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Via email

October 17, 2022

Julio Medina, Chair
Amanda Masters, Executive Director
Members of the Board of Correction
New York City Board of Correction
1 Centre Street, Rm. 2213
New York, NY 10007

Re: DOC Plans for Increased Lock-In at GRVC

Dear Chair Medina, Members of the Board and Ms. Masters,

We submit this testimony in advance of the Board of Correction Public Meeting on October 18, 2022, with respect to the agenda item, “Description of Plans to Reduce Violence, Including GRVC.” This appears to replace the Department of Correction’s variance request of October 11, withdrawn on October 14, seeking permission to lock-in all people held in GRVC for 17 hours per day. We do not know whether the Department withdrew its request because it correctly concluded that such a lock-in plan was dangerous and insufficient to correct the gross mismanagement of housing units in the agency, or whether the Department still intends to implement the 17-hour lockout out time but believes it can do so without a variance. We suspect that the City will continue to abuse emergency executive powers as it has for over a year—which overwhelmingly seek not to address well-documented issues with staff absenteeism and deployment, but rather seek reactive deprivations for people in custody who are already trapped in an inhumane environment. We ask the Board to question the Department at the meeting about this matter, and whether its “Plan” includes increased lock-in time.

Given the Department’s lack of transparency around the variance request, we write in an abundance of caution in the event the Department does intend to increase the lock-in times at

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GRVC. We strongly urge the Board to take all steps within its authority to hold the Department accountable to Minimum Standard § 1-05(b), which provides that individuals in custody shall be locked into cells for no more than 10 hours per day, should be denied. This is a bedrock standard in the City jails in place since the original adoption of the Minimum Standards, and for decades corrections officials have been able to operate the jails under these standards.¹ The current administration’s difficulties performing their basic custodial tasks do not warrant a departure from adherence to this crucial BOC standard, especially when doing so would cause destabilization of the jails and further harms to those confined at GRVC. The people who are confined at GRVC—nearly 13% of the NYC jail population²—are held there to secure their appearance at criminal trials. To lock them in concrete boxes for 17 hours each day is a mockery of the presumption of innocence, and this Board should take all measures possible to forestall this attempted erosion of constitutional norms.

Halving the lock-out period punishes incarcerated people for the Department’s staffing and supervisory failures.

The chaos, mismanagement and violence at GRVC pose a serious threat of harm to the people DOC chooses to confine there, and they demand immediate intervention. But the indicators the Department cited in its October 11, 2022 variance request in support of its chosen response of locking people into cells 17 hours per day omits crucial data about staff incompetence, which clearly point to this being the *wrong* intervention. Violence in GRVC is not occurring in a fully-staffed, well-supervised jail in which staff are reliably on post and performing basic correctional duties like locking doors. As *Nunez* counsel, we have reviewed the Department’s own investigative reports of use of force incidents in GRVC this past summer of 2022. Though these reports are deemed preliminary assessments of incidents, except for a very small fraction of cases, they are DOC’s final investigations. In those reports, the Department itself describes extraordinary degrees of staff and supervisory failures in connection with many incidents of violence: no staff on post; only one staff member assigned to a large housing unit; staff failing to lock doors; and staff mishandling initial conflicts. The *Nunez* monitor, too, has described these gross failures in great detail. For example, the Monitor reported that the May 2022 internal reviews of incidents

“identified an astonishing number of avoidable incidents with an equally astonishing array of security lapses. For example, a typical scenario is people in custody being left unsupervised with an officer off post and in unsecured cells. An assault on a person in custody ensues, prompting officers and tactical teams to intervene by using force. Quite often such force involves multiple people in custody with multiple officers utilizing all

¹ See *First Minimum Standards 1978*, New York Correction History Society, http://www.correctionhistory.org/html/chronicl/bdofcorr/1978standards/html/1978standards_p05.html#part6 (last visited Oct. 14, 2022) (original text of 1978 Min. Standards at § 6-2 “Involuntary Lock-In”).

