



**Commission of
Correction**

THE WORST OFFENDERS

**REPORT: THE MOST PROBLEMATIC
LOCAL CORRECTIONAL FACILITIES
OF NEW YORK STATE**

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CONTENTS

Executive Summary 1

Rikers Island Facilities 3

 Facilities Overview 4

 Commission Evaluations of DOC Facilities 6

 2016 Individual Facility Evaluations 6

 DOC Response to 2016 SCOC Evaluations 15

 2017 Individual Facility Evaluations 15

 Department-wide Compliance Issues 23

 Commission-issued Directives 26

 Reported Significant Facility Incidents 29

 Inmate Mortality Investigation Findings 33

 Sanitation and Physical Plant Conditions 40

Greene County Jail 45

 Facility Overview 45

 Physical Plant Conditions 45

 Facility Staffing Deficiencies 46

 Variances and Facility Construction 46

 2016 Facility Evaluation 47

 2017 Facility Evaluation 49

 Commission-issued Directives and Enforcement 50

 Reported Significant Facility Incidents 53

Erie County Holding Center and Correctional Facility 54

 Facility Overview 54

 Facility Staffing Deficiencies 54

 Commission Special Investigations 54

 Inmate Mortality Investigations 55

 2016 Facility Evaluation 57

 2017 Facility Evaluation 58

Commission-issued Directives and Enforcement	59
Reported Significant Facility Incidents	60
Dutchess County Jail	61
Facility Overview	61
Inmate Overcrowding Management	61
Inmate Mortality Investigations	61
Attorney General Inquiry – Correctional Medical Care, Inc.	62
2016 Facility Evaluation	63
2017 Facility Evaluation	63
Reported Significant Facility Incidents	64
Onondaga County Justice Center and Penitentiary	65
Facility Overview	65
Facility Staffing Deficiencies	66
Inmate Overcrowding Management	66
2016 Facility Evaluation	67
2017 Facility Evaluation	67
Civil Rights Litigation	68
Commission-issued Directives and Enforcement	69
Reported Significant Facility Incidents	70

EXECUTIVE SUMMARY

The State of New York operates a criminal correctional system comprised of two main components. At the local level, counties and the City of New York are charged with the duty to maintain and administer jails under the regulation and supervision of the State. These jails are operated by local governments and are primarily responsible for holding individuals pending adjudication, or sentenced to imprisonment for one year or less. At the state level, New York State operates a prison system, which is responsible for long-term institutionalization and rehabilitation – for sentences in excess of one year – and is under the authority of the State Department of Corrections and Community Supervision.

Pursuant to both the Eighth Amendment to the United States Constitution as well as Article I, Section Five of the New York State Constitution, the imposition of cruel and unusual punishment is strictly outlawed. While individuals housed within correctional facilities have either been charged with, or convicted of, committing a crime, we as a State must ensure that our actions do not violate the basic rights of these individuals. The State Commission of Correction (the Commission), is legally charged to regulate, supervise, and inspect the operation of local jails to ensure and enforce compliance with state law. The Commission was established by Article 17, section 5 of the New York State Constitution, and its functions, powers and duties are set forth in Article 3 of the New York State Correction Law. The general powers of the Commission include establishing minimum standards for the safe and proper operation of local jails and the inspection and enforcement of local facilities to ensure that facilities are meeting all legal requirements.

The Commission regulates the construction and improvement of local facilities, the care, custody, correction, treatment, supervision, discipline, health standards, staffing, staff behavior, staffing discipline, and related matters of all local facilities. The Commission is legally empowered to advise local facilities of any legal or regulatory violations and require remedial actions to correct any such violations. The Commission is also empowered to close local facilities deemed out of legal compliance. The Commission is empowered to do on-site inspections and to interview any administrators, staff, or inmates in said facilities. Local facilities must grant the Commission and its employees access, at any and all times, to any facility, including to all books, records, inmate medical records, or data that the Commission deems necessary.

The Commission is empowered to issue and enforce subpoenas and subpoenas *duces tecum*, administer oaths, and examine persons under oath. A person examined under oath has the right to be accompanied by counsel subject to reasonable limitations to prevent obstruction of, or interference with, the orderly conduct of the examination. The Commission, by its Correctional Medical Review Board, is also charged with examining the death of any inmate in any local facility, and may interview any facility employee or inmate in connection with that death, including members of the deceased inmate's family.

Where non-compliance with a statute or regulation is discovered, the Commission is legally empowered to direct a local facility to achieve compliance and, when necessary, may thereafter seek a judicial order for compliance in the New York State Supreme Court. The Commission may close any facility which is unsafe, unsanitary, or which is not compliant with the rules and regulations promulgated by the Commission. The Commission is also empowered

to make recommendations and reports to the Governor of the State of New York when it deems appropriate.

Findings

The Commission has conducted extensive on-site inspections, interviews, and investigations on a number of local facilities. Several facilities have been found out of compliance more than once, thus endangering the health and safety of inmates and staff members. The Commission has issued numerous corrective action directives and provided staff to closely monitor and assist with the implementation of said corrective action plans. However, despite the Commission's best efforts, some facilities still fail to meet minimum legal requirements for safe operation.

The Commission now issues this report on the five local jails that are deemed the "worst offenders" for being in violation of state law. These facilities pose an ongoing risk to the health and safety of staff and inmates and, in instances, impose cruel and inhumane treatment of inmates in violation of their Constitutional rights. Included in this report are synopses of evaluative determinations of non-compliance with state law and regulations, a description of Commission enforcement efforts, a brief analysis of significant facility incidents reported by the various facilities to the Commission, summaries of Commission investigative report findings regarding inmate mortalities, and an account of the sanitation and physical plant conditions afflicting the facilities.

The five local facilities determined as "worst offenders," after years of review, are: the New York City Rikers Island Facilities, the Greene County Jail, the Erie County Holding Center/Correctional Facility, the Dutchess County Jail and the Onondaga County Justice Center/Penitentiary.

RIKERS ISLAND FACILITIES

Rikers Island continues to be plagued by managerial failures, significant structural problems, regulatory compliance failures, identified deficiencies that remain unaddressed, and unabated harm to both staff and inmates alike. The Commission has sought to assist Rikers management in addressing these and many other deficiencies, and facilitate improvements, but those efforts have not been successful, further highlighting the need for closure of all jail facilities located on Rikers Island.

Following the August 2014 report of the United States Attorney's Office for the Southern District of New York into the treatment of adolescent male inmates on Rikers Island, the Commission dedicated additional resources to its oversight of the DOC. Additional staff were assigned to conduct comprehensive annual evaluations of DOC facility compliance with Commission regulations, and also to assist with the investigation of every inmate mortality, as conducted by the Commission's Medical Review Board. In collaboration with the New York State Office of Information Technology Services (ITS), the Commission developed a system for the reporting of significant incidents in local correctional facilities, including DOC facilities, *via* the eJusticeNY Integrated Justice Portal. Lastly, a team of Commission staff were deployed in March 2017 to conduct a three-day intensive tour of all facilities on Rikers Island to evaluate sanitation and physical plant deficiencies.

This comprehensive report's irrefutable facts make clear what is aptly described as a deeply disturbing and discouraging situation. First, the evaluations of Rikers Island reveal extensive and systemic non-compliance with fundamental and compulsory regulations intended to provide for a safe, stable and humane correctional system. Second, the DOC has demonstrated both an unwillingness and inability to take necessary actions to remedy identified violations, often concerning facility safety and security.

Despite having less than half of the inmate population confined in county jails throughout the State, the number of reported significant incidents for Rikers Island is generally far greater, markedly so with regard to violent incidents, such as assaults, sex offenses and facility disturbances. Possibly most concerning is that the number of such reported incidents has, for most significant categories, increased from 2016 to 2017; this despite the enormous amount of attention that is focused upon the island facilities. A review of inmate mortality cases includes numerous instances where a death was attributable to deficient medical care, substandard mental health services, or inadequate custody and supervision by security staff. Comprehensive physical plant evaluations of the Rikers Island facilities have exposed conditions that are unsecure, unsanitary and dangerous, for staff and inmates alike. Rikers Island is, and has been, violating essential constitutional protections and State laws. There is no Rikers Island closure plan that is legally binding on future city administrations nor is there a proposed timetable that is reasonable considering the length, seriousness and spiraling year to year increase of violent incidents and degrading conditions facing both inmates and staff.

Consequently, given the City's inaction and protracted 10-year proposal, it is now time for the Commission to examine steps to expeditiously close Rikers and to ensure that the constitutional rights of inmates and staff are protected. The New York City jail system must be brought into compliance with the laws, guarantees, and protections provided by the Federal and State constitutions.

FACILITIES OVERVIEW

Anna M. Kross Center (AMKC)

Description: Opened in 1978, AMKC houses male detainees in 78 housing areas spread over 40 acres.

Cells: 984 cells

Dorms: 656 beds

Modular (combination cells and dorms): 936

Total capacity: 2,576

12/1/17 population: 1,991 (unsentenced males)

Eric M. Taylor Center (EMTC)

Description: Opened in 1964 and expanded in 1973, was previously designated the Correctional Institution for Men.

Cells: 136 cells

Dorms: 1,468 beds

Total capacity: 1,604

12/1/17 population: 1,230 (males, predominantly sentenced)

George Motchan Detention Center (GMDC)

Description: Opened in 1971 as the Correctional Institution for Women with a capacity of 679, GMDC later became a male detention center.

Cells: 912 cells

Dorms (Modular): 659 beds

Total capacity: 1,571

12/1/17 population: 634 (males, predominantly unsentenced)

George R. Vierno Center (GRVC)

Description: Opened in 1991 as an 850-bed facility for male detainees. A 500-bed addition opened at GRVC in 1993.

Cells: 853 cells

Dorms: 376 beds

Total capacity: 1,229

12/1/17 population: 687 (unsentenced males)

North Infirmary Command (NIC)

Description: Opened in 1932, NIC consists of two infirmary buildings, one of them the original Rikers Island Hospital. The main facility has 281 beds, 84 cells and 197 beds in dorms. The Annex, converted to housing in mid-1980, has 5 cells and 153 dorm beds for housing infirmary care inmates. A 39-bed dorm was closed by the Commission in December 2016 due to inadequate living conditions.

Cells: 89 cells

Dorms: 350 beds

Total capacity: 439

12/1/17 population: 244 (sentenced and unsentenced males)

Otis Bantum Correctional Center (OBCC)

Description: Opened in 1985, OBCC includes the Department's 400-bed Central Punitive Segregation Unit.

Cells: 750 cells

Dorms: 950 beds

Total capacity: 1,700
12/1/17 population: 955 (unsentenced males)

Rose M. Singer Center (RMSC)

Description: Opened in 1988 as an 800 bed facility for female detainees and sentenced inmates. A 650 bed addition opened at RMSC in 1995 increased capacity to its present level.

Cells: 470 cells

Dorms: 978 beds

Total capacity: 1,448

12/1/17 population: 603 (all females, including minors)

Robert N. Davoren Center (RNDC)

Description: Opened in 1972, formerly Adolescent Reception and Detention Center, RNDC houses adolescent male detainees (ages 16-17) and adult male detainees.

Cells: 1,184 cells

Dorms: 50 beds

Modular (dorms): 700

Total capacity: 1,934

12/1/17 population: 663 (minor males and unsentenced adult males)

West Facility (West)

Description: Opened in 1991, as a 940-bed facility constructed of 12 Sprung-rigid aluminum framed structures covered by a heavy-duty plastic fabric. Part of the West Facility was converted into the DOC's Contagious Disease Unit (CDU) center in which 140 air-controlled housing units are reserved for male and female inmates with contagious diseases, such as tuberculosis. Reduced to 98 operational cells inside the sprung, the remaining sprung were converted to Central Intake in 2014, but closed a few months later.

Cells: 98 cells

Total capacity: 98

12/1/17 population: 47 (unsentenced males)

COMMISSION EVALUATIONS OF DOC FACILITIES

Pursuant to its authority set forth in Article 3 of the New York State Correction Law, the Commission has promulgated minimum standard regulations for the management of correctional facilities throughout the state. Contained in Chapter I of Subtitle AA of Title 9 of the New York Codes, Rules and Regulations (NYCRR), the regulations applicable to county jails and the New York City Department of Correction consist of 34 separate Parts, each of which provides regulations relevant to a particular subject matter (i.e. security and supervision, inmate visitation, legal services, etc.).

Historically, the Commission has conducted annual, comprehensive evaluations of each county jail. To ensure that every regulation is periodically examined at every local correctional facility, the Commission utilizes a cycle evaluation schedule, whereby 10 or 11 regulation Parts are evaluated at every facility in a given year. Thus, in a four (4) year span, every regulation is evaluated at least once, with the most critical regulations being evaluated on a biennial basis. Depending on the size of a facility, on-site assessment by Commission staff can typically last from 3 to 10 days, including entrance and exit interviews with facility administration. Thereafter, a written evaluation is prepared and issued by the Commission, setting forth all findings of facility non-compliance with Commission regulations, actions required of a facility to achieve compliance, and requiring a written response from the facility within 45 days. Following receipt of a local correctional facility's evaluation response, Commission staff will verify all remedial actions taken by a facility during a subsequent on-site inspection, or during the next year's scheduled cycle evaluation.

As part of its decision to dedicate additional resources to its oversight of the DOC, the Commission assigned staff necessary to conduct annual evaluations of DOC facilities, including those on Rikers Island, pursuant to the four (4) year cycle evaluation schedule, beginning in calendar year 2016. Listed below are brief summaries of the deficiencies more comprehensively listed in the Commission's written evaluation reports of DOC's Rikers Island facilities.

2016 INDIVIDUAL FACILITY EVALUATIONS

AMKC – Report issued 3/7/17

Part 7003 - Security and Supervision

- **Active Supervision:** The facility is not maintaining an active security post in units having more than 20 prisoners.
- **Supervision of Prisoners in Facility Housing Areas:**
 - a. The facility not consistently using mechanical or electrical time recording devices as required.
 - b. Constant supervision prisoners being supervised by officers of opposite gender.
- **Supervision of Prisoners outside of Facility Housing Areas:** Prisoners were observed moving through hallways unsupervised.
- **Prisoner Population Counts:**
 - a. Census verification forms have inaccurate reporting of inmates.

- b. Population counts not immediately forwarded to the Chief Administrative Officer and did not consistently document the time of review.
- **Firearms Control:** There is a lack of documentation to substantiate the facility was conducting required inspections of all personal firearms staff are authorized to use during the performance of their official duties.
- **Key Control:**
 - a. Sub-control room doors found to be left unsecured.
 - b. Issuance and return of facility keys not consistently documented in logbook. Food service and exterior dock keys not logged out.

Part 7006 - Discipline

- **Policy:** The Department's policy is inconsistent with the inmate rulebook, which is causing confusion among staff and inmates.
- **Disciplinary Sanction:** Facility policies and procedures incorrectly state that exercise can be taken as a disciplinary sanction.

Part 7008 - Visitation

- **Visitation Security and Supervision:** Facility was unable to demonstrate the completion of required visitation room searches prior and subsequent to each visitation period.

Part 7009 - Food Service

- **Policy:** Food carts and food warmers had buildup of food items from previous meal.

Part 7015 - Sanitation

- **General Facility Sanitation:** The facility had numerous areas where leaks were discovered. Due to the water leaks walls and ceilings were damaged. Peeling paint, walls with rust and holes in walls and ceilings were discovered.
- **General Facility Sanitation:** Prisoners cells found in disarray. Prisoners are not required to maintain their cells in a clean and sanitary manner.

Part 7063 - Chemical Agents

- **Use of Chemical Agent:** Facility could not demonstrate that health service staff are trained in the treatment of persons exposed to chemical agents.
- **Training in the use of Chemical Agent:** Chemical agents were being issued to staff whose training certification has expired.

EMTC – Report issued 12/14/16

Part 7003 - Security and Supervision

- **Supervision of Prisoners in Facility Housing Areas:** The facility has no functioning mechanical or electrical time recording devices.
- **Prisoner Population Counts:** Population counts take over 1.5 hours to clear. Individual prisoner counts phoned into control are not matching submitted count sheets.

- **Firearms Control:** There is a lack of documentation to substantiate the facility was conducting required inspections of all personal firearms staff authorized to use during the performance of their official duties.

Part 7006 - Discipline

- **Misbehavior Report:** The facility is not recording the time the report was written and they are not documenting that the prisoner received a copy of the report
- **Disciplinary Hearing:** The facility could not demonstrate that prisoners are receiving a copy of hearing dispositions.

Part 7007 – Good Behavior Allowances

- **Policy:** The Department was unable to demonstrate they were explaining good behavior allowance to the prisoners.

Part 7015 - Sanitation

- **General Facility Sanitation:** Prisoners cells cluttered and in disarray. Prisoners are not required to maintain cells in a sanitary condition.

Part 7063 - Chemical Agents

- **Training in the use of Chemical Agent:** Chemical agents issued to staff whose training certification has expired.

GMDC – Report issued 10/6/16

Part 7003 - Security and Supervision

- **Supervision of Prisoners in Facility Housing Areas:** The facility still has housing areas with no mechanical or electrical time recording devices.
- **Constant Supervision:** Appropriate documentation is not being maintained when *constant supervision* is ordered. Constant supervision records are documented on individual sheets with pre-established times which is inconsistent with NYS Minimum Standards.
- **Supervision of Prisoners Outside Facility Housing Areas:** Inmates were permitted to move throughout the facility hallways unsupervised.
- **Prisoner Population Counts:** The facility approves the inmate final population count without accounting for all housing area count slips. This is an improper accounting of the inmate population and can lead to a delay in responding to an escape or emergency situation.
- **Firearms Control:** There is a lack of documentation to substantiate the facility was conducting required inspections of all facility firearms.
- **Locks and Other Securing Devices:** The facility is not conducting inspections of all locks and securing devices at intervals outlined by NYS Minimum Standards to ensure they are working properly. Housing areas temporarily closed are not being assessed to ensure that all the locks and securing devices are in proper working order.

