NYC Department of Correction
Horizon Juvenile Center Dry Cells Audit Report – November 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 five (5) randomly selected dates, one (1) day for each week, during the month of November 2018:

- November 3rd
- November 9th
- November 15th
- November 20th
- November 28th

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. Subsequent audits 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 November 4, 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 November 4, 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, 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 – fourteen (14) residents
Hall 2 – five (5) residents
Hall 3 – three (3) residents
Hall 4 – eleven (11) residents
Hall 5 – seven (7) residents
Hall 6 – two (2) residents
Hall 7 – eleven (11) residents
Hall 8 – ten (10) residents
Hall 9 – four (4) residents
Hall 10 – fourteen (14) residents

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 Hall 6 and Hall 8.
- The "Notice to Residents" posters, notifying residents of the procedures for access to the bathrooms and drinking water, were posted in Hall 1, Hall 2, Hall 3, Hall 4, Hall 5, Hall 7, Hall 9 and Hall 10.

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 nine (9) of the ten

(10) halls: Hall 2, Hall 3, Hall 4, Hall 5, Hall 6, Hall 7, Hall 8, Hall 9 and Hall 10 for staff to reference. The memorandum was observed in Hall 1 only.

- Nine (9) of the ten (10) resident halls had an Overnight Response Logbook needed to properly document resident requests. One (1) hall, Hall 9, had a modified Overnight Response Logbook, discussed in the following section, that was not designed to record all required information.
- 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.

Modified Housing and Transfer Logbook/Overnight Response Logbook

Hall 9 did not have the standard Overnight Response Logbook on post. Instead of the standard Overnight Response Logbook, the hall had a modified "Housing and Transfer Logbook." Four (4) of the column headings in this modified logbook had been crossed out and replaced with column headings taken from the Overnight Response Logbook. The modified logbook included the following column headings:

- Day
- Date
- Room # (replaced the column entitled "Military Time")
- Inmate Name
- Book and Case
- Light Indicator Time (replaced the column entitled "Transfer Out")
- Bathroom Request (replaced the column entitled "Bed Cell Loc.")
- Water Request (replaced the column entitled "Transfer In")
- Housing Officer Initials/Shield
- Supervisor Sign

The modified Housing and Transfer Logbook did not include the following column headings, which appear in the standard Overnight Response Logbook:

- Time Afforded
- Remarks

The absence of columns entitled "Time Afforded" and "Remarks" resulted in a logbook format that is not sufficient for auditors to assess whether staff in the Hall 9 provided residents access to the bathrooms and drinking water within five (5) minutes of the request, absent extenuating circumstances. 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.

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.

November 3rd

On this audit date, in three (3) of the halls, Hall 2, Hall 8, and Hall 10, 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.

Logbooks Not Operationalized

On this audit date, a properly formatted, standardized Overnight Response Logbook was not located in Hall 9. As a result, on this audit date, this hall was not in compliance with the variance condition requirement that documentation be maintained relative to all bathroom and drinking water requests.

Incomplete Logbook Recording

Through the audit process, incomplete logbook recordings were noted in one (1) halls' Overnight Response Logbook. In Hall 4's logbook, on one (1) occasion, the "Light Indicator Time," which represents the time the resident made the request, was not recorded. As a result, it could not be determined whether the resident's request for bathroom access and drinking water was met within five (5) minutes.

While not violations of the variance conditions, on one (1) occasion in Hall 1's logbook, the logbook entry did not record the "Staff Member/Shield #," and in Hall 7's logbook, on one (1) occasion the logbook entry did not record the "Date." In addition, in Hall 6's logbooks, the names and/or initials of supervisors, which document their reviews of the officers' logbook entries, were not recorded.

While an Overnight Response Logbook was located in Hall 3 and 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 these halls. Entries related to change of tour were recorded in the logbooks 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 5's Overnight Response Logbook, on two (2) occasions requests to access drinking water exceeded five (5) minutes: one (1) request was granted in less than ten (10) minutes and one (1) request was granted in less than twenty (20) minutes. In each of the above instances, 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.