² September 13, 2022 Public Meeting of the New York City Board of Correction, *available at* <https://www1.nyc.gov/site/boc/meetings/september-13-2022.page> (in which Executive Director Amanda Masters noted that GRVC had a census of 726 people and DOC had a total census of 5,718 people).

manner of tactical equipment such as OC canisters, tasers, batons, chemical agent grenades, etc. In other instances, officers are slow to intervene. In some instances, officers have means of egress to summon supervisors but fail to do so and immediately resort to using force.”³

The City’s unwillingness to resolve both its staffing crisis—its inability to get correction staff to work, in the housing areas and on post—and its supervisory failures—its inability to get staff to do jobs competently—is a critical precipitating cause of the ongoing violence and chaos. For the City to respond to its own failures by seeking to lock people in their care into cinderblock cells for 17 hours per day, as their variance request sought to do, is perverse. The fuller picture makes apparent what interventions the City should be providing: namely, robust staffing of all housing units by supervisors and capable staff.

Halving the lock-out period will cause harm.

The unintended consequences of locking everyone in this large facility up for 17 hours a day will be dire. As publicly reported facts from this last year demonstrate, locking people out of sight carries serious risks, increasing the possibility that individuals will not receive medical and mental health care in time to prevent serious, even fatal, health events. Recent BOC reports have chronicled individuals choking to death or dying of drug overdoses in their housing units, with staff either unwilling or unable to leave their posts to provide aid.⁴ In several instances, incarcerated persons were the first to notice and respond to individuals in distress, even carrying them to medical care, when staff did not.⁵ Recent BOC reports also describe a correctional staff that routinely fails to

³ June 30, 2022 Status Report of the Independent Monitor, *Nunez v. City of N.Y.*, No. 11-CV-5845 (S.D.N.Y.), Dkt. 467, at 15-20.

⁴ See, e.g., Board of Correction, *February & March 2022 Deaths in DOC Custody Report and Recommendations* (“BOC 2022 Deaths Report”), at 5 (officer refusing to leave A-post to render first aid to choking individual, who later died) available at <https://www1.nyc.gov/assets/boc/downloads/pdf/Reports/BOC-Reports/deaths-report-and-chs-response-202202-202203.pdf>; Board of Correction, *Report and Recommendations on 2021 Suicides and Drug-Related Deaths in New York City Department of Correction Custody* (“BOC 2021 Deaths Report”), at 17-18 (officer ignored complaints of individual who died of overdose showing signs of severe intoxication and failed to maintain constant supervision despite the individual being on suicide watch), available at <https://www1.nyc.gov/assets/boc/downloads/pdf/Reports/BOC-Reports/2021-suicides-and-drug-related-deaths-report-and-chs-response.pdf>; Tina Moore, NYC jail workers allegedly watched as suicidal Rikers Island inmate bled to death, October 14, 2022, available at <https://nypost.com/2022/08/31/nyc-jail-workers-allegedly-watched-as-suicidal-rikers-island-inmate-bled-to-death/>.

⁵ BOC 2022 Deaths Report at 7 (“If DOC’s account is correct, it took over thirty minutes for a medical team to make their way to the unit to collect Mr. Pagan and no one responded to the unit to aid Mr. Diaz. In both instances, people in custody physically carried Mr. Pagan and Mr. Diaz closer to the clinic.”); BOC 2021 Deaths Report at 15 (“People in custody were the first to notice that Mr. Braunson was unresponsive and raised the alarm, alerting the floor officer at around 8:22 am. Video surveillance footage show that correction officers walked back and forth between the ‘A’ station and Mr. Braunson’s bed, from 8:22 am until 8:32 am, at which time medical staff arrived and began rendering aid. During that ten-minute period, uniformed staff never performed chest compressions or CPR.”); *Id.* at 17 (“Multiple people in custody told DOC investigators that Mr. Johnson was not feeling well and that, for two days—including on the night before his death—he had asked DOC staff to take him to the clinic, but they ignored his pleas. A person in custody reported that a correction officer simply walked away after Mr. Johnson complained to that officer.”); *Id.* at 19 (“Mr.

perform rounds to monitor persons in their cells, finding “DOC’s failure to regularly check on the status of every person every thirty minutes (particularly at night) is a chronic and life-threatening issue.”⁶ Cell isolation is absolutely not an answer to staff mismanagement or staff incompetence, as it does not reduce the need for sufficient and adequate staff to perform rounds, check in on people’s safety and health, and respond to requests for medical care, including medical emergencies. Rather, isolating people in cells and out of view increases the likelihood that individuals’ need for immediate medical intervention will be unnoticed or ignored, with serious results.