Part 7006 - Discipline

- **Policy:** The Department's policy is inconsistent with the inmate rulebook and is causing confusion among inmates and staff.

Part 7007 – Good Behavior Allowances

- **Policy:** The Department was unable to demonstrate they were explaining what good behavior allowance was and appropriate inmate outdates.

Part 7009 – Food Service

- **Sanitation:** Kitchen staff and inmates were not wearing hair nets during meal preparation.

Part 7015 - Sanitation

- **Housing Units:** Individual inmate cells were found to be in disarray and in many cases, in unsanitary conditions.

Part 7063 - Chemical Agents

- **Training:** The Department is issuing Chemical agents to officers whose training certification has expired.

GRVC – Report issued 12/14/16

Part 7003 - Security and Supervision

- **Supervision of Prisoners in Facility Housing Areas:**
 - a. The facility is not using mechanical or electrical time recording devices as required.
 - b. Order for additional supervision is not recorded in housing unit logbooks. Significant events are also not recorded in the logbooks.
- **Prisoner Population Counts:**
 - a. Population counts submitted are not signed by the staff completing the count.
 - b. Population counts are frequently conducted by line staff and not verified and/or reviewed by the Chief Administrative Officer.
- **Requirements of Staff:** When staff are on a post for more than one-hour they are not documenting required information in the housing area logbooks.
- **Firearms Control:** The facility was unable to demonstrate that they are conducting required inspections of all firearms.
- **Key Control:** Facility keys are not consistently logged in and out of logbook.
- **Locks and other Securing Devices:** The facility is not completing lock inspections of all areas of the facility.

Part 7006 - Discipline

- **Policy:** The Department's policy is inconsistent with the inmate rulebook and is causing confusion among inmates and staff.
- **Administrative Segregation:** The facility was unable to demonstrate that all prisoners are receiving a copy of their pre-hearing detention. The facility could not demonstrate that the Chief Administrative Officer is consistently reviewing the administrative segregation orders within 24-hours of confinement.

- **Disciplinary Sanction:** Facility policies and procedures incorrectly state exercise can be taken as a disciplinary sanction.

Part 7008 - Visitation

- **Limitation of Visits:** Visitors and inmates were not notified in writing when they were turned away from a visit.

Part 7015 - Sanitation

- **General Facility Sanitation:** Prisoners cells found in disarray. Common areas such as the hallways, elevators and sally ports were dirty and not consistently cleaned or maintained.

Part 7063 - Chemical Agents

- **Training in the use of Chemical Agent:** Chemical agents issued to staff whose training certification has expired

NIC – Report issued 12/14/16

Part 7003 - Security and Supervision

- **Supervision on prisoners in Facility Housing Areas:**
 - a. There are no housing areas that have functioning mechanical or electrical time recording devices.
 - b. The facility was not consistently documenting in area logbooks when prisoners enter or exit the housing area.
 - c. Facility staff not logging when prisoners exit or return to housing units.
- **Firearms Control:**
 - a. Personal weapons used in the performance of staff's official duties were not inspected.
 - b. Chemical agents are being issued to officers whose chemical agent training certification had expired.

Part 7006 - Discipline

- **Misbehavior Report:** Notice of Infraction did not contain a signature of the prisoner acknowledging that they received a copy of the misbehavior report.
- **Assistance to Inmates:** DOC form states that prisoners will only receive assistance with their hearing if the Adjudication Captain deems it necessary. Such practice is unacceptable.
- **Disciplinary Hearing:** Prisoners not signing that they received a copy of their hearing disposition.

Part 7007 - Good Behavior Allowances

- **Record Keeping & Regulations:** The facility was unable to demonstrate that facility staff fully explained the meaning of Good Behavior Allowances to prisoners and that prisoners acknowledge in writing that the explanation was provided.

Part 7015 - Sanitation

- **General Facility Sanitation:**
 - a. Housing areas cluttered with prisoner property.

- b. Prisoners not required to maintain housing areas in a clean and sanitary condition.
- c. Leaks in the ceiling of the visitation area.
- d. Dorm 3 flooded with approximately six (6) inches of water. SCOC required the relocation of all inmates in Dorm 3.
- e. SCOC ordered the closure of Dorm 3.
- f. The department has yet to request the reopening of Dorm 3

Part 7063 - Chemical Agents

- **Training in The Use of Chemical Agents:** Chemical agents were being issued to officers whose chemical agent training certification had expired.

OBCC – Report issued 8/3/16

Part 7003 - Security and Supervision

- **Active Supervision:** The facility is not consistently a staff post in housing areas containing more than 20 prisoners.
- **Supervision of prisoners in facility housing areas:** There are no housing areas that have functioning mechanical or electrical time recording devices.
- **Population Counts:** Population count sheets are not signed by officers completing the count. A count was observed that took over an hour to clear. Count slips called in did not match the inmate totals on submitted count sheets.
- **Firearms Control:** Staff did not consistently record the date and time an issued firearm and ammunition was returned. It was also found that personal weapons used in the performance of staff's official duties were not inspected. Chemical agents are being issued to officers whose chemical agent training certification had expired.
- **Key Control:** An intake area key box was broken and unsecured. Keys were not consistently logged in and out of logbook. Staff maintained keys that could provide inmates a means of egress from the facility.

Part 7006 - Discipline

- **Rules of Inmate Conduct:** The rules of inmate conduct concerning disciplinary sanctions differ from the facility's directive. Different infractions are listed for the same violations.
- **Administrative Segregation Pending a Hearing:** The facility is not consistently providing written notice to prisoners within 24 hours of their confinement. The facility Chief Administrative Officer is not consistently reviewing administrative segregation orders within 24 hours.
- **Disciplinary Hearing:** Prisoner hearings were adjourned for several months with no further documentation or follow-up.
- **Appeal Procedures:** Prisoners are not consistently being notified in writing of the results of their appeals.

Part 7007 - Good Behavior Allowances

- **Record Keeping & Regulations:** The facility was unable to demonstrate that facility staff fully explained the meaning of Good Behavior Allowances to prisoners and that prisoners acknowledge in writing that the explanation was provided.

Part 7008 - Visitation

- **Limitation of Visits:** The facility has a blanket policy whereby prisoners are placed on all non-contact visits due to potential visitors being found with contraband. Visitors being turned away from a visit are not provided an explanation in writing as to why visit was denied.

Part 7015 - Sanitation

- **General Facility Sanitation:** Food service areas had dirt and rust spots on ceiling and debris on floors.

Part 7063 - Chemical Agents

- **Use of Chemical Agents:** The facility was unable to demonstrate that all health service staff are trained in the treatment of persons exposed to chemical agents.
- **Training in The Use of Chemical Agents:** Chemical agents were being issued to officers whose chemical agent training certification had expired.

RMSC – Report issued 9/21/16

Part 7003 - Security and Supervision

- **Active Supervision:** The facility is not consistently maintaining an active officer post in housing areas containing more than 20 prisoners.
- **Supervision of prisoners in facility housing areas:**
 - a. There are no housing areas that have functioning mechanical or electrical time recording devices.
 - b. The facility was not consistently documenting in area logbooks when prisoners enter or exit the housing area.
- **Population Counts:** A count was observed that took over two hours to clear. Count slips called into control did not match the inmate totals on submitted count sheets.
- **Firearm Control:** Personal weapons used in the performance of staff's official duties were not inspected. Chemical agents are being issued to officers whose chemical agent training certification had expired.
- **Key Control:** Facility not consistently documenting the date/time of returned keys in the key log book.

Part 7006 - Discipline

- **Misbehavior Report:** Notice of Infraction did not contain a signature of the prisoner acknowledging that they received a copy of the misbehavior report.
- **Assistance to Inmates:** DOC form states that prisoners will only receive assistance with their hearing if the Adjudication Captain deems it necessary. Such practice is unacceptable.

Part 7007 - Good Behavior Allowances

- **Record Keeping & Regulations:** The facility was unable to substantiate that facility staff fully explained the meaning of Good Behavior Allowances to prisoners and that prisoners acknowledge in writing that the explanation was provided.

Part 7015 - Sanitation

- **General Facility Sanitation:** Prisoners cells found in disarray. Prisoners are not required to maintain their cell in a clean and sanitary manner.

Part 7063 - Chemical Agents

- **Training in The Use of Chemical Agents:** Chemical agents were being issued to officers whose chemical agent training certification had expired.
- **Storage and Maintenance of Chemical Agents:** The facility chemical agent inventory sheet was outdated and did not reflect the equipment being stored within the facility.

RNDC – Report issued 3/7/17

Part 7003 - Security and Supervision

- **Policy:** Secured cell doors can be popped open by prisoners.
- **Supervision of Prisoners in Facility Housing Areas:** The facility is not consistently using mechanical time recording devices and also has defective equipment in need of repair.
- **Constant Supervision:**
 - a. Prisoners on constant observation being supervised by officers of opposite gender.
 - b. Appropriate documentation is not being maintained when constant supervision is ordered.
- **Prisoner Population Counts:** submitted prisoner population count sheets had an inaccurate reporting of prisoners assigned to housing areas.
- **Prisoner Population Counts:** Population counts are not immediately verified and signed by the Chief Administrative Officer.
- **Firearms Control:** There is a lack of documentation to substantiate the facility was conducting required inspections of all personal firearms staff are authorized to use during the performance of their official duties.
- **Key Control:** Keys not properly logged in and out in the key control logbook.

Part 7006 - Discipline

- **Policy:** The Department's policy is inconsistent with the inmate rulebook and is causing confusion among inmates and staff.
- **Disciplinary Hearing:** Policy allows the facility to limit exercise as a disciplinary sanction. This is unacceptable.

Part 7007 – Good Behavior Allowances

- **Policy:** The Department was unable to demonstrate they were explaining good behavior allowance to the prisoners.

Part 7008 - Visitation

- **Visitation Security and Supervision:** The department was unable to demonstrate the completion of visit room searches prior and subsequent to each visitation period.

Part 7009 – Food Service

- **Medical and Religious Diets:** Facility policies do not ensure prisoners are provided with medical and religious diets.

Part 7015 - Sanitation

- **General Facility Sanitation:**

- a. Leaks are occurring throughout the facility.
- b. Walls and ceilings are rusting due to water leaks.
- c. Prisoner cells are cluttered and in disarray.
- d. Prisoners not required to maintain cells in a sanitary condition.

Part 7063 - Chemical Agents

- **Use of Chemical Agents:** Facility was unable to demonstrate that medical staff are properly trained in treatment of those exposed to chemical agents.

WEST – Report issued 9/27/16

Part 7003 - Security and Supervision

- **Supervision of Prisoners in Facility Housing Areas:** The facility does not have functioning mechanical or electrical time recording devices.
- **Firearm Inspections:** Firearm inspections did not include the inspection of personal firearms allowed to be carried in the performance of officers' official duties.
- **Key Control:** Key control cabinet contained keys no longer in use and keys in which staff could not identify. Key log does not consistently document when keys are returned.
- **Locks and other Securing Devices:** The facility was unable to demonstrate the completion of inspections conducted on all locks and securing devices.

Part 7006 - Discipline

- **Misbehavior Report:** The facility could not demonstrate that prisoners are signing for a copy of their misbehavior report. Therefore, there is no evidence that they are receiving a copy of the report.
- **Assistance to Inmates:** Facility Correction Form 6500a states that prisoners have a right to assistance with a hearing only if the adjudication Captain deems is necessary. This practice is unacceptable.
- **Disciplinary Hearing:** The facility hearing form contains no signature acknowledgement from a prisoner that they have received a copy of the misbehavior report.

Part 7015 - Sanitation

- **General Facility Sanitation:** Water leaks were found in numerous areas. The roofs appear to have been leaking for an extended period of time, resulting in damage to the walls and floors. Commission staff also found cluttered areas which pose a fire hazard, especially considering the facility's fire alarm system is inoperable.

Part 7063 - Chemical Agents

- **Chemical Agent Inspections:** Unable to demonstrate the completion of required Chemical Agent inspections.

DOC RESPONSE TO 2016 SCOC EVALUATIONS

Each of the Commission's on-site evaluations of DOC's Rikers Island facilities were conducted during calendar year 2016, as were the issuance of the resulting evaluation report, except for the reports for AMKC and RNDC, each of which were issued on March 7, 2017. Although the Commission requested timely written responses to each evaluation report (generally within 45-90 days from the date of the report), the majority of DOC's written responses were not received by the Commission until late June 2017. Thus, the majority of DOC's evaluation responses were not provided to the Commission until six (6) to eight (8) months after the reports were issued.

Despite the prolonged delay in responding to the Commission's evaluation reports, it does not appear on their face that the DOC substantially commenced remedial action before responding to the report. Using the George R. Vierno Detention Center (GRVC) as an example, the Commission issued its written evaluation report on December 14, 2016, to which the DOC responded by letter dated June 26, 2016. Notwithstanding this six (6) months available to implement corrective action to noted deficiencies, the DOC's report predominantly made references to future plans of its administration to act, stating it "will follow up with relevant officials," "will conduct periodic audits," etc. In fact, the DOC's evaluation response states, *in eleven (11) separate instances*, that DOC's administration "will issue a memorandum" to staff as a means of corrective action.

Despite the DOC's extended delay in providing the Commission its evaluation report responses, Commission staff have commenced assessing the same, and will provide the DOC its written assessment finding in forthcoming correspondence.

2017 INDIVIDUAL FACILITY EVALUATIONS

As of December 14, 2017, every on-site Cycle 2 evaluation of DOC's Rikers Island facilities has been completed by Commission staff. Initially, the Commission had withheld issuing written Cycle 2 evaluation reports to the DOC, attempting instead to first assess compliance and conclude outstanding issues regarding the Cycle 1 evaluation report. However, written evaluation reports have recently been issued for GMDC, GRVC, RNDC and EMTC, with the remainder forthcoming. Nonetheless, listed below are brief summaries of the deficiencies noted by Commission staff during Cycle 2 on-site evaluations of DOC's Rikers Island facilities in 2017.

AMKC

Part 7002 - Admissions

- **Medical Screening and Initial Screening and Risk Assessments:** The facility is not consistently completing a suicide prevention screening form on all prisoners. When forms are completed and indicators exist, supervisors are not immediately notified.

- **Staff Training:** Facility staff assigned to complete initial screening and risk assessments are not all trained in classification, as required.
- **Supervision of Prisoners in Facility Housing Areas:** When prisoners were determined to be suicidal or highly self-injurious, they were not immediately placed on *constant supervision*.
- **Supervision of Prisoners outside of Facility Housing Areas:** Prisoners were observed walking unescorted/unsupervised in facility corridors. One such prisoner was able to line up to access a vehicle transporting inmates to court. Fortunately, the prisoner was identified right before he was to access the bus. The prisoner was never identified as missing from his assigned housing area.
- **Facility Rules and Information:** The Department's last updated inmate rulebook was completed in 2007. Reviews and revision of information is required to occur on an annual basis.

Part 7003 - Key Control

- **Key Control:** The facility intake officer maintained a key that would provide inmates a means of egress from the facility intake area.

Part 7005 - Prisoner Personal Hygiene

- **Laundry and Repair of Clothing:** The facility was only providing laundry services for facility-issued uniforms and linens. Inmates are required to wash their personal clothing in buckets with soap and water in their cells and hang them to dry.

Part 7024 - Religion

- **Congregate Religious Activities:** The facility is not providing services for some religious service programs. Religious schedules are not accurate and do not describe the actual day and times services are provided.

Part 7028 – Exercise

- **Exercise Yard:** Exercise yards contained broken pieces of metal and glass. The area also contained holes and divots that are tripping hazards and can be used for the concealment of contraband. Some gates require reinforcement, while some gates, fences, and roof lines require additional concertina wire.

Part 7031 - Legal Services

- **Access to Legal Reference Material:** The facility does not have written policy or guidelines for use of all legal reference materials.

EMTC

Part 7002 - Admissions

- **Facility Rules and Information:** The Department's last updated inmate rulebook was completed in 2007. Reviews and necessary revisions are required on an annual basis.

Part 7005 - Prisoner Personal Hygiene

- **Laundry and Repair of Clothing:** The facility was only providing laundry services for facility-issued uniforms and linens. Inmates are required to wash personal clothing in buckets with soap and water in their cells and required to hang to dry.
- **Bedding:** The inmate population is not consistently issued pillows. Such failure causes tension among inmates.

Part 7025 – Packages

- **Inspection of Incoming Prisoner Packages:** The facility is not providing written notices to the inmates when their package is returned to sender or sensor items sent through the mail.

Part 7028 – Exercise

- **Exercise Area Searches:** Facility was unable to demonstrate the completion of exercise yard searches prior and subsequent to each exercise period.

Part 7031 - Legal Services

- Inmates who do not have direct access to legal reference materials are not being provided a list of available legal reference materials to be able to assist in a proper defense.

GMDC

Part 7002 - Admissions

- **Medical Screening:** The Suicide Prevention Screening Guidelines Form required by NYS standard is not being completed on all inmates admitted to the facility.
- **Facility Rules and Information:** The Department's last updated inmate rulebook was completed in 2007. Reviews and necessary revisions are required on an annual basis.

Part 7003 - Security and Supervision

- **Key Control:** The facility Intake Officer maintained a key that would provide inmates a means of egress out of the facility intake area. This lack of key control could allow inmates access to the unsecured portion of the facility.

