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Correctional Association of NY

Testimony before the NYS Assembly Committee on Correction, Chair Daniel O'Donnell re: Oversight and Investigations of the Department of Corrections and Community Supervision (DOCCS)

December 2, 2015

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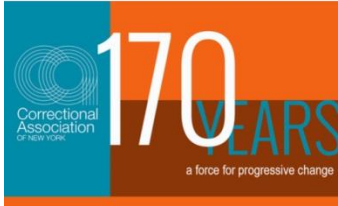
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The Correctional Association of NY (CA) would like to thank Chairperson O’Donnell and the NYS Assembly Committee on Correction for the opportunity to present testimony on this incredibly important and timely subject of oversight and investigations of the Department of Corrections and Community Supervision (DOCCS). The CA has had authority granted by the New York State legislature since 1846 to serve as one mechanism of oversight by visiting New York State’s prisons and reporting its findings and recommendations to the legislature, other state policymakers, and the public. Our access provides us with a unique opportunity to observe and document actual prison practices and to learn from incarcerated persons and staff. Based on over 170 years of experience serving as one mechanism of independent public oversight of DOCCS, and based on what we have learned from incarcerated persons, staff, administrators, and DOCCS officials, the CA is very pleased that the legislature is exploring this subject and appreciative of the opportunity to share its own insights and ideas.

This testimony will proceed in four parts. Following an executive summary, Part I will describe and assess various mechanisms for oversight and investigations of DOCCS prisons, based on experience with NY’s current systems and best practices from other states and countries. Based on this analysis, Part II will propose specific recommendations for the NY legislature and Governor to consider to provide comprehensive and effective oversight and investigations of DOCCS. Part III will describe why it is so imperative for the legislature to take action to create and expand oversight and investigative mechanisms, highlighting some of the worst abuses taking place within NY prisons. Part IV will propose that changes to oversight and investigations be part of a broader package of legislative changes in order to end the abuses taking place, transform the racist and punitive culture and environment of DOCCS prisons, and ultimately make staff, people who have been incarcerated, and all New Yorkers safer and more enriched.

[Executive Summary](#)

The longstanding and ongoing brutality, torture, and abuse taking place within New York State prisons demands that DOCCS can no longer police itself and that the legislature must make bold

fundamental changes to end the abuses occurring inside. There are effective mechanisms of oversight and investigations from other states and other countries that the NYS legislature can use as models to implement meaningful changes in New York. As experts have documented, various types of mechanisms must be implemented together, as each serves a particular function and only when carried out independently at the same time can there be effective transparency and accountability. The legislature should expand oversight at each of the following levels: (a) public oversight; (b) oversight and investigations wholly independent of NYS; (c) oversight and investigations by state agencies; (d) DOCCS agency-level mechanisms; and (e) prison-level mechanisms. Moreover, the legislature should implement these necessary changes to oversight and investigations of DOCCS with a broader package of policy changes aimed at transforming the entrenched racist and excessively punitive culture of the incarceration system in New York.

One of the most important forms of oversight of DOCCS must include **public oversight**. Two key areas where the legislature could act to bring about greater transparency are: 1) expanding media access to NYS prisons; and 2) mandating public reporting by DOCCS and other state agencies. Currently it is nearly impossible for media to video or photograph NY prisons, and extremely difficult even to interview incarcerated persons or obtain requested documents and information from DOCCS in a timely manner. The legislature should require DOCCS to have a presumption that members of the media are able to, at a minimum, confidentially interview incarcerated persons, take tours of the prisons, utilize audio and video recording for both interviews and tours, and obtain documents and information in a timely manner. Similarly, it is extremely difficult for the public to obtain even basic data and information from DOCCS and other relevant state agencies; their public reports have become fewer, often substantially delayed, with less information, and requests through the Freedom of Information Law (FOIL) have become further and further delayed – at times taking over a year to obtain. The legislature should require that DOCCS, the Office of Mental Health (OMH), the Justice Center, the State Commission of Correction, the Department of Health (DOH), the Office of Alcoholism and Substance Abuse Services (OASAS) and other state agencies make publically available, in easily accessible formats, various categories of data relevant to violence and abuse, solitary confinement, mental health care, medical care, deaths in the prisons, prison-based treatment and educational programs, shackling, and parole.

At the next level, the legislature should support **oversight and investigations wholly independent of New York State**, including by the federal Department of Justice (DOJ), United Nations bodies, the Correctional Association of NY, independent PREA auditors, local community monitors, and the courts. Given the entrenched and pervasive brutality occurring throughout NYS prisons, coupled with the widespread infliction of solitary confinement, the legislature should support the call for a statewide systemic investigation of NY prisons by the federal DOJ as the most likely body to carry out a fully independent and comprehensive evaluation. The legislature should also mandate that DOCCS allow and help facilitate the U.N. Special Rapporteur on Torture and other United Nations agencies to visit prisons in New York to

investigate the use of solitary confinement, brutality, and other abuses, particularly given the repeated unsuccessful attempts by the Special Rapporteur to gain access. Further, given existing restrictions on the CA's ability to carry out its nearly 170-year-old legislative mandate to monitor conditions in NY prisons, the legislature should augment the CA's authority, including by authorizing the CA to carry out unannounced visits and have full timely access to documents, staff, and incarcerated persons; and by requiring DOCCS to publicly respond to the CA's findings and recommendations and, if it agrees, document and take corrective action. In addition, the legislature should consider adopting a model of community oversight based on the Independent Monitoring Boards in the United Kingdom, where local community members have unfettered access to monitor, investigate, and oversee each prison. Furthermore, the legislature should strengthen the ability of incarcerated persons to bring legal cases through the judicial system. Moreover, the legislature should adopt some of the positive aspects of federal PREA auditing guidelines in developing independent oversight mechanisms for all forms of abuse, while rectifying some of the substantial limitations of the current PREA audit process.

At the state level, the legislature should expand **oversight and investigations of DOCCS by independent state agencies**, including by creating new bodies and/or enhancing existing agencies' efforts. Again given the longstanding and entrenched abuses within DOCCS prisons, there must be state-level oversight body/bodies with sufficient independence, will, and resources to carry out regular routine unannounced visits, with unencumbered and confidential access to prisons, incarcerated persons, staff, and documents, and an obligation to publically report findings and recommendations with a concomitant obligation on DOCCS to publically respond and take remedial action. The legislature could achieve these objectives in part by **expanding the authority and power of existing state agencies** to investigate DOCCS and providing them with adequate resources to perform their legislative duties.

For example, the Justice Center currently has vast powers of investigation, prosecution, subpoena, and tracking of staff abuses of people with special needs in state agencies other than prisons; the DOCCS exemption should be removed and the Justice Center should be provided additional resources to effectively carry out its mandate and apply these same powers to prisons. Similarly, SCOC – while failing to provide meaningful oversight of NY prisons in general – has carried out meaningful investigations of suicides and deaths; and its role in that specific arena should be expanded to carry out broader medical reviews and assessments of incidents of self-harm. Also, DOH should have enough resources to carry out its existing mandate to oversee HIV and hepatitis C care in NY prisons and its mandate should be expanded to have oversight over all health care. Similarly, the legislature should explore why OASAS has not been carrying out its mandate to monitor prison substance abuse treatment programs. In addition, given the extreme lack of political will for local prosecutors to take action in correction officer brutality cases (evidenced by the fact that the first ever prosecutions of non-sexual assault by COs took place this year), the legislature should expand on the Governor's appointment of a special prosecutor

for certain police killings and create a special prosecutor for cases of staff brutality of incarcerated persons.

The legislature must also **transform existing DOCCS agency-level investigative mechanisms**. Specifically, given that the existing DOCCS' Office of Special Investigations (OSI) fails to effectively investigate or address staff abuses and often serves as a cover-up for such abuses, the legislature should transfer power for investigating staff abuse of incarcerated people from OSI within DOCCS to a wholly independent investigative body outside of DOCCS. In addition, given the extreme difficulties faced in removing or disciplining an officer even in cases where DOCCS and the state want to take such action, the legislature should remove remedial decisions for staff abuse from the arbitration process and allow DOCCS/Superintendents to override bid placements in cases of staff abuse of incarcerated people. The legislature should also strengthen prohibitions and reporting requirements for staff use of force; and create automatic remedial actions, including employment termination, for substantiated staff abuse of incarcerated people. In addition, the legislature should investigate the effectiveness of DOCCS' recently implemented PREA compliance operations, and build from any positive aspects of these operations related to sexual abuse to investigate and address allegations of all types of staff abuse.

Further the legislature must **transform existing prison-level mechanisms**. The grievance system currently rules against incarcerated people in almost all cases, functions as little more than a barrier to incarcerated people filing litigation, and is not properly tracked and analyzed. It needs to be fundamentally transformed to serve a positive function, including by removing barriers that limit access to courts; adequately analyzing, publicizing and taking responsive actions individually and systemically to grievances filed; ensuring that staff involved in grieved incidents are not part of the investigations; allowing for confidential complaints, and protecting people against retaliation. The legislature should also create an independent ombudsman system to supplement the grievance system, where incarcerated people can raise confidential complaints, including through an outside hotline, and the ombudsman has the power and resources to investigate complaints, initiate remedial action, and advocate for system-wide reforms.

Similarly, the legislature needs to fundamentally transform the disciplinary system of incarcerated persons to stop it from being a system for covering up staff abuses and ensure its fairness. At a minimum, for example, the legislature should require neutral decision makers, enforceable rights to introduce evidence and call and cross-examine witnesses, and allow legal representation. Further, the legislature should require that DOCCS more thoroughly and effectively utilize the Unusual Incident Report (UIR) process to analyze and address staff abuses in the prisons. More generally, prison superintendents, DOCCS, and the state need to develop effective electronic tracking systems and means of analysis, redress, and public reporting of grievances, complaints, UIRs, Use of Force reports, investigations, lawsuits, and other measures (such as issues raised by the Inmate Liaison Committee) in order to be able to systematically analyze and address abuses and problem areas in the prisons, including by individual staff and at particular prisons, locations, and times.

All of these additional mechanisms for oversight and investigations of DOCCS – at the public, external, state, agency, and prison levels – are essential to address the longstanding and appalling abuses taking place within NY prisons. The inhumane treatment of incarcerated people cries out for change – from widespread and horrific staff brutality and violence; to the torture of solitary confinement; to failed medical and mental health services; to the shackling of pregnant women and other reproductive injustices; to the targeting of young and elderly people, people with mental health needs, and members of the LGBT community; to the broken parole system and the failures of education and reentry; to sexual violence; to all of the other abuses of women, men, and children pervasive in NYS prisons. Making all of these abuses worse, there is a complete lack of effective oversight and investigations, and a frequent utilization of existing mechanisms to cover-up rather than stop abuses taking place. In light of these deficiencies, the legislature must act to create meaningful transparency and accountability for individuals and the system.

Moreover, while greater oversight and investigations of DOCCS are essential for addressing the multitude of abuses taking place within the NY prison system, these mechanisms must be part of a **broader package aimed at transforming the entrenched racist and punitive culture** of that system and ending mass incarceration. The problems within DOCCS prisons are not the result of a “few bad apples.” The culture and environment of brutality, violence, excessive punishment, dehumanization, intimidation, fear, and abuse must end. It must be replaced by a culture that prioritizes mutual respect and communication between staff and incarcerated persons; conflict resolution, transformation, and de-escalation; and individual autonomy, support, programs, empowerment, and personal growth for incarcerated persons. Examples from around the world – such as systems in Germany, the Netherlands, Norway, and Sweden; from around the country – such as the Resolve to Stop Violence Project in San Francisco jails; and from within New York State – such as the now closed Merle Cooper program; demonstrate that an alternative culture focused on growth, transformation, and preparation for return to the community can have much more successful outcomes, including decreased violence within prisons, better job satisfaction for staff and experiences for incarcerated people; and lower recidivism rates and greater success for people returning home.

Thus, in addition to enhancing oversight and investigations, the legislature and Governor should also **adopt specific legislation to begin to transform the culture** across DOCCS prisons and move away from the use and abuse of incarceration. New York policy-makers must demonstrate their seriousness in ending staff brutality and abuse; shift away from a punishment paradigm rooted in racism toward a model premised on effective rehabilitation, treatment and growth; and reduce the number of people incarcerated to allow for greater ability to implement a more empowering culture with a smaller number of people inside and provide greater resources in outside communities. Specifically, among other **necessary policy changes**, the legislature should: 1) close Attica and end violence and abuse across NYS prisons; 2) end the torture of solitary confinement, including through passage of A. 4401 /S. 2659, A.1346A / S. 5900 and A.1347 / 5729 ; 3) raise the age of criminal responsibility; 4) end shackling of pregnant women

(A. 6430-A / S. 983-A) and promote reproductive justice; 5) release aging people from prison and meaningfully reform parole, including through the SAFE Parole Act, A. 2930 / S. 1728; 6) protect domestic violence survivors by passing the Domestic Violence Survivors Justice Act (DVSJA), A. 4409 / S. 2036; 7) expand general and higher education programs, including by reinstating TAP for incarcerated people; 8) support people with mental health needs in outside communities and in prisons; 9) stop the over-criminalization and abuse of LGBT persons; 10) adopt a modified version of Governor Cuomo's justice agenda to DOCCS prisons including a reconciliation commission, and assessing and addressing vast racial disparities between staff and incarcerated people; and 11) adopt racial impact studies for new criminal injustice policies.

All of the above changes, when combined with expanded effective oversight and investigations, will help ensure fairness in the DOCCS system and end abuses taking place; help move away from the state's reliance on incarceration; promote greater respect for the rule of law and societal institutions by staff, incarcerated people, and the public; empower healthier and more successful people who have been incarcerated; and ultimately make us all safer and more enriched.

I. Proposed New Mechanisms for Investigations and Oversight

1. Transforming Internal Prison Oversight Mechanisms

At each DOCCS prison there are several mechanisms intended to: (1) compile and assess complaints by incarcerated persons about their treatment and conditions of confinement; (2) adjudicate violations of prisons rules by the incarcerated population; and (3) investigate unusual incidents occurring at the prison, including assaultive behavior by staff or incarcerated persons, sexual abuse by staff or incarcerated persons, use of force by staff, and other uncommon occurrences at the prison that may constitute inappropriate behavior by staff or incarcerated persons or incidents that pose a significant risk to the safety of those in the prison. For incarcerated persons, they can raise concerns about their treatment by staff or about general prison conditions through the grievance process, the Inmate Liaison Committee (ILC) or through correspondence with the prison administration. Violations of prison rules by incarcerated persons are adjudicated through the prison disciplinary system, which entails three different tiers of violations and associated processes for adjudicating those alleged violations of prison rules. More serious events occurring at the prison are investigated and reported through the Unusual Incident Report (UIR) and Use of Force processes. Special investigative and reporting procedures exist for sexual abuse allegations by staff or incarcerated persons. We will briefly review each of these mechanisms and suggest potential improvements in the current processes where appropriate.

Limitations of the DOCCS Grievance System

The DOCCS grievance process is the primary mechanism incarcerated persons are told to use to raise concerns they have about their treatment, conditions of confinement, or the failure of the Department to follow prison policies and procedures that directly affect them. Overall, the CA has found that the grievance system is frequently ineffective, and when the complaints by the incarcerated population relate to the conduct of staff, grievants are too often subjected to retaliation for pursuing complaints. Because the *Prison Litigation Reform Act* (PLRA) requires that any incarcerated person who wants to seek legal redress through the federal courts must exhaust their administrative remedies, which in New York means the DOCCS grievance system, persons who want to preserve their legal rights must file a grievance and pursue all appeals of the grievance even if they have little expectation that it will result in any relief and may prompt negative responses from the facility staff.

The grievance process is defined by DOOC Directive 4040 and entails several steps an incarcerated person must take within specified time limits to pursue his/her complaint and ensure that his/her rights to file litigation are preserved.¹ Although not a prerequisite to filing a grievance, persons must first attempt to resolve their problem informally by raising it with the appropriate prison official; otherwise, the grievance can be dismissed for not taking this step.² Persons can contact the grievance office and seek their assistance with a matter, but decide not to formally file their grievance. If they want to file a grievance, they must file a complaint with the grievance clerk within 21 calendar days of an alleged occurrence upon which the grievance is based.³ Once a grievance is filed, efforts are made by the grievance supervisor to resolve the matter informally without conducting a hearing, and the grievance can thereafter be withdrawn with the consent of the grievant.⁴ In practice, many grievances are disposed of by the grievance staff at this point or even prior to the formal filing, but many persons also report to us that they are pressured to withdraw their grievance prior to conducting a hearing. If the grievance is not resolved informally, the complaint – except in cases of alleged staff abuse of incarcerated people, emergencies, unlawful discrimination or strip searches/strip frisks as discussed below – will be referred to an Inmate Grievance Resolution Committee (IGRC) hearing. The IGRC hearing will be held before a panel comprised of two incarcerated persons assigned as IGRC representatives, two prison staff members assigned to the committee by the prison administration and an IGRC chairperson who is conducting the hearing but not voting on the disposition.⁵ At the hearing, the grievance can be dismissed for several reasons, including that it is not a grievable issue, that alternative procedures exist to address the specific issue raised in the complaint or the person

¹ DOCCS Directive 4040, Inmate Grievance Program 7/12/2006.

² *Ibid.* at 701.3,(a) 701.5(b)(4)(i)(a).

³ *Ibid.* at 701.5(a)(1).

⁴ *Ibid.* at 701.5(b)(1).

⁵ *Ibid.* at 701.5(b)(2) and (3).

was not personally impacted by the action/issue raised in the complaint.⁶ In order for the IGRC to make a decision, three of the four voting members must approve the decision; otherwise, the matter is referred to the facility superintendent for resolution. Essentially, this means that the IGRC committee cannot render a decision in favor of the grievant without at least one staff member supporting the complainant. If the issue raised in the grievance requires superintendent or DOCCS Central Office action because the recommendation involves facility-wide or system-wide policy or procedure changes, the IGRC hearing decision must be written in the form of a recommendation and referred to the superintendent or DOCCS Central Office for a decision.⁷

The next step in the grievance process is an appeal to the superintendent if the grievant is not satisfied with the outcome of the hearing.⁸ The grievant must file an appeal within seven days after receipt of the IGRC decision; if no appeal is filed, it is presumed that the grievant accepts the committee's recommendation. The superintendent or his/her designee must first determine whether the grievance involves department policy or directive, in which case the grievance will be forwarded to DOCCS' Central Office Review Committee (CORC). Otherwise the superintendent will review the IGRC decision and appeal and render a decision within 20 days of receipt of the appeal. The grievance supervisor or the superintendent must verify compliance with the final decision in writing; if the decision is not implemented within 45 days the grievant may appeal to CORC citing lack of implementation.

The final step in the grievance process is an appeal to CORC if the grievant is dissatisfied with the decision of the superintendent.⁹ The appeal to CORC must be submitted within seven days after receipt of the superintendent's decision. It is sent by the grievance office to CORC within seven days and CORC has 30 days to make a determination on the appeal once it is received in Central Office.¹⁰

Table 1 summarizes the grievance process for the period 2008 through 2013, the latter date being the most recent data available from DOCCS.¹¹ During this period, both the number of grievances and the total number of contacts with the grievance office have declined by 27% and 29%, respectively, while the number of incarcerated persons in DOCCS has decreased by 12%.

⁶ *Ibid.* at 701.5(b)(4)

⁷ *Ibid.* at 701.5(b)(3).

⁸ *Ibid.* at 701.5(c).

⁹ *Ibid.* at 701.5(d)

¹⁰ *Ibid.* at 701.5(d)(3)

¹¹ The information contained in Table 1 is taken from *DOCCS Inmate Grievance Program Annual Reports* for the period 2008 through 2013.

TABLE 1 - SUMMARY OF DOCCS GRIEVANCES CALENDAR YEARS 2011-2013

Year	Griev. Files	% Fac Contact	Informal Resolve	IGRC Hearings	Dismiss	Supt. Level	Close Resolve	CORC Appeals	Non-Calendar	% Fac Contact	Total Contacts
2013	31,638	63.4%	4,245	21,156	1,147	17,800	21,704	9,934	18,226	36.6%	49,864
% File			13.4%	66.9%	3.6%	56.3%	68.6%	31.4%			
2012	32,579	60.5%	3,916	23,148	1,907	18,253	22,815	9,894	21,237	39.5%	53,816
% File			12.0%	71.1%	5.9%	56.0%	70.0%	30.4%			
2011	34,013	60.2%	3,703	23,659	1,686	19,635	22,596	11,417	22,496	39.8%	56,509
% File			10.9%	69.6%	5.0%	57.7%	66.4%	33.6%			
2010	35,600	63.3%	3,614	25,016	1,499	20,832	23,181	12,419	20,635	36.7%	56,235
% File			10.2%	70.3%	4.2%	58.5%	65.1%	34.9%			
2009	37,557	60.5%	3,729	26,548	1,844	21,732	24,402	13,155	24,556	39.5%	62,113
% File			9.9%	70.7%	4.9%	57.9%	65.0%	35.0%			
2008	43,087	61.6%	4,965	29,858	1,860	25,081	30,124	15,086	26,915	38.4%	70,002
% File			11.5%	69.3%	4.3%	58.2%	69.9%	35.0%			

The data contained in **Table 1** also prompts several observations and some concerns. First, during this period, 37% to 40% of all contacts with the grievance office are listed as non-calendar events for which no documentation is generated. Although the DOCCS Grievance Program Annual Report for 2013 characterizes these encounters as incarcerated person “contacts, clarifying issues and enabling inmates to resolve problems without submitting a formal grievance,”¹² it is our understanding from the incarcerated population that many of these contacts are in fact grievances submitted by them which were subsequently withdrawn prior to being formally recorded by the grievance office. Given that these contacts are nearly 40% of all complaints submitted by the incarcerated population, it is extremely concerning that there is essentially no record of the subject matter of these complaints, why the complaint or questions were withdrawn, and what outcome resulted from the grievance office assistance. This dearth of information is significant because many individuals report to the CA that they have been pressured to withdraw their grievances by facility staff or that their grievance was not recorded or acted upon by the facility. Without paper records of the unfiled grievance or any log or indication of what the incarcerated person was requesting or the subject matter of the complaint, it is impossible to assess whether such inappropriate suppression of complaints is occurring at a facility.

Second, it appears from the data contained in the DOCCS Annual Grievance Reports that almost one-fifth of the grievances are not processed by the IGRC at all, either informally or through a hearing. Although the DOCCS Annual Grievance Reports since 2010 are silent about these grievances, in the 2009 DOCCS Annual Grievance Report there is a summary of the grievance

¹² DOCCS Inmate Grievance Program Annual Report 2013, at 2 (2014).

program in the appendix which appears to explain how these additional grievances were processed.¹³ This statistical summary indicated that 482 grievances were withdrawn and 6,798 grievances were not heard by the IGRC, but were sent directly to the superintendent, including those that were "harassment, emergencies, unlawful or untimely."¹⁴ This group includes all grievances coded as complaints about staff conduct (code 49), which is the second most common issue grieved by the incarcerated population after medical concerns. Directive 4040, section 701.8, provides that grievances that allege employee harassment - defined as "alleged employee misconduct meant to annoy, intimidate or harm an [incarcerated person],"¹⁵ must be sent directly to the superintendent for processing. But staff conduct grievances only accounts for about 40% of these non-IGRC reviewed grievances. Directive 4040 also requires that complaints about unlawful discrimination (§ 701.9) and strip searches or strip frisks (§ 701.10) be sent directly to the superintendent. There is no code for unlawful discrimination, but Directive 4040 defines it as "[a]llegations of acts or policies which adversely affect individuals based on race, religion, national origin, sex, sexual orientation, age, disabling condition(s) or political belief."¹⁶ Given this category is not even listed in any DOCCS Annual Grievance Report and relevant codes such as religion have very small number of annual grievances, we strongly suspect this accounts for very few direct referrals to the superintendent. Similarly, all the grievances about strip searches, strip frisks or pat frisks of women amount to only 42 grievances in 2013. Given the small number of special categories of direct referrals to the superintendent, it is unclear what types of other grievances are being exempt from the hearing process. For grievances sent directly to the superintendent, no alternative hearing is held so the grievant cannot make a presentation to the person making a decision on the grievance. Nor are witnesses necessarily called, and it is unclear what record is made of the grievance investigation. For harassment grievances, the Directive 4040 requires an investigation by a supervisor, but it does not define what such an investigation entails or particularly what rights a grievant has in that investigative process.

Table 2 summarizes the grievance data for non-calendared events, informally resolved grievances and IGRC hearings and reveals that during the period 2008 through 2013, 17% to 20% of the total number of grievances filed were not processed by the IGRC or the grievance supervisor. For 2013, this amounted to 6,200 grievances (19.7%) and in 2008 it was 8,200 grievances. We strongly suspect that many of these grievances do not result in a favorable disposition for the grievant because the matter is going directly to the superintendent. When one adds together all the non-calendar contacts that are unrecorded and this latter group of grievances not processed by the IGRC, about half of the issues raised with the grievance office are not reviewed by the full IGRC or subject to an IGRC hearing.

¹³ DOCCS Inmate Grievance Program Annual Report 2009, Appendix 3 2009 Year End Statistical Report - All Facilities (2010).

¹⁴ *Ibid.*

¹⁵ *Ibid.* at 701.2(e).

¹⁶ *Ibid.* at 701.9.