Moreover, expanding the lock-in period to 17 hours each day will exacerbate the Department’s already dangerous inability to provide access to medical care in the jails. In May 2022, the Department was found to be in contempt of a December 2021 Court Order that it provide incarcerated people access to medical care. Judgment/Order, *Agnew v. New York City Department of Correction*, Index No. 813431/2021E (May 13, 2021, Sup. Ct. N.Y. Cty.) (Taylor, J.). This contempt finding was based in large part on departmental data that shows thousands of individuals are not taken to their medical appointments every month.⁷ A large percentage of these missed medical appointments are due to unavailable staff to escort people to the clinic or to get their medication. Despite DOC’s repeated representations that they have turned things around, the facts tell a different story: their own documents show 8,914 total missed appointments in July, and 9,269 missed in August.⁸ And these abysmal outcomes are occurring when individuals have freer access to a telephone for sick call than they will have with lockout time reduced in half.

We hear from our clients how difficult it can be to get the attention of housing area staff, especially when confined to a cell. It is even more difficult to convince that staff to take them seriously. This has serious, even fatal consequences.⁹ And many more persons will be unable to access care when it is dependent on an officer to escort them to the phone or to emergency care. Because the variance would double the hours confined to a cell, it would double the times when

Brown fell from his seat at 10:28 pm. People in custody tried to help one another, as multiple people slouched over and vomited. At approximately 10:33 pm, the ‘B’ post officer arrived in the housing area. Instead of rendering aid immediately or calling in an emergency, the correction officer stood by for four minutes, and watched as people in custody shook and patted Mr. Brown, trying to wake him.”)

⁶ BOC 2022 Death Report at 6-7.

⁷ DOC Monthly Medical Non-Production Reports, available at <https://www1.nyc.gov/site/doc/about/monthly-medical-reports.page>.

⁸ See Department of Correction, “Monthly Report on Medical Appointment Non-Production July 2022” at 2, available at https://www1.nyc.gov/assets/doc/downloads/pdf/Medical_July_2022.pdf; Department of Correction “Monthly Report on Medical Appointment Non-Production August 2022” at 2, available at https://www1.nyc.gov/assets/doc/downloads/pdf/Medical_August_2022.pdf.

⁹ See, e.g., BOC 2021 Death Report at 10-11 (documenting that incarcerated persons stated that Mr. Rodriguez repeatedly yelled, from the shower pen in which he was confined, “that he wanted to kill himself.” Mr. Rodriguez was confined to that shower cell for over 8 hours, before he was found inside the pen, “unresponsive, with a shirt tied around his neck and to the cuffing port,” Mr. Rodriguez was later pronounced dead.); *Id.* at 11 (Mr. Gualpa was seen engaged in a loud discussion inside the housing area because he “apparently [was] denied” access to a telephone. A few days later, after a period of several hours in which either no rounds were conducted at all and staff that did enter the housing area failed to “look inside the individual cells to verify that the people inside were alive and breathing,” he was found unresponsive in the shower pen. When medical staff pronounced him dead, his condition suggested that “he was deceased for some time before he was found.”).

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individuals are reliant on staff. The Department’s variance request shows that GRVC is, like most of the other jail facilities, under-staffed and under-supervised; increased lock-in time would significantly increase delayed and denied medical care for people confined there.

Outside of the medical care context, DOC has also shown it remains unable to provide incarcerated individuals with other basic, and often constitutionally mandated, jail services such as access to recreation, religious services, attorney visits, laundry services, and family visits. Narrowing the window in which all of these services must be provided from 14 hours to 7 hours per day is an impossible burden for a system that cannot even manage under the current regime. The predictable consequence of proceeding with a plan to significantly decrease out-of-cell time will be further deterioration of the basic jail services at GRVC.

A “seven hours out-of-cell” policy will not be seven hours in practice.