Part 7005 - Prisoner Personal Hygiene

- **Inmate Clothing:** Issuing of socks and undergarments is not consistently issued to newly admitted inmates.
- **Laundry and Repair of Clothing:** The facility was only providing laundry services for facility issued uniforms and linens. Inmates are required to wash their personal clothing in buckets with soap and water in their cells and hang them to dry.
- **Bedding:** The inmate's population is not consistently issued pillows. Such failure causes tension among inmates.

Part 7013 – Classification

- **Initial Screening and Risk Assessment:** The Suicide Prevention Screening Guidelines Form required by NYS Minimum Standards is not being completed on all inmates admitted to the facility.

- **Staff Training:** Officers assigned to complete the initial screening and risk assessment are not properly trained in classification as required.

Part 7025 – Packages

- **Inspection of Incoming Prisoner Packages:** The facility is not providing written notices to the inmates when their packages are returned to sender or sensor items sent through the mail.

Part 7028 – Exercise

- **Exercise Periods:** The facility did not maintain outdoor exercise area logbooks.
- **Exercise Areas and Equipment:** The facility does not provide appropriate outer garments during cold weather for the inmate population attending outdoor exercise.
- **Exercise Area Searches:** The facility was unable to provide documentation that the required searches were being conducted of the exercise areas.
- **Main Recreation Yard:** The facility should add concertina wire to the Main Yard gate, fence, and facility edge roofline.

Part 7031 - Legal Services

- Inmates who do not have direct access to legal reference materials are not being provided a list of available legal reference materials to be able to prepare a proper defense.

GRVC

Part 7002 - Admissions

- **Property Confiscation:** Property confiscated was not accurately inventoried. Property Confiscation sheets are not consistently signed by the inmate.
- **Facility Rules and Information:**
 - a. The facility did not have a supply of inmate rulebooks to provide inmates upon admission.
 - b. The rulebook has not been updated since 2007.

Part 7002 – Security and Supervision

- **Key Control:** The facility's Clothes Box Officer and Sanitation Officer maintained keys that could provide inmates a means of egress from the facility.

Part 7005 - Prisoner Personal Hygiene

- **Clothing:** The facility did not have a supply of socks to be issued to prisoners.

Part 7024 - Religion

- **Congregate Religious Activities:** The facility does not provide services for inmates housed in Unit 11b (young adults ages 18-21).

Part 7025 – Packages

- **Inspection of Incoming Prisoner Packages:** The facility staff (not the Chief Administrative Officer) was making a determination of whether a prisoner could place his confiscated

property in the property room. Facility staff was giving the prisoner the option to throw items away, send property out or donate them.

Part 7028 – Exercise

- **Exercise Period:** Facility logbooks do not include documentation when prisoners return from exercise.
- **Exercise Searches:** The facility is not consistently documenting the search of exercise areas prior and subsequent to each exercise period.

Part 7031 - Legal Services

- **Access to Legal Reference Material:**
 - a. Prisoners do not have direct access to legal reference materials.
 - b. The facility is not providing a list to prisoners of all reference materials available.
 - c. Reference materials are not provided to prisoners within three business days of request.
 - d. There are no written guidelines for the use of reference materials.

NIC

On-site evaluation of the facility occurred the week of December 11, 2017, and an issued report is forthcoming.

OBCC

Part 7002 - Admissions

- **Property Confiscation:** Prisoner Inventory Sheets did not match the itemized inventory sheet attached to the property bags. Prisoners are not consistently signing the inventory sheets. Property bags were found to be unsecured. Prisoner property is being released without the prisoner's signature.
- **Personal Hygiene and Clothing Issue:** Most prisoners are not issued 3 sets of uniforms as required by Command Level Orders. Prisoners were found with only 2 shirts and one pair of pants and forced to wash uniforms on the housing unit due to a shortage of uniforms.
- **Facility Rules and Regulations:** The inmate rulebook and handbook are outdated and include information that no longer applies to the facility.

Part 7005 – Prisoner Personal Hygiene

- **Haircuts:** There are inaccuracies in the inventory of barber tools.
- **Personal Health Care Items:** Linen exchange does not occur as scheduled.
- **Laundry and Repair of Clothing:** Laundry services are not taking place when scheduled. Prisoners only provided one set of clothing.
- **Bedding:** Pillowcases and sheets are not being exchanged weekly.

Part 7024 - Religion

- **Congregate Religious Services:** Religious services are cancelled due to insufficient supervisory staff.

Part 7025 – Packages

- **Inspection of Packages:** Senders are not notified when packages are disposed of due to the existence of contraband.

Part 7028 – Exercise

- **Exercise Area Searches:** The facility is not conducting exercise area searches prior and subsequent to each exercise period.

RMSC

Part 7002 - Admissions

- **Property Confiscation:** Prisoner Inventory Sheets did not match the itemized inventory sheet attached to the property bags. Prisoners are not consistently signing the inventory sheets. Property bags were found to be unsecured. Prisoner property is being released without the prisoner's signature.
- **Personal Hygiene and Clothing Issue:** Most prisoners are not issued 3 sets of uniforms as required by Command Level Orders. Prisoners were found with only 2 shirts and one pair of pants and forced to wash uniforms on the housing unit due to a shortage of uniforms.
- **Facility Rules and Regulations:** The inmate rulebook and handbook are outdated and include information that no longer applies to the facility.

Part 7005 – Prisoner Personal Hygiene

- **Haircuts:** There are inaccuracies in the inventory of tools used in the beauty parlor.
- **Personal Health Care Items:** Laundry exchange does not always take place as scheduled and did not provide for weekly exchange of bath towels.
- **Laundry and Repair of Clothing:** Laundry services do not always take place as scheduled. Laundry services not occurring two times per week. There is a shortage of uniforms throughout the facility.
- **Bedding:** Prisoners not provided with a pillow and pillowcases and sheets not being exchanged weekly.

Part 7024 - Religion

- **Congregate Religious Services:** Religious services are cancelled due to insufficient supervisory staff.

Part 7025 – Packages

- **Inspection of Packages:** Senders are not notified when packages are disposed of due to the existence of contraband.

Part 7028 – Exercise

- **Exercise Area Searches:** The facility is not conducting exercise area searches prior and subsequent to each exercise period.

RNDC

Part 7002 - Admissions

- **Facility Rules and Information:**
 - a. The facility does not consistently hand out rulebooks to prisoners upon admission.
 - b. The Department's last updated inmate rulebook was completed in 2007. Reviews and necessary revisions are to occur on an annual basis.

Part 7005 - Prisoner Personal Hygiene

- **Laundry and Repair of Clothing:**
 - a. The facility was only providing laundry services for facility issued uniforms and linens.
 - b. Inmates are required to wash their personal clothing in buckets with soap and water in their cells and then hang them to dry.
- **Bedding:** The inmate's population is not consistently issued pillows which causes tension in the inmate housing areas.

Part 7005 - Sanitation

- **General Facility Sanitation:** Laundry was unclean, with lint, dirt and dust built-up on washers, dryers, pipes and floors, creating a fire hazard.

Part 7025 – Packages

- **Inspection of Incoming Prisoner Packages:** The facility is not providing written notices to the inmates when their packages are sent back to sender or sensors items sent through the mail.

Part 7028 – Exercise

- **Exercise Periods:** Exercise is not consistently provided to all housing units daily.

Part 7031 - Legal Services

- Inmates who do not have direct access to legal reference materials are not being provided a list of available legal reference materials to be able to prepare a proper defense.

WEST

Part 7002 - Admissions

- **Property Confiscation:** Prisoner Inventory Sheets did not match the itemized inventory sheet attached to the property bags. Prisoners are not consistently signing the inventory sheets. Property bags were found to be unsecured.
- **Facility Rules and Regulations:** The inmate rulebook and handbook are outdated and include information that no longer applies to the facility.

Part 7005 - Prisoner Personal Hygiene

- **Laundry and Repair of Clothing:** Laundry services are not taking place when scheduled. Prisoners only provided one set of clothing.

- **Bedding:** Pillowcases and sheets are not being exchanged weekly.

Part 7024 - Religion

- **Congregate Religious Activities:** Prisoners not permitted to congregate for religious services. Religious activities not conducted weekly.

Part 7025 – Packages

- **Inspection of Incoming Packages:** Senders are not notified when packages are disposed of due to the existence of contraband.

Part 7028 – Exercise

- **Limitation of Exercise:** Prisoners are not notified in writing when their recreation is denied or revoked.

Part 7031 - Legal Services

- **Policy:** Facility was unable to substantiate that prisoners have access to legal reference materials.
- **Mutual Prisoner Legal Assistance:** Prisoners are not permitted to meet for the purpose of discussing and preparing legal materials.

DEPARTMENT-WIDE COMPLIANCE ISSUES

As explained above, the majority of the Commission's evaluative reports are the result of individual facility audits, and detail findings specific to such facility. Nonetheless, certain programs, services and duties required by Commission regulations are, in the DOC, run centrally above the facility level. In these instances, the Commission has elected to evaluate the DOC's overall compliance in a single report. Listed below are summaries of the Commission's recent findings with regard to department-wide issues.

9 NYCRR Part 7016 - Inmate Commissary

Per Commission regulations, in the discretion of the Commissioner, a commissary may be established and operated for the purpose of making available, for sale to prisoners, items deemed proper and consistent with the health and welfare of the prisoners and the security of the facility. The prices of the items offered for sale shall be fixed by the Commissioner so that the commissary operation is self-supporting and provides a modest return above costs. The profits resulting from the sale of commissary items must be deposited in a separate bank account and utilized only for purposes of prisoner welfare and rehabilitation. Lastly, Commission regulations require that commissary accounts be maintained in a manner which fully substantiates all purchases, sales and expenditures, and that arrangements be made for periodic audits of the commissary accounts by the appropriate municipal agency.

Upon review, Commission staff found that the DOC operates a commissary program that is neither self-supporting nor provides a modest return above costs. Records reviewed from the period of 2014 – March 2017 show the DOC's commissary program operated at a loss of \$11,465,031.00, leaving no profits for prisoner welfare and rehabilitation. Furthermore, the DOC was unable to provide an appropriate list of agency staff whose primary functions were the operations of the commissary program. There is a lack of accountability for payment of these positions from the commissary account, as DOC financial and budget staff "*just estimate*" the personnel costs. This estimate in staffing commissary positions cost the inmate commissary account \$29,541,819.00 in a 3 year and 3-month review period.

Since 2004, DOC has not had an audit of its commissary operations performed by an appropriate outside authority. As of March 2017, there was \$3,538,419.60 waiting to be transferred to the *Police Property Payable Fund*. As the Commission questions whether transferring abandoned inmate funds to this account is permissible by state law, this finding will be referred to the Office of the New York State Comptroller for appropriate review and action.

The above findings and referrals were set forth in a Commission report addressed to the DOC on November 3, 2017. The Commission is reviewing DOC's response to the report, which was received on December 5, 2017.

9 NYCRR Part 7022 - Reportable Incidents

New York State Correction Law and Commission regulations require that local correctional facilities report to SCOC significant and unusual events, such as prisoner deaths, escapes, facility fires, service disruptions, inmate group actions, etc. In most cases, these reports must be submitted to SCOC within 24 hours of occurrence. In case of an inmate death, the facility must report the death within 6 hours of the pronouncement of death, and in several other instances

(major disturbance, hostage situation, firearm discharge, etc.) the report is required immediately. Incident reports must be submitted to the Commission via the eJusticeNY Integrated Justice Portal, in accordance with the requirements set forth in the Commission's *Reportable Incident Guidelines*.

Upon Commission staff review, it was found that DOC's policies and procedures do not comply with corresponding Commission regulations, in that DOC's incident categories and definitions do not align with Commission regulations or the *Reportable Incident Guidelines*. Additionally, it was evident that DOC is not reporting certain categories of incidents, nor transmitting required reports consistently within the time periods required, each as required by Commission regulations and the *Reportable Incident Guidelines*.

The above findings were set forth in a Commission report addressed to the DOC on November 15, 2017. The Commission is awaiting DOC's response to the report, which was requested by January 2, 2018.

9 NYCRR Part 7039 – Fire Prevention and Safety

To safeguard the lives and property of all occupants, and to minimize the possibility of fire emergencies or other similar hazards, Commission regulations require local correctional facilities to practice proper fire prevention and safety measures, to include the development and implementation of written policies and procedures, the performance of annual fire and safety inspections by the appropriate authority having code enforcement jurisdiction, the performance of weekly fire hazard inspections by facility staff, and the provision of appropriate training to facility staff.

Upon Commission staff review, EMTC and GMDC do not maintain operable fire alarm systems, and are thus required by code to perform and document 30-minute fire watches. Nevertheless, DOC could not provide documentation that such fire watches were being performed. Commission staff noted fire extinguishers in many that were not inspected in a timely manner, or replaced when expired, as well as pull stations and emergency exit signs that were non-functioning. Further, Commission staff noted an absence of posted evacuation plans, and required weekly fire inspections, conducted by department staff, did not account for the entire facility. There are multiple penetrations in firewalls throughout all the buildings on Rikers Island without appropriate fire stop material, a condition which is infrequently noted on fire hazard inspections. Fire doors were observed propped open with wooden door stops. Commission staff observed exposed electrical wires and multiple extension cords utilized throughout Rikers Island facilities, though such violations are not documented on the fire safety inspection reports.

Required annual inspections by the appropriate code enforcement authority have not been conducted at Rikers Island facilities within the required time frames. Additionally, the Officer assigned to the EMTC fire safety position has not received the appropriate training, required by Commission regulations and the New York State Office of Fire Prevention.

The above deficiencies were observed by Commission staff during recent on-site evaluations of Rikers Island facilities, occurring over four (4) separate dates in October 2017. Corresponding findings and required actions will be contained in a forthcoming Commission

report to DOC, requesting a response which details the remediation taken to achieve compliance.

9 NYCRR Part 7040 - Maximum Facility Capacity

To promote a safe, secure and healthy correctional environment, Commission regulations place a limit on the total number of inmates confined at any given time within each local correctional facility. To accomplish this, regulations require the Commission to formulate a written maximum facility capacity that specifies all properly equipped individual occupancy housing units (cells) and multiple occupancy housing units (double cells, dorms), and determines the maximum number of inmates that can be housed within the facility.

Upon Commission staff review, it was discovered that, in multiple facilities, the DOC has housed inmates in areas that have been identified as closed by the Commission's written maximum facility capacity report, thus violating the corresponding regulation. Although DOC's administration has been notified that an amended maximum facility capacity must be requested and received from the Commission before opening a closed housing unit for inmate population, DOC continues to fail in this regard.

The above deficiencies were observed by Commission staff during recent on-site evaluations of some Rikers Island facilities, occurring in November 2017. On-site evaluations of additional facilities are scheduled, after which corresponding findings and required actions will be contained in a forthcoming Commission report to DOC, requesting a response which details the remediation taken to achieve compliance.

COMMISSION-ISSUED DIRECTIVES

Pursuant to Correction Law section 46(4), in any case where a Commission regulation or law relating to a correctional facility has been violated, the Commission “shall notify the person in charge or control of the facility of such violation, recommend remedial action, and direct such person to comply with the rule, regulation or law, as the case may be.” As set forth above, regulation violations discovered and cited by Commission staff in local facility evaluations are, in the majority of cases, immediately remedied, with the actions taken set forth in the facility’s written response to the evaluation.

In the Commission’s experience, only rarely does a situation necessitate the further notification of the violation and direction of compliance, commonly referred to as a “Directive.” However, upon subsequent non-compliance by the facility following the issuance of a Directive, Correction Law section 46(4) allows the Commission to apply to the Supreme Court for an order directing compliance with the regulation or law. Upon the Supreme Court’s issuance of such an order, further noncompliance would constitute contempt of court, and be punishable as such.

Over the past two (2) years, the Commission has issued the following Directives to the DOC following sustained non-compliance with Commission regulations at Rikers Island facilities:

Robert N. Davoren Complex (RNDC)

In September 2015, the Commission issued a Directive to New York City Department of Correction at the Robert N. Davoren Complex for the violation of 9 NYCRR sections 7003.3(a), 7003.3(e), 7003.3(f), §7003.8(g) and 7063.5(c). The Directive cited the DOC for the failure to maintain minimum levels of inmate supervision and the failure to regularly perform mandated annual chemical agent training for officers. Specifically, in multiple housing units that contain more than twenty inmates, required security posts routinely lacked the continuous occupation of a correction officer. Also, inmate housing units lacked functioning mechanical or electrical time recording devices, necessary to record the completion of required officer supervisory visits of inmates secured in their individual housing unit while general supervision is performed. Absent these functioning mechanical or electrical time recording devices, the required records from these devices were not maintained by the DOC, nor were the records periodically reviewed by the Chief Administrative Officer. Furthermore, officers routinely ordered, supervised, and utilized chemical agents without having received the required annual training.

DOC was directed to maintain active supervision of inmates within a multiple occupancy housing unit by assigning a correction officer to continuously occupy a security post within any such unit in which more than twenty inmates are housed. DOC was also directed to install, maintain and utilize functioning mechanical or electrical time recording devices to record the completion of each required supervisory visit whenever all prisoners are secured in their individual housing units and general supervision is performed and for the facility’s chief administrative officer to retain and periodically review the printed records of the time recording devices to verify that officers are properly completing their supervisory rounds. Lastly, DOC was directed to ensure that all facility staff with the authority to order the use of chemical agents, supervise such use, or use chemical agents, receive the required annual training and to ensure that those who have not been trained in the use of chemical agents or who have not received the required annual training do not order the use of chemical agents, supervise such use, or use chemical agents.