TABLE 2-Summary of Non-IGRC and Non-calendared Grievances 2008-13

Year	Griev. Files	Inform. Resol.	% Resol.	IGRC Hearings	% Hear.	Non IGRC	% to Supt.	Non-Calend.	Total Non-Cal & Non-IGRC	% of Total	Total Contacts
2013	31,638	4,245	13.4%	21,156	66.9%	6,237	19.7%	18,226	24,463	49.1%	49,864
2012	32,579	3,916	12.0%	23,148	71.1%	5,515	16.9%	21,237	26,752	49.7%	53,816
2011	34,013	3,703	10.9%	23,659	69.6%	6,651	19.6%	22,496	29,147	51.6%	56,509
2010	35,600	3,614	10.2%	25,016	70.3%	6,970	19.6%	20,635	27,605	49.1%	56,235
2009	37,557	3,729	9.9%	26,548	70.7%	7,280	19.4%	24,556	31,836	51.3%	62,113
2008	43,087	4,965	11.5%	29,858	69.3%	8,264	19.2%	26,915	35,179	50.3%	70,002

Third, it is impossible to assess the effectiveness of the grievance process from the DOCCS data. There is almost no data on the outcomes from the grievance process to determine whether: (a) the complainant was (1) denied, deprived or delayed in receiving some essential service, item or benefit and/or (2) treated inappropriately by staff; or (b) some prison or DOCCS policy, directive or process violated the rights of the complainant and required modification. Moreover, there is no indication whether and what DOCCS did in response to these complaints and whether the action taken adequately addressed the concerns raised by the grievant.

The data provided by DOCCS about outcomes is unclear in several respects. As noted above, there can be no assessment of the outcome from the 37% to 40% of contacts with the grievance office that are not calendared since we do not know anything about what was sought or done.

Of the 30 to 40 thousand grievances actually filed each year, generally about 10% to 13% of the grievances are informally resolved, from which we may conclude that the grievant was not interested in pursuing the complaint further. This may mean that the matter was resolved, but it could also mean that the grievant decided to withdraw the request for a hearing because his complaint was not supported by evidence or inconsistent with departmental policies, or because he was pressured by staff or fearful of retaliation. As we discuss later in this testimony in greater detail, we have much anecdotal evidence to suggest that these latter situations occur on a regular basis, particularly when the complaint is directed at behavior by staff.

IGRC hearings are conducted for about 67% to 71% of the filed grievances. Of these, approximately 4% to 6% of all filed grievances are dismissed because the complainant failed to pursue other means to resolve the problem prior to filing the grievance or the issue was not grievable. Of the remaining 63% to 67% of all filed grievances, the IGRC makes some determination, but it is very difficult to identify whether positive action was taken to address the grievants' concerns. Of all the IGRC hearings, annually 79% to 84% of the grievances are appealed to the superintendent, suggesting that the vast majority of grievants are not satisfied with the hearing results. Although some of the remaining 16% to 21% of grievants who do not appeal may be satisfied, it is also likely that a substantial number of them decided to take no

further action due to exhaustion from the process, the limited likelihood of reversing the decision, the tight timing of the superintendent appeal process, or other factors such as pressure from staff or fear of reprisals. Finally, DOCCS data indicates that 54% to 61% of all superintendent reviews are appealed to CORC. Again, the reasons for not taking an appeal to Central Office are varied, but it is unlikely that most of these individuals are somehow satisfied with the results, given our understanding that superintendents rarely reverse negative results of the IGRC hearing.

The DOCCS Annual Grievance Reports include numbers of cases that the Department asserts were closed or resolved at the prison level. But this figure, listed in **Table 1**, only represents the total number of grievances filed minus the number of grievances appealed to CORC. DOCCS does not publicly report any other analysis of the facility-based resolutions as to the nature of the outcome and the satisfaction of the grievants in the facility grievance process. In the limited circumstances where the CA has obtained slightly more information about the outcomes of the grievance process from individual prisons, the outcomes appear to be almost completely unfavorable to grievants. At Cape Vincent, for example, in 2011 not one of the 229 formal grievances was resolved by the grievance committee in a matter favorable to the grievant, and only one grievance was answered by the Superintendent in a manner favorable to the grievant.¹⁷ As discussed below, we have extensive data from incarcerated persons who have provided their assessment of the grievance system through CA surveys indicating great dissatisfaction with the grievance system.

The DOCCS grievance data also indicates the subject matter of the grievances filed. Each grievance is given a code by the grievance supervisor and that designation determines how it is processed and recorded. A grievance can be given only one code, even if the facts raised in the complaint may raise multiple issues. For the past decade, the five most grieved issues – collectively representing over half of all grievances filed – in order of most common are: medical care, staff conduct, housing unit issues, conditions/treatment in the special housing units (SHU) and packages. **Table 3** summarizes the number of grievances and the percentage these represent of all grievances filed during the past five years for which data is available, 2009 to 2013.

¹⁷ According to data provided by the facility, of the 103 grievances heard by the grievance committee, 32 were resolved in a manner unfavorable to the grievant and 50 were appealed by the grievant to the Superintendent (for a total of 80%), 19 were referred to the Superintendent, and two were passed to the Superintendent after a deadlock. Of the grievances directly filed with the Superintendent and those appealed, the Superintendent answered 144 grievances (more than 99%) in a manner unfavorable to the grievant, and one in favor.

TABLE 3 - SUMMARY OF GRIEVANCE ISSUES 2009 - 2013

Year	Total	Medical - 22		Staff Conduct-49		Housing - 23		SHU - 24		Packages -30	
		#	%	#	%	#	%	#	%	#	%
2013	31,638	6,141	19.4%	5,471	17.3%	1,971	6.2%	1,488	4.7%	1,381	4.4%
2012	32,579	6,362	19.5%	5,296	16.3%	1,952	6.0%	1,719	5.3%	1,336	4.1%
2011	34,013	6,313	18.6%	5,882	17.3%	2,126	6.3%	1,644	4.8%	1,256	3.7%
2010	35,600	6,812	19.1%	6,131	17.2%	2,196	6.2%	1,627	4.6%	1,494	4.2%
2009	37,557	7,281	19.4%	6,491	17.3%	2,301	6.1%	1,422	3.8%	1,615	4.3%

In the DOCCS Annual Grievance Reports, there is limited analysis of the nature of the complaints raised in each of these categories. More importantly, to the extent that the topics are discussed generally, the reports infer that many of the grievances are assumed to be unfounded. For example, when discussing code 49 staff conduct, the 2013 DOCCS Grievance Program Annual Report states: "The perception among staff is that some of the harassment complaints are filed in an attempt to discredit misbehavior reports and to recover the \$5.00 surcharge imposed."¹⁸ The report recognizes that this code is one of the most grieved categories "... due to the wide range of issues that could be perceived and presented by [incarcerated persons] as inappropriate staff conduct or harassment. A review of the titles in this code substantiates that these types of grievances are inflated by [incarcerated person] perception, any differences of opinion with staff and an [incarcerated person]'s unfamiliarity with facility policies or statewide rules."¹⁹ There is no hint in this report that some of the complaints raised about staff might be meritorious or require corrective action. Similarly, in the section discussing medical grievances, the report seems to focus on excuses for the high grievance rate due to non-existent medical problems, patient anxiety, and inappropriate, unreasonable or unrealistic desires by grievants to receive medical treatments, some of which are not "medically indicated by facility doctors."²⁰ The tone of these reports and the anecdotal evidence the CA has obtained from survey responses from incarcerated persons reinforces the view that the facility staff is overly skeptical of any complaints by the incarcerated population and therefore reluctant to take any meaningful action that will alter the current status quo.

We are particularly concerned with how dismissive the Department appears to be concerning the seriousness of the two most common grievance issues - medical care and staff conduct - and how no progress has been made to reduce the frequency of these complaints. Moreover, we are unaware of any statement by the Department that these levels of complaints are concerning to administrative officials or that they are developing any plans to take action to reduce the level of these types of grievances. With no leadership being exhibited on these issues from Central

¹⁸ DOCCS Inmate Grievance Program Annual Report 2013, at 5 (2014)

¹⁹ *Ibid.*

²⁰ *Ibid.* at 4.

Office, it is not surprising that facility staff would mirror the perception that there should not be any great concern or action to address these long-standing problems.

In addition to analyzing the system-wide data, the grievance information provided annually by DOCCS permits a closer look at facility-specific information. **Appendix A** is a summary of the grievance information for the 53 prisons for which such data is available for the period 2009 through 2013. This summary presents the number of grievances and rates of the grievances per 1,000 persons within the prison for the following grievances at each prison: total grievance, medical, staff conduct, housing and SHU. **Appendix A** sorts the data by gender, security level, and the overall rate of grievances at each facility from highest rate to lowest. Reviewing this information reveals some dramatic trends. For the five year period 2009-13, several maximum security prisons have overall grievance rates two to four times the rate for the entire Department. Although one might suspect that Southport and Upstate, two prisons primarily housing persons in isolated confinement, would have the highest rates, other maximum security prisons in the group with the most grievances - Wende, Shawangunk, Auburn, Great Meadow, Five Points and Sullivan - are not likely candidates for grievance rates as high as they are in this period. Equally perplexing is the low rates for problematic prisons such as Attica and Clinton Main, which have grievance rates 31% to 37% below the average for all maximum prisons and almost one-half the rates of the general population maximum security prisons cited above at the high end of the rate scale. We believe the low levels of grievances at Attica and Clinton are more reflective of the barriers and fears incarcerated people experience in filing grievances, rather than any indication of fewer problems in the prisons. There is similar variability with the medium security prisons. Overall, the rate of grievances in medium security prisons is almost one-third that in the maximum prisons, but within that group there are wide differences. The medium security prisons at the high rate (Collins, Marcy, Gouverneur, Orleans and Fishkill) are three to six times the rate of those prisons with the lowest rates (Hudson, Adirondack, Greene, Washington, Ulster, Ogdensburg and Chateaugay). Although some distinction can be made between these groups of prisons, there is no obvious reason why such variability should exist. More importantly, the silence of the DOCCS reports about the dramatic variability among the prisons in overall grievance rates is a concern as it further indicates the failure of the Department to utilize the grievance process to assess how the prisons are functioning.

Looking at the grievance rates for the four most frequently grieved issues, medical, staff conduct, housing and SHU, also illustrates significant variability. Complaints about medical care are almost three times higher in maximum security prisons compared to medium facilities. There is also great variability among the prisons, with those of high rates being four to nine times that of the low rate prisons. The data is also similar for staff conduct grievances. For maximum security prisons, the high end rates are three to eight times the rates for prisons at the low end. For medium security prisons, those at the high end are about three times the rate for prisons at the low end. As with the other categories, the maximum security prison rate for staff conduct is

about two and one-half the rate for medium security prisons. Similar patterns exist with grievances about (1) housing conditions and services and (2) conditions and treatment in the Special Housing Units. This data on the issues that are frequently grieved by the prison population should prompt a substantial investigation by the Department. This investigation should be used to evaluate why there is such variability in these rates, and more importantly, what overall actions it could take to reduce the rates of grievance in each of these categories, with a particular focus on those prisons with the highest rates of grievances. Since DOCCS does not even publish the grievance rates by prison in its annual grievance report and does not comment on this issue, it appears that little attention and efforts are being made to address these problems.

Incarcerated Persons Assessments of Grievance System in CA Survey Responses

The CA has been concerned with and written about the grievance process for many years. We have attempted to document the incarcerated population's concerns with the grievance system by surveying incarcerated persons at each prison we visit about their assessments of the grievance process, and more recently, what problems they have experienced with staff once they have made a complaint to the prison about their treatment. **Table 4** summarizes the assessment by persons in the prisons' general population who answered mailed-in CA surveys at 47 different prison visits we have conducted between 2006 and 2014. More than 7,500 persons have provided us with this information about their prison experience and nearly 7,000 have specifically answered the question about whether they assess the grievance system as poor, somewhat effective, or good. As **Table 4** demonstrates, the vast majority of respondents are dissatisfied with the grievance process. Overall, 72% of the survey respondents rated the system as poor, 21% reported it as somewhat effective and only 7% assessed it as good. The CA asks incarcerated persons to rate many aspects of the services and conditions within the prison. Their assessments of the grievance system are more critical than any other services provided in the prison. It is substantially worse than their assessment of healthcare, mental health care, substance abuse treatment, or programs in transitional services. Equally disturbing is the general uniformity of the criticism, a critique we generally do not experience with other aspects of prison services and conditions. Specifically, at 85% of the prisons we have visited at least two-thirds of the respondents rated the grievance system as poor. Only three prisons had a poor rating less than 50%. In addition, less than 10% of survey participants at more than 80% of the prisons rated the grievance system as good. The only reasonable conclusion from this data is that the process is fundamentally flawed, and the problems are not due to the inadequacy of specific individuals conducting the process but rather fatal deficiencies in the system itself.

In assessing why people were so dissatisfied with the grievance process, the most disturbing problem we have detected is that staff at the prisons frequently retaliate against persons who raise complaints about their treatment by prison staff. **Table 5** contains a summary of the

responses from survey participants when asked if they have ever been retaliated by staff for filing a complaint. Nearly half answered they had been targeted at least once and more than 25% reported this happened frequently. If we focus on those respondents who had filed a grievance at that prison, their responses are even worse. For these individuals, more than 60% had experienced retaliation and 32% of these respondents reported that the retaliation was frequent. **Table 5** contains a summary by prison and demonstrates that retaliation is common throughout the Department, including maximum and medium facilities. Three-quarters of the prisons had at least 40% of the respondents reporting that they had been retaliated against by staff.

If you write a grievance, they make you sign off, if you don't you get beat up and a new charge. If you research the altercations you will see it's because there was grievances and complaints written on officers – Anonymous.

TABLE 4 - Prison Grievance System Effectiveness - Q55

Ranking	Prison	Poor	Somewhat Effective	Good	Total	Score
1	Woodbourne	19.3%	38.6%	42.2%	100.0%	1.7711
2	Downstate	36.4%	36.4%	27.3%	100.0%	2.0909
3	Otisville	40.3%	45.5%	14.3%	100.0%	2.2597
4	Elmira	56.4%	29.1%	14.5%	100.0%	2.4188
5	Mid-State	60.3%	25.0%	14.7%	100.0%	2.4551
6	Clinton Annex	60.9%	29.7%	9.4%	100.0%	2.5156
7	Marcy	64.5%	24.3%	11.2%	100.0%	2.5327
8	Altona	67.3%	20.4%	12.2%	100.0%	2.5510
9	Sullivan	66.7%	22.2%	11.1%	100.0%	2.5556
10	Sullivan 2013	63.5%	30.2%	6.3%	100.0%	2.5714
11	Collins	66.7%	25.2%	8.1%	100.0%	2.5854
12	Mohawk	67.0%	25.0%	8.0%	100.0%	2.5893
13	Sing Sing	68.8%	23.1%	8.1%	100.0%	2.6063
14	Shawangunk	65.8%	29.7%	4.5%	100.0%	2.6126
15	Cayuga 2013	66.7%	28.0%	5.3%	100.0%	2.6133
16	Livingston	69.8%	23.3%	7.0%	100.0%	2.6279
17	Auburn	68.5%	27.0%	4.5%	100.0%	2.6404
18	Hudson	70.6%	23.5%	5.9%	100.0%	2.6471
19	Gouverneur	75.9%	13.8%	10.3%	100.0%	2.6552
20	Wallkill	68.6%	28.6%	2.9%	100.0%	2.6571
21	Groveland	72.3%	21.3%	6.4%	100.0%	2.6596
22	Great Meadow 2010	71.4%	25.0%	3.6%	100.0%	2.6786
23	Great Meadow	74.0%	21.2%	4.8%	100.0%	2.6923
24	Cape Vincent	76.0%	17.3%	6.7%	100.0%	2.6933
25	Bare Hill	74.4%	21.7%	3.9%	100.0%	2.7047
26	Hale Creek	76.0%	20.0%	4.0%	100.0%	2.7200
27	Five Points 2013	77.0%	18.3%	4.7%	100.0%	2.7225
28	Wende	77.9%	16.8%	5.3%	100.0%	2.7252
29	Franklin	78.3%	15.9%	5.8%	100.0%	2.7254
30	Attica	76.9%	19.4%	3.8%	100.0%	2.7312
31	Fishkill	76.8%	19.6%	3.6%	100.0%	2.7320
32	Cayuga	78.3%	17.5%	4.2%	100.0%	2.7417
33	Wyoming	78.9%	17.5%	3.5%	100.0%	2.7544
34	Coxsackie	80.2%	15.1%	4.7%	100.0%	2.7558
35	Five Points	78.5%	19.0%	2.5%	100.0%	2.7600
36	Clinton	80.6%	15.0%	4.4%	100.0%	2.7611
37	Greene	79.2%	18.1%	2.8%	100.0%	2.7639
38	Greene 2013	81.8%	13.6%	4.5%	100.0%	2.7727
39	Wyoming 2014	79.7%	18.0%	2.3%	100.0%	2.7734
40	Mt. McGregor	83.1%	11.9%	5.1%	100.0%	2.7797
41	Washington	82.5%	13.6%	3.9%	100.0%	2.7864
42	Oneida	82.4%	14.9%	2.7%	100.0%	2.7973
43	Gowanda	85.3%	11.8%	2.9%	100.0%	2.8235
44	Watertown	84.8%	13.6%	1.5%	100.0%	2.8333
45	Green Haven	89.8%	6.8%	3.4%	100.0%	2.8644
46	Lakeview	94.6%	2.7%	2.7%	100.0%	2.9189
47	Willard	96.2%	0%	3.8%	100.0%	2.9231
	Total	72.0%	21.0%	7.0%	100.0%	

TABLE 5 - How Often Does Staff Retaliate Against You for Using the Grievance System - Q54

Ranking	Prison	Very Frequently	Frequently	Once in a While	Once	Never	Total	Score
1	Downstate		7.1%	14.3%	7.1%	71.4%	100.0%	4.4286
2	Hudson	5.6%	11.1%		16.7%	66.7%	100.0%	4.2778
3	Otisville	6.9%	1.7%	10.3%	24.1%	56.9%	100.0%	4.2241
4	Altona	7.1%	9.5%	4.8%	11.9%	66.7%	100.0%	4.2143
5	Fishkill	8.2%	7.7%	6.6%	11.5%	66.1%	100.0%	4.1967
6	Hale Creek	11.5%	7.7%	3.8%	7.7%	69.2%	100.0%	4.1538
7	Lakeview	13.8%	3.4%	3.4%	13.8%	65.5%	100.0%	4.1379
8	Collins	7.6%	9.5%	8.6%	11.4%	62.9%	100.0%	4.1238
9	Woodbourne	9.6%	7.1%	8.3%	13.5%	61.5%	100.0%	4.1026
10	Groveland	11.3%	9.6%	1.7%	15.7%	61.7%	100.0%	4.0696
11	Livingston	9.0%	7.7%	12.8%	9.0%	61.5%	100.0%	4.0641
12	Elmira	10.0%	7.3%	9.1%	17.3%	56.4%	100.0%	4.0273
13	Cayuga 2013	7.6%	15.2%	4.5%	13.6%	59.1%	100.0%	4.0152
14	Willard	8.0%	20.0%		8.0%	64.0%	100.0%	4.0000
15	Cape Vincent	10.4%	10.4%	7.5%	13.4%	58.2%	100.0%	3.9851
16	Wyoming 2014	12.2%	9.2%	9.2%	9.2%	60.2%	100.0%	3.9592
17	Marcy	13.7%	11.6%	3.2%	13.7%	57.9%	100.0%	3.9053
18	Sing Sing	12.3%	7.3%	13.4%	11.7%	55.3%	100.0%	3.9050
19	Great Meadow 2010	9.8%	5.9%	19.6%	15.7%	49.0%	100.0%	3.8824
20	Walkkill	10.3%	17.2%	3.4%	13.8%	55.2%	100.0%	3.8621
21	Clinton	15.4%	9.6%	7.1%	10.3%	57.7%	100.0%	3.8526
22	Watertown	14.3%	14.3%	2.0%	12.2%	57.1%	100.0%	3.8367
23	Mid-State	11.3%	14.2%	7.8%	13.5%	53.2%	100.0%	3.8298
24	Auburn	12.6%	14.3%	8.0%	12.2%	52.9%	100.0%	3.7857
25	Mohawk	13.7%	10.8%	9.8%	16.7%	49.0%	100.0%	3.7647
26	Mt. McGregor	8.3%	18.8%	10.4%	14.6%	47.9%	100.0%	3.7500
27	Attica	14.7%	12.9%	9.8%	10.4%	52.1%	100.0%	3.7239
28	Gouverneur	12.2%	16.2%	6.8%	18.9%	45.9%	100.0%	3.7027
29	Wende	11.6%	14.0%	13.2%	17.1%	44.2%	100.0%	3.6822
30	Bare Hill	12.7%	13.5%	11.0%	19.0%	43.9%	100.0%	3.6793
31	Cayuga	15.4%	13.2%	11.0%	11.0%	49.5%	100.0%	3.6593
32	Five Points 2013	14.9%	13.7%	11.4%	11.4%	48.6%	100.0%	3.6514
33	Gowanda	17.6%	8.8%	11.8%	14.7%	47.1%	100.0%	3.6471
34	Oneida	11.3%	18.9%	9.4%	15.1%	45.3%	100.0%	3.6415
35	Sullivan	16.7%	9.1%	15.2%	12.1%	47.0%	100.0%	3.6364
36	Sullivan 2013	11.1%	12.7%	20.6%	15.9%	39.7%	100.0%	3.6032
37	Greene 2013	23.5%	10.2%	4.1%	10.2%	52.0%	100.0%	3.5714
38	Coxsackie	20.2%	11.8%	9.2%	15.1%	43.7%	100.0%	3.5042
39	Wyoming	18.8%	11.3%	11.3%	21.3%	37.5%	100.0%	3.4750
40	Shawangunk	12.2%	20.4%	13.3%	16.3%	37.8%	100.0%	3.4694
41	Franklin	15.6%	19.0%	10.1%	13.9%	41.4%	100.0%	3.4641
42	Greene	19.0%	13.5%	11.1%	15.9%	40.5%	100.0%	3.4524
43	Five Points	17.7%	17.1%	9.4%	14.9%	40.9%	100.0%	3.4420
44	Clinton Annex	17.2%	15.5%	15.5%	15.5%	36.2%	100.0%	3.3793
45	Green Haven	18.9%	17.0%	18.9%	17.0%	28.3%	100.0%	3.1887
46	Washington	28.9%	14.5%	6.6%	15.8%	34.2%	100.0%	3.1184
47	Great Meadow	27.7%	16.0%	17.0%	7.4%	31.9%	100.0%	3.0000
	Total	13.8%	12.3%	9.5%	13.8%	50.6%	100.0%	

Starting in 2010, the CA expanded its inquiry into the nature of the retaliation experienced when someone filed a complaint with the prison. Nearly 1,000 persons responded to this question describing whether and how they were mistreated by staff. An analysis of their answers presents a very disturbing picture of the types of actions taken by staff to retaliate against a person who files a complaint and/or to intimidate people from filing complaints in the future. **Table 6** contains our summaries of the 750 survey answers in which an incarcerated person described inappropriate actions taken by staff.

TABLE 6 – Major Categories of Retaliation by Staff for Filing a Complaint

Type	Assaulted by staff	Denied Essential Services	False Tickets given or threatened	Cell Searched Repeatedly	Mail or Packages Tampered with
Number	49	117	108	85	48
Type	Threatened by staff	Harassed by staff verbally or other	Locked in cell or denied program	Property taken or destroyed	Lost Job
Number	165	74	38	42	24

Many survey respondents reported that they felt very intimidated by these actions and threats by staff, and that sometimes the explicit intent was to get them to withdraw their grievance.

Respondents also reported that they were locked into their cell, sometimes for days, without any disciplinary action, just for filing a grievance against their housing officer or another staff member who is friends with the housing officer. We were told repeatedly that although the staff directly involved in the grievance may not take direct action, other officers would act as his/her proxy to retaliate against the grievant. Moreover, many survey participants reported that the threats and retaliation were done by sergeants and other senior staff in the presence of correction officers. The common thread in these descriptions is that the retaliation is frequent, it is tolerated by administrative staff, and filing additional complaints about the retaliation will often result in further abuse, rather than halting the mistreatment.

Many of the [people incarcerated] here at [prison] are reluctant to speak out against the many abuses being carried out here, because the certainty of retaliation is very real and the officers use other selected [incarcerated people] to carry out any hits. The retaliations are not always physical because they leave marks on the body- so they'll play psychological intimidation and instill fear in the minds of many [people]; those are some of those you hear about all of a sudden committing suicide. – Anonymous.

the threats and retaliation were done by sergeants and other senior staff in the presence of correction officers. The common thread in these descriptions is that the retaliation is frequent, it is tolerated by administrative staff, and filing additional complaints about the retaliation will often result in further abuse, rather than halting the mistreatment.

Summary of the Deficiencies in the Grievance Process

Given the analysis of the data from DOCCS and the information obtained from the CA prison visits and surveys of incarcerated persons, the following deficiencies must be addressed in order to improve the fairness and effectiveness of the grievance process;

1. All complaints should be promptly documented in the system, and grievants should be informed that their complaints have been received and recorded in the grievance system.

The non-calendared contacts must be recorded and catalogued so that there is a record of what concerns incarcerated persons are raising with the grievance staff.