November 9th

On this audit date, in seven (7) of the halls, Hall 1, Hall 4, Hall 5, Hall 6, Hall 7, Hall 8, and Hall 10, 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 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 2's logbook, on five (5) occasions, and in Hall 9's logbook, on four (4) occasions, the "Light Indicator Time," which represents the time the resident made the request, was not recorded. As a result, it could not be determined whether access to the bathrooms and/or drinking water was provided within five (5) minutes.

While not a violation of the variance conditions, in Hall 3's logbook, the names and/or initials of supervisors, which document their reviews of the officers' logbook entries, were not recorded.

November 15th

On this audit date, in six (6) of the halls, Hall 2, Hall 3, Hall 4, Hall 5, Hall 7, and Hall 8, 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 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 one (1) occasion, 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. As a result, it could not be determined whether access to the bathrooms and/or drinking water was provided within five (5) minutes.

While not violations of the variance conditions, in Hall 6's logbook, the names and/or initials of supervisors, which document their reviews of the officers' logbook entries, were not recorded. In addition, in Hall 9's logbook, on one (1) occasion, the logbook entry did not record the "Date" and the "Room #." Furthermore, in Hall 10's logbook, on two (2) occasions the logbook entries did not record the "Staff Member/Shield #."

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, "Waiting for other residents to lock-in" was recorded.

November 20th

On this audit date, in six (6) of the halls, Hall 2, Hall 6, Hall 7, Hall 8, Hall 9 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

While not violations of the variance conditions, in Hall 1's logbook, on one (1) occasion, the logbook entry did not record the "Room #." In Hall 3's logbook, on four (4) occasions, the logbook entry did not record the "Date" and "Room #." In Hall 4's logbook, on one (1) occasion, the logbook entry did not record the "Book and Case #."

While an Overnight Response Logbook was located in Hall 5, no entries related to requests for access to bathrooms and/or drinking water were recorded had been recorded on this audit date and, as a result, it could not be determined through a logbook review whether any residents requested access to the bathrooms and/or drinking water 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 3'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 ten (10) minutes. In the same hall's logbook, on one (1) occasion fulfilling the request to access drinking water exceeded five (5) minutes and was granted in less

than ten (10) minutes. In each of the above instances, 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.

November 28th

On this audit date, in two (2) of the halls, Hall 6 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 Recordings and/or No Logbook Entry

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

While not violations of the variance conditions, in Hall 3's logbook, on one (1) occasion, the logbook entry did not record the "Room #." In Hall 5's logbook, on four (4) occasions the logbook entry did not record the "Date." In addition, in Hall 8's logbook, on three (3) occasions, the logbook entry did not record the "Room #."

Although an Overnight Response Logbook was located in Hall 9, no entries had been recorded on this audit date and, as a result, it could not be determined through a logbook review whether any request for access to the bathroom and/or drinking water was made in this hall. Entries related to change of tour were recorded in the logbooks 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 a request to access the bathroom exceeded five (5) minutes and was granted in less than twenty (20) minutes. In the same hall's logbook, on one (1) occasion a request to access drinking water exceeded five (5) minutes and was granted in less than twenty (20) minutes. In addition, in Hall 7's Overnight Response Logbook, on one (1) occasion a request to access the bathroom exceeded five (5) minutes and was granted in less than ten (10) minutes. On each of the above occasions, due to incomplete logbook recording, no entries

were recorded in the "Remarks;" therefore the circumstances that resulted in the delayed response time could not be determined.

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. Through this second audit, several issues were again 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, facility administration confirmed 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.[3]
  - A logbook entry must be recorded when no residents request access to the bathrooms and/or drinking water during a particular overnight period.
- 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.

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

- 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 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 following recommendations for corrective action should be instituted and incorporated into the Programs Memorandum:

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 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.

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

- The 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.