On October 21, 2015, the DOC responded to the Directive by indicating that they would assign an additional officer in the two identified housing units to the “C” post. The DOC also indicated that they planned to restore the previously installed watch tour system to be operational by the end of December 2015. In its response to the 2016 Directive for AMKC (detailed below), the DOC indicated that these watch tour systems were in place and operational. With regard to the issuance of chemical agents, the DOC indicated that the RNDC had established and implemented new written procedures to enforce and maintain compliance with the requirements. The DOC also indicated that they were working with the Correction Academy to schedule training for all RNDC staff whose chemical training had expired.

Anna M. Kross Center (AMKC)

In March 2016, the Commission issued a Directive to New York City Department of Correction at Anna M. Kross Center for the violation of 9 NYCRR sections 7003.3(a), 7003.3(e), and 7003.3(f). The Directive cited the DOC for the failure to maintain minimum levels of inmate supervision. Specifically, in multiple housing units that contain more than twenty inmates, required security posts routinely lacked the continuous occupation of a correction officer. Also, inmate housing units lacked functioning mechanical or electrical time recording devices, necessary to record the completion of required officer supervisory visits of inmates secured in their individual housing unit while general supervision is performed. Absent these functioning mechanical or electrical time recording devices, the required records from these devices were not maintained by the DOC, nor were the records periodically reviewed by the Chief Administrative Officer. The DOC was directed to maintain active supervision of inmates within a multiple occupancy housing unit by assigning a correction officer to continuously occupy a security post within any such unit in which more than twenty inmates are housed. The DOC was also directed to install, maintain and utilize functioning mechanical or electrical time recording devices to record the completion of each required supervisory visit whenever all prisoners are secured in their individual housing units and general supervision is performed and for the facility’s chief administrative officer to retain and periodically review the printed records of the time recording devices to verify that officers are properly completing their supervisory rounds.

On May 26, 2016, the DOC responded to the Directive by indicating that the DOC planned to install electrical time recording devices in cell housing areas in all of the DOC’s correctional facilities. The DOC indicated that the watch tour system was already in place at Robert N. Davoren Center and George M. Motchan Center. The DOC went on to indicate that the watch tour system would be installed and implemented in George R. Vierno Center and Anna M. Kross Center by the end of 2016. On September 15, 2016, the DOC responded to the Directive by indicating that the DOC plans to request funding in the City’s January 2017 Financial Plan to fund a capital project for the installation of Control Stations for the six West Modular Housing Units at Anna M. Kross Center that would be posted with officers who would monitor the West Modular Housing Units using cameras and intercoms.

Anna M. Kross Center (AMKC) – Reportable Incidents

In August 2017, the Commission issued a Directive to New York City Department of Correction at Anna M. Kross Center for the violation of 9 NYCRR §7022.3(a)(1). The Directive cited the DOC for not making an immediate notification of a reportable incident as required by

regulation. Specifically, the DOC failed to properly notify the Commission of the escape of an inmate until more than five hours after the escape occurred. The DOC was directed to review and modify, if necessary, all operational documents that do not comport with the timelines for reporting reportable incident and to ensure that all personnel at the DOC who are assigned or may be assigned to report a reportable incident to the Commission follow the required reporting timeframes.

By letter dated September 12, 2017, the DOC responded to the Directive, alleging that it “has taken and is taking corrective actions and measures to comply with the requirements cited by the [Commission].” Among the planned action described, the DOC stated that it “is revising” a Departmental Directive regarding reporting significant facility incidents, and that it “will be issuing new command level procedures” to delineate lines of responsibility for reporting incidents. Verification of such action by Commission staff is forthcoming.

Anna M. Kross Center (AMKC) – Construction and Renovation

In September 2017, the Commission issued a Directive to New York City Department of Correction at Anna M. Kross Center for the violation of 9 NYCRR §7001.1. The Directive cited the DOC for failing to obtain prior approval by the Commission for construction and renovation projects. Specifically, the DOC failed to properly seek and obtain prior Commission approval for the installation of fence/support posts and concertina wire in the walk-way of the main outdoor exercise yard. The DOC was directed to review and modify, if necessary, all operational documents that do not comport with the requirement of prior approval for construction and renovation projects.

On October 24, 2017, the DOC responded to the Directive by indicating that they are drafting an Operations Order to establish policies and procedures for requesting construction/renovation projects which will specifically stat that any plans and specifications for the construction and/or renovation of detention facilities must be submitted to the Commission for review and that approval from the Commission must be obtained prior to an advertisement for bids. The DOC also stated that if there is no bidding procedure for a project, then the Commission’s approval must be obtained before any construction or renovation is undertaken.

REPORTED SIGNIFICANT FACILITY INCIDENTS

New York State Correction Law and Commission regulations require that all local correctional facilities report to the Commission significant and unusual events, such as prisoner deaths, escapes, facility fires, service disruptions, inmate group actions, etc. In most cases, these reports must be submitted to the Commission within 24 hours of occurrence. In the case of an inmate death, the facility must report the death within 6 hours of the pronouncement of death, and in several other instances (major disturbance, hostage situation, firearm discharge, etc.) the report is required immediately. Historically, such reporting was accomplished by a combination of telephone, facsimile, e-mail and other outdated electronic means, which rendered the data incapable of effective review, tracking and analysis. Collaborating with the New York State Office of Information and Technology Services (ITS), the Commission took steps to facilitate all such incident reporting via the eJusticeNY Integrated Justice Portal. Besides the obvious benefits to the Commission's data collection and management, correctional facilities will have the ability to search an individual inmate's institutional incident history. Such incident reporting has been operation and mandatory for both the DOC and county jails as of January 1, 2016.

Listed below are the total number of reported significant facility incidents for Rikers Island facilities, by incident category, together with the corresponding aggregate totals for all county jails in New York State. When comparing incident totals between Rikers Island facilities and county jails, it is important to note that the average daily inmate population for Rikers Island facilities, since 2016, is approximately **7,249**, while the average daily inmate population for county jails in that same period is **15,462**. Thus, the average aggregate daily population of county jails is *more than double* that of the facilities on Rikers Island.

Despite this population disparity, the number of incidents reported in each significant category are, in almost every instance, considerably higher for Rikers Island facilities than for county jails. Specifically, the number of inmate group/gang assaults and inmate/inmate assaults are more than double the corresponding totals of county jails, and the number of inmate/personnel assaults on Rikers Island is ten (10) times more. The number of both reported major and minor disturbances are more than double the amount reported in county jails. With regard to reported sex offenses, each category reflects a considerably greater amount of incidents in Rikers Island facilities than county jails.

COMPARISON OF SIGNIFICANT INCIDENTS REPORTED BY RIKERS ISLAND FACILITIES AND COUNTY JAILS, BY INCIDENT CATEGORY

**For the period of January 1, 2016 to November 27, 2017, as of 9:30 a.m.

Incident Category	Rikers Total	County Jails
Declared State of Emergency	0	1
Abscondence	0	2
Arrest of Staff	2	3
Attempted Escape	3	19
Capture/Erroneous Release	3	8
Capture/Escape	4	6
Discharge of Firearm	1	4

Erroneous Release	5	16
Escape/Other Agency Supervision	1	8
Evacuation of Facility	0	1
Fire/Non-arson	3	7
Fire/Arson	9	0
Fire/Unknown Source	0	1
Group Contagious Illness	0	2
Hospital Admission of Inmate	129	2175
Individual Inmate Disturbance	3989	2120
Inmate Accidental Injury	51	195
Inmate Attempted Suicide	12	267
Inmate Contagious Illness	4	15
Inmate Group Action	38	6
Inmate Group/Gang Assault	214	57
Inmate Self-Inflicted Injury	20	249
Inmate/Inmate Assault	2370	804
Inmate/Inmate Sexual Offense	77	13
Inmate/Personnel Assault	2723	263
Inmate/Personnel Sexual Offense	10	5
Inmate/Visitor Assault	5	0
Inmate-Introduced Contraband	746	1247
Major Disturbance	63	20
Major Maintenance/Service Disruption	5	37
Minor Disturbance	1472	699
Natural/Civil Emergency	0	1
Newborn/Infant Death	0	1
Personnel Accidental Injury	7	19
Personnel Death	6	6
Personnel Group Action	0	2
Personnel/Inmate Assault	509	3
Personnel/Inmate Sexual Offense	192	14
Personnel-Introduced Contraband	11	5
Release of Hospitalized Inmate	5	288
Unknown Source-Contraband	468	221
Visitor Assault	7	0
Visitor/Inmate Assault	2	0
Visitor-Introduced Contraband	357	162
TOTALS	13523	8972

Also relevant and revealing is a comparison of the number of significant facility incidents, reported by Rikers Island facilities, by year from 2016 to 2017. Listed below are the total number of reported significant facility incidents for Rikers Island facilities in 2016 and 2017, by incident category, for the period of January 1st to November 25th.

Comparing 2017 to 2016, Rikers Island facilities experienced significant increases in the number of inmate group/gang assaults and inmate/personnel assaults, while seeing the number of reported individual inmate disturbances double and reported minor disturbances nearly triple. Reported sexual offenses, in both the inmate/inmate and personnel/inmate categories, both experienced significant increases from 2016 to 2017.

COMPARISON OF SIGNIFICANT INCIDENTS REPORTED BY RIKERS ISLAND FACILITIES FROM 2016 TO 2017, BY INCIDENT CATEGORY

Incident Category	1/1/16-11/25/16	1/1/17-11/25/17	% Change
Arrest of Staff	2	0	
Attempted Escape	2	0	
Capture/Erroneous Release	0	3	
Capture/Escape	2	2	0%
Discharge of Firearm	1	0	
Erroneous Release	0	5	
Escape/Other Agency Supervision	0	1	
Fire/Arson	2	6	200%
Fire/Non-arson	1	2	100%
Hospital Admission of Inmate	5	123	2300%
Individual Inmate Disturbance	1209	2547	110%
Inmate Accidental Injury	21	26	23%
Inmate Attempted Suicide	3	9	200%
Inmate Contagious Illness	1	3	200%
Inmate Group Action	20	17	-15%
Inmate Group/Gang Assault	55	143	160%
Inmate Self-Inflicted Injury	13	6	-54%
Inmate/Inmate Assault	1204	1048	-13%
Inmate/Inmate Sexual Offense	29	48	66%
Inmate/Personnel Assault	1104	1479	34%
Inmate/Personnel Sexual Offense	7	3	-57%
Inmate/Visitor Assault	1	4	300%
Inmate-Introduced Contraband	223	491	120%
Major Disturbance	31	31	0%
Major Maintenance/Service Disruption	3	2	-33%
Minor Disturbance	355	1045	194%
Personnel Accidental Injury	7	0	
Personnel Death	4	2	-50%

Personnel/Inmate Assault	205	286	40%
Personnel/Inmate Sexual Offense	90	100	11%
Personnel-Introduced Contraband	5	3	-40%
Release of Hospitalized Inmate	0	5	
Unknown Source-Contraband	203	248	22%
Visitor Assault	5	2	-60%
Visitor/Inmate Assault	0	2	
Visitor-Introduced Contraband	144	194	35%
TOTAL	4957	7886	59%

INMATE MORTALITY INVESTIGATION FINDINGS

The Commission's Correctional Medical Review Board is statutorily required, pursuant to Correction Law §47(1)(a), to "[i]nvestigate and review the cause and circumstances surrounding the death of any inmate of a correctional facility," and thereafter "submit its report to the commission and, where appropriate, make recommendations to prevent the recurrence of such deaths to the commission and the administrator of the appropriate correctional facility." Correction Law §43 provides that the Medical Review Board shall consist of consist of six (6) uncompensated members, appointed by the Governor and confirmed by the New York State Senate, and chaired by one of the members of the Commission of Correction.

In recent years, the Medical Review Board has investigated numerous Rikers Island mortality cases wherein the inmate's death was directly attributable to grossly negligent medical and mental health treatment, the failure of DOC security staff to provide adequate levels of inmate supervision and care, and the failure of both entities to follow established policy and procedure. Examples of such cases are listed below, together with a synopsis of the Medical Review Board's findings contained in the Commission-issued report.

AMKC

Individual 1

DOD: 2013

COD: MEDICAL – OVERDOSE

MOD: ACCIDENT

ISSUES: MEDICAL CARE

- A review of the referral to the KEEP (methadone) program for screening of appropriate level of dependence was not done prior to Individual 1 being placed in the program.
- Individual 1 was inappropriately placed in a methadone program without supporting documentation of previous methadone programs, without any documented symptoms of withdrawal, and without any MD assessment or chart review. Urine toxicology was negative for methadone. Inmate denied being on methadone program in the community numerous times.
- Individual 1 was placed on a Librium protocol without any signs of withdrawal. All assessments for withdrawal scored "0".
- Individual 1 was not seen and evaluated by the MD after completion of dual detox protocol and beginning methadone. Failure of medical to comply with their own policy and procedure for Opioid Treatment Program which requires patients to be monitored for signs of over-sedation and respiratory depression which Individual 1 was noted by other inmates to have.

Individual 2

DOD: 2013

COD: COMPLICATIONS OF DIABETES

MOD: NATURAL

ISSUES: ADMISSIONS AND MEDICAL CARE

- Individual 2 reported history of diabetes and was noted to be vomiting with falling and unsteady gait during his admission processing. Individual 2 was not given proper medical care.

- Failure by DOC staff to follow Operations Order 22/91 *Emergency Health Care Log* which states inmates will be afforded prompt medical attention when required.
- Failure by NYC DOC staff to follow DOC Operation Order *Processing and Monitoring New Admission 16/89 (K)* that states from time of admission to DOCS to the time housed in Rikers Island Facility Timeframe for DOC/Medical processing (four hours), to housing assignment (four hours). Individual 2 was not taken to the medical clinic for almost 12 hours after his admission.
- Failure of RN to perform an assessment when summoned for a sick inmate and failure to properly document the encounter.
- Failure of NYC DOC staff to maintain documentation of emergencies in the log book.

Individual 3

DOD: 2013

COD: DIABETIC KETOACIDOSIS AND SEPSIS

MOD: HOMICIDE

ISSUES: MULTIPLE MEDICAL CARE, SECURITY AND SUPERVISION, AND CIVIL RIGHTS VIOLATION ISSUES

- Inadequate psychiatric care as a sub-therapeutic antipsychotic was ordered without clinical indication.
- Failure by medical staff to complete ordered lab work in a timely manner.
- Medication order for insulin was discontinued without any physician order or review.
- Failure to produce Individual 3 to five specialty clinic appointments for his diabetes management.
- Inadequate psychiatric care by failing to recognize changing behavior and acts of self-injury subsequent to a medication change.
- Inadequate medical care by failing to conduct a thorough chart review and missing that Individual 3 had no current insulin order.
- Failure of medical staff to enter proper medical data.
- Failure to have Individual 3 produced for glucose readings 48 times in a 28-day period between 8/7/13 and 9/5/13.
- Inadequate medical care by a physician reviewing Individual 3's chart who missed his current medication regimen, and marking "no" for serious persistent mentally ill despite Individual 3's extensive psychiatric history.
- Failure of DOC officers to document reasons why Individual 3 was keeplocked in his cell. Additionally, no disciplinary or administrative segregation documentation was filed in justification of the keeplock placement.
- Failure of DOC officers to assure that meals were provided to Individual 3.
- Inadequate medical care as Individual 3 was denied access to medication while keeplocked in his cell from 9/4/13 to 9/10/13.
- Failure of DOC officers to provide Individual 3 access to a shower.
- Failure of DOC officers to provide Individual 3 access to exercise outside his cell.
- Inadequate mental health care in violation of Correctional Health Services Policy that requires a mental health clinician to see any patient daily in a mental health observation unit 7 days a week.
- Failure to provide adequate medical care in violation of Correction Law sections 137(6) and 500-k that require medical staff to examine confined inmates every 24 hours.
- Multiple failures by DOC officers to maintain a constant supervision post on another inmate in the housing unit in violation of 9 NYCRR §7003.2(d).

- DOC officers shutting off water to Individual 3's cell denying him access to water for over 4 ½ days without any documented order or return of water for drinking or sanitation purposes.
- Violations by DOC officers to provide other keep locked inmates in the same housing area access to showers and exercise in excess of 72 hours.
- Deliberate falsification of official records by DOC officers and supervisors who made log book entries of completing supervisory tours when recorded video footage shows no actual visits were conducted.
- Multiple failures of DOC supervisors to document and intervene with the grossly obvious unsanitary conditions inside Individual 3's cell.
- Failure of DOC officer to notify the medical clinic that Individual 3 was critically ill. Individual 3 was found unresponsive in his cell, naked, and covered in feces.

Individual 4

DOD: 2013

COD: PERFORATED ULCER

MOD: NATURAL

ISSUES: MEDICAL CARE

- Medical staff failed to properly diagnose and treat Individual 4's perforated ulcer and fatally misdiagnosed him with gastroenteritis.

Individual 5

DOD: 2013

COD: SUICIDE

MOD: SUICIDE

ISSUES: SECURITY ISSUES, FAILURE TO FOLLOW POLICY, MEDICAL AND MENTAL HEALTH CARE

- Individual 5 was documented on the DOC *Arrest and Classification Risk Form* as showing signs of mental illness however this was contraindicated on the completion of the form by the Supervisor.
- DOC staff failed to follow proper policy and procedure for suicide screening. The *Suicide Prevention Screen* (Form 330 ADM) was scored as a "4" with the first five questions left blank. Individual 5 did answer yes to wanting to hurt himself. The proper procedure was not followed with that response. Constant supervision was not initiated per DOC Directive *Suicide Prevention #4521*.
- DOC does not provide any refresher training for suicide prevention
- A use of force occurred following Individual 5's self-harm attempt and there was insufficient documentation on the Injury to Individual 5 report under DOC Directive 4516. DOC staff failed to indicate that Individual 5 made an attempt to hurt himself.
- DOC staff failed to provide mental health housing when ordered.
- DOC staff failed to submit a mental health referral for an inmate in distress following a PROBE team response for violent conduct.
- DOC staff failed to document another attempt at self-harm, failed to generate a mental health referral, and failed to report or document incident which is violation of DOC Directive 4521 *Suicide Prevention* and DOC Directive 4018 *Referral of Inmates to Mental Health Services*.
- DOC staff violated Operation Order 16/89, *Processing and Monitoring New Admission* which allows a maximum 16-hour time frame, where Individual 5 was kept for approximately 19 hours in a holding pen.