2. There must be summary records kept and made public about the outcome of the grievance process in each case and at each levels of the process. Specifically, separate outcomes should be noted at the informal resolution stage, hearing results, superintendent reviews and CORC appeals. This information should not only be included in the actual grievance folder, but also summarized in the system-wide data about the process. The outcome summary should include whether any Department action was needed to address the issues raised in the grievance. Frequently, the response to a grievance may report that it is granted in part, but that section of the decision is only a recognition that some events asserted in the grievance occurred, not that additional action is needed by the prison to resolve the issue.
3. The large number of grievances sent directly to the superintendent should be separately evaluated and more effective and transparent mechanisms should be implemented to improve investigations of these complaints, grievants' access to the decision-makers, and the recordkeeping of this process.
4. Records of any grievance withdrawn should be specifically maintained with an indication by the grievant why he/she has decided on this course of action.
5. Persons involved in the grievance review process should not be directly involved in incidents alleged in the complaint. Particularly for staff conduct complaints, supervisory staff are often part of the investigative process, even though they are supervisors of the staff about which the complaint is directed.
6. Mechanisms should be created and records maintained about any grievances that are lost. Grievants should be encouraged to contact the grievance office if they do not promptly receive a receipt of their grievance.
7. Efforts must be made to end the pervasive pattern of retaliation and threats by staff directed at grievants who file complaints about their treatment in the prison. Although Section 701.6(b) of Directive 4040 asserts that no reprisals shall be taken against an incarcerated person who utilizes the grievance system,²¹ the overwhelming evidence we have obtained from incarcerated persons with whom we have communicated demonstrates that this prohibition is not enforced.
8. DOCCS fails to maintain, track, and analyze records from the grievance process that indicate which DOCCS staff have been subjected to complaints by the prison population, as well as other indicators such as the prisons, locations, and shifts of incidents that have been grieved. Specifically, neither facility-based administrative staff nor DOCCS Central Office have any summary records indicating who, how often, and for what reasons Department staff have been the subject of complaints by incarcerated persons, and whether any findings have been made that the staff's conduct was inappropriate, or the

²¹ DOCCS Directive 4040, Inmate Grievance Program, at 701.6(b) (2006).

staff failed to perform their duties in accordance with Department policies and procedures. Mechanisms should be developed on both the facility and system levels to record, track, and utilize this information for corrective action.

Alternatives to Address Deficiencies in the Current Grievance System

Although most correctional jurisdictions have grievance systems, there is not any one grievance model that stands out as best practices for complaints by incarcerated persons. Although the Prison Litigation Reform Act²² (PLRA) requires exhaustion of local administrative remedies prior to seeking a federal remedy, the act does not define what are the minimal requirements for an administrative remedy. Rather, grievance programs are certified by the Attorney General, and these programs must meet the standards specified in federal regulations.²³ These federal standards are very general, defining minimal standards for initiating a complaint, mandating an advisory role for incarcerated persons and staff, prohibiting persons involved in the complaint to be part of the review process, requiring a written decision disposition, and mandating fixed time limits and requiring a review process outside the immediate facility command.²⁴ The regulations also mandate an emergency procedure if the delays in the complaint process would expose the grievant to risk of serious harm and prohibits reprisals for filing a complaint.²⁵ The regulations do not, however, mandate what the facility must do in evaluating the grievance, what procedural rights the grievant has during the process, who should be part of the review process, and the qualifications of those participating in the process. It is clear DOCCS written guidelines meet these minimal standards, but these standards for the most part do not address the deficiencies noted above. A limited review of grievance protocols at the federal and state level also fails to reveal another written grievance process that is obviously superior to the DOCCS policies.

Given this situation, it would be useful for the legislature to look outside the current grievance process to identify more effective and fair complaint resolution mechanisms. One such system is an ombudsman process that is employed frequently in other institutional settings, is used in a limited way in corrections in the United States²⁶ and is more widely employed in an international setting for correctional systems abroad. It is our understanding that the Corrections Committee will be receiving expert testimony about this model from officials that have employed it elsewhere. Consequently, we want to only emphasize a few points about the potential for using an ombudsman in New York.

²² 42 U.S.C. 1997e(a) (1996)

²³ The minimum standards for correctional grievance procedures are defined at 28 C.F.R. §§ 40.1-40.10 (2007).

²⁴ 28 C.F.R. § 40.7.

²⁵ *Ibid.* §§ 40.8 and 40.9.

²⁶ See Brian Heskamp, *The Prisoner's Ombudsman: Protecting Constitutional Rights and Fostering Justice in American Corrections*, Ave Maria Law Review, 527, 531-36 (2008).

First, the creation of an ombudsman in New York would not be a substitution for the grievance system, but rather an important enhancement of the process incarcerated persons could employ to resolve complaints they have about staff, conditions, or processes within a prison and/or the Department. There must be some internal mechanism for the prison to review complaints and most ombudsman offices are supplements to the internal agency compliant process. The essential components of an ombudsman are independence, impartiality and confidentiality.²⁷ None of these exist with the current grievance system. The ombudsman should not report to the agency being reviewed, and typically does not have the authority to order changes to agency policies and actions, but rather only makes recommendations. In resolving issues the ombudsman acts as a mediator, and therefore, it is crucial that both sides view his/her role as impartial. Ombudsman can also initiate investigations that address systemic issues with the intent to make recommendations to the agency for policy changes.

Second, to be effective an ombudsman office would have to have the following requirements. It must be statutorily independent from DOCCS, both in fact and as perceived by the incarcerated population and the public. It must have sufficient resources to respond to the many complaints that will inevitably be addressed to it if it is shown to be both fair and effective. Its essential powers must include unrestricted and ready access to incarcerated persons and staff, ability to promptly review and obtain copies of needed documents, authority to issue public reports about non-confidential matters, and the ability to advocate for change both within DOCCS and publicly. Included within the unrestricted access to incarcerated persons should be an ability for people incarcerated to confidentially communicate with the ombudsman office through a confidential hotline,²⁸ as well as through privileged mail correspondence and legal visits. Regarding a hotline, the state should explore the possibility of implementing a confidential telephone hotline, where incarcerated persons can call to report staff abuses. An example outside of the prison context that could serve as a model for such a hotline is the hotline in state institutions other than prisons for reporting abuse against people with disabilities to the Justice Center.²⁹ As noted below, PREA standards also encourage, though do not mandate, the use of toll-free independent external hotlines for incarcerated persons to report sexual abuse.³⁰ DOCCS

²⁷ American Bar Association, Standards for the Establishment and Operation of Ombuds Offices, at 2 (revised February 2004).

²⁸ An example outside of the prison context that could serve as a model for such a hotline is the hotline in state institutions other than prisons for reporting abuse against people with disabilities to the Justice Center. See NYS Justice Center, *Contact Us, Report Abuse*, available at: <http://www.justicecenter.ny.gov/about/contact-us>. PREA standards also encourage, though do not mandate, the use of toll-free independent external hotlines for incarcerated persons to report sexual abuse.

²⁹ See NYS Justice Center, *Contact Us, Report Abuse*, available at: <http://www.justicecenter.ny.gov/about/contact-us>.

³⁰ *National Standards to Prevent, Detect, and Respond to Prison Rape*, United States Department of Justice, 28 CFR Part 115, §§ 115.51(b), 115.53, Overview Comments at p. 101, May 16, 2012, available at: http://ojp.gov/programs/pdfs/prea_final_rule.pdf (“*PREA Regulations*”). PREA does require that each correction department provide at least one mechanism for incarcerated persons to report sexual abuse to an external entity that is not part of the department and is wholly independent. *Ibid.* at §115.51(b), Overview Comments at p. 101.

should utilize and expand upon these models to allow incarcerated persons to report staff abuse more generally to an ombudsman or other independent external entity.

As one example within the United States of an independent ombudsman that investigates complaints by incarcerated persons, Alaska has an Office of the Ombudsman with statutory authority to investigate complaints against all state government agencies and employees, including complaints against the prison system and prison staff by people incarcerated in the state prisons.³¹ The Alaska Ombudsman has complete access to the prisons, people incarcerated, and all relevant documentation.³² It has the power to interview prison staff, examine confidential documents, conduct unannounced visits and inspections of the prisons, hold private hearings, and issue subpoenas.³³ Also, people incarcerated in Alaska's prisons have the ability to communicate with the Ombudsman confidentially through the mail and unmonitored telephone calls.³⁴ Further, the Alaska Ombudsman publicly publishes its investigations, findings, and recommendations online.³⁵ Recently, for example, the Alaska Ombudsman issued a public report on a complaint regarding improper placement of a person in solitary confinement for two years.³⁶

As one example in the international context, the United Kingdom has an independent Ombudsman as one part of its extensive system of prison oversight and investigations (including its separate Prison Inspectorate and its separate Independent Monitoring Boards). The role of the Ombudsman is to investigate individual complaints by incarcerated persons (as well as people on probation and in immigration detention centers) regarding any and all aspects of treatment, care, and conditions, as well as deaths of people who are incarcerated or have recently been released from prison.³⁷ The Ombudsman can try to settle a complaint prior to a full investigation, and then can carry out a full investigation – including communicating with the complainant via phone or visits, interviewing of staff, and prison site visits.³⁸ The Ombudsman can make recommendations in individual cases for monetary compensation, change of prison policy, an apology, and/or overturning an unfair punishment,³⁹ The prison system or other relevant authority must determine whether it accepts the recommendations, lay out the specific steps it will take within specific timeframes to address the Ombudsman's recommendations,⁴⁰ and then provide evidence

³¹ See Michele Deitch, *Independent Correctional Oversight Mechanisms Across the United States: A 50-State Inventory*, Pace Law Review, Sept. 2010, Vol. 30, Issue 5 Fall 2010, art. 21, p. 1782-1783, available at: <http://digitalcommons.pace.edu/cgi/viewcontent.cgi?article=1764&context=plr>; <http://ombud.alaska.gov/about-the-O.php>.

³² *Ibid*; see, e.g., <http://ombud.alaska.gov/Matrix.pdf> at p. 14-23.

³³ See <http://ombud.alaska.gov/about-the-O.php>; <http://www.correct.state.ak.us/corrections/pnp/pdf/101.07.pdf>.

³⁴ *Ibid*.

³⁵ *Ibid*; see, e.g., <http://ombud.alaska.gov/Matrix.pdf> at p. 14-23.

³⁶ Ombudsman Complaint A2015-0320, State of Alaska Ombudsman, Finding of Record and Closure, Aug. 31, 2015, available at: http://ombud.alaska.gov/reports/A2015-0320_DOC-final-public.pdf.

³⁷ <http://www.ppo.gov.uk/about/vision-and-values/terms-of-reference/>.

³⁸ <http://www.ppo.gov.uk/investigations/make-complaint/what-to-expect/>.

³⁹ <http://www.ppo.gov.uk/investigations/make-complaint/complaints-faq-2/>.

⁴⁰ <http://www.ppo.gov.uk/about/vision-and-values/terms-of-reference/>.

demonstrating how the prison system implemented the recommendations.⁴¹ According to the Ombudsman, its recommendations are “usually accepted and implemented.”⁴² People can also appeal actions by the Ombudsman to a higher authority.⁴³ The Ombudsman produces individual reports for each complaint investigation, as well as engages in systemic and thematic analysis, including producing annual reports highlighting key complaints, investigations, analysis and statistics, and lessons learned.⁴⁴

We look forward to discussing further with the Assembly the potential for an ombudsman for DOCCS, building off of the experiences in places like Alaska and the UK. We also recommend that the Committee urge DOCCS to take action to address the deficiencies we have identified with the current grievance process.

Disciplinary System for Incarcerated Persons

The legislature needs to fundamentally transform the disciplinary system of incarcerated persons to stop it from being a system for covering up staff abuses, ensure its fairness, and utilize it as a mechanism of investigation of staff abuse. More specifically, the legislature should require, for example, that the disciplinary procedures be conducted by neutral-decision makers – rather than

Beaten as Retaliation for Filing a Grievance

*I got beaten badly . . . because I wrote a grievance. The CO I had grieved punched me in the face, and then he and other COs started beating me. I ended up with a busted lip, a cut on my thumb, and marks on my wrist. Almost two weeks later when I went to the hearing for assault on staff charges, the hearing officer cut the tape off and said to me, "Listen you little f*ck. I run this hearing, not you." An escort CO grabbed my neck. He punched me in the face, grabbed me by the arm, and removed me from the hearing room. Another officer brought me to a corner away from any cameras. A CO punched me in the face. They brought me back to my cell and told me they would be back. Some officers came back. They slammed me on the ground and started beating me. They brought me to the shower and a CO started slamming my face against the walls of the shower. I was already bleeding from my face, and they still kicked me in the face. They finally stopped and I was laying in a pool of my own blood. I was taken to an outside hospital. I got stitches in my chin and my eyebrow. – Anonymous.*

DOCCS staff; provide meaningful due process though enforceable rights to introduce evidence, call and cross-examine witnesses; and allow incarcerated persons to have legal representation by

⁴¹ <http://www.ppo.gov.uk/investigations/make-complaint/what-to-expect/>.

⁴² <http://www.ppo.gov.uk/investigations/make-complaint/complaints-faq-2/>.

⁴³ *Ibid.*

⁴⁴ <http://www.ppo.gov.uk/about/vision-and-values/terms-of-reference/>; <http://www.ppo.gov.uk/investigations/make-complaint/what-to-expect/>; http://www.ppo.gov.uk/wp-content/uploads/2015/09/PPO_Annual-Report-2014-15_Web-Final.pdf; <http://www.ppo.gov.uk/document/learning-lessons-reports/>; <http://www.theguardian.com/society/2015/sep/29/prisoners-legal-letters-opened-ombudsman>.

pro bono lawyers, law students, or approved paralegals or peer advocates. The legislature should at least require that these and other procedural protections particularly be implemented in instances where the disciplinary tickets allege assault on staff or physical confrontations with staff, where an incarcerated person asserts s/he was assaulted by staff, and/or where an incarcerated person asserts s/he was issued the ticket as retaliation for a claim of staff misconduct. If done properly and fairly, by neutral decision-makers in a meaningful process with the assistance of counsel, these procedures for assessing alleged disciplinary infractions of incarcerated persons could serve as an opportunity for DOCCS to assess, evaluate, and track complaints of staff misconduct.

These changes are necessary because while the disciplinary system should serve as a mechanism of investigating alleged misconduct by incarcerated persons and bringing accountability, instead it often serves as an abusive and arbitrary method of punishment, abuse, and cover-up. The sheer volume of disciplinary tickets imposed on incarcerated persons indicates the extremely punitive nature of this system. In the less than four years from January 2010 to November 2013 – the most recent data obtained by the CA through a FOIL request – DOCCS held a total of 269,188 disciplinary hearings and issued 53,760 SHU sentences and 102,407 keeplock sentences. In other words, DOCCS is issuing more than 70,000 disciplinary tickets per year, resulting in around 14,000 SHU sentences and 26,700 keeplock sentences per year.

In the vast majority of cases where correction officers are claiming that they were victims of an assault by an [incarcerated person], perhaps 75 to 80% of these allegations, the [incarcerated persons] are being charged with assault on staff in order to justify an unprovoked attack on the [incarcerated person] by guards. – Anonymous.

Reports by incarcerated persons indicate that the disciplinary system is used to cover-up staff abuses in two main ways: 1) directly issuing a disciplinary ticket against an incarcerated person to cover-up an assault or other misconduct by staff; and 2) setting someone up or issuing a false or frivolous disciplinary ticket as retaliation for an incarcerated person raising a complaint.

With respect to the direct cover-up of assaults, based on the CA's years of investigations and countless interviews with incarcerated people, it appears to be a routine, ordinary practice for

Why is it that the majority of assault on staff occurs while an [incarcerated person] is placed against a wall, being pat frisked? Why didn't the [person] just assault the officer before being placed on the wall? Why are the injuries suffered by the [incarcerated person] worse than the injury the officer claims to have suffered? – Anonymous.

correction officers to issue tickets for assault on staff and other charges after they beat someone up. Innumerable people incarcerated across NY prisons repeatedly and frequently report that after they are beaten by staff, they receive a disciplinary ticket for a false claim for assault on staff and/or other false disciplinary infractions. If a person is found guilty at a disciplinary hearing, then her/his

claim of abuse against staff in later proceedings will face even more hurdles. Particularly given that – in sharp contrast to the substantiation of complaints about officers in the grievance system – approximately 95% of disciplinary hearings result in guilty findings, correction officers can easily issue a false disciplinary ticket as a mechanism to cover-up the officers' own abuses. Even worse, many people have reported to the CA that after being severely beaten by COs, they received new outside criminal charges and additional prison time as a way to cover-up the culpability of the officers.

Eight Months in Solitary and a Parole Denial for Getting Beaten By Staff

*I'm in my late 50s. One day because I didn't have my ID, COs told me to get on the wall. After they cleared the corridor, there were multiple COs and a sergeant there. I had parole coming up in a couple months. They pushed my legs as far apart as possible. A CO sexually abused me — he stuck his hand in my crack and was very harsh. Then I was struck on the face with a fist. Someone threw me on the floor. Someone grabbed my hands and pulled them behind my back while another CO kned me in the back. Others were slapping and hitting me. They said things like "shut up you f*cking sp*ck." Then they pulled the pin and more COs came. They picked me up by the handcuffs and they mushed my face into the corner of the wall. For beating me up they charged me with assault on staff and another false ticket, and gave me eight months of SHU time. The Parole Board denied me. – Anonymous.*

As an example of the use of tickets to cover-up assaults by staff, for all Unusual Incidents at Clinton C.F. in which staff members were involved in 2012 and 2013, there was no injury to staff whatsoever in over 96% of the UIRs, minor injury in 3.4% and moderate injury in only half of one percent. For assault on staff UIRs in particular, there was no staff injury whatsoever in 72% of the UIRs in 2012 and 2013, minor injury in just under 25%, and moderate injury in just under 4%. By contrast, for incarcerated persons involved in assault on staff UIRs in 2012 and 2013, DOCCS reported that only 13% of incarcerated persons had no injury while 87% suffered a minor injury. These sharp differences in injury outcomes for staff and incarcerated persons during reported assaults on staff – whereby staff are generally not receiving injuries and incarcerated persons are suffering injuries – raise not only concerns that staff are responding to minor misconduct with excessive use of force, but also that staff are actually assaulting incarcerated persons and then writing up the incidents as assaults on staff. Having 72% of assault on staff UIRs result in *no* staff injury and 87% of those same assault on staff UIRs result in injury to an incarcerated person raises serious questions about potential false claims that incarcerated people assaulted staff as a cover-up for staff assaulting incarcerated people.

They set me up with a weapon for writing complaints and talking to the CA about what's happening in New York State corrections. They planted a weapon in my cell and sent me to SHU for six months. It didn't matter that the [more than 20] years I've been in jail, I've never been caught or charged with a weapon. – Anonymous.

As an additional form of cover-up of abuses, as discussed above with respect to the grievance system, many incarcerated people report that they receive false or frivolous disciplinary tickets as retaliation for filing complaints related to staff misconduct. As one incarcerated person wrote “a good number of infractions are falsified and retaliatory.” People have reported that they have faced false tickets as retaliation, not just for filing grievances, but for speaking with the media and even for communicating with the Correctional Association.

Moreover, exemplifying the lack of neutrality of DOCCS hearing officers in disciplinary proceedings, many incarcerated people report that hearing officers themselves will admit off-the-record that they know the incarcerated person is right but they have to discipline her/him anyway. As one incarcerated person wrote, “when you prove your innocence at a Tier II or Tier III hearing, the hearing officer will sentence you, and turn off the tape, and tell you off the record my hands are tied – I had to give you something. There is no justice or honor whatsoever, and these officers are the ones doing crime and hurting and beating us up every chance they get.”

Planted Weapon and Five Months in Solitary for Getting Beaten By Staff

*One day, an officer went crazy on me. This officer is a loose cannon and so corrupt. He has set up a lot of people and sent a lot to the box. On this day, I was taken from my cell, searched, and handcuffed by this officer. While I was handcuffed, this C.O. in front of the sergeant called me n****r and smacked me in the back of my head multiple times. Then, the officers escorted me to the shower. While I was still handcuffed in the back, one of the officers pushed me very hard into the shower stall and my shoulder hit the sharp metal divider. The above-mentioned CO then again called me a n****r very loudly in front of the whole company. Then, my cell was searched and they claimed to have found a weapon. I was sent to the box on the trumped up weapons charge and was there for five months. And, while in the box, six others told me they were there because of made up weapons charges. – Anonymous.*

Moreover, this unfair and arbitrary disciplinary process has a racially disparate impact. The people subjected to isolated confinement through the disciplinary processes in New York State prisons are disproportionately Black people, representing 60% of the people in SHU compared to the already vastly disproportionate 50% of people in NYS prisons and 18% of the total NYS population.⁴⁵ Moreover, youth of color are even more disproportionately subjected to isolated confinement through the disciplinary processes. Looking at a snapshot of the major isolated confinement units in New York State that hold people in isolation for the longest periods of time – namely Southport and Upstate Correctional Facilities, which are entire prisons dedicated to isolated confinement (essentially supermax prisons), and the SHU 200s or S-blocks, which are 200-bed freestanding isolated confinement units – black youth represented an even more

⁴⁵ See, e.g., New York Civil Liberties Union, “*Boxed In – The True Cost of Extreme Isolation in New York’s Prisons*”, p. 24 (2012) available at: <http://www.nyclu.org/publications/report-boxed-true-cost-of-extreme-isolation-new-yorks-prisons-2012>.

disproportionate 66% of the young people aged 21 or younger in isolated confinement, compared to 61% of all youth 21 and under in the DOCCS system.⁴⁶

DOCCS Unusual Incident Reports

The legislature should require DOCCS to more fairly and accurately investigate so-called unusual incidents within the prisons, and to better track, analyze, and utilize these incidents to help stop staff abuse and address problems within the prison system.

DOCCS Directive 4004 requires the reporting of all "Unusual Incidents" that occur within a facility to DOCCS Central Command Center and to prepare appropriate documentation about these incidents.⁴⁷ An unusual incident is defined as "a serious occurrence that (1) may impact upon or disrupt facility operations, or (2) that has the potential for affecting the Department's public image, or (3) that might arouse widespread public interest."⁴⁸ In addition to this broad definition, an unusual incident also includes events that involve use of chemical agents, staff use of a weapon, or results in moderate or serious injury to any incarcerated person or staff. Directive 4004 includes an Appendix A that more explicitly defines 22 incident categories. The directive requires that these incidents be recorded in a computerized Unusual Incident System that is used to make reports to DOCCS' Communications Control Center promptly after the incident has occurred. The final Usual Incident Report (UIR) is entered into this computerized system by prison staff and includes not only narrative information about the incident but also codes that indicate such items as the location where the event happened, more explicit indication of the nature of the event or persons affected, the type of force used by staff, the type of weapon involved in the incident, the level of injuries, the role of persons identified in the report, such as "perpetrator", "participant", "victim" or "witness", and the title of staff involved. The narrative descriptions must respond to specific questions posited for each category of UIR. The UIR is not completed until the superintendent has electronically approved it, and then it is printed in DOCCS Central Office for review and filing.

We have two main observations about the UIR process; one directed to the investigative aspect of this reporting and the second dealing with the UIR as a monitoring instrument. Concerning the investigative elements of the UIR, the directive is silent about the investigative process within the facility in terms of who will perform this function, when it should be completed and what steps should be taken to compile the information requested in the UIR. For example, for assault UIRs the directive specifies that the facility report must include the following supplemental clarifying information: "Name/number of affected [incarcerated persons] plus any witnesses. Name/title of employee, visitor, volunteer, etc. Results of medical exam. Prognosis of

⁴⁶ Analysis of information obtained from DOCCS. Young people aged 21-and-under represented just over 7.5% of all people incarcerated in Southport, Upstate, or one of the S-blocks.

⁴⁷ DOCCS Directive 4004 Unusual Incident Report (2009).

⁴⁸ *Ibid*, at § (II)(A).

victim/life threatening. Weapon used if any. Name of outside hospital/ambulance. Who notified. Location/status of perpetrator and victim after medical treatment.”⁴⁹ It does not mandate that there be statements taken of all witnesses or that the alleged perpetrator be afforded an opportunity to examine the statements of staff or address the assertion in those statements as to their validity. In fact, the directive requires that supporting documentation, such as witness statements, be included only if they are “absolutely necessary to clarify the incident.” (underline in text).⁵⁰ These documents are not forwarded to DOCCS Central Office, but are only filed with the facility hard copy of the report. The reluctance of the prisons to seek incarcerated persons as witnesses in UIR assault on staff cases is made quite apparent after examining the Department’s annual analysis of UIRs contained in DOCCS Unusual Incident Report January – December 2013.⁵¹ In that report, discussed in more detail below, Table 5.1 indicates that in the 647 incidents of assault on staff there were only 31 incarcerated persons identified as witnesses or bystanders, representing at most a single witness in less than 5% of the cases.⁵² The potential that there would be so few witnesses in the dense population that is prison when a confrontation is occurring between an incarcerated person and staff is inconceivable and therefore, it is reasonable to conclude that the UIR process is obviously under-reporting the presence of incarcerated witnesses and that it is possible DOCCS is not seeking input from incarcerated persons who may present testimony that would contradict the staff’s version of the event. Consequently, we question whether the facility investigative process is fair and comprehensive and are concerned that the summary of the incident to Central Office may be biased or inadequate. It is also unclear to what extent Central Office reviews these reports and requires clarifying or supplemental information.