If the Department follows through on the plan sought in its variance request, “seven hours out-of-cell” will regularly fail to be seven hours for the people in GRVC general population. The Board need not even look outside GRVC to find compelling, recent evidence of that contention—consider Enhanced Supervision Housing (ESH), the units DOC already operates in that facility with a required “seven” hours out of cell. Just four months ago, during the June 14, 2022 Board public meeting, Board Member Jacqueline Sherman summarized the Board’s observations plainly: “based on the Board’s monitoring, the ESH units are not in compliance with BOC Minimum Standards for Enhanced Supervision Housing. Of utmost concern, as a few members have pointed out, it appears that people in custody are *routinely locked in in ESH units for 23 hours at a time*... People in custody are routinely *denied lockout time* and other than recreation and a shower, they are isolated for long periods of time.”¹⁰ Further, the Prisoners’ Rights Project hears frequent complaints that even recreation time is denied for days at a time and has recently heard this complaint from individuals in GRVC.

Board Member Dr. Robert Cohen noted during the June meeting that “there is no program staff” in the units, and that some “social work [staff] talk to people through the bars, through the space on the side of their cell doors,” after which Commissioner Molina confirmed that the Department was relying on cell-side programming for individuals in those units at that time.¹¹ Board Member Felipe Franco explained yet more concerns about access to required services like phones, saying, “all the units that we visited are struggling with phone access, particularly. In some of them the phones are not even available, they have to get phones with a cord to the cell.”¹²

Though DOC leadership has at various points claimed improvements to conditions in ESH—as we can expect them to do now—any improvements have been short-lived. Indeed, the Board itself

¹⁰ June 14, 2022 Public Meeting of the New York City Board of Correction, *available at* <https://www1.nyc.gov/site/boc/meetings/june-14-2022.page> (relevant segments beginning at 1:31:17, 1:35:09; emphasis added).

¹¹ June 14, 2022 Meeting, beginning at 1:45:21.

¹² June 14, 2022 Meeting, beginning at 1:46:39.

has reported that failures of this type have existed since the very inception of the ESH model. Issues identified by Board staff in those 2017 reports included:

- **Serious disruptions to medical and mental health access.** The Board found that in Young Adult ESH, “the Department did not produce 30% (n=14) of scheduled health encounters, and 23% (n=31) of scheduled mental health encounters.”¹³ The problem was prevalent for adults in ESH, too: “Nearly a quarter (24%, n=239) of all health encounters and 28% (n=1,016) of all mental health encounters for ESH patients were not seen due to either DOC non-production or CHS cancellations.”¹⁴
- **Failures to provide out-of-cell time.** Due to facility-wide and ESH area lockdowns, individuals in YA ESH had 39% fewer potential hours of out-of-cell time than the minimum hours required under ESH Minimum Standards.¹⁵ Adults had 12% fewer hours than the hours to which the Standards entitle them.¹⁶
- **Failures to provide recreation.** “Recreation is consistently understaffed, causing the recreation staff to have difficulty providing timely-daily recreation to each house.... [p]articipation in daily recreation is very low, with an average of only 20% of young adults participating.”¹⁷
- **Disruptions to programming.** Board staff also found in 2017 that in ESH—despite how central programming should have been in the model, considering that participation was required to advance between levels—“Board staff observations and DOC staff confirm[ed] there [were] frequent disruptions to programming while it [wa]s in session.”¹⁸

Another reason that out-of-cell time will almost certainly be routinely disrupted for people incarcerated at GRVC is the heightened number of tactical search operations being conducted at the facility. Indeed, the court-ordered Action Plan in *Nunez* requires a violence reduction plan, begun at RNDC, to be expanded to GRVC within 60 days of the Order, which was in mid-August.¹⁹ The violence reduction plan requires “increased searches and tactical search operations.”²⁰ These searches and operations pose serious disruptions to the housing units in which they are conducted and often take a significant period of time to complete. Those searches—and any incidents, alarms, escort failures, or other symptoms of the well-documented dysfunction in DOC—will diminish already restricted out-of-cell time.

¹³ An Assessment of Young Adult Enhanced Supervision Housing, New York City Board of Correction (April 2017), available at <https://www1.nyc.gov/assets/boc/downloads/pdf/Reports/BOC-Reports/2017.07.24%20-%20FINAL%20YA%20ESH%20Report%207.24.2017.pdf> (“Assessment of Young Adult ESH”) at p. x.