- Failure of DOC staff to complete maintenance work on the shower frame in AMKC Intake Pen #8

Individual 6

DOD: 2014

COD: ACCIDENT – EXTREME HYPERTHERMIA

MOD: ACCIDENT

ISSUES: MECHANICAL FAILURE OF HEAT REGULATION IN CELL, LEAD TO TERMINAL LIVING CONDITION, FAILURE OF DOC STAFF TO PROPERLY SUPERVISE

- Individual 6 had a long history of mental health issues and was placed in mental health observation housing in AMKC.
- Due to a failure of a regulator on the heat system, the temperature inside Individual 6's cell remained in excess of 100 degrees, a temperature incapable to maintain stable health with prolonged exposure.
- The DOC officer assigned to supervise the housing area failed to conduct required supervisory visits in violation of 9 NYCRR §7003.3(c).
- The DOC officer assigned to supervise the housing area falsely documented the log book that rounds were complete. The officer was terminated and criminally charged.
- Individual 6 suffered a terminal seizure due to prolonged exposure to the excessive heat. When Individual 6 was found he was in rigor mortis indicating death in excess of over two hours. This indicates that supervisory rounds were not completed in compartment with 9 NYCRR §7003.2.
- DOC staff failed to recognize and address a serious environmental condition that affected the safety and health of the inmates. The area supervisors during tours failed to recognize and take appropriate action of the excessive temperatures on the unit.

Individual 7

DOD: 2015

COD: CHRONIC SUBSTANCE ABUSE

MOD: NATURAL

ISSUES: FAILURE TO IDENTIFY FOR DRUG WITHDRAWAL, INADEQUATE FIRST AID AND EMERGENCY RESPONSE

- DOC staff failed to identify and institute precautionary measures for a new admission inmate at high risk for experiencing drug withdrawal.
- DOC staff failed to provide adequate first aid and cardiopulmonary resuscitation at the terminal event.
- DOC staff failed to provide proper security by allowing inmates to remain in the area of a life-threatening emergency.
- Several of the responding officers, including supervisors, were out of compliance with DOC policy and SCOC regulations for First Aid/CPR/AED certification at the time of the incident.

GRVC

Individual 8

DOD: 2012

COD: INGESTION OF CAUSTIC CHEMICAL

MOD: HOMICIDE (NEGLECT OF MEDICAL CARE)

ISSUES: SANITATION (SEWAGE BACK UP), DELIBERATE REFUSAL OF DOC STAFF TO OBTAIN MEDICAL ASSISTANCE, FAILURE TO PROPERLY SUPERVISE

- A sewage backup occurred in the housing area due to a plumbing failure. Inmates were issued “soap balls” to clean their individual cells. A “soap ball” was a packet of highly concentrated detergent intended to be diluted in a mop bucket for cleaning. Individual 8 swallowed one in an attempt to have his housing assignment changed.
- Individual 8 began having severe esophageal corrosion and burning due to the caustic chemicals in the soap packet. Individual 8’s requests for medical help were deliberately ignored by the officer and captain assigned to supervise the area.
- The officer was terminated and the captain was convicted of violating Individual 8’s civil rights and sentenced to five years in federal prison.
- Individual 8 was found in full *rigor mortis* the following morning by medical staff on rounds.

NIC

Individual 9

DOD: 2012

COD: HOMICIDE – USE OF FORCE BY OFFICERS

MOD: HOMICIDE

ISSUES: USE OF FORCE. FALSIFIED DOCUMENTATION BY DOC OFFICERS

- Individual 9 had multiple medical issues including chronic kidney failure and required dialysis.
- Individual 9 had been hospitalized 11 times during his incarceration.
- Individual 9 reportedly got into a confrontation with officers in his housing area. Officers reported that Individual 9 attempted to strike them with his cane, and force was used by officers to control him. Physical findings at Individual 9’s autopsy contradicted the officers’ reports and showed that he had multiple injuries not consistent with the reported use of force.
- Investigation by the US Attorney’s office found that officers violated Individual 9’s civil rights by assaulting him while he was restrained. Officers were found guilty of falsely documenting the incident.

OBCC

Individual 10

DOD: 2013

COD: PERITONITIS DUE TO NECROSIS OF THE STOMACH FROM POSSIBLE INGESTION OF CAUSTIC SUBSTANCE

MOD: NATURAL

ISSUES: FAILURE TO PRODUCE TO MEDICAL AND FOLLOW POLICY

- Failure of DOC and medical to have Individual 10 produced to medical appointments. Individual 10 missed eight medical encounters to evaluate his asthma. These were documented as “no show” and a pattern of missed appointments for the medical contractor

was noted as a finding which led to poor medical care in past cases.

- DOC failed to follow Operation Order *Daily Sick Call* in that Individual 10 requested to see medical and witnesses attested that it was not afforded to him.
- DOC failed to provide proper access to medical as Individual 10 was informed there was no sick call due to a holiday. The Operation Order *Daily Sick Call* states sick call is offered daily.
- DOC failed to maintain proper documentation as sick call forms completed by inmates were not accessible to Commission staff.
- DOC failed to document refusal of attendance to meals or refusal of meals

Individual 11

DOD: 2013

COD: SUICIDE – HANGING

MOD: SUICIDE

ISSUES: SECURITY AND SUPERVISION, POLICY AND PROCEDURE, MENTAL HEALTH CARE

- DOC officers failed to follow Directive, *Inmate Observation Aide*, as the Suicide Prevention Aide did not make rounds per the directive and the officers did not enforce the directive with the assigned aides.
- DOC failed to provide proper supervision as rounds were not completed for three consecutive 30 minute intervals.
- An inadequate emergency response by DOC staff in that the cell was not entered for three minutes because the senior officer felt Individual 11 may have been “playing possum.”
- An inadequate emergency response by DOC staff in that CPR was not initiated by discovering officers for eight minutes.
- Inadequate security inspection by DOC staff as emergency equipment on the punitive segregation unit was missing.
- Inadequate response by DOC staff related to Individual 11 making suicidal statement.
- Failure by DOC staff to have Individual 11 produced for mental health encounters nine times, with a lack of follow up by mental health care providers.
- Inadequate mental health care as Individual 11 refused three times to attend mental health encounters, and mental health clinicians failed to follow up.
- Inadequate mental health care as there was an inadequate assessment of Individual 11 prior to his placement into punitive segregation
- Inadequate mental health care as there was a lack of collaboration and adequate assessment by a mental health physician’s assistant and her collaborating physician.

Individual 12

DOD: 2014

COD: SEIZURE

MOD: NATURAL

ISSUES: MEDICAL CARE AND SUPERVISION

- DOC staff failed to provide proper supervision in accordance with 9 NYCRR §7003.2(a).
- DOC failed to provide proper supervision in accordance with 9 NYCRR §7003.2(b).
- Inadequate medical care as Individual 12 was not delivered his anti-seizure medication on a regular basis while housed in punitive segregation.
- Individual 12’s prescriptions were not properly transferred between facilities when moved into punitive segregation.

- Proper lab monitoring of Individual 12's anti-seizure medication was not performed.
- DOC staff failed to comply with Operations Order 22/91, *Emergency Health Care Log*, by failing to refer Individual 12 to medical despite him making numerous requests.

RNDC

Individual 13

DOD: 2015

COD: SUICIDE HANGING

MOD: SUICIDE

ISSUES: SUPERVISION AND MENTAL HEALTH CARE

- Inadequate mental health care as there was no follow up by the psychiatric nurse practitioner when made aware of Individual 13 refusing transfer to C-71.
- Failure of medical provider to recognize a pattern of self-injurious behavior as risk factor of suicidal intent.
- Failure to provide a psychiatric evaluation following referral by medical provider. Inmate was evaluated by non-physician level clinician.
- Failure of DOC staff to immediately place Individual 13 on a suicide watch as ordered, resulting in Individual 13 being transferred back to general population and placed in his cell with no precautions.
- Failure by DOC staff to complete a Suicide Risk Screen on a new admission.
- Failure of DOC staff to secure the area of a medical emergency, resulting in inmates having access to an unconscious inmate without supervision.

SANITATION AND PHYSICAL PLANT CONDITIONS

For a three (3) day period of March 18, 2017 to March 20, 2017, six (6) Commission staff performed comprehensive tours of each DOC correctional facility on Rikers Island, for the sole purpose of noting and assessing facility sanitation and physical plant conditions. Besides making notes of observed deficiencies, Commission staff took over 1,300 pictures documenting the same. Commission staff were, at all times, accompanied by staff of DOC's Office of Policy and Compliance. Set forth below are synopses of conditions observed by Commission staff during said tours, by facility:

AMKC

- Facility not consistently issuing toilet paper, undergarments and pillows. Inmates take toilet paper from a roll hanging in the sub-control room.
- Intake area toilet and sink did not flush or work.
- Housing units have sheets covering the cell door windows or such windows are covered with magazine pictures.
- Clotheslines allowed to be hung across the cell to which creates poor sightlines into the cell.
- Officer leaving unsecured keys laying around in unsecured control room.
- Fire doors, exterior doors rotted on bottom.
- Facility providing laundry services only once a week (per inmates and facility staff), not the required twice, and have inmates wash their own laundry in provided white wash buckets.
- Facility is not consistently issuing pillows, nor is there a schedule to launder blankets (staff and inmates advise that blankets can go months without being washed).
- Inmate cell areas, common areas, shower areas, and bathroom areas are unsanitary.
- Peeling paint, rust, water damage, and deteriorating walls, floors and ceilings throughout the facility due to water leaks and water damage. Toilets and sinks leaking.

EMTC

- Abandoned post - facility staff conducting cross tour supervision (unit 10 Lower was without an Officer from 3:31PM until 4:20PM on 3/18/17).
- Cracked dorm windows: EMTC 5 Upper.
- Broken Dorm window repaired with a piece of Plexiglas cover: EMTC 5 Upper.
- Lights out/not working causing poorly lit areas.
- Intake Officer maintains keys that opens exterior door. 6 Lower (Unit Paws for Purpose) housing officers maintain exterior fire door keys to let the dogs out to go to the bathroom.
- 12 Upper - no hot water. Last work order placed 12/3/16.
- Inmate cell areas, common areas, shower areas, and bathroom areas are unsanitary. Additionally, there is peeling paint, rust, water damage, and deteriorating walls, floors and ceilings due to water leaks and water damage. Toilets and sinks leaking.
- EMTC 5 Upper has plastic bags over windows to stop drafts from entering through the windows.
- 12 Lower janitor's closet appears to have mold on the ceiling.
- Exit door lights out.
- Multiple fire extinguishers are tagged as being expired; one with questionable charge level.

- EMTC 10 Main shows fire alarm system reading a fire alert, but no acknowledgement. Advised the fire alarm system is down so staff consider it a false alarm and ignore.
- Facility fire safety system is reported to be only 75% complete.
- Damaged and bent beds.

GMDC

- Facility's main control room closed for (non-approved) renovation. Area sealed and notices of asbestos abatement posted on door.
- Multiple housing areas were closed for construction and or renovation (GMDC 8 Main A; & 8 Main B).
- GMDC 6 Main B, has hole cut out/missing blocks running up/down cell exterior wall.
- 6 Main B, heating radiator torn out of cell.
- GMDC Dorm 6 has plywood over the floor for support.
- GMDC 6 Upper B operates on the BAR, no key tumblers and electric locks do not consistently work.
- GMDC 6 Main B, has hole cut out/missing blocks running up/down cell exterior wall.
- GMDC 2 Upper, Plexiglas replaced window is broken open, pen stuck through to show non-secure window.
- GMDC Main Corridor Hallway Lights have no security cover over the light bulbs.
- 2 Upper B Side, no hot water; last work order was 2/17/17.
- 9 Main A, water leak down the wall.
- Inmate cell areas, common areas, shower areas, and bathroom areas are unsanitary. Additionally, there is peeling paint, rust, water damage, and deteriorating walls, floors and ceilings due to water leaks and water damage. Toilets and sinks leaking.
- Rodent Infestation.
- Insect infestation.
- GMDC 2 Upper - water in plumbing chase.
- GMDC Mod 4, weak floor, floor sinks when you step on it.
- GMDC Dorm 6 - pails catching water dripping from the ceiling.
- Exit door lights out.
- GMDC 6 Main B, Fire Exit Door and stairway has water leaks, water damage, rusted and corroded fire hatch that goes to the roof, falling pieces of ceiling.

GRVC

- Looking glass window on cell doors in 2B Isolation provide poor visibility into an inmate's cell due to such windows being scratched.
- Other units have sheets covering the cell door windows or such windows are covered with magazine pictures.
- Control room doors left ajar.
- Officers allow clotheslines to be hung across the cell to which creates poor sightlines into the cell.
- Broken window in GRVC Segregation Intake.

- Off-going staff leave post before properly relieved due to relief staff being used for searches. Unit Bldg. 15 A last entry was at 7:30am, relieving staff did not get on unit until approximately 9:30am.
- Housing area 2B Isolation has drains that backup and cause sewage to overflow out of the drains and onto the housing area floors (per Officer working the housing area).
- Inmate cell areas, common areas, shower areas, and bathroom areas are unsanitary. Additionally, there is peeling paint, rust, water damage, and deteriorating walls, floors and ceilings due to water leaks and water damage. Toilets and sinks leaking.
- Insect and rodent infestation is evident. Pictures taken of bugs and mice in the facility housing areas and plumbing chaises.
- GRVC Bldg. 15 control room has water leak that falls from ceiling and down onto electronics.
- GRVC 7B has exposed uncapped wires in plumbing chase.

NIC

- NIC main building was completely closed. Unable to get someone to escort SCOC staff through the building as no one on duty knew the keys to the areas.
- Annex is open, but many areas cannot be accessed without going to the main facility to obtain keys.
- Water leaks evident throughout facility.
- Numerous floor patches throughout facility.
- Inmate property is scattered throughout the facility.
- Security camera covered with paper.
- Medical room not secured, allowing inmate access to medical equipment.
- Metal floor covering not secured in place.
- Vents are dirty.
- Showers in need of repair and replacement.
- Wheelchair-bound inmates in infirmary have no access to shower chairs.
- Garbage bags stacked on loading dock. It was explained that the compactor is broken.
- Residential-type "bug zapper" hung in the intake area due to insect infestation.
- Exposed electrical wires.
- Exposed hot water tank wires.
- Several housing unit egress doors blocked.

OBCC

- Many security windows repaired with non-secure plexiglass.
- Evidence of water leakage throughout facility.
- Inmate property is scattered throughout the facility.
- Inmates allowed to cover their cell windows.
- Ceilings throughout the facility have fallen.
- Exterior doors are rusted.
- CERT room not secured and accessible to inmates in Admission area.
- Vents are dirty.

- Showers are in need of repair and replacement.
- Inmate water fountains are rusted.
- Exposed electrical wires.
- Cells are used for storage.
- Showers peeling paint and dirty.
- Major water leak on right side elevator.
- elevator broken and not operational.
- Shower drain not draining, flooding the shower area.
- Shower not operational.
- Captains office was barricaded with plywood and officer had no access.
- A/C Units were in the wall and drained into hallways.
- Main structure hallways have multiple leaks from the roof into the corridors. Ceiling tiles falling down in many areas.
- Many of the exterior doors are rusted to the point of unsafe.

RMSC

- Many security windows repaired with non-secure plexiglass.
- Non-security grade lighting.
- Evidence of water leaks throughout the facility.
- Inmate property scattered throughout the facility.
- Lock and doors have key numbers on them.
- Porcelain toilets and sinks.
- Many showers and toilets are in poor condition and not cleaned.
- Clogged and non-operational toilets and showers.
- Vents are not cleaned.
- Rusted ceilings throughout the facility.
- Traps are not replaced in a timely manner.
- Water closets are extremely dirty and have exposed wires in them.
- Infestation of fruit flies in several areas.
- Several water leaks into electrical fixtures.
- Exposed electrical wires.
- Access to non-secured electrical panels.
- Supplies stacked to the ceilings.
- Flammable items stacked above and adjacent to dryer vents.
- Closed cells are used for storage.

RNDC

- Commission staff notified by Key Control Officer that many locks cannot be replaced as the doors are filled with asbestos
- Security windows repaired with non-secure plexiglass.
- Non-security grade lighting.
- Basement had a wide hole through the concrete floor, approximately 15–20 feet deep.
- Numerous water leaks in basement.

- Staff dining area has significant roof leak.
- Lock and doors have key numbers on them.
- Inmates can open newly installed slider doors on the housing units.
- Porcelain toilets and sinks.
- Many bunks are bent and need to be replaced.
- Many showers and toilets are in poor condition and not cleaned.
- Roof leaks throughout the building.
- Vents are not cleaned.
- Rusted ceilings throughout the facility.
- Water leaks into electrical fixtures.
- Exposed electrical wires in basement area.
- Access to unsecured electrical panels.
- Supplies stacked to the ceilings.
- Flammable items stacked above and by dryer vents.