Separate from the investigative process entailed in the UIR system, we believe it is useful to comment on the potential for UIR information to be used as an oversight/monitoring tool for the individual prisons and DOCCS Central Office administrators. The annual reports from Central Office about UIRs is illustrative of what data analysis is possible, but also evidence of the shortcomings of the Department’s effort to utilize information to identify areas of concern and to develop measures to improve conditions inside the prisons. A close examination of the latest DOCCS report, Unusual Incident Report January – December 2013, reveals the potential for aggregating and comparing data to show trends and outliers occurring inside the system and at each prison. That report contains multiple tables listing the types of incidents and the rate of those incidents at each prison and sometimes within specialized units. It also contains summaries of the use of weapons, role of incarcerated persons in these incidents, the location of incidents and the injuries to staff. These types of data are very useful to get a comprehensive

⁴⁹ *Ibid.* at Appendix A, item 2.

⁵⁰ *Ibid.* § IV, E(1).

⁵¹ DOCCS Unusual Incident Report January – December 2013 (December 2014) available at http://www.dccs.ny.gov/Research/Reports/2015/UI_Report_Jan-Dec_2013.pdf.

⁵² *Ibid.* at 20 (Table 5.1).

view of the incidents and the potential impact on the incarcerated population and staff. What is glaringly missing in the report is any analysis of why there are significant variations in the frequency of these events by facility and security level, and whether the data suggest that there are problems at certain facilities, by certain staff, in certain locations or shifts, or for certain types of unusual events that could be avoided or reduced by employing new procedures or changing DOCCS policies. The lack of any real analysis of causes and outcomes leads us to question why the compilation is made and whether DOCCS administrators believe these levels of undesirable occurrences in the prison are acceptable and/or uncorrectable.

A few more specific observations about the UIR data are also appropriate. The report contains an analysis of injuries to staff and generally indicates that, fortunately, staff experience very few serious injuries, that most staff are not injured at all and that most injuries are only minor.⁵³ What is surprising is that there is no comparable data for the incarcerated population involved in these incidents. Why would such data not be presented for them and does this represent some lack of concern about how incarcerated people are impacted by the adverse events in the prison and, for confrontations occurring with staff, the potential that incarcerated persons are receiving disproportionate injuries inflicted by staff? The data on weapon use by incarcerated people also deserves some closer scrutiny. We are pleasantly surprised how rarely persons involved in assault on staff incidents are reported using any weapons. Of the 647 assault on staff incidents a cutting/stabbing weapon was involved in only 5 cases, less than 1% of the incidents; other weapons other than throwing fluids occurred in only 61 incidents, 50 of which involved “other” objects.⁵⁴ In 528 incidents it was reported that the incarcerated persons used his/her body in confronting staff. We believe this data may suggest that most incidents occur as a result of an unpremeditated confrontation between the incarcerated person and staff, rather than a planned attack by an incarcerated person. But more analysis is needed to better identify the types of confrontations that occur most frequently so measures could be taken to hopefully reduce them through de-escalation techniques. Finally we believe additional attention should be paid to the use of force by staff, particularly in the case of assaults on staff. The report indicates that 122 times in the 647 incidents, representing 19% of the events, staff struck the incarcerated person.⁵⁵ We question whether this data is an accurate reflection of actual events, given the descriptions of confrontations we have heard about from incarcerated people and the disciplinary reports we have examined. But more importantly, even if this data is an accurate representation of the use of force, why is it necessary in one-fifth of these incidents for the staff to strike the person rather than using their training to de-escalate or restrain the person? An analysis of the appropriate use of force needs to be addressed by the Department, and the UIR data is a useful place to start that analysis.

⁵³ *Ibid.* at 38-39.

⁵⁴ *Ibid.* at 16-18.

⁵⁵ *Ibid.* at 40-41.

We believe the UIR process has some problematic aspects in terms of accuracy and completeness. But it also demonstrates that systemic collection of data can be very valuable for understanding what is occurring inside. The legislature should require the Department to thoughtfully perform that analysis in a comprehensive and effective way, with public reporting, so that undesirable outcomes can be reduced and avoided.

Overall Prison-Level Change

Overall, for prison-level mechanisms, the legislature should require DOCCS to fundamentally transform the grievance and disciplinary systems for incarcerated persons, create more effective and independent complaint mechanisms – such as through an independent ombudsman and neutral disciplinary hearing decision makers, and better utilize all available mechanisms and data to address individual and systemic problems and abuse within the prisons. Far too often, both the grievance system and the disciplinary system are incredibly biased against incarcerated people, result in unfair outcomes, and are either ignored or used to cover-up staff abuse rather than utilized to redress individual complaints and systemic problems. Similarly, individual prisons, the Department, and the State fail to sufficiently track, analyze, and utilize other sources of information, such as UIR and Use of Force reports to carry out redress. Overall, prison superintendents, DOCCS, and the state need to develop effective electronic tracking systems and means of analysis, redress, and public reporting for all relevant indicators, including grievances, complaints, UIRs, Use of Force reports, investigations, lawsuits, and other measures (such as issues raised by the Inmate Liaison Committee).

2. Transforming Agency Level Mechanisms

Agency level investigation mechanisms must also be transformed by the legislature to ensure effective and timely accountability for staff abuse and misconduct. Specifically, the legislature should take action to: a) transfer power for investigating staff abuse of incarcerated people from the Office of Special Investigations (OSI) to an independent investigative body outside of DOCCS; b) remove remedial decisions for staff abuse from the arbitration process; c) strengthen prohibitions and reporting requirements for staff use of force; and d) create automatic remedial actions, including employment termination, for substantiated staff abuse of incarcerated people. The legislature should also: (e) investigate the effectiveness of DOCCS' recently enacted PREA compliance operations, and build from any positive aspects of these operations related to sexual abuse to investigate and address allegations of all types of abuse.

My personal experiences over the last 20 years have shown me that everything about DOCCS' ability to unbiasedly police and correct itself is obsolete and at this point farcical.”– Anonymous.

Transferring power from OSI to an independent investigative body

As one part of this transformation, the legislature should remove the investigatory powers for individual complaints out of DOCCS' own Office of Special Investigations (OSI) (formerly Inspector General's office or IG) and out of DOCCS altogether. The investigative body must be wholly independent of DOCCS in order to be effective. This outside investigative body must have increased capacity to promptly

I have been assaulted at this prison on two different occasions by several correction officers. It was retaliation and the facility administration covered the abuse up. The Inspector General office also investigated these misconducts and covered them up with the facility. . . . In all of these areas, the state officials need to hire independent people who are not biased. The system needs to change as a whole and the investigations need to be done by outside agencies who have no ties to DOCCS. – Anonymous.

and thoroughly respond to complaints, carry out investigations, and take appropriate remedial action to both protect incarcerated persons raising complaints and more effectively address abuses across DOCCS prisons.⁵⁶ This body must have the ability, capacity, and will to carry out investigations across all NYS prisons.⁵⁷ As one example, California has an Office of the Inspector General that is external from the corrections department and has authority under the

A sergeant bumped me for no reason, and an officer pushed my face into the wall. Then they said I tried to assault them. It would be better if the inspector general placed investigators posing as [incarcerated people] so that they can see how staff is treating [us]. --Anonymous

law to conduct audits and criminal investigations. It has unlimited access to prisons, employees and documents; is required to operate a toll-free public line for employees; and allows for people incarcerated in California to send complaints via mail.⁵⁸

This transfer of powers is necessary because current investigations by OSI/former IG and follow-up remedial steps currently fail to provide effective investigations and enforcement, and has even been complained about as a mechanism for cover-up of abuses rather than accountability. Various currently and formerly incarcerated persons repeatedly report concerns about the lack of capacity and independence of

I recently had a confrontation with two officers who threatened physical violence against me. I wrote to the Inspector General's office, and they referred it to the captain, who did nothing. It is just a joke to these people. --Anonymous

⁵⁶ See, e.g., John J. Gibbons and Nicholas de B. Katzenbach, Commission Co-Chairs, *Confronting Confinement: A report of the Commission on Safety and Abuse in America's Prisons*, June 2006, p. 44, available at: http://www.vera.org/sites/default/files/resources/downloads/Confronting_Confinement.pdf ("Report of the Commission on Safety and Abuse").

⁵⁷ *Ibid.*

⁵⁸ See <http://www.oig.ca.gov/>; Michele Deitch, *Independent Correctional oversight Mechanisms Across the United States: A 50-State Inventory*. Pace Law Review, 30 (21). p. 39, Available at: <http://digitalcommons.pace.edu/cgi/viewcontent.cgi?article=1764&context=plr>.

the OSI/IG, particularly given that many OSI employees are former DOCCS correction officers and some will return to being correction officers. Incarcerated persons also frequently raise concerns that the OSI has little or no ability to protect or transfer them after raising complaints to the OSI, and that they often do not receive any information from the OSI about its investigations or follow-up action after raising a complaint and/or being interviewed by the OSI. As one representative person reported in a survey to the CA, “due to no concern in Albany at all, the Inspector General’s officer does not answer complaints filed or sent to them.”

Removing staff abuse remedial decisions from arbitration

In addition to transferring the investigations from OSI to an independent agency, the legislature must remove remedial decisions in cases of staff abuse of incarcerated people from the flawed arbitration processes. Specifically,

No staff is held accountable for his or her actions. They act with impunity because the only investigation comes from a peer. --Anonymous

DOCCS should be granted the authority to make remedial decisions, including removal of staff, in cases where there is substantiated staff abuse of incarcerated persons, and as discussed below, some forms of substantiated staff abuse should result in automatic remedial action, including loss of employment.

Never Heard Anything from the IG

Multiple security staff . . . rushed into my cell . . . One of the COs threw me into a headlock and kned me on my back while I was still in bed. I was just in my drawers with no shirt on. . . . Officers twisted my arms behind my back, and put handcuffs on me real tight to the point where it cut off circulation and I ended up with bruises on my wrists. Staff yanked me up by my handcuffs and [an] officer punched me in the ribs causing me to keel over. An officer punched me in the back of my head and my temple, causing me to drop back to the ground. Staff continued to bend, twist, and stretch my limbs; bump and smash my head into the wall; chop me in my testicles; and beat me up. . . . When I requested to see medical, security staff said I was not going to see medical. . . . I was in a lot of pain, couldn’t sleep, and ended up pissing blood. . . . I wrote a grievance about the incident, and after it was denied I appealed it. Someone from the Inspector General’s (IG) office interviewed me and the other witnesses, but I never heard anything as a follow-up to their investigation. – Anonymous.

These changes are necessary because currently even in situations where OSI investigations result in findings of misconduct and serious abuse, and even when DOCCS wants to take appropriate remedial action, the union contract and employee discipline processes leave DOCCS and the

state often unable to bring about accountability.⁵⁹ Under the current contracts with security staff, if DOCCS moves to fire an employee for abuse against incarcerated persons and if the union files a grievance contesting the charges, then the final and binding decision – if a settlement is not reached – is made by an arbitrator chosen by both sides of the dispute.⁶⁰ As exposed by Tom Robbins and the [New York Times](#), of the 110 cases brought against security staff since 2010 by the Department, only eight resulted in employees losing their jobs, while 80 were settled with lesser penalties and 22 resulted in arbitration decisions. In the situation highlighted in Robbins' expose, correction officials determined that a CO who had brutally kicked an incarcerated person in the groin – causing blinding pain – had used excessive force and lied; the officials tried to fire him; an arbitrator also found the officer guilty of excessive force and lying, but reduced the penalty from dismissal to suspension. DOCCS refused to allow the CO back to work anyway, the union then sued, a supreme court judge overturned the arbitrator's decision, the union then appealed the decision, and the case is still pending while the officer remains a state employee. Robbins also documented other incidents in which officers charged with blows to the head, other physical abuse, and excessive force against incarcerated persons received between eight- and 20-day suspensions.

The [brutalization of George Williams at Attica](#)⁶¹ exemplifies the failures of the current lack of accountability even in the rare cases where staff abuse is exposed and investigated. Three officers – Sgt. Sean Warner, CO Keith Swack, and CO Matthew Rademacher – beat Mr. Williams nearly to death, leaving him with, among other injuries, a broken shoulder, several cracked ribs, two broken legs, and an orbital fracture around his eye. Even in this incredibly rare situation (*rare in terms of the response, not rare in terms of the abuse*) where there were investigations by the IG and state police, media exposes of the abuse, and the first prosecution in the history of DOCCS of an officer for non-sexual assault on an incarcerated person, the officers pled guilty to a misdemeanor of misconduct, quit their jobs, and retained their pensions.⁶²

Prohibitions and reporting requirements for staff use of force

As one mechanism for strengthening the ability to take remedial action against staff who engage in abuse of incarcerated persons, there must be a strictly enforced, no tolerance policy for more encompassing improper and excessive use of force by staff across NYS prisons. Under current regulations, DOCCS allows physical force to the degree reasonably required to be used, and

⁵⁹ See, e.g., Tom Robbins, *Guarding the Prison Guards: New York State's Troubled Disciplinary System*, The New York Times, Sept. 27, 2015, available at: http://www.nytimes.com/2015/09/28/nyregion/guarding-the-prison-guards-new-york-states-troubled-disciplinary-system.html?_r=0.

⁶⁰ *Ibid.*

⁶¹ See Tom Robbins, *A Brutal Beating Wakes Attica's Ghosts*, The New York Times, Feb. 28, 2015, available at: <http://www.nytimes.com/2015/03/01/nyregion/attica-prison-infamous-for-bloodshed-faces-a-reckoning-as-guards-go-on-trial.html>.

⁶² See Tom Robbins and Lauren D'Avolio, *3 Attica Guards Resign in Deal to Avoid Jail*, The New York Times, March 2, 2015, available at: <http://www.nytimes.com/2015/03/03/nyregion/attica-prison-guards-plead-guilty-in-2011-inmate-beating-case.html>.

allows employees to lay hands on or strike an incarcerated person if the employee reasonably believes that physical force is reasonably necessary for self-defense, to prevent injury to person or property, to enforce compliance with a lawful direction, to quell a disturbance, or to prevent an escape.⁶³ The legislature

The brutality that happens in every facility which is documented as a use of force is not properly investigated and is covered up and rubber stamped by the facility officials. The employees falsify reports and go out on compensation for the alleged injuries they supposedly suffered. The [incarcerated person] is seriously hurt and no charges are ever brought against the officials. --Anonymous

should require restrictions on the use of force to be strengthened to ensure that force by staff is used only in rare circumstances, with the least amount of force necessary, as a last resort method in response to imminent violence or harm to staff or other incarcerated persons.⁶⁴ The legislature should also mandate that the use of force in circumstances such as the following be strictly and explicitly prohibited: as punishment; as a response to verbal insults, threats, or failure to follow orders; or as retaliation.⁶⁵ The legislature should also strictly prohibit certain actions by staff, including utilizing certain types of force, such as headshots, or any excessive level of force, humiliation or provocation of incarcerated persons, pressuring or coercing incarcerated persons or staff to not report a use of force incident, verbal harassment, threats, racial and homophobic slurs, and obscenities.⁶⁶

Sexually Abused and Given SHU Time

COs brought me out for a urine analysis. Then, while I was handcuffed, one CO grabbed me and a second CO touched my testicles and tried to masturbate me. When I didn't get an erection, the CO hit me on the face and told me that the next time he tells me to get it up for him I better do so. I filed a grievance about the incident and filed a complaint with the Inspector General's office (IG). As retaliation, a CO came to my cell and called me a "b*tch" and told me that my grievance was going to go nowhere but that I was going to get "f*cked." The next day I received a fabricated misbehavior report for allegedly threatening to throw feces and sentenced to an additional three months in SHU. They also then placed a plexiglass cell-shield over my cell.— Anonymous.

Furthermore, the legislature should mandate that any use of force – defined as broadly as possible – requires prompt, accurate, specific, detailed, and complete reporting, documenting,

⁶³ DOCCS Directive 4944, Use of Physical Force, 12/29/2014.

⁶⁴ See, e.g., *Report of the Commission on Safety and Abuse* at 32-33; Preet Bharara, *CRIPA Investigation of the New York City Department of Correction Jails on Rikers Island*, US Department of Justice, US Attorney, Southern District of NY, p. 53, Remedial Measure C(1)(c), Aug. 4, 2014 (“*DOJ 2014 Report*”).

⁶⁵ *DOJ 2014 Report* at 53.

⁶⁶ *Ibid.* at 53, Remedial Measure C(1)(c), 58, Remedial Measure F(7) (Remedial Measure C(1)(c) notes that “headshots are considered an excessive and unnecessary use of force, except in the rare circumstances where an officer or some other individual is in imminent risk of serious bodily injury and no more reasonable method of control may be used to avoid such injury.”).

investigating, and systemic tracking.⁶⁷ All staff who use force, witness an incident, or provide medical or other attention following the use of force must be responsible for such reporting and documenting, and all investigations should include reviewing video recordings and obtaining accounts of incarcerated persons who were involved in or witnessed the use of force.⁶⁸ There also must be mechanisms for staff to make reports confidentially about incidents that they witnessed, and there must be protections in place for staff to be free from retaliation by other staff for reporting incidents.⁶⁹ DOCCS must be required to have a zero tolerance policy with regard to non-compliance with these reporting and investigating requirements, taking necessary and appropriate responsive actions for those who do not comply.⁷⁰ In addition, the legislature should mandate that DOCCS create and follow strengthened mechanisms for collecting, tracking, and publicly reporting use of force incidents and follow-up actions and outcomes.⁷¹

Nothing Happens When Officers Beat Us Up

I was cuffed behind my back and a CO put a hand around my neck and choked me. Another CO threw me down to the floor. They punched me in the back and kicked me in the back, leg, and face. They beat me up for more than two full minutes. I was taken to the medical area and they put me in a room that is basically the “beat up room.” . . . COs did a strip search and then one CO started choking me . . . I temporarily lost consciousness. Someone then smacked me in the face and threw me to the floor. COs started punching me, kicking me, kneeling me in my stomach, and punching me in the face. I took a severe beating, became dehydrated, and couldn’t breathe. . . . Medical failed to document the injuries that I suffered, including a broken bone in my face, a chipped tooth, and a busted lip. They took me to a mental health crisis observation room. After several days, they took me to the SHU, and gave me a ticket for assault on staff, disobeying a direct order, creating a disturbance, and lock-in procedures. I got 150 days in the box. . . . Almost everyone on my company in the SHU were there for an alleged assault on staff after being assaulted by staff . . . This is what they do here: call people out, beat them, and plant weapons on them. . . . I filed a grievance and appealed to Albany and never heard back from them. The OSI interviewed me in July and said they were going to do something but I can read people and I didn’t think they were going to do anything. Nothing has happened and it has been more than 90 days since then. . . . If we assault COs, the state would be so quick to issue a new charge. Yet, nothing happens when officers beat us up. – Anonymous.

Remedial actions for substantiated staff abuse

In turn, there must be more effective remedial measures taken for any violations of the policies and practices discussed above, including any unnecessary or excessive use of force, verbal

⁶⁷ *Ibid.* at 54-57 (specifying that the definition of the “use of force” should include “any instance where staff use their hands or other parts of their body, objects, instruments, chemical agents, electric devices, fire arms or any other physical method to restrain, subdue, intimidate, or compel an [incarcerated person] to act in a particular way.”).

⁶⁸ *Ibid.* at 56-57.

⁶⁹ *Report of the Commission on Safety and Abuse* at 93.

⁷⁰ *DOJ 2014 Report* at 54-55.

⁷¹ *Ibid.* at 55.

harassment and threats, failure to follow use of force reporting requirements, pressuring incarcerated persons from withdrawing complaints, engaging in retaliatory conduct, and failure to promptly and properly address violence between incarcerated persons.⁷² In addition to removing remedial decisions from the arbitration process, the legislature should mandate that certain staff violations automatically result in employment termination, such as hitting incarcerated persons already in restraints, kicking incarcerated persons on the ground, unnecessarily hitting incarcerated persons in the head, using unnecessary or excessive use of force that results in serious injury, sexual assaults, intentionally filing a false use of force report or failing to report serious incidents involving use of force.⁷³ Furthermore, any legislation passed should also apply remedial sanctions to supervisory staff who fail to adequately supervise staff who engage in improper conduct.⁷⁴

DOCCS Prison Rape Elimination Act (PREA) Compliance Activities

The Prison Rape Elimination Act, enacted in 2003, was intended to protect incarcerated persons from prison rape and other acts of sexual abuse and harassment by staff or incarcerated persons in federal, state and local facilities.⁷⁵ Federal rules approved by the US Department of Justice in May 2012 articulated national standards to prevent, detect, and respond to sexual abuse in correctional facilities.⁷⁶

DOCCS has articulated a zero tolerance policy for sexual abuse or sexual harassment in its prisons and therefore, has attempted to implement PREA standards in its facilities. In an effort to comply with the federal standards it has adopted two Directives, 4027A and 4028A, which detail how DOCCS will attempt to prevent, detect and respond to allegations of sexual abuse and/or harassment by incarcerated persons or DOCCS staff, respectively.⁷⁷

We will not attempt to evaluate DOCCS efforts related to prison sexual abuse and sexual harassment, but want to briefly discuss the investigative processes used by the Department for allegations of sexual abuse or harassment as an example of the Department's system-wide procedures to address complaints by incarcerated persons. DOCCS has a Deputy Commissioner for PREA Compliance, Jason Effman, and a Sexual Abuse Prevention and Education Office and their efforts have resulted in a more rigorous process to respond to incidents of sexual abuse.

Under DOCCS policies, Directive 4028A (III)(B), incarcerated persons can report verbally or in writing to any DOCCS staff any incident of staff sexual abuse, sexual threats, staff voyeurism or

⁷² See, e.g., DOJ 2014 Report at 61, Remedial Measures H(1).

⁷³ See, e.g., DOJ 2014 Report at 61, Remedial Measures H(2).

⁷⁴ See, e.g., DOJ 2014 Report at 62, Remedial Measures H(8).

⁷⁵ 42 U.S. Code §§ 15601 – 15609.

⁷⁶ DOJ, National Standards to Prevent, Detect, and Respond to Prison Rape, 28 CFR Part 115 available at http://ojp.gov/programs/pdfs/prea_final_rule.pdf.

⁷⁷ DOCCS Directive 4027A, Sexual Abuse Prevention & Intervention – Inmate-on-Inmate (2011); DOCCS Directive 4028A, Sexual Abuse Prevention & Intervention – Staff-on-Inmate (2011).

any act of retaliation by staff against an incarcerated person for reporting an incident of sexual abuse. Any employee receiving such report must immediately notify his/her supervisor or higher prison officials and must complete a written report by the end of the shift. Reports of sexual abuse are confidential and information received should only be shared with essential DOCCS personnel involved in the reporting, investigation, discipline and treatment process. The Facility Watch Commander is required to initiate the Department's sexual abuse protocol to preserve evidence and address the medical and other needs of the victim.

It is our understanding that investigations of any report of sexual abuse/harassment are conducted by the Office of Special Investigations Sex Crimes Unit. DOCCS asserts that members of this unit have received extensive training in how to investigate sexual abuse incidents. DOCCS also has a Letter of Understanding with the NY State Police to work cooperatively during the investigation of potential sex crimes.⁷⁸

DOCCS recently issued a report about its investigative activities concerning sexual abuse and sexual harassment for calendar years 2013 and 2014.⁷⁹ It indicates that there were 353 allegations of sexual victimization in CY 2013 and 491 allegations in CY 2014, an increase of 39%. In 2014, there were 233 allegations of staff sexual misconduct, 165 staff sexual harassment allegations, 47 allegations of nonconsensual acts with an incarcerated person, 18 allegations of sexual abuse by an incarcerated person, and 14 allegations of sexual harassment by an incarcerated person.⁸⁰ Of all the allegations of sexual abuse and sexual harassment by staff or another incarcerated person, nine incidents were substantiated in CY 2013 and 19 cases were substantiated in CY 2014.⁸¹ The Report also described DOCCS efforts "to combat sexual abuse," including the hiring of assistant deputy superintendent PREA compliance managers at 10 prisons, funding a pilot project that provides a rape crisis hotline and emotional support services to people at 27 prisons, the development of peer educational films on how to avoid sexual violence, and additional training for staff. It also announced that the Westchester County District Attorney's Office had successfully prosecuted three DOCCS employees who had engaged in sexual abuse in Bedford Hills in 2014 and another employee at that prison was recently arrested and charged. Finally, the Report announced that DOCCS has begun outside PREA audits starting in October 2015.

Although the CA has not had an opportunity to evaluate the effectiveness of the above measures or investigate whether incarcerated persons or staff believe that there has been a positive impact of these policies in reducing or preventing sexual abuse, the Department's activities related to

⁷⁸ Letter from Jason Effman, DOCCS Associate Commissioner to Joseph D'Amico, Superintendent NYS Police re Implementation of the Prison Rape Elimination Act Standards, May 2 2014 available at http://www.doccs.ny.gov/PREA/NYSP_Letter_of_Understanding.pdf.

⁷⁹ DOCCS Annual Report on Sexual Victimization 2013-2014 (2015) available at http://www.doccs.ny.gov/PREA/Report_on_Sexual_Abuse_Version_IV_2013-2014.pdf.

⁸⁰ *Ibid.* at 5-6.

⁸¹ *Ibid.* at 7-8.