¹⁴ An Assessment of Enhanced Supervision Housing, New York City Board of Correction (April 2017), available at https://www1.nyc.gov/assets/boc/downloads/pdf/Reports/BOC-Reports/FINAL-BOC-ESH_Assessment-Adults-2017.04.26.pdf (“Assessment of ESH”) at p. viii.

¹⁵ Assessment of Young Adult ESH, p. x.

¹⁶ Assessment of ESH, p. ix.

¹⁷ Assessment of Young Adult ESH, p. x.

¹⁸ Assessment of Young Adult ESH, p. viii.

¹⁹ Order: Action Plan, *Nunez v. City of N.Y.*, No. 11-CV-5845 (June 14, 2022 S.D.N.Y.), Dkt. 465, § A.1.a-b.

²⁰ *Id.*

A seven-hour policy will not produce a seven-hour practice. The predictable result, therefore, of the Department taking this path is that the City will soon find itself squarely violating state law. Because the HALT Solitary Act mandates that incarcerated people receive a *full* seven hours of time out of cell each day—not eaten away with the predictable lock-ins that DOC will use—there is no room for the City to falter in implementing this lockdown plan. Yet falter they will, because they always have.

The Department’s reliance on *Nunez* is misplaced.

Finally, as *Nunez* counsel we must address the Department’s attempt to hide behind the *Nunez* monitor in seeking its now-withdrawn variance request. It is disingenuous for the Department to invoke the *Nunez* monitor here while disregarding the Monitor’s many strong and trenchant public recommendations about changes the Department must make to quell violence in GRVC.

As a threshold matter, the Monitor found in his most recent report that the Department was not following its own rules in ESH—which, again, allows for the same minimal lock-out time the Department wishes now to impose on the general population at GRVC.²¹ The Monitor reported that DOC had resorted to locking people in cells for *nearly the entire day*, and that “procedures to afford an opportunity for lock-out and protocols to ensure safety in the common areas were not being followed.”²² The Monitor also suggested that the Department did not yet have “detailed insight” into why lock-out procedures in ESH had failed thus far—i.e., the Department did not know how to fix the problems that resulted.²³

Moreover, none of the court-ordered relief in *Nunez* has required the Department to use a protracted scheme of isolation for general population units. But the Monitor reports have, with increasing urgency, recommended several other immediate and necessary changes the Department must make to reduce violence, such as: adequate staffing, increased ratios of supervising officers, and adherence to basic security protocols like locking doors and rounding.²⁴ Indeed, several requirements of the Action Plan are targeted at such failures.²⁵

It is thus misleading for the Department to suggest the *Nunez* monitor supports a variance, with no concomitant acknowledgement that the Monitor has also long insisted upon adequate staffing levels, increased supervisors in units, significant improvement in staff performance and mechanisms to ensure that rounding and robust programming. Those elements are part of the basic,

²¹ June 30, 2022 Monitor Report at 20-21.

²² *Id.*

²³ *Id.*

²⁴ See June 30, 2022 Monitor Report at 13-17 (describing a culture of violence and rampant basic security failures); *March 16, 2022 Special Report of the Independent Monitor, Nunez v. City of NY*, No. 11-CV-5845 (S.D.N.Y.), Dkt. 438, at 3-15 (describing ineptitude and poor deployment of supervisors, effect of inadequate staffing and poor security practices, and alarming violence indicators).

²⁵ See, e.g., Action Plan § A.1.d, requiring that the Department “immediately institute improved practices to ensure routing touring is occurring,” including an electronic accountability system, rather than relying on DOC staff’s historically untrustworthy representation in logbooks that rounding had been completed.

sound correctional practice to which the Monitor's recommendations have tried to elevate the Department over the course of many years. We have all seen that failing to implement those basic correctional practices is dangerous. And yet the Department's variance request did not address those concerns, but sought only to further isolate and restrict people in custody.

We urge you to confirm the Department's plans for compliance with Minimum Standard § 1-05(b) and use all mechanisms available to ensure compliance. We welcome the opportunity to discuss these matters further.

Regards,

/s/

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