WEST

- Security windows repaired with non-secure plexiglass.
- Construction project in kitchen area not secured from inmates.
- Non-security grade lighting.
- Inmate property is scattered throughout the facility.
- Doors to main facility broken and not operational.
- Water leaks in tent structure.
- Substructure of floor rotted through.
- Inmates hang sheets over their housing area, preventing officer supervision.
- Exposed electrical wires.
- Supplies stacked to the ceilings.
- Closed cells are used for storage.
- Snow is not removed from external doors, preventing emergency egress.
- Floor tiles missing.
- Leaks from roof rotted the floor in an unsecured pen.
- Toilets in pens extremely filthy.
- All exterior doors were not secured or locked. Inmates were able to let themselves out if they desired.
- All exterior doors were blocked by snow covering.
- Front door not secured. Work order submitted on 3/15/2017.

GREENE COUNTY JAIL

The Greene County Jail, originally constructed in the early 1900s, has outlived its usefulness and requires replacement. Disagreement between local officials had long delayed the process of constructing a new jail, to which point the county is exploring the possibility of housing its inmates at the Columbia County Jail as part of a “shared services” agreement. Although recognizing that facility replacement is important, the Commission’s paramount concern remains with the management and operation of the current facility which, in recent years, has deteriorated to the detriment of inmate and staff safety. Absent demonstrated and immediate improvement of present jail operations, it is foreseeable that the Commission will be forced to institute further enforcement action, to possibly include closure.

FACILITY OVERVIEW

Description: Opened in 1905, Greene County Jail houses male and female detainees in 10 housing areas. The jail stands on less than one acre.
Cells: 46 cells (30 of which are authorized for occupancy)
Dorms: 10 beds
Authorized capacity:40
12/30/17 population: 21 inmates in-house and 11 inmates boarded out

PHYSICAL PLANT CONDITIONS

2010

SCOC evaluated the extent of the jail’s physical plant continued deterioration, noting that the first floor is partially supported by horizontal steel beams and adjustable lally columns; that other sections of the basement ceiling have deteriorated to the extent that steel reinforcement bars are exposed; and that interior and exit doors require adjustment or replacement due to the shifting and continued settling of the building.

As a result, the Commission ordered the closure of a six-bed cell block on the first floor directly above the basement lally columns. The Commission also directed Greene County to arrange for a study to be performed by a qualified engineering/architectural firm to assess the structural integrity of the jail along with compliance with the Uniform Fire Prevention and Building Code.

Greene County subsequently contracted with an engineering firm to assess the structural integrity of the jail. The resulting report from the engineering firm set forth findings that the basement ceiling spalling of concrete near the lally columns’ steel plate was evidence of water seeping into this area of the basement; that basement wall cracking observed was attributed to masonry expansion and contraction in the absence of an expansion joint; that leaks in the first floor housing shower area are the likely source of water observed leaking in the basement; and that Greene County maintenance staff had replaced interior and exterior doors that were functioning properly. Consequently, the engineering firm found no observable structural issues that precluded the use of the six cell block, provided that the county extend the steel plate, beam and columns from the existing area it covers to the exterior wall that is common to the shower above, installs and secures an additional two lally columns to support the beam and plate; installs a non-porous/nonslip liner in the bottom of the shower that extends

over the existing wall liner; and removes all loose spalling concrete from the basement ceiling until sound material is observed, remove scale from the exposed reinforcing steel, repair the concrete with Vertipatch concrete repair mix, and apply an appropriate sealant.

2013

During a site visit, SCOC staff noted a paraplegic inmate housed in the facility, though his wheelchair did not fit into his cell, nor into the shower in his assigned housing area. By February 21, 2013 correspondence, SCOC prohibited the facility from housing any inmates who rely on wheelchairs, crutches, canes, walkers and/or prosthetic limbs for daily use.

2016

During evaluation visits in March and April of 2016, SCOC staff noted that the windows in three (3) second floor cells were either inoperable, stuck in the open position, or had broken glass, exposing inmates to the elements. Nevertheless, the facility continued to house inmates in these cells. The facility was also found to have regularly abandoned required housing posts, reassigning such staff to inmate transports. As a result, the Commission ordered the closure of the D-Block 2nd Floor Right housing area (8 beds) and the D-Block 2nd Floor Left housing area (8 beds), for a total of 16 beds.

FACILITY STAFFING DEFICIENCIES

Historically, Greene County has struggled to hire and retain correction officers to work in the Greene County Jail. Officers who are hired for the jail often leave to work for the New York State Department of Corrections and Community Supervision (DOCCS) at either the Coxsackie or Greene Correctional Facilities for significantly higher wages and benefits. Such departures often occur after the county has paid for staff to attend basic corrections training (4 to 6 weeks) and on-the-job training at the jail.

Shortages in total staffing levels have resulted in the reduction of allowable inmate capacity, cited regulation violations, and a resulting Directive. As discussed with Greene County officials, construction of a new county jail facility may attract more Correction Officer candidates, a result experienced by other New York counties in similar situations.

VARIANCES AND FACILITY CONSTRUCTION

The Greene County Jail does not maintain an outdoor exercise area of sufficient size to comply with compulsory regulation. To provide Green County the opportunity to develop a long-term plan (i.e., construct a new facility) that would satisfy this requirement, the Commission has approved a temporary variance that permits the facility to operate with the undersized outdoor exercise area. Conditions set forth as part of this variance includes the development of a long-term plan to address this issue.

Subsequent to the granting of this variance, Greene County contracted with the SMRT architectural firm to design a new jail that will meet the county's long-term capacity needs. Throughout this process, Commission staff have met with jail and county officials, as well as SMRT representatives to provide technical assistance in the design of a new jail. Nevertheless, the Greene County Legislature recently voted to continue on parallel paths to address overcrowding. The first permits the design phase of a new jail to continue, while the second focuses on a possible shared-services agreement with Columbia County that would permit the

housing of Greene County inmates at the Columbia County Jail. The Commission continues to provide both counties with technical assistance as such an arrangement continues to be explored.

2016 FACILITY EVALUATION

In March and April 2016, SCOC staff completed comprehensive evaluations of the Greene County Jail. A report of findings and required actions was forwarded to Sheriff Seeley on May 27, 2016. Such findings included:

Policies and Procedures

- Several operational policies and procedures were found to be outdated, with the most recent revisions dating back to 2006, completed by the previous administration.
- Many policies and procedures do not reflect actual jail operations.

Part 7003 - Security and Supervision

- **Written Policy:**
 - a. Last updated in 2006
 - b. Does not reflect all security-related facility operations.
 - c. Missing required Minimum Standard elements
- **Policy:** the facility implemented a blanket policy in which all inmates deemed to be a risk of self-harm were required to wear suicide smocks. Such inmates must be placed on constant supervision – in such instances, there is no need to deprive inmates of clothing required by regulation.
- **Documentation:** Facility staff failed to document that the exterior windows of three cells were broken
- **Firearms Control:** Facility could not demonstrate that firearms were inspected as required.
- **Lock Inspections:** numerous inspections completed by facility staff did not identify the broken exterior windows in three cells.

Correction Law sections 137(6) and 500-k

The facility was found to have been locking inmates in their cells for a preponderance of the day as a matter of routine practice. Such inmates did not pose a threat to the safety and security of the facility, staff, or other inmates, and the facility could not justify such lock-ins. *The facility has taken corrective action to address this violation.*

Part 7006 - Discipline

- **Written Policy:**
 - a. Policy and procedures did not reflect operational practice.
 - b. Improperly permitted staff to lock inmates in their cells for extended periods of time.
 - c. Improperly permitted staff to impose loss of inmate privileges.
 - d. Sanctions differed from those outlined in the inmate rulebook

The facility has revised the Discipline policy but it has yet to be implemented.

Part 7008 - Visitation

- **Written Policy:**

- a. Last revised in 2011
 - b. Did not address all required Minimum Standard elements
- **Initial Visit:** Facility practice improperly counted inmates' initial visit towards the required two hours of visits weekly. *The facility has taken corrective action to address this violation.*
 - **Limitation of Visits:** Facility improperly implemented a practice whereby visitors were refused entry if they did not meet certain dress code guidelines.

Part 7009 - Food Service

- **Written Policy:**
 - a. Policy and procedures were last revised in 2005
 - b. Did not reflect current operational practice
- **Nutritional Adequacy:** Facility menus were not approved by a nutritionist or dietician certified by the State Education Department. *The facility has taken corrective action to address this violation.*
- **Policy:** On occasion, facility mental health staff were improperly ordering a finger-food diet for inmates placed on constant supervision.

Part 7016 - Commissary

- **Purchases:** Facility improperly used commissary profits to pay for services rendered to inmates.

Part 7030 - Non-Discriminatory Treatment

- **Policy:** Facility did not have a written policy as required
- **Practice:** Female inmates were not subject to extended cell lock-in time as were male inmates. *The facility has taken corrective action to address this violation.*

Part 7032 - Grievance Program

- **Written Policy:**
 - a. Policy and procedures were last revised in 2009, and not annually as required.
 - b. Policy did not address several elements required by Minimum Standards.
- **Practice:**
 - a. Facility lacked a truly functioning inmate grievance program.
 - b. Grievances were not processed by the facility as required,
 - c. Staff assigned to the grievance program were not permitted sufficient time to process grievances filed by inmates.

Correction Law §500-c (Physical Plant)

- **Control Room:** serves numerous functions in light of the insufficient space provided by the physical plant. Shift supervisors work out of the control room.
- **Programs:** the program areas are insufficient
- **Inmate Property:** due to lack of sufficient space, inmate property is stored in the basement.
- **Inmate Holding:** the facility lacks an appropriate area to hold inmates pending transport or completion of the admissions process. Inmates are placed on a bench, handcuffed to a bull-ring.

- **Law Library:** is located within the indoor exercise area
- **Professional Visitors:** there is insufficient space for professional visitors

Outdoor Exercise: the facility's outdoor exercise area is not of sufficient size to meet the requirements of Part 7028, Exercise. The Commission currently permits this arrangement through a variance.

Part 7041 - Staffing

- **Staffing Levels Total:** The facility does not maintain a sufficient number of security staff to meet the requirements of the Commission's Position and Staffing Analysis for the Greene County Jail.
- **Daily Posts:**
 - a. The facility was found to have been abandoning staff posts required by the Commission's Position and Staffing Analysis.
 - b. Staff were being reassigned from required posts to conduct inmate transports. *The facility has taken corrective action to address this violation.*

2017 FACILITY EVALUATION

In December 2017, SCOC staff completed a comprehensive evaluation of the Greene County Jail. While the evaluation report has not yet been issued, notable findings include:

Part 7002 – Admissions

- **Rulebook:** the inmate rulebook is not current

Part 7005 – Prisoner Personal Hygiene

- **Clothing:** Facility not consistently issuing socks, underwear, and t-shirts
- **Soap/Toothpaste:** facility is not replenishing soap or toothpaste unless the inmate is indigent.
- **Laundry/Repair of Clothing:** schedule only allows for laundering of clothing only once per week, not twice as required.
- **Bedding:** inmates are not consistently issued pillows

Part 7013 – Classification

- **Policies/Procedures:** the facility administration has neither review nor revised the classification policy and procedures annually as required.
- **Objective System:** the facility does not utilize a formal and objective system for inmate classification
- **Categories:** facility is commingling minimum, medium, and maximum security inmates in the same housing areas
- **Medical Screening:** the facility does not screen new admissions for medical conditions requiring immediate treatment
- **Housing Assignment:** after initial screening and risk assessment, inmates are consistently placed in a housing area designated for classification purposes
- **Training:** staff have not completed required classification training

Part 7016 – Commissary

- **Purchases:** the facility has used commissary profits to make improper purchases (i.e., items or services that the facility is required to provide by Minimum Standard regulations).

Part 7022 – Reportable Incidents

- **Policies/Procedures:** facility has no policy that reflects current practice or regulations.
- **Reporting:** the facility has failed to report all incidents that meet SCOC criteria
- **Guidelines:** the facility does not make available to all staff the reportable incident guidelines information established by the Commission

Part 7028 – Exercise

- **Periods:** see *Variance and Construction* section above.

Part 7039 – Fire Prevention and Safety

- **Policies/Procedures:** the facility does not have current written policies and procedures that address the elements of this Part
- **Weekly Inspection:** the facility does not consistently conduct weekly fire safety inspections
- **Annual Inspection:** The CAO has not made arrangements for an annual fire safety inspection as required

COMMISSION-ISSUED DIRECTIVES AND ENFORCEMENT

The Commission's May 27, 2016 evaluation report required a response from Sheriff Seeley by June 27, 2016. Sheriff Seeley failed to respond to the evaluation. As a result, the Commission forwarded to Sheriff Seeley two reminders (7/21/16 and 9/28/16) that such response was due immediately. Sheriff Seeley failed to respond to either reminder or the original evaluation report.

On November 15, 2016, the Commission issued a Directive to the Greene County Jail for operating without required policies and procedures, or with required policies and procedures that do not reflect actual facility operations, for continuing to confine male inmates in their cells for a preponderance of each day without need, for continuing to operate an inmate food service program with menus that have not been reviewed and approved by a nutritionist or dietician certified by the State Education Department, for continuing to implement discriminatory treatment against male inmates who are subject to cell confinement and lack a functioning inmate grievance program. The Greene County Jail was directed to update all of the facility's written policies, particularly with regard to security and supervision, inmate discipline, good behavior allowances, visitation, inmate classification, nondiscriminatory treatment and inmate grievances; to discontinue the practice of confining inmates to their cells for a preponderance of each day, without the need for order or discipline and absent any specific determination or order of the facility's chief administrative officer; to obtain review and approval of all inmate food program menus by a nutritionist or dietician certified by the State Education Department; to discontinue the discriminatory treatment of male inmates who are subject to routine cell confinement; to establish, implement and maintain a formal inmate grievance program that comports with all of the regulatory requirements set forth in Part 7032; to provide any inmate incarcerated in Greene County Jail access to the facility's grievance program; to make formal

grievance forms readily accessible so that an inmate may file a grievance; to ensure that, within five business days of receipt of a grievance, the grievance coordinator shall issue a written determination, a copy of such is to be provided to the inmate; to ensure that, within five business days of receipt of a grievance appeal, the chief administrative officer shall issue an written determination, a copy of such is to be provided to the inmate; to ensure that, within three business days after receipt of the grievant's notice of appeal, the grievance coordinator shall submit the appeal, the accompanying investigation report and all other pertinent documents to the Commission's Citizens' Policy and Complaint Review Council; to ensure that if a grievant is released or transferred from the facility prior to the resolution of a grievance, the chief administrative officer shall cause a determination to be made on such a grievance; to ensure that if the chief administrative officer denies such grievance, he/she shall submit the grievance to the Citizen's Policy and Complaint Review Council; to ensure that for any grievance that was initially submitted electronically to the Citizen's Policy and Complaint Review Council and the Council has issued its determination to the chief administrative officer and the grievance coordinator in a similar manner, the grievance coordinator has printed and provided a copy of the written determination to the grievant, if he/she is still incarcerated in the facility, within one business day; to maintain a centralized record of each grievance that is filed; and to provide facility staff an orientation with regard to the facility's grievance program, which is to include any newly implemented grievance policy.

On December 13, 2016, Greene County responded to the Commission's Directive by indicating that the jail continues to update any and all policies which may reasonably require updating to bring them into conformity with the daily operations. It also insisted that the jail does not confine male inmates in their cells for a preponderance of the day, without need, and denies that it engages in discriminatory housing policy based upon gender. Greene County indicated that all food service menus in use at the Greene County Jail are approved and supplied by the New York State Department of Corrections and Community Supervision (DOCCS). If an inmate requests a dietary substitution or a request due to religious observance or directed by health care professionals and the substituted portion deviates from the caloric and/or nutritionally approved statistic, the substituted portion is selected from a New York State Department of Corrections approved menu. Greene County indicated that the Greene County Jail implemented the Commission's recommendations related to the exit interview of April 11, 2016 and that all grievance related matters are monitored on a bi-weekly basis. Greene County responded by indicating that grievance forms are readily accessible to all inmates at all housing units and through the law library programs. Greene County indicated that all grievances are processed on a timely basis, a written determination from the grievance coordinator is given to the inmate within five days of receipt, the chief administrative officer's determinations are within five business days of receipt and all notices of appeal are directed to the Commission within the time frames of 9 NYCRR §7032.5. Lastly, it was alleged that the jail has instituted all policies and procedures recommended by the Commission relating to inmate grievances, including maintenance of individual file folders, maintenance of a grievance log book subject to bi-weekly review to ensure complete compliance.

On January 4, 2017, the Commission forwarded to Greene County its assessment of the county's response to the directive, requesting justification as to why locking inmates in their cells for certain time frames is necessary for maintenance or order of discipline. The Commission also indicated that field staff were in the process of reviewing the submitted policies and procedures and that these items would remain open pending the review. The Commission also

requested documentation from a dietician or nutritionist certified by the New York State Department of Education, demonstrating that all food and beverage items served at the Greene County Jail met the current recommended daily allowances of the Food and Nutrition Board of the National Academy of Sciences, Nation Research Council. The Commission requested Greene County Jail's Classification policies and procedures as the County's response did not address this issue.

On January 18, 2017, Greene County responded to the Commission's assessment of their response. Greene County indicated that all inmates are not locked in their cells for the entire 7:45 a.m. to 11:30 a.m. time frame, 12:15 p.m. to 4:15 p.m. time frame and 4:45p.m. to 6:45 p.m. time frame. Greene County indicated that inmates are taken out of their cells for various activities, such as exercise or showers. Greene County indicated that they had contracted a certified dietician to review the food menus and once the reviews have been completed, they will be forwarded to the Commission. Greene County did send the Classification policies and procedures at this time for the Commission's review.