PREA deserve comment. First, the amount of attention from Central Office and the utilization of resources for this issue are commendable. Second, it appears that there are greater levels of transparency and accountability surround sexual victimization than other forms of abuse in the system, although access to PREA records by outside agencies can be problematic. We are impressed with the prompt reporting of cases in the Annual Report for CY 2013 and CY 2014. Third, having a dedicated unit who allegedly has received specialized training to investigate sexual abuse cases is appropriate. As is discussed elsewhere in this testimony, however, we are very concerned generally about the effectiveness and fairness of the Office of Special Investigations and therefore, cannot assess whether the Sex Crime Unit of OSI is performing adequately. Fourth, it is unclear to what extent DOCCS has established a tracking system to more closely monitor the behavior of staff who have been accused of sexual misconduct but for whom the charges have not been substantiated and whether the Department has exercised greater authority over the assignments of these individuals to avoid the possibility of future inappropriate behavior toward the incarcerated population. If contractual obligations or DOCCS policies preclude such scrutiny and supervision, we believe action should be taken to change these barriers to prison safety.

We urge the legislature to investigate how effective the DOCCS PREA compliance operations are, and if it is clear that these procedures are being successful in identifying abuse, that it urge DOCCS to consider adopting some of the PREA measures for investigations of more general allegations of abuse and for actions enforcing the policies against staff mistreatment of the prison population.

Overall Agency-Level Change

Overall, for agency-level mechanisms, the legislature must ensure that there are effective mechanisms in place to bring accountability for staff misconduct, have measures to both prevent and address inappropriate and excessive use of force. The combination of OSI investigations, limitations on superintendents to move or remove abusive officers, and the ineffective arbitration processes again act as more of a cover-up than a system of investigations and accountability. The legislature must remove general investigations of staff abuse from OSI to an independent state investigative body and strengthen and meaningfully enforce prohibitions and reporting requirements for the use of force. If they are being implemented effectively, the PREA compliance operations could provide some components that could be utilized for this alternative system of investigations and accountability for all forms of staff abuse.

3. Strengthening, Expanding, and Creating External Semi-Independent State Agency Mechanisms

Beyond changes to the prison- and agency-level mechanisms and in addition to oversight independent of New York State (discussed below), the legislature should also ensure that there is adequate state agency oversight of DOCCS prisons, whether by increasing the authority and

resources of the agencies that already have some oversight of DOCCS, or creating a new independent state agency, or some combination of both. As discussed further below with respect to oversight bodies wholly independent of the state, including the CA, any state agency/agencies with oversight of DOCCS prisons, should have the types of aspects outlined by the ABA and Professor Deitch and others (and discussed in more depth below), including: complete independence of DOCCS; regular and routine investigations; unrestricted access to DOCCS prisons, people incarcerated, staff, and documents and records; sufficient funding and staffing; timely public reporting requirements; and powers to ensure remedial action taken in response to the agency's recommendations.

As an example of a government agency with oversight responsibilities of prisons, the Prisons Inspectorate in the UK is statutorily mandated to inspect prisons throughout the country. This body must inspect every adult prison at least two times within every five year period (and all facilities holding people under 18 twice every three years). It has the ability to enter every prison at any time and has complete access to all prisons, people incarcerated in the prisons, staff working in the prisons, and all relevant documents.⁸² Prior to inspections, the Inspectorate utilizes confidential surveys for incarcerated people regarding all aspects of prison life, and engages in system-wide analysis of survey responses.⁸³ The inspections themselves are typically week-long, and the Inspectorate has keys to every area of every prison and inspects the prisons without the presence of staff, has confidential meetings with incarcerated people, staff, and administrators individually and in groups, and reviews all of the prison's records.⁸⁴ Following their inspections, the Inspectorate makes assessments and recommendations, each prison must create an action plan indicating whether and how they will carry out each recommendation, 95% of which the prison accepts, and the Inspectorate evaluates implementation.⁸⁵ The inspectorate makes public all of its inspection reports, as well as thematic reviews on systemic issues facing the entire prison system.⁸⁶

We believe incorporating many of the powers and mechanisms employed by the UK Inspectorate in those entities performing oversight of New York prisons would substantially increase the level of transparency and accountability needed to ensure that DOCCS facilities are safe and humane.

Existing State Agencies with Oversight Responsibilities

There are several state agencies that are already involved at some level in the monitoring of DOCCS prisons and the treatment of its population often for only a limited set of issues and with

⁸² See, e.g., Anne Owers, *Prison Inspection and the Protection of Prisoners' Rights*, 30 PACE L. REV. 1535, 1540 (2010), available at: <http://digitalcommons.pace.edu/cgi/viewcontent.cgi?article=1754&context=plr>.

⁸³ *Ibid.* at 1540.

⁸⁴ *Ibid.* at 1541.

⁸⁵ *Ibid.* at 1542.

⁸⁶ *Ibid.* at 1543.

varied degrees of effectiveness. These include: (1) State Commission of Correction (SCOC); (2) Justice Center for the Protection of People with Disabilities (Justice Center); (3) NYS Department of Health (DOH); and (4) Office of Alcoholism and Substance Abuse Services (OASAS). We will briefly describe the duties of each of these agencies and make some general observations about their effectiveness in oversight of the areas in which they have statutory authority to review DOCCS policies and practices. In general, we find these agencies have had only limited impact on how DOCCS treats people inside and often fail to vigorously exercise their powers to monitor actual prison practices or press DOCCS to modify its policies and procedures.

With the exception of the State Commission of Correction, the oversight duties of the other state agencies arise from recently enacted statutory authority to monitor specific aspects of DOCCS operations. These provisions generally mandate that the agency monitor some aspect of care provided to persons incarcerated in state prisons or evaluate a specific program to determine its effectiveness. These limited oversight duties represent a relatively new model for monitoring prison conditions in that an agency with expertise in a specific subject is charged with assessing the services provided by DOCCS and sometimes the Office of Mental Health (OMH) in the prisons, assisting them in developing more effective policies and procedures, but providing only limited or no authority to force changes to the operation of the prisons.⁸⁷ In contrast, SCOC has very broad authority to examine all aspects of DOCCS prisons and has greater authority to mandate policy and procedural changes.

Limitations of State Commission of Correction

In 1973 the state legislature removed the State Commission of Corrections (SCOC) from the direct supervision of the Commissioner of Corrections and made it an independent state agency. Its authority is detailed in Article 3 of the New York State Correction Law.⁸⁸ Section 45 provides fairly expansive functions, powers, and duties of the Commission, including the right to: (1) make recommendations to administrators of correctional facilities⁸⁹ for “improving the administration of such correctional facilities and the delivery of services;” (2) “visit, inspect and appraise the management of” state and local facilities; and (3) promulgate rules and regulations establishing minimum standards for the “care, custody, correction, treatment, supervision, discipline, and other correctional programs for all persons confined in correctional facilities.”⁹⁰

⁸⁷ See Jack Beck, *Role of the Correctional Association of New York in a New Paradigm of Prison Monitoring*, 30 Pace Law Review 1572, 1592-1605 (2010) for a more detailed examination of this new paradigm.

⁸⁸ N.Y. Correction Law §§ 40 - 48.

⁸⁹ A correctional facility is defined for the purposes of the SCOC as “any institution operated by the state department of correctional services, any local correctional facility, or any place used, pursuant to a contract with the state or a municipality, for the detention of persons charged with or convicted of a crime, or, for the purpose of this article only, a secure facility operated by the state division for youth.” *Ibid.* at § 40(3).

⁹⁰ *Ibid.* at §§ 45(2), (3) and (6).

The SCOC can close any correctional facility which is "unsafe, unsanitary or inadequate to provide for the separation and classification of [incarcerated persons] required by law or which has not adhered to or complied with the rules or regulations promulgated with respect to any such facility by the commission."⁹¹ The SCOC is mandated to make an annual report to the governor and legislature concerning its work.

The SCOC also has significant powers to facilitate its exercise of its duties. Specifically, it has access to any facility at any time, to documents, records and data from the correctional system, and any information from any officer or employee of the correctional facility.⁹² It can also issue a subpoena and administer oaths and examine persons under oath. The SCOC can also go to the state supreme court to force the correctional facilities to comply with its rules and regulations about the conditions within the facilities or the care of any incarcerated person.⁹³

Despite these broad powers, SCOC has done very little to monitor conditions in the state prisons or to evaluate the treatment of the incarcerated population, with the exception of healthcare discussed below. The SCOC has promulgated limited regulations about the state prisons outside of the area of medical care. Specifically, Chapter V Minimum Standards and Regulations for Management of State Correctional Facilities contains provisions about the physical plant of the prisons (environmental health and safety, sanitation and facility capacity), personal hygiene for incarcerated persons, rights of access to educational and library services, protocols for the use of chemical agents, and a prohibition against nondiscriminatory treatment.⁹⁴ In addition, there are more detailed provisions about health services that define the essential elements of a functioning medical department in the prisons.⁹⁵

More disturbing, however, than the limited promulgation of comprehensive regulations about DOCCS is the SCOC's failure to actively monitor either the policies or practices within the state prisons. Even state officials have noted this lack of active monitoring of the prisons. The Office of the New York State Comptroller, Division of State Government Accountability, performed an evaluation of the SCOC in 2006 and concluded: "SCOC relies on inspections to determine whether correctional facilities are complying with the regulations governing their operations. However, SCOC stopped inspecting DOCCS correctional facilities when its staffing levels were reduced during the 1990s."⁹⁶ The report noted that SCOC had declined from 66 employees in

⁹¹ *Ibid.* at § 45(8).

⁹² *Ibid.* at §46(1).

⁹³ *Ibid.* at § 46(4).

⁹⁴ Title 9 NYCRR Parts 7006 – 7695.

⁹⁵ *Ibid.* at § 7651.

⁹⁶ NYS Comptroller, NYS Commission of Correction: Oversight of Correctional Facilities and Handling of Grievances and Complaints Report 2006-S-93, at 4 (2008) available at <https://osc.state.ny.us/audits/allaudits/093008/06s93.pdf>.

1990 to 35 by fiscal year 2006-07. In the current fiscal year, 2015-16, its staffing has been further reduced to 32.

The current SCOC Annual Report for 2014, issued in June 2015, further demonstrates that lack of attention to conditions in the state prisons beyond new construction and healthcare.⁹⁷ Although extensive information is provided about the county jails and the inspections performed by SCOC staff of these facilities, there is almost no discussion of the state prison system. Concerning DOCCS facilities, the report describes the activities of the SCOC Medical Review Board with a particular focus on the Forensic Medical Unit, which performs investigations of incarcerated person mortalities in both prisons and jails. The Annual Report also notes its review of 18 construction projects in the prisons. But almost no other mention is made of the prisons or any activity to monitor conditions in these facilities. It is clear that very little of SCOC's activities are focused on the conditions for and treatment of incarcerated people in our prisons.

The one area where SCOC has made a more concerted effort to evaluate the treatment of people in the state prisons is work by the SCOC Medical Review Board. Sections 43 and 47 of the Correction Law require SCOC to convene a Medical Review Board (Board) to review the deaths of all persons who died in any correctional facility and to "investigate and report to the commission on the condition of systems for the delivery of medical care to [incarcerated persons] of correctional facilities and where appropriate recommend such changes as it shall deem necessary and proper to improve the quality and availability of such medical care."⁹⁸ To support the Board, SCOC has a Forensic Medical Unit, which assists in the investigations of deaths, including making site visits to the facilities, and also provides technical assistance to state and local facilities concerning improvements in health care delivery.

For the state prisons, the Board has produced many substantive reviews of deaths, which have identified deficiencies in medical and mental health care of persons who have died while in custody. For example, in calendar year 2014, full Board case investigations and reviews were conducted for six deaths in state prisons (out of 26 such reviews by the Board) and seven abridged Board investigations and reviews were held for state prisons deaths of 11 abridged mortality investigations conducted during that year. It should be noted, however, that there are approximately 120 deaths each year in the prisons, so full or abridged investigations occur in only a small percentage of the cases, although medical records for each death are reviewed by the Board. The Board has been particularly vigilant in reviewing suicides in the prisons and has identified problems in medical care, mental health services or treatment by security staff that may have contributed to or failed to prevent the suicide.

⁹⁷ SCOC, New York State Commission of Correction Annual Report for Year 2014 (2015) available at http://www.scoc.ny.gov/pdfdocs/annualreport_2014.pdf.

⁹⁸ N.Y. Correction Law § 47(e).

There is very little evidence, however, that the Board is exercising its broader authority to report on systems for delivery of medical care. We are unaware of any examples of the Board or the Forensic Medical Unit investigating medical care systems in the state prisons outside of a specific investigation of a death. Moreover, there are no reports by the SCOC indicating that it is performing these investigations or has made any recommendations to DOCCS on how to improve general medical delivery systems.

Given the limited resources of SCOC and the apparent unwillingness of the agency to take more aggressive action to monitor general prison conditions, we believe it would be ineffective to focus on expanding SCOC activities to include the assessment of the treatment of incarcerated persons by staff, including acts of violence and abuse. The expertise that has been developed by the Board and the Forensic Medical Unit suggest, however, that it may be feasible to enhance SCOC oversight of medical and mental health care in the prisons. In particular, we believe that the Board should be charged with investigating serious incidents of self-harm that occur throughout the Department. Moreover, when patterns of self-harm or examples of poor quality of care are identified by mortality reviews or from other information that comes to the attention of the SCOC, the Board should be assigned to investigate these situations. This will require additional staff, but since the SCOC has lost more than one-half of its staff since 1990 when the prison population was the same as it is now, it is reasonable to expand those resources to address the critical issue of healthcare which plagues our current system. With this expanded emphasis, we would also urge that SCOC be pressured to produce its reports on deaths and other medical matters in a more timely fashion and in a public manner (with appropriate personal identifying information of incarcerated people redacted), but again, this can only be accomplished if additional resources are provided to SCOC.

Role of the Justice Center for the Protection of People with Special Needs

The Justice Center for the Protection of People with Special Needs (Justice Center) was created by the “Protection of People with Special Needs Act,” which was primarily codified into Article 20 of NY Executive Law and became operational in the summer of 2013. The primary role of the Justice Center is to protect vulnerable persons, defined as “a person who, due to physical or cognitive disabilities or the need for services or placement, is receiving services from a facility or provider agency”⁹⁹ within the system of State Oversight Agencies.¹⁰⁰ The Justice Center is intended to protect this vulnerable population from abuse, neglect or mistreatment and to be an advocate for them to ensure they receive quality of care. The Justice Center has both law enforcement powers and significant powers to advocate for this patient population, including

⁹⁹ Article 20 NY Executive Law § 550 (5).

¹⁰⁰ The state agencies covered by Article 20 include: Office for People with Developmental Disabilities, Office of Mental Health, Office of Alcoholism and Substance Abuse Services, Office of Children and Family Services, Department of Health and the State Education Department. *Ibid.* at § 550 (4).

access to all facilities and subpoena powers; mandate to require state agencies to develop and implement prevention and remediation plans in situations of abuse and neglect and then to approve, provide oversight over, and evaluate compliance with those plans; prosecutorial authority via a Special Prosecutor / Inspector General and all concomitant powers, such as the ability to obtain warrants; responsibility to collect, track, analyze, publicly report on, and develop prevention initiatives related to abuse and neglect statewide; and management of a 24/7 hotline for reporting allegations of abuse and neglect from service providers, mandatory reports, witnesses or others.¹⁰¹ Unfortunately, correctional facilities were exempt from the list of State Oversight Agencies and therefore, all the powers the Justice Center has to protect vulnerable persons are inapplicable to people in state and local correctional facilities.

Separate and apart from Article 20, the Justice Center was also assigned the duties of the now defunct Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC) related to CQC's obligation to monitor implementation of the SHU Exclusion Law.¹⁰² The SHU Exclusion Law mandates that, unless exceptional circumstances exist, any incarcerated person with serious mental illness cannot be placed in a disciplinary confinement unit, known as a Special Housing Unit (SHU), for more than 30 days.¹⁰³ The law further provides that these diverted persons must be sent to a residential mental health treatment unit (RMHTU) in the prisons where the patient will generally receive four hours of therapy five days per week. The law requires appropriate screening of persons admitted to disciplinary confinement to determine if they meet the criteria for diversion and defines the procedures to be employed in evaluating the patient for diversion and treatment. It also specifies how prison authorities may restrict services and conditions in the RMHTU, and limits the use of sanctions such as additional disciplinary confinement and the imposition of a restricted diet for patients who suffer from serious mental illness. The substantive provisions of the SHU Exclusion Law providing for the diversion of people to the RMHTUs and the other protections provided to persons with disciplinary sanctions with serious mental illness went into effect on July 1, 2011.

Another component of the SHU Exclusion Law mandates that the Justice Center be "responsible for monitoring the quality of care provided to [incarcerated persons] with serious mental illness pursuant to article forty-five of the Mental Hygiene Law. The Justice Center shall have direct and immediate access to all areas where state [incarcerated persons] are housed, and to clinical and department records relating to [patients'] clinical conditions. The Justice Center shall maintain the confidentiality of all patient-specific information."¹⁰⁴ In addition, the law states that the Justice Center "shall monitor the quality of care in residential mental health treatment

¹⁰¹ See, e.g., <http://www.justicecenter.ny.gov/about/faq#t43n51>; http://www.justicecenter.ny.gov/monthly_data_report_October-2015; <http://www.justicecenter.ny.gov/annual-report-governor-and-legislature-june-30-2013-june-30-2014>.

¹⁰² NY Correction Law § 401-a (1).

¹⁰³ NY Correction Law § 137 (6) (d)(i).

¹⁰⁴ NY Correction Law § 401-a (1).

programs and shall ensure compliance with" the requirements of Sections 137 and 401 of the Corrections Law, which incorporate the substantive provisions of the SHU Exclusion Law described above.¹⁰⁵ Finally, the law specifies that the Justice Center should convene an advisory committee consisting of mental health experts and advocates, as well as family members of formerly incarcerated individuals.

Since the SHU Exclusion Law was enacted, and in particular during the last two years when the Justice Center was performing the oversight duties under that Law, this oversight function has produced some meaningful assessments of mental health care in the prisons. Specifically, CQC and the Justice Center have produced reports about (1) persons who experienced mental health crisis, (2) analysis of the screening process for determining whether a person should be on the mental health caseload; (3) reviews of care in the non-disciplinary prison residential mental health treatment units; and (4) assessments of the services provided to people in the SHUs to determine whether OMH is promptly and regularly evaluating individuals to determine if they should be transferred to an RMHU or need mental health services. It is our opinion that these reports generally have been thorough and balanced in their assessments of services and the needs of the patients, and as such, have prompted both DOCCS and OMH to make some policy and procedural changes and enhance training to address noted deficiencies.

But improvements are needed to fully realize the potential oversight responsibilities under the current SHU Law. Foremost is the need for additional resources. There are more than 9,500 patients on the OMH caseload in the prisons at any one time, representing 18% of the entire prison population, and estimates range up to 40% of persons incarcerated in our prisons at some point during their incarceration may need mental health care. There are more than 4,000 persons in disciplinary confinement in 47 different prison units and about 13,500 persons are sentenced to the SHU each year. With only five staff members, it is impossible for the Justice Center to perform its duties in a timely manner. Family members of persons with mental illness inside have been pressing the Justice Center to investigate allegations of improper care of their loved ones. It appears that the limited resources available to the Justice Center assigned to the correctional system makes it practically impossible for the Center to be responsive to these complaints, even in situations that present dire circumstances for the affected patients. In addition, the scope of the Justice Center's reviews of the SHUs has been relatively limited, focusing primarily on the procedural aspects of care and compliance with the law, including whether assessments are done in the mandatory time frames and whether documentation of patient reviews and treatment plans is completed fully and appropriately.¹⁰⁶ Moreover, the Justice Center has yet to report on the disciplinary Residential Mental Health Treatment Units – one of the key components of the SHU Exclusion Law as the sites of diversion from SHU.

¹⁰⁵ *Ibid.* at § 401-a (2).

¹⁰⁶ The Justice Center has done relatively more extensive substantive reviews in incidents where incarcerated people have committed suicide within DOCCS custody.

Ultimately, despite whatever work the Justice Center (and CQC before it) have done, as discussed below, there remain serious concerns about the implementation of the SHU Exclusion Law. Some of the most pressing concerns include: (a) over 700 people with mental health needs on the OMH caseload still in solitary on any given day; (b) questions about major shifts in diagnoses that make fewer patients eligible for diversion from the SHU; (c) people remaining in disciplinary RMHTUs for months and years; (d) people in RMHTUs facing staff physical and verbal abuse, excessive disciplinary tickets, and too frequent confinement of 23-24 hours a day due to program denials or refusals; and (e) high rates of self-harm and suicide within SHUs and in DOCCS generally.

Another noted problem is the failure of the Justice Center to meet its statutory obligation to make public its reports and findings. Advocates and family members have waited patiently for more than a year for the Center to post its work product, but Justice Center documents have not been made available despite repeated requests to the agency leadership. Moreover, advocates waited over eight months and had to engage in repeated advocacy simply to receive documents requested under the Freedom of Information Law (FOIL) on the Justice Center's basic monitoring of SHUs. The Justice Center's credibility is being threatened by this failure to make public its activities, and the lack of transparency raises the concern that state officials are attempting to cover up potential negative findings about the care of mental health patients in our prisons.

As discussed below, the legislature must ensure that the Justice Center publicly reports its findings in a timely manner as already required under the SHU Exclusion Law. Also at the very least, given the pendency of a new budget proposal for the next fiscal year, it is important that the legislature signal to the Governor and ensure that adequate resources must be allocated to the Justice Center so it can perform its statutory duties. We believe the Assembly should also consider expansion of the Justice Center's jurisdiction, and that substantial increases in its staffing should be authorized if its role in the prisons is increased. When the Justice Center was created, advocates for the incarcerated population sought to include correctional institutions in Title 20 definition of State Oversight Agencies. Although we were unsuccessful in that advocacy effort, that decision should be reconsidered.

It is unreasonable to exempt institutionalized vulnerable people in prison, who are being entirely cared for by a state agency, from the protections afforded to these individuals by the Justice Center if they were receiving services from any other state agency providing care. Prisons are even more closed institutions and the barriers to care and the likelihood of staff abuse in a correctional setting are even greater than in other state agency residential programs that are primarily designed to meet the needs of these vulnerable patients. The SHU Exclusion Law does not apply to incarcerated persons who have physical or developmental disabilities and the special prison units for these patients are totally outside the purview of the Justice Center. The

additional investigative and enforcement powers provided for in Title 20 would benefit the advocacy efforts by the Justice Center for patients with mental health needs in our prisons. This would include enhanced access to staff, records and the ability to hold abusive staff accountable. Moreover, including prisons in the definition of State Oversight Agencies would permit the Justice Center to allocate some of the staff now assigned to Title 20 duties to perform some activities for the forensic patients.

We urge the Assembly to explore the needs of the Justice Center for enhanced resources to meet its current legislative mandate and the possibility that its jurisdiction could be increased to better protect vulnerable persons in our prisons. We also suggest the Assembly press the Justice Center to make public the work it is currently doing to assess its effectiveness in monitoring implementation of the SHU Exclusion Law and evaluating mental health care in the prisons.

NYS Department of Health (DOH) Oversight of HIV and Hepatitis C (HCV) Care in the Prisons

Section 206 (26) of the Public Health Law (DOH Oversight Law) requires DOH to annually review the policies and practices of DOCCS concerning HIV and HCV care, including prevention of these diseases, and to determine whether such policies and practices are "consistent with current, generally accepted medical standards and procedures used to prevent the transmission of HIV and HCV and to treat AIDS, HIV and HCV among the general public."¹⁰⁷ Upon completion of each review, the law mandates DOH to, in writing, either approve DOCCS policies and practices or direct DOCCS to "implement a corrective plan to address deficiencies." The DOH Oversight Law authorized DOH to visit prisons, interview staff and incarcerated persons, inspect policy and procedure manuals and medical protocols, review medical grievances, and inspect a representative sample of patients' medical records. Finally, the DOH Oversight Law requires DOH prior to initiating its review to notify the public of the scheduled review and invite them to provide relevant information. These duties have been delegated to the AIDS Institute (AI) to perform, but limited funding has been allocated in the AI budget to conduct these activities.

Although DOH has performed some aspects of its mandate under the law, it could improve its oversight activities by: (1) increasing the frequency of its review process and providing more effective notice to the public; (2) enhancing the scope of its review; and (3) augmenting its methods of review.

We believe the DOH Oversight process presents opportunities to improve medical care for people incarcerated as well as continuity of care for those persons leaving prison and to facilitate the integration of criminal justice involved persons into the healthcare system changes being

¹⁰⁷ NY Public Health Law § 206 (26).

implemented through NYS Medicaid redesign and the Affordable Care Act. The insights gained from the AI monitoring process and the relationships established between DOCCS medical and administrative staff and the AI have the potential not only to improve prison care and continuity of care for patients leaving the system, but also to help inform the broader process of designing community care that will effectively integrate *all* patients released from DOCCS with significant medical issues into community-based care.

The CA has carefully monitored the DOH Oversight Law and in particular how the AIDS Institute has performed its evaluation of prison care. The CA has submitted two extensive comments on our assessment of HIV and hepatitis C care in NYS prisons in 2010 and in 2013.¹⁰⁸ We extensively commented on the state of DOH monitoring in both of those reports and will only briefly summarize our critique here. Specifically we concluded:

1. The AI annual review in the past few years has consisted of assessing a very limited number of facilities with relatively small numbers of patients. For example in 2013, it evaluated only four prisons with a combined population of 4,400 people, representing less than 8% of the DOCCS census.
2. We are pleased that in the last two years AI is actually reviewing medical charts to evaluate care. We are concerned, however, that with respect to HCV care, the instrument is very limited and is not evaluating whether patients are receiving treatment for HCV.
3. We are not aware that the AI review includes interviews with patients or an examination of system-wide data which may indicate whether general healthcare systems are functioning properly at the prison with adequate staff. These major system flaws could go undetected with the limited chart reviews being performed.
4. We remained concerned about the reluctance of AI to effectively solicit information about HIV and HCV care from incarcerated patients, the public or prison advocates. Almost no effort is made to inform the public where AI is going and when. Nor are their results readily available for public scrutiny or comment. Without this effort to inform the affected community, the agency is not meeting its statutory duty or the intent in enacting this law.

