and, as a result, it could not be determined whether the resident's request was met within the required five (5) minute period. While not violations of the variance conditions, on six (6) occasions in Hall 1, logbook entries were incomplete as the room number of the resident that made the request was not recorded. It is important to note that the individualized logbook entries include the name of the resident that made the request.

October 13th

On this audit date, based on a review of the halls' Overnight Response Logbooks: two (2) of the Halls, Hall 4 and Hall 8, properly recorded all the logbook information documenting that residents were afforded access to the bathroom and/or drinking water within five (5) minutes in compliance with the variance conditions.

Logbooks Not Operationalized

On this audit date, Hall 10 had not begun the use of the Overnight Response Logbook and, as a result, an audit to assess compliance with the variance condition that residents be escorted to unoccupied housing area bathrooms or drinking water within five (5) minutes of the request, absent extenuating circumstances, could not be conducted in this area. Additionally, an Overnight Response Logbook was not located in Hall 9. Based on the above, these hall areas were not in compliance with the variance condition requirement that documentation be maintained relative to all bathroom and drinking water requests.

Incomplete Logbook Recording and/or No Logbook Entry

Through the audit process, incomplete logbook recordings were noted in a number of the halls' Overnight Response Logbooks and, as a result, it could not be determined whether access to the bathroom and/or drinking water was provided within five (5) minutes. In Hall 3's logbook, on one (1) occasion, the time afforded was not recorded and in Hall 7's logbook, on two (2) occasions the light Indicator light time, which represents the time the resident made the request, was not recorded. While not a violation of the variance conditions, on one (1) occasion in Hall 5's logbook, the logbook entry did not record the room number for the resident that made the request. It is important to note that the individualized logbook entries include the name of the resident that made the request.

While an Overnight Response Logbook was located in Hall 1, no entries had been recorded on this audit date and, as a result, it could not be determined, through a logbook review, whether any requests for access to the bathroom and/or drinking water was made in that hall.

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 provided exceeded five (5) minutes. On this audit date, based on a review of Hall 2's Overnight Response Logbook, on two (2) occasions requests to access the bathroom exceeded five (5) minutes, one (1) request was provided in less than ten (10) minutes and the other in less than twenty (20) minutes. In the same hall's logbook, on two (2) occasions access to drinking water exceeded five (5) minutes, one request was provided in less than ten (10) minutes and the other request was provided within less than twenty (20) minutes. In each of the above instances, due to

incomplete logbook recording, no reason was noted; therefore the circumstances that resulted in the delayed response time could not be determined.

October 18th

On this audit date, based on a review of the halls' Overnight Response Logbooks: three (3) of the housing areas, Hall 1, Hall 3, and Hall 6 properly recorded all the logbook information documenting that residents were afforded access to the bathroom and/or drinking water within five (5) minutes in compliance with the variance conditions.

Logbooks Not Operationalized

On this audit date Hall 10 had not begun the use of the Overnight Response Logbook and, as a result, an audit to assess compliance with the variance condition that residents be escorted to unoccupied housing area bathrooms or drinking water within five (5) minutes of the request, absent extenuating circumstances, could not be conducted based on a logbook review in that hall. Additionally, an Overnight Response Logbook was not located in Hall 9. Based on the above, these hall areas were not in compliance with the variance condition requirement that documentation be maintained relative to all bathroom and drinking water requests.

Incomplete Recordings and/or No Logbook Entry

Through the audit process, incomplete logbook recordings were noted in a number of halls' Overnight Response Logbooks and, as a result, it could not be determined whether access to the bathroom and/or drinking water was provided within five (5) minutes. In both Hall 4's logbook and Hall 7's logbook, on one (1) occasion each, the light Indicator light time, which represents the time the resident made the request, was not recorded. While not a violation of the variance conditions, on one (1) occasion in Hall 5's logbook, the logbook entry did not record the room number for the resident that made the request.

Although an Overnight Response Logbook was located in Hall 2 and Hall 8, no entries had been recorded on this audit date and, as a result, it could not be determined through a logbook review, whether any requests for access to the bathroom and/or drinking water was made in those halls.

October 22nd

On this audit date, based on a review of the halls' Overnight Response Logbooks: two (2) of the housing areas, Hall 1 and Hall 7, properly recorded all the logbook information documenting that residents were afforded access to the bathroom and/or drinking water within five (5) minutes in compliance with the variance conditions.

Logbooks Not Operationalized

On this audit date, an Overnight Response Logbook was not located in Hall 9. Based on the above, this hall area was not in compliance with the variance condition requirement that documentation be maintained relative to all bathroom and drinking water requests.