Pursuant to Correction Law §45(8)(a), on May 25, 2017, the Commission issued a citation to the Greene County Sheriff, Greene County Attorney, and the Chairman of the Greene County Legislature to appear before the Commission on July 12, 2017 due to the finding that the Greene County Jail was unsafe, unsanitary, inadequate to provide for the separation and classification of prisoners as required by law and has not adhere to or complied with the rules and regulations promulgated by the Commission. This appearance was adjourned until July 25, 2017.

On June 24, 2017, Greene County Sheriff responded to the Citation. In that response, Greene County indicated that no mandatory facility officer posts are being abandoned to perform inmate transports, that all broken windows in the Greene County Jail have been repaired and inspected by Commission staff, that the inmate food program menus have and will continue to be reviewed and approved by a nutritionist. Greene County also indicated that all required facility policies and procedures are or will be revised where applicable and bound in a single volume together with all current jail policies, that their inmate grievance program will be double checked regularly to ensure that investigative reports are attached and all appeal documents have been timely filed. Greene County also indicated that they would release all inmates from their cells from 7:30 am to 10:00 pm daily except for scheduled shift changes and discipline. Greene County provided documentation that the sewer back-up issue was fixed and was cleaned up. Greene County also requested assistance with regard to classification of inmates at the Greene County Jail.

Based upon the representations of Sheriff Seeley in his response to the Citation, the Correction Law §45(8) hearing was indefinitely adjourned on July 25, 2017. The Commission continues to monitor the Greene County Jail to ensure all violations are satisfactorily addressed.

REPORTED SIGNIFICANT FACILITY INCIDENTS

Number of reported incidents per category, from 1/1/16-12/26/17

Hospital Admission of Inmate	1
Inmate Self-Inflicted Injury	2
Inmate/Personnel Assault	1
Inmate-Introduced Contraband	2
Unknown Source-Introduced Contraband	1
Visitor-Introduced Contraband	1

ERIE COUNTY HOLDING CENTER AND CORRECTIONAL FACILITY

Managerial shortcomings of the Erie County Sheriff's Office have contributed to numerous serious incidents at the Erie County Holding Center and Erie County Correctional Facility, including inmate escapes, assaults, and deaths. Consequently, the Commission has previously been required to commence enforcement action (i.e., issuance of Directives, applications for Supreme Court order) against the Erie County Sheriff for the failure to correct identified violations of law and compulsory state regulations. Although the Commission will continue to work with the Sheriff's Office to correct identified regulatory violations and maintain compliance, further enforcement action will be instituted where warranted.

FACILITY OVERVIEW

Erie County Holding Center

Description: Opened in 1938, the Erie County Holding Center is a 7-story high-rise facility that houses pre-trial and sentenced inmates in 30 housing areas.

Cells: 528 cells

Dorms: 112 beds

Authorized capacity: 640

12/30/17 population: 347 inmates in-house and 2 inmates boarded out

Erie County Correctional Facility

Description: Opened in 1985, the Erie County Correctional Facility houses pre-trial and sentenced inmates in 42 housing areas.

Cells: 406 cells

Dorms: 388 beds

Total authorized capacity: 794

12/30/17 population: 592 inmates

Note: Both facilities are under the charge of the Sheriff of Erie County.

FACILITY STAFFING DEFICIENCIES

In 2011 and 2012, Commission staff updated the Position and Staffing Analyses at the Erie County Holding Center and Correctional Facility. An April 17, 2012 report outlined the daily and total staffing requirements for both facilities. Unfortunately, Erie County had failed to maintain required staffing levels of the Commission's previous staffing analyses. As a result, Erie County had to hire 72 new Correction Officers and implement a myriad of in-house promotions to meet the required staffing levels. The Commission worked with Erie County on a multi-year plan that allowed for the necessary hires and promotions to meet staffing requirements.

COMMISSION SPECIAL INVESTIGATIONS

2010 - Escape from Custody

Inmate Brian Collins escaped from the confines of the Erie County Holding Center and gained access to the rooftop of the facility. The escape resulted from the failure of facility management and staff to observe established practices and Minimum Standard regulations. The ECSO

addressed identified deficiencies and took corrective action to include, but not limited to, revision of administrative orders and policy and procedures, increase of supervisory staff tours of housing areas, and staff remedial training. One deputy was terminated, and several others were disciplined.

2015 - Escape from Custody

Inmate Thomas Walsh escaped from Buffalo City Court while in the custody of the Erie County Sheriff's Office (ECSO). The escape resulted from the failure of ECSO transport officers to supervise Walsh in accordance with Minimum Standard regulations, staff assignment practices, and limitations caused by on-going construction at the Buffalo City Court Building. Actions taken by the ECSO to correct identified deficiencies included revision of policies and procedures, reinforcement of staff expectations, amendment to staff assignment protocols, and enhancement of the department's Field Training Officer Program.

2016 – Inmate/Inmate Assault

In September 2016, inmate Carl Miller was assaulted by another inmate while being incarcerated at the Erie County Correctional Facility. Miller had previously requested to be placed in protective custody due to his concerns of being harmed by other inmates. The assault resulted in serious injuries to Miller that required a lengthy hospitalization. The assault occurred due, in part, to the failure of supervisory staff to ensure Miller remained locked in his cell until other housing arrangements could be made, and line staff's failure to observe administrative and security protocols, as well as Minimum Standard regulations. Actions taken by the ECSO to correct identified deficiencies included additional training for supervisory and line staff, review of relevant policy and procedures with staff, revision to applicable policies and procedures relating to security and supervision and other areas.

INMATE MORTALITY INVESTIGATIONS

ERIE COUNTY HOLDING CENTER

Individual 14

DOD: 2012

COD: SUICIDE - HANGING

MOD: SUICIDE

ISSUES: MEDICAL AND MENTAL HEALTH CARE

- Inadequate care by nursing staff who failed to adequately screen Individual 14 for mental health issues and appropriately refer him to mental health as a priority case.

Individual 15

DOD: 2012

COD: HOMICIDE – TRAUMATIC ASPHYXIA

MOD: HOMICIDE

ISSUES: USE OF FORCE, SUPERVISION, MEDICAL AND MENTAL HEALTH CARE

- Inadequate management plan by Erie County deputies for inmates with mental illness in an acute crisis state.
- Improper restraint technique used by deputies who placed a spit mask over Individual 15's face and tied it tightly around his neck and then added a pillow case over his face that seriously restricted his airway and breathing while placed prone on a gurney.

Deputies also violated specific agency policy and procedures which prohibited such actions.

- Failure of the deputies to allow the responding EMS personnel to adequately assess Individual 15 and assure he was breathing adequately.
- Failure of supervisors to properly supervise a use of force by staff.
- Inadequate mental health care by Erie County MH clinicians who failed to have a management plan for inmates who are in acute crisis state.
- Failure by the Erie County MH clinicians to recognize Individual 15's acute psychosis and immediately refer him to a psychiatric provider.

Individual 16

DOD: 2014

COD: NATURAL – PERFORATED ULCER

MOD: NATURAL

ISSUES: INADEQUATE MEDICAL CARE

- Erie County nursing staff failed to perform an adequate medical assessment on Individual 16, utilized treatment protocols for suspected cardiac issues on a person with no known cardiac history and then returned him to his housing area without any physician notification or evaluation.
- Erie County jail physician failed to recognize the seriousness of Individual 16's illness and failed to order a hospital evaluation and treatment after the use of a cardiac treatment protocol on a patient with no known cardiac history.
- Erie County medical providers failed to properly review and sign telephone orders.
- Erie County medical providers failed to assure Individual 16's lab work was completed.
- Erie County medical providers failed to obtain releases for Individual 16's community medical records.
- Erie County medical providers failed to recognize that Individual 16 had continued unresolved complaints of abdominal pain, for over an eight-hour period, with signs of hypoperfusion and failed to immediately seek hospital treatment for him.

Individual 17

DOD: 2014

COD: UNKNOWN – AS LISTED

MOD: UNKNOWN

ISSUES: OPEN INVESTIGATION – MULTIPLE MEDICAL MENTAL HEALTH AND MINIMUM STANDARD VIOLATION ISSUES

- Current in-progress investigation by SCOC/MRB. Issues identified to date show serious lapses in both medical and mental health care. Individual 17 languished in a cell for over 10 days in an acute state of psychosis without any crisis psychiatric intervention or attempts to emergently hospitalize. Individual 17 continued to deteriorate with an inability to adequately feed, hydrate, or manage her activities of daily living. She was brought to the hospital in a state of acute renal failure after a suffering a cardiac arrest at the jail. She was resuscitated and brought to the hospital where her condition continued to deteriorate over several days. She was released from custody prior to her death.

2016 FACILITY EVALUATION

In June, July, August and October of 2016, Commission staff completed the Minimum Standard evaluation of the Erie County Holding Center and Erie County Correctional Facility. The report was issued November 2, 2016. Below are the significant findings.

Part 7003 - Security and Supervision

- **Supervision of prisoners within facility housing areas:** The facility is not accurately documenting active and general supervision. Facility policy did not articulate the requirement of recording the level of supervision.
- **Additional Orders of Supervision:** The facility was not consistently documenting the name of individuals making such determination for additional supervision and they were not documenting the underlying reason for additional supervision.
- **Documenting Significant Events/Activities:** The facility was not documenting significant events in the housing unit logbooks.
- **Population Counts:** Written results from prisoner population counts are not consistently being forwarded to central control.
- **Firearms Control:** Inspections only being conducted yearly.
- **Locks and Securing Devices:** Inspection sheets did not identify or define all securing devices. The sheet was revised when Commission staff was onsite and the matter was closed.

Part 7006 - Discipline

- **Misbehavior Reports:** The facility is not recording the time on the disciplinary reports.

Part 7007 - Good Behavior Allowances

- The facility was not requiring inmates to acknowledge in writing that this part had been explained to them.

Part 7008 - Visitation

- **Availability of Visits:** The facility was distributing visitation information sheets that differed from facility policy.
- **Visitor Identification and Registration:** Facility staff requiring proof of address for prospective visitors.
- **Contact Visitation:** Signage at the facility allows for physical contact at the end of the visit only.
- **Limitation of Visits:** Visits being denied due to clothing worn by prospective visitors. Decisions to deny or limit visits are not documented and given to all those affected.

Part 7009 - Food Services

- **Nutritional Adequacy:** Portion size is not consistent with published menu. Menus not certified by dietician.
- **Medical Diets:** Medical substitution list not certified by a dietician.
- **Religious Diets:** Religious substitution list not certified by a dietician.

Part 7015 - Sanitation

- **General Facility Sanitation:** Facility staff did not have 24-hour access to sanitation equipment and supplies. The facility addressed the matter and ordered a key to be kept in the watch commanders office. This matter was closed.

- **Kitchen Sanitation:** During the first site visit the kitchen at the Holding Center was found to be deficient in acceptable sanitation standards. The facility addressed the matter and on the second site visit the kitchen had been cleaned and the matter was closed.

Part 7030 - Nondiscriminatory Treatment

- **Policy:** The facility did not have a policy on nondiscriminatory treatment and no information was contained in the inmate handbook. The facility addressed this immediately and the matter was closed.

Part 7032 - Grievance Program

- **Policy:** Grievance policy not reviewed/revised since 2010.
- **Program Requirements:** The informal grievance process was not completed within 24hours therefore denying inmates access to the formal grievance process.
- Grievance investigations not completed fully and do not detail all facts resulting from relevant interviews. In some cases, there was no documentation at all.
- Grievance being returned as too vague, outside control of the CAO or as non-grievable. After a review it was found that the majority of the grievances should have been processed. A grievance workshop was provided to facility staff in September and October of 2016.
- Grievance timelines not being followed.
- **Continuation and Termination of Grievances:** When inmates were released the CAO was not rendering decisions consistently. When a denial was issued the grievance was not forwarded to the CPCRC for review and determination.
- **Grievance Coordinator Responsibilities:** Facility Grievance staff was not aware of how to electronically submit grievances to the CPCRC.

Part 7063 - Chemical Agents

- **Recording the use of Chemical Agents:** Facility staff not documenting the approximate length and time of exposure.

2017 FACILITY EVALUATION

In September and October 2017, Commission staff completed Minimum Standard evaluations of the Erie County Holding Center and Erie County Correctional Facility. Although the report is pending release, below are the significant findings.

Part 7002 - Admissions

- **Inmate Property:** At the Erie County Holding Center, some property was destroyed with no justification or required documentation.
- **Inmate Rulebook** – At the Holding Center, newly admitted inmates were being issued obsolete versions of the facility rulebook.

Part 7005 – Prisoner Personal Hygiene

- **Laundry:** At the Holding Center, laundry services were only provided once per week, not twice as required. The facility took immediate corrective action by revising protocols to ensure requirements are observed. Considered Closed.

Part 7013 – Classification

- **Commingling:** At the Holding Center, minimum security female inmates were improperly housed with maximum security inmates.
- **Risk Assessment:** At the Holding Center, the screening process did not take into account all relevant data when determining housing or special needs.
- **Override Decisions:** At the Holding Center, an improper blanket policy had been implemented whereby some overrides were automatically determined based on instant offense.

Part 7022 – Reportable Incidents

- **Reporting:** Correctional Facility submissions of reportable incidents to the Commission lacked sufficient information and detail.

Part 7039 – Fire Prevention and Safety

- **Inspections:** Weekly fire and hazard safety inspections were not completed on a consistent basis.

COMMISSION-ISSUED DIRECTIVES AND ENFORCEMENT

On May 16, 2017, the Commission issued a directive to the Erie County Correctional Facility for failing to report significant facility incidents as required by the Commission's regulations, 9 NYCRR §7022.1, §7022.2(b), and §7022.3(a). Specifically, Erie County Correctional Facility failed to report inmate attempted suicides on March 23, 2013, April 24, 2013, December 7, 2013 and September 2, 2015 and failed to properly report an incident involving Carl Miller occurring on September 30, 2016. The Erie County Correctional Facility was directed to ensure that all significant facility events and incidents are reported to the Commission consistent with the Commission's *Reportable Incident Guidelines for County Correctional Facilities* and to submit to the Commission by June 6, 2017 documentation substantiating compliance with the Directive.

On June 2, 2017, Erie County responded to the directive. Erie County indicated that even though they maintain that they documented and reported the incidents in question correctly, they were committed to be in full compliance with the Standards. Erie County indicated that the Command Level Staff were fully briefed on the Commission's interpretation of the terms "life threatening injury" and "life threatening situation" and staff had been advised that the intent of the inmate should not factor into how an incident was categorized. Erie County also indicated that Command Level Staff will review all incidents electronically within 24 hours of occurrence to ensure accurate information is relayed to the Commission and that Line-Up training has been scheduled for facility Watch Commanders and additional training for First-Line Supervisors will be scheduled to ensure accurate information is submitted. Erie County also indicated that in instances where medical and/or mental health determinations determine the categorization of an incident, sufficient information that justifies the decision will be provided to the Commission.

On June 7, 2017, the Commission forwarded to Erie County its assessment of the County's response to the directive, indicating that the actions taken were acceptable and that on-site verification by Commission staff would occur during future visits.

REPORTED SIGNIFICANT FACILITY INCIDENTS*Number of reported incidents per category, from 1/1/16-12/26/17***ERIE COUNTY HOLDING CENTER**

Attempted Escape	2
Erroneous Releases	1
Hospital Admission of Inmate	423
Individual Inmate Disturbance	41
Inmate Accidental Injury	22
Inmate Attempted Suicide	10
Inmate Group Assault/Gang Assault	14
Inmate Self-Inflicted Injury	11
Inmate/Inmate Assault	97
Inmate/Inmate Sexual Offense	4
Inmate/Personnel Assault	20
Inmate-Introduced Contraband	51
Major Maintenance/Service Disruption	2
Minor Disturbance	1
Personnel Accidental Injury	6
Personnel/Inmate Sexual Offense	2
Release of Hospitalized Inmate From Custody	101
Unknown Source-Introduced Contraband	15
Visitor-Introduced Contraband	1

ERIE COUNTY CORRECTIONAL FACILITY

Hospital Admission of Inmate	18
Individual Inmate Disturbance	11
Inmate Accidental Injury	40
Inmate Attempted Suicide	2
Inmate Group Assault/Gang Assault	2
Inmate Self-Inflicted Injury	5
Inmate/Inmate Assault	82
Inmate/Personnel Assault	6
Inmate-Introduced Contraband	24
Personnel Accidental Injury	3
Personnel-Introduced Contraband	1
Release of Hospitalized Inmate from Custody	2
Unknown Source-Introduced Contraband	13
Visitor-Introduced Contraband	3

DUTCHESS COUNTY JAIL

For decades, Dutchess County failed to properly plan to provide sufficient capacity at its county jail, resulting in annual expenditures of millions of dollars to board overflow inmates to other county jails, some located more than two hours from Poughkeepsie. In 2015, the Commission granted a variance for 200 temporary modular dorm beds placed on the current jail property to alleviate the county's financial burden of boarding inmates, contingent upon the county actively moving forward with the construction of new jail space. The Commission continues to work closely with Dutchess County in the planning and design of a new jail expansion project, with an anticipated completion of 2023.

FACILITY OVERVIEW

Description: The Dutchess County Jail houses pre-trial and sentenced inmates in 13 housing areas.
Cells: 292 cells
Dorms: 0 beds
Variance Beds: 200 beds (modular dorms)
Authorized Capacity: 492 beds
12/30/17 population: 374 inmates in-house and 5 inmates boarded out

INMATE OVERCROWDING MANAGEMENT

For decades, the Dutchess County Jail experienced significant inmate overcrowding, due primarily to the county's failure to add needed capacity to the jail. For an extended period of time, the jail routinely boarded out in excess 200 inmates to other county jails throughout the state. Such boarding was estimated to cost approximately \$6 million per year.