We urge the Assembly to inquire about the funding for the DOH Oversight Law to ensure that sufficient resources are being provided to DOH so that the statutory mandate can be meaningfully implemented. We also urge the legislature to press DOH to make its efforts and results publicly available and to facility input from those who are directly affected, their families and advocates who are aware of deficiencies in care. Moreover, the legislature should consider

¹⁰⁸ CA 2013 Comments Concerning DOH Oversight of HIV/HCV Care in New York Prisons (2013) available at <http://www.correctionalassociation.org/wp-content/uploads/2013/10/CA-Memo-2013-Comments-DOH-Oversight-Law-Final-Draft.pdf>; CA Memorandum Implementation of Public Health Law § 206(26) (6/30/2010).

expanding DOH's mandate with respect to New York prisons beyond HIV and HCV care so that DOH has oversight over all medical care in the prisons as it does for medical care provided throughout New York.

NYS Office of Alcoholism and Substance Abuse Services Oversight of Prison Treatment Programs

In April 2009, the NYS legislature and then Governor Patterson passed legislation that significantly reformed the Rockefeller Drug Laws (RDL) by restoring discretion to the courts to divert some individuals from prison to community-based treatment, reducing the sentences for some offenses, authorizing a limited number of individuals already incarcerated to seek reductions in their current sentences, and including funds for community-based treatment programs for those diverted from the criminal justice system.¹⁰⁹

In addition, this reform to the Rockefeller Drug Laws mandated that the New York State Office of Alcoholism and Substance Abuse Services (OASAS) monitors prison-based, substance abuse treatment programs, develops guidelines for the operation of these programs and releases an annual report assessing the effectiveness of such programs.¹¹⁰ Prior to this provision, OASAS did not monitor any prison-based treatment programs except for two existing facilities: (1) Willard Drug Treatment Center, a 90-day intense treatment readiness program at a facility operated jointly by DOCS and the Division of Parole primarily designed for technical parole violators; and (2) Edgecombe Correctional Facility, a recently created 30-day treatment readiness program for parole violators.

Following enactment of the law, OASAS issued its first and apparently only report in December 2010.¹¹¹ In this report, OASAS described its activities in 2010 including: (1) development of operating regulations for the Willard Drug Treatment Campus; (2) establishment of specialized re-entry programs at three prisons; (3) development of the Transition from Prison to Community Initiative, which was designed to improve re-entry for persons being released from prison to parole supervision; (4) establishment of a criminal justice, judicial and chemical dependency

¹⁰⁹ See <http://www.correctionalassociation.org/wp-content/uploads/2009/05/analysis-of-rockefeller-reform-bill.pdf>.

¹¹⁰ Section 19.07 (h) of the New York Mental Hygiene Law provides: "The office of alcoholism and substance abuse services shall monitor programs providing care and treatment to inmates in correctional facilities operated by the department of correctional services who have a history of alcohol or substance abuse or dependence. The office shall also develop guidelines for the operation of alcohol and substance abuse treatment programs in such correctional facilities in order to ensure that such programs sufficiently meet the needs of inmates with a history of alcohol or substance abuse or dependence and promote the successful transition to treatment in the community upon release. No later than the first day of December each year, the office shall submit a report regarding the adequacy and effectiveness of alcohol and substance abuse treatment programs operated by the department of correctional services to the governor, the temporary president of the senate, the speaker of the assembly, the chairman of the senate committee on crime victims, crime and correction, and the chairman of the assembly committee on correction."

¹¹¹ OASAS Report on NYS DOCS Addiction Services (12/1/2010).

database to better track outcomes; and (5) an agreement between the Commissioners of OASAS and DOCS to establish a goal of OASAS, certifying all addiction services programs offered by the Department.¹¹² OASAS also reported that it had certified five Department treatment programs at Arthur Kill, Taconic, Hale Creek, Gowanda and Albion Correctional Facilities.

In 2011, OASAS apparently developed better guidelines for the operation of addiction services in the prisons and certified four of the approximately 50 substance abuse programs in the prisons. There was no annual report about the agency's correctional activities, but in the one-page OASAS 2011 Outcome Dashboard Results document summarizing all of the agency's activities for the year, it was reported that the agency had partially achieved its plan to certify five more DOCCS treatment programs.¹¹³ In the OASAS 2012 Dashboard, it was reported that OASAS was planning to attempt to certify six additional DOCCS substance abuse treatment programs but also stated that it had certified four such programs in 2011, as previously noted.¹¹⁴ There appears to be no document indicating whether the plans for 2012 were in fact implemented, and therefore, it is impossible to verify whether these certifications occurred. Moreover, no 2012 annual report was issued detailing OASAS activities in the prisons. The only other OASAS document that we could identify that speaks to the issue of evaluating substance abuse programs in DOCCS is the OASAS 2011 Interim Report concerning the OASAS Statewide Comprehensive Plan for 2010-14.¹¹⁵ In that report it stated that the Department and OASAS had developed a Memorandum of Understanding and operating guidelines for the certification of DOCCS treatment programs. It also noted the five prison-based treatment programs already certified and identified in the 2010 Annual Report of DOCCS addiction services, and predicted that all Department addictions services programs "will be certified by 2015."¹¹⁶

Unfortunately, after the 2011 Interim Report and the 2012 Dashboard, we cannot identify any further activities by OASAS to monitor or certify any DOCCS treatment programs or otherwise monitor the effectiveness of the programs. The OASAS 2014 Interim Report documenting progress on the Statewide Comprehensive Plan for 2013-2017 is silent on any correctional based activities by OASAS. Moreover, no annual report as required by the RDL Reform Law has been issued since the end of 2010. It should be noted that the OASAS and DOCCS Commissioners, who negotiated the memorandum of understanding between the agencies, are no longer in their positions, and it appears any cooperation between DOCCS and OASAS may have ceased.

¹¹² *Ibid.* at 2.

¹¹³ OASAS 2011 Outcome Dashboard Results available at https://www.oasas.ny.gov/pio/oasas/documents/Metrics_2011Results.pdf

¹¹⁴ OASAS 2012 Outcome Dashboard available at <https://www.oasas.ny.gov/pio/oasas/documents/2012dashboard.pdf>.

¹¹⁵ OASAS 2011 Interim Report on OASAS Statewide Comprehensive Plan 2010-14 (2011) available at <https://www.oasas.ny.gov/pio/commissioner/documents/5YPIntReport2011.pdf>

¹¹⁶ *Ibid.* at 6.

Given this situation, one must conclude OASAS' statutory obligation to monitor prison substance abuse treatment programs has been ignored for at least three years and there are no apparent plans we can identify for OASAS to revitalize those activities. We urge the legislature to question both agencies about the lapse in these monitoring activities to ensure the law is enforced.

Independent Prosecutor

As another state-level investigative mechanism, the legislature should require the creation of a statewide independent prosecutor to investigate and prosecute incidents of staff brutality within the prisons. Earlier this year, Governor Cuomo appointed the state attorney general to serve as a special prosecutor to investigate some police killings.¹¹⁷ New York should build upon this new initiative to have an independent prosecutor for serious incidents of staff brutality by correction officers. As former Governor and Attorney General Eliot Spitzer articulated in his call for federal prosecution or a statewide special prosecutor for correction officer brutality in New York, an independent prosecutor is necessary because of the lack of political will by local prosecutors to pursue cases against law enforcement officers who, along with their union, are politically powerful locally and statewide.¹¹⁸ As noted above, the prosecution of officers Warner, Swack, and Rademacher in the brutal beating of George Williams was reported by DOCCS to be the first time in DOCCS history that any correction officer was prosecuted for non-sexual assault of an incarcerated person. Given the long and well-documented history of frequent staff brutality against incarcerated people,¹¹⁹ the lack of a single prosecution prior to March 2015 clearly indicates an inability for local prosecutors to provide appropriate accountability for officer abuse. Even in this sole prosecution, the local district attorney stated that the case had “never been about jail for these officers.”¹²⁰ In sharp contrast to heavy-handed prosecutions of people in the community, primarily Black and Latino people, as well as of incarcerated people in the prisons, the complete lack of prosecutions of the most horrific assaults and even murders by correction officers displays the gross disparities of justice and accountability in need of rectification.

¹¹⁷ See, e.g., Noah Remnick, *Cuomo to Appoint Special Prosecutor for Killings by Police*, The New York Times, July 7, 2015, available at: <http://www.nytimes.com/2015/07/08/nyregion/cuomo-to-appoint-special-prosecutor-for-killings-by-police.html>; Mark Berman, *New York will have a special prosecutor look into some deaths at the hands of police*, The Washington Post, July 10, 2015, available at: <https://www.washingtonpost.com/news/post-nation/wp/2015/07/10/new-york-will-have-a-special-prosecutor-look-into-some-deaths-at-the-hands-of-police/>.

¹¹⁸ Eliot Spitzer, *How to Deal with Prison Brutality: It's time to take these cases away from local prosecutors*, The Marshall Project, Oct. 5, 2015, available at: <https://www.themarshallproject.org/2015/10/05/how-to-deal-with-prison-brutality#.oOVqP4w4>.

¹¹⁹ See, e.g., Matthew Purdy, *Brutality Behind Bars*, The New York Times, Dec. 19, 1995, available at: <http://www.nytimes.com/1995/12/19/nyregion/brutality-behind-bars-special-report-prison-s-violent-culture-enveloping-its.html?pagewanted=all>.

¹²⁰ Quoted in The Editorial Board, *Abuse at Attica Calls for Federal Scrutiny*, The New York Times, March 4, 2015, available at: <http://www.nytimes.com/2015/03/04/opinion/abuse-at-attica-calls-for-federal-scrutiny.html>.

Overall State-Level Change

Overall, there must be more effective and comprehensive state-level oversight and investigations of DOCCS prisons. For oversight, whether by creating a new entity or expanding the powers and resources of existing state agencies, the oversight body/bodies must at a minimum have sufficient independence from DOCCS, as well as political capital, resources, and authority to carry out regular routine unannounced visits, with unencumbered and confidential access to prisons, incarcerated persons, staff, and documents, and an obligation to publically report findings and recommendations with a concomitant obligation on DOCCS to publically respond and take remedial action. For state-level investigations, the prison exemption should be removed from the Justice Center so that it can utilize its full investigative and prosecutorial powers to protect people with special needs in the state prisons, and the legislature should create an independent special prosecutor for cases of correction officer brutality.

4. Strengthening and Expanding Outside Oversight and Investigation Mechanisms

In addition to the prison-level, agency-level, and state agency mechanisms for individual complaints, investigations, and oversight, the New York legislature should support additional mechanisms for independent external investigations, oversight, and accountability, including federal Department of Justice (DOJ) investigations, authorizing international bodies to inspect NY prisons, augmenting the Correctional Association's authority, community member oversight, fostering greater access to litigation, and external auditing of PREA compliance.

Department of Justice

Regarding DOJ, the extreme, pervasive, entrenched, and systemic staff brutality, abuse, racism, dehumanization, and intimidation coupled with the widespread infliction of solitary confinement across New York State prisons (discussed further below) demands an independent and comprehensive investigation of DOCCS prisons. Only investigators completely outside of the state can provide a fully independent and fair evaluation of what is taking place inside of New York's prisons. The 2013 and 2014 DOJ investigation into Rikers Island uncovered and documented horrific staff brutality and provided invaluable recommendations¹²¹

From Rikers to Attica, Clinton to Ulster and Fishkill, well documented and widespread reports of abuse by corrections officers have been detailed in a manner that evokes images of an era we thought long gone. . . . The frequency and breadth of the problem suggest that this is not an instance of a 'few bad apples' The only plausible answer to the problem of brutality in our prisons is twofold: eliminate arbitration with respect to prison employment, and turn over responsibility for the prosecution of violence in prisons to either a statewide special prosecutor or federal authorities
 –Former Governor Spitzer

¹²¹ See, e.g., Preet Bharara, *CRIPA Investigation of the New York City Department of Correction Jails on Rikers Island*, US Department of Justice, US Attorney, Southern District of NY, p. 58, Remedial Measure F(8), Aug. 4,

that have helped – along with activists’ advocacy, media coverage, Board of Correction action, and lawsuit settlement – lead to necessary changes and continuing policy debates about how to stop abuses taking place.¹²² The criminal division of DOJ is already conducting criminal investigations into the beating of Mr. [George Williams](#) at Attica C.F., officer [misconduct](#) related to security breaches at Clinton C.F., and the Fishkill C.F. [killing of Samuel Harrell](#).¹²³ The New York legislature and Governor should join efforts to urge the Civil Rights Division of DOJ to expand upon these individual criminal investigations and initiate a system-wide and comprehensive investigation of DOCCS prisons; and urge DOCCS to cooperate fully with any DOJ investigations and recommendations.

International Bodies

As a further mechanism of outside oversight, the legislature should mandate that DOCCS allow the U.N. Special Rapporteur on Torture and other United Nations agencies to visit prisons in New York to investigate the use of solitary confinement, brutality, and other issues raised throughout this testimony, and that DOCCS help facilitate full-access site visits to all state prisons requested by the Special Rapporteur and other UN bodies. For more than two years, the UN Special Rapporteur on Torture has repeatedly requested access to prisons in the US, including to New York State prisons, and he has been repeatedly denied, as have other UN human rights experts such as the Chairperson of the UN Working Group on Arbitrary Detention.¹²⁴ The Special Rapporteur on Torture has made visits to numerous countries all over the world from Russia to Pakistan, Brazil, Kenya, Greece, Mexico, Sri Lanka, Turkey, Denmark,

2014 (“DOJ 2014 Report”), available at:

<http://www.justice.gov/usao/nys/pressreleases/August14/RikersReportPR/SDNY%20Rikers%20Report.pdf>.

¹²² See, e.g., http://www.nyc.gov/html/boc/downloads/pdf/BOCRulesAmendment_20150113.pdf;
<http://www.justice.gov/usao-sdny/file/479956/download>; <http://cityandstateny.com/closing-rikers/>;
<http://www.nytimes.com/2015/07/19/opinion/shut-down-rikers-island.html>.

¹²³ See <http://www.nytimes.com/2015/05/18/nyregion/justice-department-reviewing-abuse-of-inmates-at-attica.html>;
<http://www.cnn.com/2015/06/29/us/new-york-prison-investigation/>;
http://www.nytimes.com/2015/08/28/nyregion/us-to-join-inquiry-into-death-of-new-york-prisoner.html?_r=0.

¹²⁴ See, e.g., *UN Human Rights Experts Reiterate their Call to Visit the US to Advance Criminal Justice Reforms*, United Nations, July 21, 2015, available at:

<http://www.ohchr.org/FR/NewsEvents/Pages/DisplayNews.aspx?NewsID=16257&LangID=E>; Aylin Manduric, *UN Human Rights Experts (Again) Push for Access to U.S. Prisons, Call for Solitary Reform*, Solitary Watch, July 24, 2015, available at: <http://solitarywatch.com/2015/07/24/un-human-rights-experts-again-push-for-access-to-u-s-prisons-call-for-solitary-confinement-reform/>;

Jean Casella and James Ridgeway, *UN Torture Investigator Barred from Visiting American Supermax Prisons*, March 18, 2015, available at: <http://solitarywatch.com/2015/03/18/un-torture-investigator-barred-from-visiting-american-supermax-prisons/>; Sarah Shourd, *Why The U.S. Won’t Let the U.N. Look Inside Its Prisons*, The Daily Beast, March 16, 2015, available at:

<http://www.thedailybeast.com/articles/2015/03/16/the-u-s-won-t-let-the-u-n-look-at-prisons-to-investigate-solitary-confinement.html>; Marlies Talay, *Activists Urge U.S. Government to Grant UN Torture Expert Access to New York’s Prisons*, Dec. 9, 2013, available at: <http://solitarywatch.com/2013/12/09/activists-urge-u-s-government-grant-un-torture-expert-access-new-yorks-prisons/>;

http://www.nyclu.org/files/releases/ExtremeIsolation_UNletter_2.5.13.pdf; http://solitarywatch.com/wp-content/uploads/2013/12/HRD-letter-to-US-State-Department_final.pdf.

Nepal, Tunisia, Spain, and many more.¹²⁵ New York should help support the Special Rapporteur to visit New York prisons, so that – as with all of the Rapporteur’s visits – he can complete a mission report with conclusions and recommendations “intended to assist Governments in identifying factors which may contribute to torture, and provide practical solutions to implement international standards.”¹²⁶

Correctional Association – Auditor/Monitor of the Prisons

The Correctional Association of NY (CA) is one of only two independent organizations in the United States with legislative authority to visit prisons and report on conditions of confinement. Since 1846, the CA has carried out this special legislative mandate to keep policymakers and the public informed about conditions of confinement that affect both incarcerated persons and corrections staff. As an independent citizens’ organization, it is dedicated to involving the public and individuals directly affected by the criminal justice system in prison monitoring and advocacy. The Prison Visiting Project (PVP) and the Women in Prison Project (WIPP) of the CA are responsible for performing this monitoring function in both the male and female DOCCS facilities.

Broadly defined, the monitoring work of the CA includes: (1) visiting state correctional facilities on a regular basis and issuing detailed reports of findings and recommendations to state corrections officials, state legislators and the public; (2) preparing and distributing in-depth studies on critical corrections topics, which include findings and practical recommendations for improvements; (3) advocating for reform at public hearings, in meetings with state agency personnel and elected officials, at local and national conferences and in discussions with the media; and (4) helping raise the visibility of corrections-related issues through publishing research reports and gaining media attention, posting fact sheets and prison reports on the CA website, and making presentations at community forums and academic and professional conferences.

In 1973, the state legislature modified the statute authorizing the CA to visit prisons and report their findings to the legislature.¹²⁷ At that time there were only about 12,500 persons incarcerated in the state prisons, although that number was about to change dramatically with the enactment of the Rockefeller Drug Law.

Now, more than 40 years later, it is much more challenging to monitor the DOCCS system with so many more people inside and many more prisons to inspect. We believe it is time to re-examine the authority the CA has to effectively monitor the prison system and report its findings

¹²⁵ See <http://www.ohchr.org/EN/Issues/Torture/SRTorture/Pages/Visits.aspx>.

¹²⁶ <http://www.ohchr.org/EN/Issues/Torture/SRTorture/Pages/Visits.aspx>.

¹²⁷ 1973 McKinney Session Laws, Chapter 398, § 16 (1973).

and recommendations to the legislature and the public. Moreover, much work has been done by experts such as Professor Michele Deitch, Professor Michael Mushlin, and others about what oversight entails and the varied mechanisms that are needed to provide adequate supervision, transparency and monitoring of these closed systems.

Professor Deitch urges that prison oversight be accomplished by utilizing multiple mechanisms to accomplish transparency and accountability. She emphasizes in her analysis that each element is necessary and not a substitute for other mechanisms. Her description of the role of inspection and monitoring is instructive:

*Monitoring involves an entity outside of the corrections agency with the power and the mandate to routinely inspect all correctional institutions in a jurisdiction – not just those with publicized problems – and to report publicly on how people within each prison or jail facility are treated. More so than any other oversight function, the inspection/monitoring function is intended to be preventative in nature. ... Regular monitoring helps keep the quality of correctional services high, because the staff's knowledge that an inspector could arrive at any time acts as a means of informal control over staff behavior.... Monitoring is not about blame for past mistakes, it is about preventing occurrences in the future and about improving the current state of correctional facilities. It is about finding ways for the agency and outside stakeholders to meet agreed-upon goals. Notably, the monitoring function does not necessarily have an enforcement mechanism (unlike a regulatory body); the recommendations of an inspector are advisory in nature. The monitor's strength comes from the power of persuasion, not control. Another distinguishing feature of the inspection function is that the emphasis is on how [incarcerated people] are treated and how prison life affects them. The monitor looks holistically at interactions and institutional cultures that are not always captured by standards and policies, or even by performance measures. Similarly, an inspector does not rely too heavily on general statistical measures for his assessment, given that aggregate statistics can sometimes mask the fact that appropriate treatment or services may have been denied to certain [incarcerated people] or groups of [people]. External scrutiny of this type helps reassure citizens that prison and jail conditions are appropriate and consistent with constitutional requirement.*¹²⁸

The CA agrees with this analysis of purpose and impact of prison monitoring and asserts that it is attempting to meet these objectives. To do that, however, requires better access to the prisons, the people living and working there and to the documents and records needed to fairly and

¹²⁸ Michele Deitch, *Distinguishing the Various Functions of Effective Prison Oversight*, 30 Pace Law Review 1438, 1443-44 (2010).

comprehensively assess the impact of incarceration on the staff and persons confined to these facilities.

Both national and international organizations support the proposition that independent oversight is needed to make transparent what is occurring inside and to provide a mechanism to hold these institutions accountable for the treatment of persons they confine. The Commission on Safety and Abuse in America's Prisons thoroughly examined the issues of prison safety and the treatment of those inside and concluded that:

*Every public institution – hospitals, schools, police departments, and prisons and jails – needs and benefits from strong oversight. Perhaps more than other institutions, correctional facilities require vigorous scrutiny: They are uniquely powerful institutions, depriving millions of people each year of liberty and taking responsibility for their security, yet are walled off from the public. They mainly confine the most powerless groups in America—poor people who are disproportionately African-American and Latino. And the relative safety and success of these institutions have broad implications for the health and safety of the public.*¹²⁹

In assessing how to provide oversight of the America's prison, the Commission recommended that every state should create an independent agency to monitor prisons and jails. In describing that oversight, it explicitly noted that although independent monitors have no formal enforcement authority, the corrections departments “should be required to formally and publicly respond to its findings and to document compliance, or noncompliance, with its recommendations.”¹³⁰

The American Bar Association (ABA) passed a resolution in 2008 calling for the establishment of public entities to regularly monitor and report to the public on conditions of confinement in all detention facilities in local, state and federal jurisdictions. It urged implementation of independent oversight because inspections can lead to improved safety and enhanced services that will better prepare persons returning home to be successful upon reentry. It also stressed that inspections can prevent problems and be a catalyst for cost-effective interventions that can help institutions avoid costly litigation. Monitor findings can assist agencies in getting needed funds and help correctional administrators in making better-informed decisions about its policies.¹³¹

¹²⁹ *Report of the Commission on Safety and Abuse*, at 77.

¹³⁰ *Ibid.* at 81.

¹³¹ ABA Res. 104B, Key Requirements for the Effective Monitoring of Correctional and Detention Facilities (2008), available at http://www.americanbar.org/content/dam/aba/directories/policy/2008_am_104b.authcheckdam.pdf.

The ABA Resolution had 20 recommendations for how to implement effective oversight. Professor Deitch summarized the most critical elements of the ABA resolution as follows.

1. The oversight body must be independent of the correctional agency under review;
2. It must have a mandate to conduct regular, routine inspections;
3. It must have unfettered, "golden key" access to the facilities, incarcerated persons, staff, and records, including the ability to conduct unannounced inspections;
4. It must be adequately resourced, with appropriately trained staff;
5. It must have a duty to report publicly their findings and recommendations;
6. It must use an array of methods of gathering information and evaluating the treatment of incarcerated people; and
7. The agency must be required to cooperate fully in the inspection process and to respond promptly and publicly to the monitoring body's findings and recommendations.¹³²

The CA could enhance its monitoring activities if these standards were applied to its oversight process. Based on these types of analyses and recommendations and based on the CA's own more than 170 years of experience and the limitations it has faced in carrying out its mandate, some examples of how the legislature could augment the CA's authority include:

- Granting the CA the authority to make **unannounced visits** to DOCCS prisons. Currently, the CA has to provide substantial advance notice to prison authorities before carrying out a monitoring visit to a particular prison.
- Allowing the CA to have **confidential communications** with incarcerated persons throughout its monitoring visits. Currently, DOCCS staff members are always present when the CA interacts with people during its monitoring visits, and the CA can only speak confidentially with incarcerated people through written correspondence in the mail or during separate one-on-one legal visit interviews.
- Granting the CA the ability to **obtain access to all relevant documents** and to receive those documents in a timely manner. Currently, the CA is able to obtain some information and data from individual prisons, and otherwise has to obtain information via FOIL requests, which, as discussed below, can take months and even over a year to be filled and may provide limited information.
- Providing the CA with the authority to **communicate directly with individual DOCCS and OMH staff** members confidentially and mandatorily during its monitoring visits and via written surveys. Currently, there are limited interactions between the CA and individual staff members – particularly security staff – during its monitoring visits.
- Requiring DOCCS and OMH to **publicly respond in writing to the CA's findings and recommendations**, to determine and state whether or not it accepts each CA

¹³² Michele Deitch, *The Need for Independent Prison Oversight in a Post-PLRA World*, Federal Sentencing Reporter, Vol. 24, No. 4, 236, 241 (2012).

recommendation, and to the extent it accepts a recommendation, to develop, report, and and implement **corrective action in response** to the findings and recommendations. Currently DOCCS and OMH do not provide any public response to the CA's findings and recommendations nor are they required to take any corrective action.

There are many international models of agencies authorized to inspect correctional facilities. Two of the most prominent are Great Britain's Majesty's Inspectorate of Prisons and the Council of Europe's Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. Although it is premature to discuss the exact parameters of an expansion of the CA's monitoring authority, these international models, along with state and national models, should be consulted in assessing what are best practices.