Incomplete Logbook Recording and/or No Logbook Entry

Through the audit process, incomplete logbook recordings were noted in a number of halls' Overnight Response Logbooks, and, as a result, it could not be determined whether access to the bathroom and/or drinking water was provided within five (5) minutes. In Hall 6's logbook, on one (1) occasion, the time afforded was not recorded, and in both Hall 3 and Hall 6's logbooks, on three (3) occasions each, the light Indicator light time, which represents the time the residents made the request, was not recorded.

While not violations of the variance conditions, there were a number of instances where some identifying information was not recorded in the some halls Overnight Response Logbooks as noted below:

In Hall 3's logbook, on two (2) occasions the logbook entry did not record the book and case number of the resident that made the request, and on one (1) occasion the logbook entry did not record the date. In Hall 4's logbook, on three (3) occasions the logbook entry did not record the room number of the resident that made the request. In Hall 5's logbook, on one (1) occasion the logbook entry did not record the room number of the resident that made the request, and on one (1) occasion the logbook entry did not record the book and case number of the resident that made the request. In Hall 6's logbook on three (3) occasions, the logbook entry did not record the date.

While an Overnight Response Logbook was located in Hall 8 and Hall 10, no entries had been recorded on this audit date and, as a result, it could not be determined through a logbook review whether any requests for access to the bathroom and/or drinking water was made in those halls. Furthermore, while the Overnight Response Logbook located in Hall 2 had an entry for change of tour, no other entries had been recorded on this date and, as a result, it could not be determined through a logbook review whether any requests for access to the bathroom and/or drinking water was made in that hall.

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 provided exceeded 5 (five) minutes. On this audit date, based on a review of Hall 4's Overnight Response Logbook, on one (1) occasion, a request to access the bathroom exceeded five (5) minutes, and was provided in less than ten (10) minutes. In the same hall's logbook, on one (1) occasion access to drinking water exceeded five (5) minutes, and was provided in less than ten (10) minutes. In

each of the above instances, due to incomplete logbook recording, no reason was noted; therefore the circumstances that resulted in the delayed response time could not be determined.

October 31st

On this audit date, based on a review of the halls' Overnight Response Logbooks: six (6) of the halls, Hall 1, Hall 3, Hall 5, Hall 7, Hall 8, and Hall 10 properly recorded all the logbook information documenting that residents were afforded access to the bathrooms and/or drinking water within five (5) minutes.

No Logbook in Hall

Overnight Response Logbook was not located in Hall 9.

Incomplete Logbook Recording and/or No Logbook Entry:

Through the audit process, an incomplete logbook recording was noted in one (1) hall's Overnight Response Logbook. In Hall 4's logbook, on two (2) occasions, the logbook entries did not record the date.

While an Overnight Response Logbook was located in Hall 2 and Hall 6, no entries had been recorded on this audit date and, as a result, it could not be determined through a logbook review whether any requests for access to the bathroom and/or drinking water were made in those halls. Based on the above, these hall areas were not in compliance with the variance condition requirement that documentation be maintained relative to all bathroom and drinking water requests.

Audit Recommendations

The Department commenced the audit process in October 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. Through this first 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. Improvements in compliance were noted over the course of the audit period. The following recommendations for corrective action should be instituted.

Notice to Residents

- To facilitate the posting of the notice related to the variance conditions, designate supervisory staff assigned to the housing area/halls to verify 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 notice is posted in a timely manner, or that copies of the notice are issued to residents.

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

- To facilitate complete and consistent recording of resident requests to access the bathroom and/or drinking water within five (5) minutes, and to record any extenuating circumstances that result in a delay in providing such access:
    - all officers should be provided with the Programs Memorandum, which provides written instruction on the procedures to follow and all information that is to be recorded in the Overnight Response Logbook
    - maintain such memorandum at each hall post for Officers to reference, as needed
    - provide Officers with training on proper logbook entries and related procedures, inclusive of instructions that where no resident requests have been made to access the bathroom and/or drinking water during a particular overnight period, a logbook notation must be recorded indicating that no requests were made.
- Designate supervisory staff with the responsibility of reviewing the Overnight Response Logbooks daily to verify complete and consistent recording and that access to bathrooms and drinking water has been afforded. When logbook deficiencies are noted, implement corrective action to address and rectify in a timely manner. Additionally, if the deficiency is related to an Officer's failure to record the requests, require that the assigned Officer prepares and submits a written explanatory report.
- Facility administration should ensure that the resident rooms, in each housing area hall, are numbered and labeled for proper identification and recording in the Overnight Response Logbook.
- To facilitate the above logbook recordings and supervisory oversight, the recommendations for corrective action should be incorporated into the Programs Memorandum.