In 2014, the Commission provided Dutchess County valuable assistance by authorizing 200 variance beds through the use of four temporary modular housing units erected on the jail property. Such variances were granted on the condition that the county accelerate its efforts to design and construct a new jail expansion. The county set an original goal of 2017 for construction completion and opening of the jail expansion. However, significant delays by the county have pushed the proposed completion date to 2023.

The Commission continues working with jail and county officials as part of the design phase of the project.

INMATE MORTALITY INVESTIGATIONS

Individual 18

DOD: 2011

COD: SUICIDE

MOD: SUICIDE - HANGING

ISSUES: MEDICAL AND MENTAL HEALTH CARE

- Inadequate medical care by medical providers from CMC, Inc. regarding withdrawal management where a benzodiazepine was prescribed to Individual 18 still experiencing signs of intoxication without a physician's exam being completed.
- Individual 18's prior history of a suicide attempt and documented suicidal ideation by nursing staff was not addressed during the psychiatric assessment for continuation of constant supervision.
- Social worker from CMC, Inc. failed to review Individual 18's history of suicide attempt and current suicidal ideation.
- Social worker from CMC, Inc. failed to refer Individual 18 to psychiatry for a follow up when his clinical presentation indicated such was needed.

Individual 19

DOD: 2014

COD: SUICIDE

MOD: SUICIDE (HANGING)

ISSUES: MEDICAL AND MENTAL HEALTH CARE

- Jail staff did not immediately refer Individual 19 to mental health at admission despite his reporting a mental health history and being documented as acting strangely.
- Nursing staff from CMC, Inc. failed to recognize Individual 19's symptoms of mental illness at his admission assessment and take proper precautions.
- Social work staff from CMC, Inc. failed to recognize Individual 19's signs of mental illness and take appropriate actions.
- Jail staff failed to recognize signs of acute mental illness in Individual 19 and refer him to mental health after an incident in a hallway where Individual 19 could not properly follow staff commands.

ATTORNEY GENERAL INQUIRY – CORRECTIONAL MEDICAL CARE, INC.

The Commission and its Medical Review Board investigated six inmate deaths, occurring between 2009 and 2012, at five different county jails contracting with Correctional Medical Care, Inc. (CMC) for inmate health services. CMC is a for-profit business incorporated in Pennsylvania, whose owner is not a licensed medical professional, that previously contracted with thirteen (13) upstate counties. In each of the six inmate death investigation reports, including Individual 18 at the Dutchess County Jail, the Commission and its Medical Review Board revealed that there were egregious lapses in medical care on the part of CMC, to include unlicensed and inexperienced staff, inadequate staffing, a lack of adequate medical oversight, and a failure to adhere to medical and administrative protocols and procedures.

In addition to referring individual healthcare providers to the Office of Professional Discipline and the Office of Professional Medical Conduct, the cases were referred to the New York State Attorney General, requesting an investigation as to whether CMC was illegally engaging in the practice of medicine. Following the referral, the Office of the Attorney General (OAG) caused an inquiry to be made to certain business practices of CMC relating to its delivery of health care services to county inmates. In September 2014, OAG entered into an Assurance of Discontinuance with CMC, whereby CMC agreed to restructure its New York State business operations and contracts, pay for the services of an independent contract monitor, and pay stated amounts of restitution and penalties.

2016 FACILITY EVALUATION

Part 7070 – Educational Services for Youth

- **Policies and Procedures**
- **Educational Services:**
 - a. the facility is not providing educational services to eligible youth, as required, in particular, minors.
 - b. The facility has not made arrangements with the school district to provide such required services

2017 FACILITY EVALUATION

Policies and Procedures:

The Commission found multiple policies and procedure violations during the 2017 evaluation. Many of the policies were found to be outdated and not in compliance with NYS Minimum Standards. The department's policies have not been reviewed by administrative staff as mandated by standard and lack direction to subordinate staff or provide outdated and incorrect information. The following is a list of policies identified that were not in compliance during the evaluation period:

- | | |
|-----------------------------|------------------------------|
| * Inmate rulebook | * Classification |
| * Commissary | * Correspondence |
| * Reportable Incidents | * Religion |
| * Legal Services | * Fire Prevention and Safety |
| * Maximum Facility Capacity | * Correction Law 611 |

Part 7002 - Admissions

- **Property Confiscation:** Confiscated prisoner personal property was not kept in a safe and secure manner. It was found that the hallway door to the property room and the inner door were both unsecured allowing unauthorized access.

Part 7005 - Prisoner Personal Hygiene

- **Clothing:** Female inmates were not being allowed to receive brassieres via packages, as required.

Part 7008 - Visitation

- **Availability of Visits:** The visitation schedule outlined in the inmate rulebook conflicted with actual practice.
- **Contact Visits:** The facility improperly implemented a blanket policy in inmates placed on constant supervision were only permitted non-contact visits with their families.

Part 7013 – Classification

- **Policy:** the facility's written policy and procedures on inmate classification do not reflect current practice, and in some instances, violates Minimum Standard regulations.

Part 7016 - Commissary

- **Purchases:** the facility improperly used commissary profits to purchase items/services that did not benefit the welfare and rehabilitation of inmates, as required.

- **Audit:** the facility could not demonstrate that periodic audits of the commissary program had been completed, as required.

Part 7028 - Exercise

- **Exercise Periods:** the facility was not providing lock-in inmates with the required amount of outdoor exercise on a daily basis.
- **Searches:** the facility was not searching outdoor exercise areas as required.

Part 7031 - Legal Services

- **Notary Public:** the facility was improperly charging inmates for notary services and providing limited notary access to indigent inmates.

Part 7039- Fire Prevention and Safety

- **Fire and Safety Inspections:** the facility has not requested from the appropriate authority an annual fire inspection of the jail.
- **Hazards:** the facility was not addressing, in a timely manner, fire hazards identified during fire safety inspections.

REPORTED SIGNIFICANT FACILITY INCIDENTS

Number of reported incidents per category, from 1/1/16-12/26/17

Fire/Non-arson	1
Hospital Admission of Inmate	100
Individual Inmate Disturbance	14
Inmate Accidental Injury	9
Inmate Attempted Suicide	9
Inmate Self-Inflicted Injury	6
Inmate/Inmate Assault	7
Inmate/Personnel Assault	7
Inmate-Introduced Contraband	9
Major Disturbance	1
Major Maintenance/Service Disruption	5
Minor Disturbance	5
Personnel Accidental Injury	1
Personnel/Inmate Assault	1
Unknown Source-Introduced Contraband	2
Visitor-Introduced Contraband	8

ONONDAGA COUNTY JUSTICE CENTER AND PENITENTIARY¹

Effective January 1, 2018, the Onondaga County Department of Correction has merged with the Onondaga County Sheriff's Office, with the Sheriff assuming custody and control of the Penitentiary in Jamesville. Historically, the Sheriff's downtown Justice Center has experienced overcrowding, often necessitating the boarding of 90 inmates to the Penitentiary. While obvious benefits will result from the merger, inmate overcrowding at the Justice Center may still necessitate added capacity at either facility. The Commission has provided technical assistance to both facilities by identifying existing areas that could be readily converted to appropriate inmate housing, advice that recently led to the identification and realization of 26 added beds to the Penitentiary. Operationally, the Commission has cited the Justice Center after discovering that mandated officer posts have been routinely abandoned, apparently caused by the administration's inability to mandate overtime based on unfavorable provisions of the collective bargaining agreement. The Commission will continue working with the Onondaga County Sheriff to remediate this issue and ensure that both facilities maintain the necessary complement of security staff.

FACILITY OVERVIEW

Onondaga County Justice Center

Description: Opened in 1995, the Onondaga County Jail houses pre-arraigned arrestees and pre-trial and sentenced inmates in 30 housing areas.

Cells: 593 cells

Dorms: 78 beds

Total authorized capacity: 671 beds

12/30/17 population: 537 inmates in-house and 54 inmates boarded out to the Onondaga County Penitentiary.

Onondaga County Penitentiary

Description: Opened in 1983, the Onondaga Penitentiary previously housed only Onondaga County sentenced inmates. In recent years, the facility has also housed unsentenced inmates boarded from the Onondaga County Justice Center. The facility houses inmates in 30 housing areas.

Cells: 190 cells

Dorms: 348 beds

Total authorized capacity: 538 beds

12/30/17 population:

¹ On November 7, 2017, Onondaga County voters approved a proposal that would merge the Onondaga County Department of Correction (DOC) with the Onondaga County Sheriff's Office and the Onondaga County Jail (Justice Center), effective January 1, 2018.

FACILITY STAFFING DEFICIENCIES

In 2017, Commission staff identified numerous instances at the Justice Center in which daily posts required by the Commission's Position and Staffing Analysis were not filled. These instances were attributed, by the Sheriff's Office, to a provision in the current Collective Bargaining Agreement which allows officers to obtain a physician's certification report restricting work of overtime entirely or limiting overtime on a voluntary basis. The Commission continues to work with the Onondaga County Sheriff's Office in addressing this matter.

INMATE OVERCROWDING MANAGEMENT

For the past several years, the Onondaga County Justice Center has experienced significant inmate overcrowding. To assist the county, the Commission has routinely approved Substitute Jail Orders, in accordance with Correction Law §504, that permit the Justice Center to board overflow inmates to the Penitentiary. The Commission also assisted by authorizing temporary capacity variances at both facilities. With the January 1, 2018 merger of both departments, the Onondaga County Sheriff will assume custody of both facilities, rendering reliance on Substitute Jail Orders moot. However, lack of sufficient housing at the Justice Center still requires the county's attention.

In 2016, Commission staff visited the Justice Center for the purpose of identifying potential areas that could be converted to housing space. Commission staff identified two areas that could be converted to housing, thus, adding approximately 40-beds to the facility's capacity. These areas would require certain upgrades (i.e., adding of toilets, sinks, and showers, etc.) in order to house inmates.

In 2016, Commission staff visited the Penitentiary also for the purpose of identifying potential areas that could be converted to housing space. Commission staff identified two current housing areas, the capacities of which could be increased with minimal upgrades (toilets, sinks, etc.). The Penitentiary requested and received authorization from the Commission to increase the capacity in these two housing areas, realizing an increase of 26-beds.

In recent years, Onondaga County has commenced discussions on long-term planning to address overcrowding, including the construction of another tower (housing areas). The county will likely take a wait-and-see approach as to the impact the merger will have on overall operations and available housing.

The Commission remains available to provide technical assistance to the county in this endeavor.

2016 FACILITY EVALUATION

Commission staff completed Minimum Standard evaluations of the Onondaga County Justice Center during multiple site visits. Violations are noted below.

Part 7003 – Security and Supervision

- **Key Control:** Justice Center staff were observed leaving computer touchscreens unattended and unsecured, thus creating a potential security breach.

Part 7006 – Discipline

- **Discipline:** Justice Center housing deputies were permitted to arrange for plea bargaining with inmates as part of informal discipline. Such a practice is not authorized by Commission regulations.

Part 7032 – Grievance Program

- **Inmate Access:** Serious concerns have arisen as to whether inmates are provided access to grievance forms at the Justice Center.
- **Grievable Issues:** A review of inmate grievances filed at the Justice Center revealed instances in which the facility improperly denied grievances as being timely.
- **Documentation:** A review of inmate grievances filed at the Justice Center revealed instances in which the grievance coordinator closed the grievance but failed to provide supporting documentation as to why.

2017 FACILITY EVALUATION

Commission staff completed Minimum Standard evaluations of the Onondaga County Justice Center and Penitentiary during multiple site visits. Violations are noted below.

Part 7002 – Admissions

- **Inmate Handbook:** The Justice Center and Penitentiary inmate handbooks included rules and policies that violate several Commission regulations.
- **Property Destruction:** The Penitentiary was found to have been destroying certain types of inmate personal property (lighters, etc.) confiscated during the admissions process. The facility addressed this matter.

Part 7005 – Prisoner Personal Hygiene

- **Clothing:** At the Justice Center, several instances were noted in which inmates placed on constant supervision were not provided required clothing or bedding.
- **Shaving:** The Penitentiary was found to have been improperly limiting the opportunity of certain inmates' ability to shave on a daily basis.

Part 7013 – Classification

- **Initial Screening:** Neither the Justice Center nor the Penitentiary captures an inmate's entire history of detention nor does its classification instrument address all necessary elements as required as required by this section.
- **Review:** The Justice Center's review of inmate classifications does not take into account all relevant information.
- **Commingling:** The Justice Center was found to have been commingling inmates of different custody levels and housing males and females together in the medical unit.

Part 7016 – Commissary

- **Purchases:** The Justice Center and Penitentiary were found to have made improper purchases, using commissary profits, that do not benefit inmate welfare and rehabilitation.

Part 7024 – Religion

- **Services:** The Penitentiary was found to have been restricting inmates of certain classifications from participating in congregate bible study and Quran study programs. The facility addressed this issue.

Part 7028 – Exercise

- **Exercise:** Determinations as to whether or not the exercise yards’ louver doors (which open to allow a view to the outside) are made by deputies instead of the watch commander.

Correction Law §611 (Restraint of Pregnant Inmates)

- **Policy and Practice:** The Justice Center’s policy and procedures do not address all requirements and, in some instances, violate the requirements of this law.

CIVIL RIGHTS LITIGATION

In September 2016, a class action complaint was filed against the Onondaga County Sheriff, various jail officials, and the Syracuse City School District in United States District Court for the Northern District of New York. The complaint alleged that 16 and 17-year-old inmates at the Onondaga County Justice Center were routinely subjected to the imposition of solitary confinement in violation of the Eighth and Fourteenth Amendments, and were thereafter denied minimal education instruction and special education guaranteed by state law.

The action was settled in June of 2017 when the Onondaga County Sheriff stipulated that such inmates would only be confined to a cell upon a determination that there exists an imminent safety threat that “less restrictive measures cannot adequately resolve,” with such confinement lasting for only the minimum period necessary to resolve such safety threat. Additionally, the Syracuse School District agreed to provide such inmates access to education, special education services, and an incentive program to encourage better behavior among teen inmates.

It should be noted that this action, and similar litigation against the Broome County Jail, was the impetus for the creation of new Commission regulations. Proposed in late 2017 and scheduled for adoption in early 2018, the Commission’s new regulations will create a presumption that every inmate in administrative or punitive segregation will be allowed out of his cell for a minimum of four hours a day, which may only be denied upon a written determination of the facility’s chief administrative officer that doing so would jeopardize facility safety, security or good order. Furthermore, the regulations will require enhanced reporting, by a facility to the Commission, of designated instances of cell confinement, and the denial of certain essential services, such as educational programs. Once effective, the Commission will have a greater capacity to sufficiently identify, monitor and investigate problematic inmate deprivations similar to that alleged in Onondaga and Broome counties.

COMMISSION-ISSUED DIRECTIVES AND ENFORCEMENT

In November 2012, it was brought to the Commission's attention that inmates, whose custody was legally transferred from the Justice Center to the Penitentiary, nevertheless remained under the supervision of deputies employed by the Onondaga County Sheriff. The Commission sent a Notice of Violation to both the Onondaga County Sheriff and the Onondaga County Department of Correction's Commissioner informing them of the violation of Correction Law §504 and §500-a. On November 20, 2012, the Commission issued a directive to the Onondaga County Penitentiary for allowing the detention and confinement of inmates, committed to the custody of the Onondaga County Sheriff, within the Onondaga County Penitentiary. Specifically, the Onondaga County Penitentiary was in violation of Correction Law §500-a(1), in that the Onondaga County Penitentiary was allowing the detention and confinement of inmates, committed to the custody of the Onondaga County Sheriff, within the Onondaga County Penitentiary and supervised by the deputies of the Sheriff. The Commissioner of the Onondaga County Penitentiary was directed to refrain from detaining and confining inmates committed to the Onondaga County Sheriff within the Onondaga County Penitentiary.

On December 27, 2012, the Commissioner of the Onondaga County Penitentiary agreed that inmates who were transferred from the Onondaga County Justice Center to the Onondaga County Penitentiary by a Substitute Jail Order would be supervised by Correction Officers from the Onondaga County Department of Correction.

In 2014, the Onondaga Deputy Sheriff's Benevolent Associate sued Onondaga County and Sheriff Kevin Walsh in order to have the Deputy Sheriffs supervise the inmates who were being housed from the Onondaga County Justice Center in the Onondaga County Penitentiary. On February 11, 2016, the judge hearing the case, granted the Defendant's motion for summary judgement.

REPORTED SIGNIFICANT FACILITY INCIDENTS

Number of reported incidents per category, from 1/1/16-12/26/17

ONONDAGA COUNTY JUSTICE CENTER

Capture/Erroneous Release	1
Discharge of Firearm	2
Erroneous Releases	3
Individual Inmate Disturbance	88
Inmate Attempted Suicide	11
Inmate Self-Inflicted Injury	6
Inmate/Inmate Assault	13
Inmate/Inmate Sexual Offense	1
Inmate/Personnel Assault	5
Inmate-Introduced Contraband	32

Minor Disturbance	35
Release of Hospitalized Inmate from Custody	1
Unknown Source-Introduced Contraband	1
Visitor-Introduced Contraband	1

ONONDAGA COUNTY PENITENTIARY

Capture/Erroneous Release	1
Erroneous Releases	1
Evacuation of Facility	1
Hospital Admission of Inmate	52
Individual Inmate Disturbance	49
Inmate Attempted Suicide	9
Inmate Group Assault/Gang Assault	3
Inmate Self-Inflicted Injury	9
Inmate/Inmate Assault	27
Inmate/Personnel Assault	4
Inmate-Introduced Contraband	21
Minor Disturbance	16
Personnel Death	1
Unknown Source-Introduced Contraband	4
Visitor-Introduced Contraband	2