Community Monitors

Regarding community member oversight, the legislature should grant greater access for members of the public to inspect conditions in the prisons, most preferably in the form of independent community monitors. As an example and possible model to follow, the United Kingdom has a system of Independent Monitoring Boards (IMB), in which local ordinary members of the public apply and are granted authority to regularly monitor prison conditions.¹³³ Every prison, immigration detention center, and some short term holding facilities in the country have an IMB – consisting of unpaid (other than some expenses reimbursements) local volunteers selected by the Justice Ministry – carrying out regular monitoring visits at least two to three times per month¹³⁴ and often on a near weekly or even daily basis.¹³⁵ Every prison has an IMB (135 in total) made up of 12 to 20 members, for a total of over 1,850 people.¹³⁶ IMBs can carry out unannounced visits to the prisons at any time and have confidential communications with incarcerated people, given that members have “unrestricted access to their local prison or immigration detention centre at any time and can talk to any [incarcerated person] or detainee they wish to, out of sight and hearing of members of staff.”¹³⁷ IMB members literally have “keys to the prison” and can come in at any time day or night and go to any program or cellblock area in the prison and communicate with people incarcerated.¹³⁸ Incarcerated people can make confidential requests to see the IMB, and authorities also may call in the IMB to observe if a

¹³³ See <http://www.imb.org.uk/about-us/>; James Ridgeway and Jean Casella, *Oversight in British Prisons: Lessons for the US?*, The Crime Report, Aug. 12, 2013, available at: <http://www.thecrimereport.org/news/inside-criminal-justice/2013-08-oversight-in-british-prisons-lessons-for-the-us>; Vivien Stern, *The Role of Citizens and Non-Profit Organizations in Providing Oversight*, 30 PACE L. REV. 1529 (2010), available at: <http://digitalcommons.pace.edu/cgi/viewcontent.cgi?article=1753&context=plr>.

¹³⁴ <http://www.imb.org.uk/about-us/>.

¹³⁵ Ridgeway and Casella, *Oversight in British Prisons*.

¹³⁶ Stern, *The Role of Citizens and Non-Profit Organizations in Providing Oversight*, at p. 1530.

¹³⁷ <http://www.imb.org.uk/about-us/>.

¹³⁸ Ridgeway and Casella, *Oversight in British Prisons*.

major incident occurs at the facility, such as a riot or death.¹³⁹ The IMB may even observe and monitor specific incidents where there is a high risk of staff abuse, such as when a person is forcibly being put in restraints to ensure against excessive force, when a person is being placed in solitary confinement, and as part of a team (including an IMB member, a chaplain, a medical care representative and a segregation unit manager) that regularly reviews at least every two weeks each person being held in solitary confinement.¹⁴⁰ In addition to monitoring and investigating individual situations and providing preventive oversight, the IMBs also engage in systemic analysis, including by publicly issuing an annual report (available online in a timely manner – reports for the period July 2014 to June 2015 are already publicly available).¹⁴¹ These reports provide for each prison, in depth documentation of key concerns and issues, data and analysis, program or area specific assessments, and recommendations.¹⁴² Although the IMB system has some limitations, including its lack of authority to mandate changes,¹⁴³ it provides an incredible amount of oversight and investigations by local community members, and should serve as a model for New York to adopt a similar program where each prison is assigned a team of local community members with unfettered access and oversight functions.

Access to the Courts

There must be reforms to strengthen the ability of incarcerated persons to bring cases through the judicial system. The courts can provide an important mechanism for raising complaints and bringing accountability, although the efficacy of litigation by incarcerated persons is substantially impaired due to stringent judicial interpretations of the constitutional rights of incarcerated persons as well as restrictions on litigation imposed by the 1996 Prison Litigation Reform Act (PLRA).¹⁴⁴ While reform of the PLRA at the federal level is essential for making judicial oversight more effective,¹⁴⁵ New York legislators can help improve access to the courts. Although other people submitting testimony with greater expertise in litigation matters will offer more comprehensive reforms for improving such access, the legislature should, for example, increase funding to Prisoners Legal Services to allow this agency to expand their ability to represent people who are incarcerated. The legislature could also increase access to the law library and enhance law library capacity to allow incarcerated persons to electronically copy and paste, and save typed materials. In addition, as discussed above, the state should remove barriers within the grievance process to ensure incarcerated persons can bring their cases in court. Further, the legislature should require DOCCS to properly and effectively track complaints and

¹³⁹ <http://www.imb.org.uk/about-us/>.

¹⁴⁰ Ridgeway and Casella, *Oversight in British Prisons*; Stern, *The Role of Citizens and Non-Profit Organizations in Providing Oversight*, at p. 1530-1533.

¹⁴¹ <http://www.imb.org.uk/reports/>.

¹⁴² <http://www.imb.org.uk/reports/2015-annual-reports/>; see, e.g., <http://www.imb.org.uk/wp-content/uploads/2015/10/Altcourse-2014-15.pdf>.

¹⁴³ Ridgeway and Casella, *Oversight in British Prisons*; Stern, *The Role of Citizens and Non-Profit Organizations in Providing Oversight*, at p. 1530-1534.

¹⁴⁴ See *Report of the Commission on Safety and Abuse* at 84-85.

¹⁴⁵ *Ibid.* at 85-87.

litigation brought against individual officers, at particular prisons, and in particular areas of prisons, and should maintain those records in easily retrievable and searchable formats.

External Auditing of DOCCS PREA Compliance

PREA also provides an example of oversight by agencies outside of the state that could be improved, strengthened, and expanded beyond sexual abuse to apply to all forms of staff abuse of incarcerated people. Earlier in the testimony we outlined what efforts DOCCS is making to prevent, detect and respond to sexual victimization of incarcerated people consistent with the federal guidelines to implement the Prison Rape Elimination Act (See pages 37-39 above). In this section we want to briefly discuss the auditing requirements of PREA, which mandate that the correctional system ensure that each facility in the system is audited by an independent auditor at least once during every three year period starting August 2013.¹⁴⁶ DOCCS has just started the auditing process in October 2015 so we cannot comment on what is happening in New York. Rather, we believe it is useful to note positive aspects of the PREA auditing process mandated by the federal guidelines for consideration in determining what oversight should occur for other aspects of prison conditions and to express some concerns we have about the limitations on the PREA audit process.

The federal PREA auditing guidelines, sections 115.401 – 115.405, outline the major components of any auditing process: auditor qualifications; auditor powers, audit content and findings; prison audit corrective plan; and audit appeals.¹⁴⁷ Concerning the auditor qualifications, it is commendable that the rules require all auditors to be certified by the Department of Justice and that it is possible to have an auditor decertified if that person is not properly fulfilling the auditor's duties. The auditor must be paid by the correctional department or state but the position is intended to be independent of the correctional agency, in that the auditor cannot be an employee of the agency or under the direct authority of the agency; nor can the auditor have worked for or undertake a contract with the agency for three years prior to or after the audit process. The auditor can, however, work for another state agency, and explicitly can be a member of an inspector general's or ombudsman office that is external to the correctional department. Two concerns have been raised by commentators on the PREA auditor provisions: (1) the state is not required to contract with an auditor for any fixed time, but can change frequently and therefore, the auditor will not develop a relationship with the agency or credibility with the incarcerated population and the tenuousness of the contractual relationship may lead to the auditor biasing results to ensure continued employment; and (2) the experience to date with some auditors in other jurisdictions has frequently been less than satisfactory, particularly those who work in for-profit agencies that are charging significantly lower rates but are producing inadequate audits that consistently find full compliance. Whoever is assigned

¹⁴⁶ DOJ, National Standards to Prevent, Detect, and Respond to Prison Rape, 28 CFR § 115.401.

¹⁴⁷ *Ibid.* at §§ 115.401 – 115.405.

auditing functions must have true independence both from the authority of the agency being reviewed and from fiscal pressures that may bias the process.

The PREA auditors have expansive authority under the rules to access the facilities, review relevant documents and communicate confidentially with the incarcerated population and staff. In addition, the rules require that the auditor review a sample of relevant documents and other records concerning sexual victimization and interview a representative sample of incarcerated persons. The rules also require that the auditor make a determination as to each PREA standard whether the institution is in full compliance. To assist in this process, auditing instruments have been developed by the PREA Resource Center which the auditor is directed to complete. Overall we believe the audit process is well defined and the auditor is provided with sufficient authority to perform an effective audit. The concerns expressed by PREA advocates in light of the many audits that have been made public to date are that in practice the audit themselves appear to be deficient and that there is a lack of mechanisms to assess whether the audit process is effective. The Department of Justice is not substantively reviewing the audits and there does not appear to be any well-defined means for others to raise concerns about the audit outcome.

The final issue related to the audit process and the whole PREA compliance effort is that there is very little enforcement power by the federal government or private citizens to ensure that the correctional systems are complying with these standards. The only mechanism that exists is the potential for the federal authorities to impose a 5% reduction in federal funds to the state if the state fails to comply with the standards or fails to assert that it is making efforts to comply. It is unlikely that this remedy will be imposed, and in some jurisdictions the penalty of non-compliance is much less expensive than the cost to reach full compliance. Therefore, it is important when developing standards to be monitored by oversight mechanisms to ascertain what recourse exists when an institution is unwilling to comply and to develop tools or other measures to incentivize correctional systems' cooperation with the oversight process and their compliance with the standards being used to judge their activities.

Overall looking at both state agency oversight and oversight independent of New York, there should be a multitude of mechanisms of periodic, independent, sufficiently empowered and funded outside inspection, oversight, and monitoring of DOCCS prisons by governmental and non-governmental entities.¹⁴⁸

Overall External-Level Change

Overall, there must be a number of different mechanisms of investigations and oversight wholly independent of New York State to ensure meaningful and comprehensive transparency and accountability. A system-wide federal DOJ investigation would provide an essential major step

¹⁴⁸ *Report of the Commission on Safety and Abuse*, at 16 (concluding that “the most important mechanism for overseeing corrections is independent inspection and monitoring” by an entity “sufficiently empowered and funded to regularly inspect conditions of confinement and report findings to lawmakers and the public.”).

toward bringing to light the pervasive abuses taking place behind the walls and proposed mechanisms to stop the abuses. Allowing international bodies, like the UN Special Rapporteur on Torture, will assess prison conditions from international human rights standards and provide prison administrators and the state a unique perspective on proposed changes. Augmenting the CA's authority to carry out its nearly 170-year-old mandate, as well as considering local community monitoring will allow for a continued and greatly enhanced levels of fully independent public oversight by concerned community members. Looking at both state agency oversight and these forms of oversight independent of New York, there should be a multitude of mechanisms of periodic, independent, sufficiently empowered and funded outside inspection, oversight, and monitoring of DOCCS prisons by governmental and non-governmental entities.¹⁴⁹ Furthermore, exploring the PREA audit process will also provide insights into how and how not to implement meaningful outside oversight.

5. Expanding Public Oversight and Transparency

One of the most important forms of oversight of DOCCS must include *public* oversight. For purposes of public oversight there needs to be greater transparency in the operations of NYS prisons. Greater transparency is needed in order to shine a light on the abuses taking place, allow members of the public, the press, and policy-makers to know what is happening behind the walls, and prevent and deter violence and abuse.¹⁵⁰ This section highlights two key areas where the legislature could act to bring about greater transparency: 1) expanding media access to NYS prisons; and 2) mandating public reporting by DOCCS and other state agencies.

Expanding media access

The legislature should require that DOCCS increase access to NYS prisons to the media (as well as policy-makers, advocates, and other members of the public). As epitomized by the horrific Abu Ghraib abuses documented in photographs, media coverage of prison abuses can help spur much needed public debate, public scrutiny, and ultimately government accountability for what takes places inside prisons.¹⁵¹ Members of the press should have the ability to tour DOCCS prisons, interview and correspond with incarcerated persons freely and confidentially, and utilize photographs and videos inside of the prisons. As the Commission on Safety and Abuse

¹⁴⁹ *Report of the Commission on Safety and Abuse*, at 16 (concluding that “the most important mechanism for overseeing corrections is independent inspection and monitoring” by an entity “sufficiently empowered and funded to regularly inspect conditions of confinement and report findings to lawmakers and the public.”).

¹⁵⁰ See, e.g., James M. Byrne, *Myths and Realities of Prison Violence: A Review of the Evidence*, Victims and Offenders, Vol. 2, Issue 1, p. 84 (2007) (finding that “it is essential . . . to implement an external review system of the prison experiences as a mechanism for informing the public about the detrimental effects of prison violence on both individuals and neighborhoods.”).

¹⁵¹ See, e.g., Susan Sontag, *Regarding the Torture of Others*, *The New York Times*, May 23, 2004, available at: <http://www.nytimes.com/2004/05/23/magazine/23PRISONS.html?pagewanted=all>; Paul Starr, *The Meaning of Abu Ghraib*, *The American Prospect*, June 2004, available at: <http://www.princeton.edu/~starr/articles/articles04/Starr-MeaningAbuGhraib-6-04.htm>; Jameel Jaffer and Amrit Singh, *Commentary: Photos key to exposing prisoner abuse*, CNN, May 20, 2009, available at: <http://us.cnn.com/2009/POLITICS/05/19/jaffer.detainee.photos/index.html>.

recommended, “every prison and jail should allow the press to do its job,” including through “access to facilities, to [incarcerated persons], and to correctional data.”¹⁵²

Currently, various members of the media have informed the CA of the immense barriers faced in reporting stories related to NY prisons. Reporters have noted very limited, to no, ability in practice to record – with video, audio, or photographs – anything taking place within the prisons. They have also noted the extreme difficulties in even conducting interviews with incarcerated persons, often leading reporters to meet with incarcerated persons as general visitors and thus without the ability to speak confidentially or bring in regular paper and pens to take notes during an interview (and certainly not recording devices). Moreover, incarcerated people have faced retaliation from DOCCS staff for communicating with the media. Further, reporters have complained about the inability or long delays to obtain information and documents requested through the Freedom of Information Law (FOIL).

Our Voices are Not Heard

Some people have been handcuffed, then beaten with sticks, and **the cries for help are so loud but useless**, because there is no help. So **our voices remain trapped behind this wall**. Before the Attica riot in 1971, a lot of inhumane acts were going on in Attica. **The 1971 riot led people across the country to hear the voice of incarcerated persons**, exposing the foulness of the torture and inhumane conditions. Today, the same foulness that went on in the past is going on today. But **this time our voices are not being heard. Incidents are not being exposed to the public**. I am a NYC resident, and my family has never heard or seen reports on the violence the officers carry out on incarcerated persons, even the ones that result in the killing of an incarcerated person. The only time some things are reported are in these little towns and it’s only a one sided story that the media hears. When our voices are heard, exposing the evil that’s taking place, it will bring more supporters and media. When there are no consequences or anyone exposing a person’s devilish acts, he will continue to act. – Anonymous.

According to the DOCCS directive on media access people held in the general population may only be interviewed by the media at the discretion of the Commissioner, and people in pre-hearing or disciplinary confinement in the SHU or keeplock are barred from interviews. The Public Information Officer (PIO) and the Commissioner have to give approval for the date, time, and length of any interview as well as whether any equipment or photographs, film, or video are allowed. Reporters have informed the CA that these requirements have proven difficult to obtain in practice. Also, even if granted permission, media are barred from video-taping while walking through a prison and must obtain approval from a Superintendent or designee to stop to take specific pictures, and all photographs taken while on DOCCS property require prior PIO

¹⁵² *Report of the Commission on Safety and Abuse*, at 16.

permission. Absent seeking approval and permission, members of the media are alternatively allowed to visit incarcerated people in the general visiting room as a regular visitor, but are barred from using cameras or tape recorders and are limited only to so-called “flex pens” issued by the visiting room officer. As one example of restrictions placed on media, *Solitary Watch* – a web-based project focused on bringing news about solitary confinement into the public – repeatedly sought access to view SHU and Residential Mental Health Units in New York and was denied all access.¹⁵³

By contrast, other states allow greater access to the media. On the topic of solitary confinement, Colorado allowed extensive video footage in its supermax prison by *National Geographic*¹⁵⁴ and Maine allowed extensive video footage by *Frontline*¹⁵⁵ over an extended period of time in its solitary confinement units. According to the Colorado directive on media policy, “It is the policy of the Department of Corrections (DOC) to provide a public information program that encourages Departmental interaction and contact with representatives of the media and the public, within the security limitations of facilities. . . the DOC is committed to informing the public and the media of events within the agency’s areas of responsibility . . . DOC encourages cooperation with professional news reporters and camera crews as a means of fulfilling the obligation of a public agency to keep the public informed with accurate information.”¹⁵⁶ Although the Colorado procedures do still have severe restrictions on press access and videotaping, the DOC administration has allowed for some greater access in practice.

A bill in California, AB 1270, that has been proposed numerous times and was last vetoed by the Governor after passing the Assembly and Senate in California in 2012, would have allowed any press to interview people incarcerated in California prisons – while utilizing audio and video recording devices and without auditory monitoring – unless the interview would “pose an immediate and direct threat to the security of the institution or the physical safety of a member of the public.”¹⁵⁷

The legislature should expand upon these more open media policies and require DOCCS to have a presumption that members of the media are able to, at a minimum, confidentially interview incarcerated persons, take tours of the prisons, utilize audio and video recording for both interviews and tours, and have full and automatic access to requested documents and records in a timely manner.

¹⁵³ Jean Casella and James Ridgeway, *New York Prisons Bar Media from Solitary Confinement Units*, Solitary Watch, May 17, 2014, available at: <http://solitarywatch.com/2014/05/17/new-york-prisons-ban-media-solitary-confinement-units/>.

¹⁵⁴ <http://channel.nationalgeographic.com/explorer/episodes/solitary-confinement/>.

¹⁵⁵ <http://www.pbs.org/wgbh/pages/frontline/locked-up-in-america/>.

¹⁵⁶ <https://drive.google.com/file/d/0B4vYiI52TzO6WWVuMkNwSEdwaDQ/view>.

¹⁵⁷ http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB1270.

Mandating Public Reporting

The legislature should require that DOCCS, OMH, the Justice Center, SCOC, OASAS, and other state agencies make publically available, in easily accessible formats, various categories of data relevant to such issues as violence and abuse, solitary confinement and alternatives, mental health care, medical care, deaths in the prisons, prison-based treatment and programs, shackling, and parole.¹⁵⁸ Currently, it is very difficult to obtain even the most basic relevant data or information. For example, as we approach 2016, the last available DOCCS data on unusual incident reports and grievances comes from 2013 and are in formats that are difficult to utilize for further analysis. The Office of Mental Health does not appear to have any forensic-related reports publicly displayed on its website,¹⁵⁹ and the Justice Center – despite a legislative mandate to oversee and report on the SHU Exclusion Law’s implementation¹⁶⁰ – has not publicly reported any of its monitoring of SHU or RMHTU units.

Although there is a right to seek records from these agencies through the Freedom of Information Law (FOIL), DOCCS has often delayed and limited the information provided for months and even beyond a year. For example, a FOIL request made by the CA in September 2014 for some basic information at one prison is still outstanding as of the time of the finalization of this testimony in December 2015. Each month, DOCCS sends a reissued form letter indicating that the request is still under review. Similarly, it took over eight months to receive reports requested from the Justice Center regarding monitoring of the SHU Exclusion Law.

Most relevant to staff violence and abuse, the legislature should require that DOCCS issue quarterly public reports about individual DOCCS prisons and system-wide on such data as Unusual Incident Reports, Disciplinary Tickets/Misbehavior Reports, Use of Force Reports and Investigation Reports, Staff Discipline, Grievances, Injuries to staff and incarcerated persons, Deaths, Suicides, Sexual Violence as collected through the Prison Rape Elimination Act (PREA), Program Capacity and Utilization, and use of Isolated Confinement.

More specifically related to solitary confinement, DOCCS should be required to report monthly: the number of people in isolated confinement and alternative units, the characteristics of people in such confinement (including related to age, race, gender, and mental health, health, pregnancy, and LGBTI status), and the lengths of stay in such confinement. In turn, DOCCS should be required to compile such information and, at least, annually publish the data and a statistical analysis of the data so that the public is able to have an understanding of how solitary confinement and/or alternatives to isolation are being utilized in the state.

¹⁵⁸ See, e.g., *Report of the Commission on Safety and Abuse*, at 16.

¹⁵⁹ See <https://www.omh.ny.gov/omhweb/resources/publications/> and <https://www.omh.ny.gov/omhweb/statistics/index.htm>.

¹⁶⁰ See, e.g., N.Y. Correct. Law § 401-a(2) (requiring the Justice Center to make publicly available reports of New York State’s progress with implementing the SHU Exclusion Law).

OMH should also be required to publically report, at a minimum: their annual Corrections-Based Operations Statistical Report, quarterly reports on the Active Mental Health Inmate-Patients Housed in Special Housing Units, monthly CNYPC Net Facility Caseload Census, and monthly CNYPC Program Census.

Similarly, the Justice Center should be required to publically report on its website in a timely manner its reviews of the SHUs and Residential Mental Health Treatment Units, and any other documentation made in connection with its mandate to monitor the implementation of the SHU Exclusion Law. Also, the SCOC should be required to post publicly on its website in a timely manner all of its death reviews – with names and identifying information redacted. In the same manner, the legislature must clarify, enforce, and provide sufficient funding for the Department of Health (DOH) to carry out its legislative mandate to investigate and publically report on HIV and Hepatitis C care in the state prisons as required under the DOH Oversight Law. As discussed further below, OASAS also must carry out its legislative mandate to issue an annual report related to the operation of substance abuse treatment programs in DOCCS prisons.

Expanding Cameras and Body Cameras as Part of Broader Transparency Efforts

Connected to public oversight, and as an independent mechanism of transparency, DOCCS should increase the number of cameras, including body cameras, in prisons across the state *if* other mechanisms, such as those described throughout this testimony, are put in place, and ensure that there are enhanced policies for preservation and review of camera footage by outside investigative and monitoring agencies. Cameras are a highly expensive, and too often unreliable mechanism, and certainly should not be viewed as a panacea. However, cameras can potentially provide some level of transparency and accountability if utilized in conjunction with the other mechanisms already described, as well as other safeguards. For example, coupled with the need for cameras, the legislature should require DOCCS to create better mechanisms for preservation and dissemination of visual and audio recordings.¹⁶¹ Such recordings can provide evidence of specific incidents of violence and abuse, and can also serve as a means of refuting alleged misconduct by staff or incarcerated persons.¹⁶² Cameras can also serve as a deterrent to misconduct,¹⁶³ and to the extent recordings are disseminated as a mechanism of public transparency. In addition, as many people incarcerated across DOCCS prisons have recommended to the CA, there should be independent reviewers of camera footage, potentially both in real time and through preservation and review.

Overall Public Oversight Change

Overall, the New York legislature must empower the public and the press to shine a light on what is happening behind the walls. Prisons are designed not only to keep people in, but to keep

¹⁶¹ *Ibid.* at 11, 34. See also DOJ 2014 Report at 52.

¹⁶² Report of the Commission on Safety and Abuse at 34.

¹⁶³ *Ibid.*

the public out, and the legislature should take substantial steps to remedy that situation in New York. The public and the press can serve as one of the most important forms of oversight to a system too often without transparency. Expanding media access to the prisons, requiring better use of cameras and body-cameras, and mandating timely and comprehensive reporting by DOCCS, OMH, the Justice Center, SCOC, DOH, OASAS, and other agencies will help expose abuses taking place within the prisons, as well as areas of best practices, and in turn will help the public and the legislature know in an ongoing way what changes need to take place.

II. Conclusions and Recommendations regarding Oversight and Investigations

The New York legislature has an opportunity to adopt necessary and important steps to create more effective oversight of DOCCS prisons and investigations of abuses taking place. To that end, as discussed throughout, the legislature should consider adopting the below measures (or some combination of them) in order to create a strong system of independent, interconnected, mutually reinforcing mechanisms, each serving its own separate important function and together collectively bringing greater transparency and accountability for the state prison system.

Specifically, the New York State legislature and the Governor should:

1. **Expand Public Oversight and Transparency:** Expand **media access** to the prisons and people incarcerated, including with a presumptive allowance of audio, photographic, and video recording. Also require **mandatory public reporting** by DOCCS, OMH, the Justice Center, Department of Health (DOH), SCOC, OASAS, and other state agencies, including collecting and periodically publicizing data most relevant to such topics as staff violence and abuse, solitary confinement, mental health care, medical care, deaths in the prisons, prison-based treatment and educational programs, shackling, and parole.
2. **Support Investigations and Oversight Wholly Independent of New York State:** Support the call for a **system-wide federal investigation by the Department of Justice**, and urge full cooperation with such an investigation by DOCCS and all state agencies. Also, require **access by the UN Special Rapporteur** against Torture, and other international investigative and oversight bodies to NY prisons. In addition, **augment the authority of the Correctional Association**, including by requiring DOCCS to respond to the CA's findings in writing and develop corrective action where necessary, as well as authorizing the CA to utilize unannounced visits, access to all relevant documents, confidential communications with incarcerated people during monitoring visits, and unencumbered access to speak with staff. Further, consider creating a **new local community monitoring system**, based off of the UK's Independent Monitoring Boards, where local members of the public have unfettered access to monitor and investigate conditions inside of each prison. Also, strengthen the ability of incarcerated people to **bring legal cases**, and adopt positive aspects of the **PREA audit process**.

- 3. Create and Expand Independent State Agencies' Oversight and Investigations:** Expand the authority of existing state agencies and/or create new mechanism(s) to ensure there is an **independent oversight body/bodies**, with the power, independence, and sufficient funding to carry out regular routine unannounced visits, with unencumbered and confidential access to prisons, incarcerated persons, staff, and documents, and with an obligation to publically report its findings and recommendations with a concomitant obligation on DOCCS to publically respond and take remedial action. For expanding existing agencies, provide sufficient resources, independence, and will to the **Justice Center, SCOC, DOH, and OASAS** to carry out their mandates; and remove the exemption of prisons from the full powers of the **Justice Center**, and expand the **SCOC's** review of medical care to look at systemic problems and acts of self-harm. Also, create an **independent statewide Special Prosecutor** to investigate DOCCS' staff abuse of incarcerated people.
- 4. Transform Agency-Level Investigations and Accountability:** Remove investigations of staff abuse of incarcerated persons **from the OSI to an independent state agency** that has complete independence, capacity, and will to investigate. Remove barriers to accountability, such as **removing mandatory arbitration** and allowing superintendents to override bid placements in cases of staff abuse of incarcerated people. Strengthen prohibitions, reporting requirements, and remedial actions for **inappropriate / excessive staff use of force**. Investigate the effectiveness of DOCCS' PREA compliance operations, address limitations, and adopt positive aspects for all types of staff abuse.
- 5. Transform Prison-Level Investigations and Accountability:** Create an **independent ombudsman** office to investigate and administratively resolve complaints by incarcerated persons about conditions and treatment in prison, and mandate a confidential outside hotline. Fundamentally **transform the failed grievance system** – which rules against incarcerated people in almost all cases and functions little more than a barrier to litigation – including by properly analyzing and responding individually and systemically to grievances filed, protecting people against retaliation, and ensuring staff involved in grieved incidents are not part of the investigations. Similarly, fundamentally **transform the disciplinary system of incarcerated persons** – which is fundamentally unfair and too often a cover up for staff abuses – including by requiring neutral decision-makers, enhancing procedural protections, and allowing legal representation. Require **DOCCS to effectively track, analyze, publicly report on, and effectively rectify** all indicators of individual and systemic abuse, including grievances, other complaints, UIRs, Use of Force reports, investigations, lawsuits, and issues raised by the ILC.
- 6. Adopt Oversight/Investigations Mechanisms as Part of Broader Transformation:** As discussed below, ensure new oversight and investigations mechanisms are one part of a

package of **broader cultural transformation** within prisons and **broader policy reforms** of the incarceration system to fully address the abuses taking place. Transform the culture within prisons to address racism and end the punishment paradigm, including through programming, empowerment, transformation, de-escalation, and communication. Close **Attica**, end the torture of **solitary confinement**, end **shackling** of pregnant women and promote **reproductive justice**, increase access to **higher education**, support people with mental health needs, reduce the number of people incarcerated (including by **raising the age**, releasing people on **parole**, passing **DVSJA**, ending **targeting of LGBT persons**).

III. Why it is so Important to Have Changes in Investigations and Oversight

The New York legislature must implement some of the above mechanisms because of the longstanding and ongoing brutality, torture, and mistreatment taking place within New York State prisons. DOCCS can no longer police itself and the legislature must make bold fundamental changes to end the abuses taking place, utilizing some of the above best practices from other jurisdictions. More specifically, the inhumane treatment of incarcerated people cries out for change – from widespread staff brutality and violence; to the torture of solitary confinement; to failed medical and mental health services; to the shackling of pregnant women and other reproductive injustices; to the targeting of young and elderly people, people with mental health needs, and members of the LGBTI community; to the broken parole system and the failures of education and reentry; to sexual violence¹⁶⁴; and to all of the other abuses of women, men, and children pervasive in NYS prisons. Making all of these abuses worse, there is a complete lack of effective oversight and investigations, and a frequent utilization of existing mechanisms to cover-up rather than stop abuses taking place.

1. Widespread Staff Brutality, Violence and Abuse

New York State prisons are plagued by a pervasive and entrenched culture of staff brutality, violence, abuse, racism, dehumanization, and intimidation. As CA reports on [Clinton](#), [Attica](#), [Greene](#), [Fishkill](#) Correctional Facilities and other prisons have long documented,¹⁶⁵ and as exposed by the brutal [beating of George Williams](#) at Attica, [systematic beatings at Clinton](#) in the wake of the June 2015 escape from that facility, and the recent [killings of Samuel Harrell at](#)

¹⁶⁴ Sexual violence is an ongoing and pervasive problem in both women's and men's prisons in New York. While sexual violence is not extensively covered in this testimony, there is a great need to address the horrific violations taking place, and the CA will defer to the testimony of others who have more expertise in this area. More generally, this testimony obviously is not able to cover all of the innumerable abuses taking place within the prison system and aims to just highlight some of the egregious abuses taking place.

¹⁶⁵ See <http://www.correctionalassociation.org/wp-content/uploads/2015/03/Clinton-Correctional-Facility-Final-Draft-2.pdf>; <http://www.correctionalassociation.org/wp-content/uploads/2015/02/Attica-2014-CA-Updated-Report-Final.pdf>; <http://www.correctionalassociation.org/wp-content/uploads/2014/10/Greene-C.F.-Report-Final.pdf>; <http://www.correctionalassociation.org/wp-content/uploads/2013/12/Fishkill-C.F.-Final-Report.pdf>.

[Fishkill](#)¹⁶⁶ and Karl Taylor at Sullivan, these abuses and their cover-ups are regular and typical practices. An underlying culture and environment of abuse – not a few individual bad actors – drive the dehumanization and brutalization taking place. This culture is undergirded and fueled by racism, staff impunity, a lack of meaningful programs, a history of violent repression (especially at Attica and Clinton), and a reliance on force, punishment, and disempowerment.

This staff violence is intrinsically linked with the systemic racial disparities in the targeting of Black and Latino people in the New York State prison system. Nearly 75% of the people incarcerated in New York prisons are Black (49%) and Latino (24%), vastly disproportionate to the percentage of Black (13%) and Latino (17%) people in New York State as a whole. Yet, the vast majority of Correction Officers (COs) are white, and at some prisons, there are no or almost no Black COs. At Clinton for example, DOCCS has reported at times that there was not one Black CO at the prison. Moreover, disproportionately, staff harassment, brutality, and abuse are often most directed at Black and Latino people. As one person incarcerated in NY reported:

I've been to several prisons where 99% to 100% of the staff were all white. And these facilities are where the most brutal abuses to [incarcerated people] happen. . . . They can oppress, brutalize, and get away with murdering people of color without reprisal or consequences. There is no accountability or transparency within DOCCS and the staff and unions know that they are cloaked. . . . It kills me how politicians on the news posture about "terrorism" and "domestic terrorism," when for the past 30 years of my adult life, I've been living in fear of the 'domestic terrorist' of murderous, racist prison guards who will gang up on you and brutally beat my Black [self] to death and after I'm beaten, bloodied and dead, they toss a weapon near my dead body and write up a false report that justifies them murdering me.

This section of the testimony briefly highlights brutality taking place at Clinton, Attica, Great Meadow, Southport, Greene, Wyoming, and Fishkill. Although some of these prisons stand out with respect to the severe levels of violence, brutality, racism, and other staff misconduct; staff abuse is not limited to these facilities but is system-wide. The CA constantly receives information regarding brutal staff assaults on people in prisons across the DOCCS system – in both medium and maximum security facilities.

The physical abuse of [incarcerated persons] in NYS DOCCS is at an all-time high. I thought Attica Correctional Facility was the worst. Great Meadow and Clinton Correctional Facilities are becoming worse. [People] are getting fed up. – Anonymous

¹⁶⁶ See <http://www.nytimes.com/2015/03/01/nyregion/attica-prison-infamous-for-bloodshed-faces-a-reckoning-as-guards-go-on-trial.html>; <http://www.nytimes.com/2015/08/12/nyregion/after-2-killers-fled-new-york-prisoners-say-beatings-were-next.html>; http://www.nytimes.com/2015/08/19/nyregion/fishkill-prison-inmate-died-after-fight-with-officers-records-show.html?ref=nyregion&_r=0.

Clinton, the largest prison in New York State (incarcerating over 2,500 people), is a maximum security facility with an infamous history of brutality. As reported in the [CA's 2014 Clinton report](#), as well as its [August 2015 documented investigations](#),¹⁶⁷ officers at Clinton have engaged in the most horrific racially-based violence against incarcerated people long before the June 2015 escape, in its immediate aftermath, and still today. Reminiscent of torture that has taken place at Abu Ghraib, Guantanamo Bay, and secret black sites across the globe, multiple people at Clinton reported to the CA that COs suffocated them by placing plastic bags over their heads during staff physical assaults or interrogations (consistent with *New York Times* [reports](#) that COs at Clinton, including so-called [Captain America](#),¹⁶⁸ suffocated people using plastic bags and threatened waterboarding). This suffocation technique was reported to the CA to have occurred both before the escape and in the aftermath of the escape. Additionally, people incarcerated at Clinton have given first-hand accounts of being punched, kicked, thrown to the ground, hit in the face and head, kneed, thrown against the wall, stomped on, hit with batons, choked, given black eyes, had limbs twisted, teeth cracked, bones broken, and suffering other physical abuse, verbal harassment, and threats by staff, both before and after the escape, and often when already cuffed with their hands behind their back. Moreover, people reported that they received false tickets as retaliation for raising complaints about their abuse, that medical staff failed to properly document the injuries suffered, and that grievances and OSI investigations had not led to any concrete responses. These allegations must be taken in the context of 31 deaths that occurred at Clinton from 2007 to 2013, at least two of which had SCOC reports indicating they occurred following physical assaults by staff, and the fact that there was no staff injury at all in 72% of assault on staff UIRS and injuries to incarcerated people in 87% of those same assault on staff UIRs.¹⁶⁹

Similarly at Attica – another large, infamously abusive maximum security people (incarcerating over 2,000 people), the 2014 CA-issued [Voices from Attica](#),¹⁷⁰ a compilation of narratives, experiences, and insights from people incarcerated at Attica, as well as a [2014 report about staff violence and abuse at Attica](#),¹⁷¹ detailed the high levels of race-based staff violence and brutality. Nearly all CA interviewees at Attica reported at least weekly staff beatings that could happen to any person for any reason, involving punches, kicks, beating with batons, choking, smashing people's heads against walls, and sexually abusive searches. Officer intimidation is so rampant at the prison that people at Attica walk with their heads down, prohibited from looking at baton-

¹⁶⁷ CA 2014 report on Clinton, available at: <http://www.correctionalassociation.org/wp-content/uploads/2015/03/Clinton-Correctional-Facility-Final-Draft-2.pdf>; *10 Things You Need to Know about Brutality and Abuse at Clinton C.F.*, Correctional Association of NY, September 2015, available at: <http://www.correctionalassociation.org/news/10-things-you-need-to-know-about-brutality-and-abuse-at-clinton-c-f>.

¹⁶⁸ <http://www.nytimes.com/2015/10/02/nyregion/prison-guard-known-as-captain-america-is-feared-on-upstate-cell-block.html>.

¹⁶⁹ See CA 2014 report on Clinton, p. 10, available at: <http://www.correctionalassociation.org/wp-content/uploads/2015/03/Clinton-Correctional-Facility-Final-Draft-2.pdf>.

¹⁷⁰ <http://www.correctionalassociation.org/wp-content/uploads/2014/10/Voices-From-Attica-2014.pdf>.

¹⁷¹ <http://www.correctionalassociation.org/wp-content/uploads/2014/12/Attica-2014-CA-Updated-Report-Final1.pdf>.

wielding officers. Forty-three years after the Attica uprising and its violent suppression by the state, Attica continues to operate as a real and symbolic epicenter of state violence and abuse behind the walls. The ongoing and pervasive racialized brutality and abuse make it only more clear that NYS officials must close Attica.

At Southport – one of two super-maximum security prisons in New York State, with a primary purpose of holding people in solitary confinement – the CA’s 2015 full monitoring visit, 190 surveys from incarcerated people, and follow-up interviews with almost 40 people revealed extreme staff violence against people held in their cells 22-24 hours a day without any meaningful human contact or programs. Scores of people at Southport also reported the most extreme forms of staff brutality, in addition to the facts that a vastly disproportionate 89% of people held in solitary at Southport are Black or Latino people; an average of 70% to 85% of people at Southport do not go to recreation and thus spend 24 hours a day in their cell;¹⁷² innumerable people receive additional SHU tickets while in the SHU with 98% of hearings resulting in guilty findings; and almost 100 people each year are released directly from the SHU at Southport to the outside community.

At Great Meadow C.F. – a maximum security prison that incarcerates approximately 1600 people, including almost 440 people on the OMH caseload – the CA’s December 2014 monitoring visit and July and November 2015 follow-up interviews also revealed extreme staff brutality and punishment, most disturbingly targeted against people with severe mental illness. At a prison where 78% of incarcerated people are Black and Latino, Great Meadow has one of the highest rates among all DOCCS prisons of Unusual Incident Reports in which force was used per year and the highest percentage of SHU sentences that were for six months or more. The CA has recently repeatedly received reports from people incarcerated of assaults by staff that resulted in such severe injuries as broken bones and a collapsed lung. Most disturbing, people in the Behavioral Health Unit – the mental health alternative to SHU at Great Meadow – have faced severe staff brutality as well as incredibly high rates of disciplinary tickets while on the unit with 68 tickets issued per year on a unit that has only 30 people at any given time.

Greene C.F. – about which the CA issued an [October 2014 report](#),¹⁷³ based on a full monitoring visit in 2012 and follow-up interviews and investigations in 2014 – was most disturbing for the staff abuse of young people. While Greene is a medium security prison, has one of the highest concentrations of young people in the NYS prison system (including 16- and 17-year-olds and a median age of 22), and has a population where 82% of people incarcerated are Black or Latino, Greene also had some of the worst reported levels of staff violence and brutality, targeted primarily at young people. Nearly 90% of respondents to a CA survey at Greene reported that

¹⁷² People report that they often do not go to recreation because they are denied recreation by staff or choose not to go because such factors as abuse faced by staff on the way to recreation, harsh weather conditions, and/or the fact that recreation only takes place alone in another cage without any equipment.

¹⁷³ <http://www.correctionalassociation.org/resource/greene-correctional-facility-2>.

physical abuse by staff occurs frequently, 97% reported that young people face more abuse than others, and 86% of survey respondents who were 16 or 17 when they entered DOCCS reported a physical confrontation with staff (compared to 26% for all people across DOCCS prisons).

Wyoming C.F. – about which the CA conducted a full monitoring visit in 2014 – is a medium security prison next to Attica C.F., and unfortunately, the CA also received a large number of complaints about staff violence and intimidation. Many people who the CA met during our visit referred to Wyoming as a “hands-on” facility, reported that officers used unnecessary force, and described officers beating up incarcerated people, including some who were already subdued and/or shackled. A substantial number of people described how staff will purposefully bring incarcerated people into the small doorway at the entrance of the dorm buildings in order to physically assault them.

At Fishkill, Samuel Harrell was [reportedly](#) beaten to death by COs earlier this year.¹⁷⁴ Fishkill is a medium security prison that incarcerates on average 1,600 people, including over 550 people on the OMH caseload. Mr. Harrell – who had serious mental health needs – was killed in the area of the prison (housing areas 21 and 21A) that the CA noted was very problematic in its 2013 [report about Fishkill](#).¹⁷⁵ Fishkill is also the prison in which 21-year-old Benjamin Van Zandt was driven to take his own life while in solitary confinement.¹⁷⁶ Many incarcerated people continue to report to the CA that staff abuses continue to take place at Fishkill, including in the housing areas of 21 and 21A.

I do understand I've done many bad things that I'm not proud of. All I ask is that my life not be threatened and that I get what I'm supposed to. No more, no less. I do realize that I did the crime and now I have to do the time. But what the officers and staff members are doing is above and beyond. – Anonymous.

These brief notes on these prisons only begin to give a picture of the pervasive racism-fueled staff brutality that permeates the entire DOCCS prisons system. These, and other, types of abuses indicate why it is so imperative for NY to create and expand the mechanisms of oversight and investigation described above, as well as the fundamental changes to the culture and environment of DOCCS prisons described below.

¹⁷⁴ <http://www.nytimes.com/2015/08/19/nyregion/fishkill-prison-inmate-died-after-fight-with-officers-records-show.html?ref=nyregion&r=0>; <http://www.nytimes.com/2015/09/10/nyregion/-2015-09-10-nyregion-fishkill-correctional-facility-inmate-speaks-out-about-abuse-as-family-sues-over-death.html>.

¹⁷⁵ <http://www.correctionalassociation.org/resource/fishkill-correctional-facility-2>.

¹⁷⁶ <http://www.timesunion.com/local/article/21-year-old-state-prisoner-from-Selkirk-hangs-5870531.php>; <http://www.timesunion.com/tuplus-local/article/The-brief-anguished-life-of-a-mentally-ill-inmate-6327006.php>; <http://www.gothamgazette.com/index.php/government/5945-one-raise-the-age-story-at-center-of-push-for-legislative-action>.

2. The Systematic Torture of Solitary Confinement

Interconnected with the overall abusive, racist, and punitive culture that fuels the staff brutality described above, and often used as one method of helping to cover up such brutality, is the pervasive use of solitary confinement. New York State continues to systematically inflict the torture of solitary confinement at alarming rates, and dramatically increased its use across the prison system after the Clinton escape. Currently, on any given day, more than 4,000 people are held in Special Housing Units (SHU) – one form of solitary confinement – in New York prisons, and an additional estimated 1,000 or more people are held in keeplock, another form of solitary confinement. On June 1, 2015 (just prior to the escape from Clinton), 3,621 people were held in the SHU in NY. This number of people in the SHU had remained relatively consistent over several months, with 3,628 people in the SHU on January 22, 2015. However, following the escape, by the middle of July the total number of people in the SHU across NYS prisons was over 3,900 people and since August the number has remained over 4,000, with 4,092 people in SHU as of November 9, 2015. This rate of 7.84% of all people incarcerated in the SHU, is the highest rate potentially ever in the history of New York prisons, more than a third higher than the rate in the early 2000s, and even higher than its previous peak in 2012 prior to some limited reforms to the use of solitary in the state prisons.¹⁷⁷

As the legislature is aware, contrary to popular belief, isolated confinement is not primarily used to address chronically violent behavior or serious safety or security concerns, but often comes in response to non-violent prison rule violations, or even retaliation for questioning authority, talking back to staff, or filing grievances. Moreover, lengthy solitary confinement sentences are frequently imposed using assault on staff allegations after staff have brutalized an incarcerated person. Whether for disciplinary confinement, administrative segregation, or protective custody reasons, people in either SHU or keeplock in NYS prisons spend 22 to 24 hours per day locked in a cell, without any meaningful human interaction, programming, therapy, or generally even the ability to make phone calls, and often being allowed only non-contact visits if they receive visits at all. The sensory deprivation, lack of normal human interaction, and extreme idleness that result from the conditions in solitary confinement have long been proven to lead to intense suffering and physical and psychological damage,¹⁷⁸ and to increase the risk of suicide and self-

¹⁷⁷ See Jack Beck, Testimony before the Hearing of the NYS Assembly's Corrections and Mental Health Committees, Mental Health Services in NY Prisons, Nov. 13, 2014, p. 19, available at: <http://www.correctionalassociation.org/wp-content/uploads/2014/11/Testimony-by-Jack-Beck-11-13-2014-re-Mental-Health-Services-FINAL.pdf>.

¹⁷⁸ See, e.g., <http://www.newyorker.com/news/news-desk/kalief-browder-1993-2015>; Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, Journal of Law & Policy, Vol. 22:325 (2006), available at: <http://law.wustl.edu/journal/22/p325grassian.pdf> ("Psychiatric Effects of Solitary"); Craig Haney, *Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement*, 49 Crime & Delinq. 124 (Jan. 2003), available at: <http://www.supermaxed.com/NewSupermaxMaterials/Haney-MentalHealthIssues.pdf>; Stuart Grassian and Terry Kupers, *The Colorado Study vs. the Reality of Supermax Confinement*, Correctional Mental Health Report, Vol. 13, No. 1 (May/June 2011); Sruthi Ravindran, *Twilight in the Box: The suicide statistics, squalor & recidivism haven't ended solitary confinement. Maybe the brain studies will*, Aeon Magazine, Feb. 27, 2014, available at:

harm.¹⁷⁹ Moreover, solitary is also recognized as causing a deterioration in people's behavior, while restrictions on the use of solitary have had neutral or positive effects on institution safety.¹⁸⁰ Further, as noted above, solitary is disproportionately imposed on Black and Latino people.¹⁸¹

There is a growing trend and consensus around the country and internationally toward ending this torture of solitary confinement. President Obama, Supreme Court Justice Kennedy, and the Pope have all strongly denounced the use of solitary confinement.¹⁸² The newly revised "United Nations Standard Minimum Rules for the Treatment of Prisoners" – otherwise known as the "Nelson Mandela Rules" or "Mandela Rules" – place an absolute prohibition of solitary confinement beyond 15 consecutive days.¹⁸³ These rules are the product of five years of negotiation and deliberation involving UN member countries (including the United States, whose delegation included corrections commissioners), intergovernmental organizations, civil society groups, and independent experts. The Mandela rules were adopted earlier this year by the UN Commission on Crime Prevention and Criminal Justice as well as the entire UN Economic and Social Council, were further presented this month here in New York,¹⁸⁴ and are expected to be considered and adopted by the entire UN General Assembly later this year.¹⁸⁵ The rules reflect and indicate the growing international consensus that solitary confinement beyond 15 consecutive days amounts to torture and should be banned for all people. Yet, in New York

<http://aeon.co/magazine/living-together/what-solitary-confinement-does-to-the-brain/>; Joseph Stromberg, *The Science of Solitary Confinement*, Smithsonian Magazine, Feb. 19, 2014, available at: <http://www.smithsonianmag.com/science-nature/science-solitary-confinement-180949793/#.Uwoq5RsSWaQ.email>.

¹⁷⁹ Homer Venters, et. al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, American Journal of Public Health, Mar. 2014, Vol. 104, No. 3, available at:

<http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2013.301742>. A separate recent panel of scientists at the annual meeting of the American Association for the Advancement of Science also further reported on the harmful psychological and neurological effects of solitary. See Joseph Stromberg, *The Science of Solitary Confinement*, Smithsonian Magazine, Feb. 19, 2014, available at: <http://www.smithsonianmag.com/science-nature/science-solitary-confinement-180949793/#.Uwoq5RsSWaQ.email>.

¹⁸⁰ http://www.vera.org/sites/default/files/resources/downloads/solitary-confinement-misconceptions-safe-alternatives-report_1.pdf.

¹⁸¹ *Criminal Justice Case Processing of 16-17 Year Olds*, New York State Division of Criminal Justice Services, Office of Justice Research and Performance, p. 3, Jan. 4, 2013 (documenting disproportionate arrests and sentencing to incarceration for Black and Latino youth). Even if people of color were subjected to solitary confinement at the same rates as white people once they are in prisons, the disproportionate arrests, prosecutions, sentencing, and incarceration of Black and Latino persons means that these individuals face solitary confinement at a higher rate. Moreover, as noted above, people of color are even more disproportionately sent to solitary than their already disproportionate incarceration.

¹⁸² See, e.g., <http://solitarywatch.com/2015/07/14/obama-in-criminal-justice-speech-denounces-the-overuse-of-solitary-confinement-in-u-s-prisons/>; <http://solitarywatch.com/2015/06/23/supreme-court-justice-kennedy-denounces-human-toll-of-solitary-confinement-and-invites-constitutional-challenge/>; <http://solitarywatch.com/2014/10/26/pope-francis-denounces-solitary-confinement-calls-for-prison-conditions-that-respect-human-dignity/>.

¹⁸³ See Rules 43-44, <http://www.penalreform.org/wp-content/uploads/2015/05/MANDELA-RULES.pdf>.

¹⁸⁴ <http://www.un.org/apps/news/story.asp?NewsID=52190#.Vh0nmnpViko>.

¹⁸⁵ See Remarks by President of the UN General Assembly, Oct. 7, 2015, available at: <http://www.un.org/pga/70/2015/10/07/high-level-presentation-of-the-nelson-mandela-rules/>.

State, thousands of people continue to spend months and years in solitary, and some people have spent decades in solitary, including upwards of 30 years.¹⁸⁶

Something must be done to end this torturous practice and to create mechanisms for oversight and investigations of its use. Several bills currently pending in the NY legislature would make substantial progress in the direction of the international trends toward ending the torture of solitary. A bill that has already passed the Assembly, A. 1346A / S. 5900 would, among other limitations, prohibit solitary for all people with mental illness and any person under the age of 21. Similarly, A. 1347 / 5729, which also already passed the Assembly, would prohibit solitary confinement for women who are pregnant, have recently given birth, or who have infants in the prison nursery program. In addition, the Humane Alternatives to Long Term (HALT) Solitary Confinement Act, A. 4401 / S. 2659 would ensure that no person is subjected to the torture of solitary confinement beyond 15 days and create more humane and effective alternatives.

3. Abuse Targeted at Certain Populations of People

Young People

New York is one of two states that automatically prosecutes 16- and 17-year-olds as adults in the criminal justice system with zero exceptions, even for minor offenses. In 2013, there were 33,404 arrests of 16- and 17-year-olds in New York State.¹⁸⁷ Black and Hispanic youth make up 72 percent of all arrests and 77 percent of all felony arrests statewide, despite making up only 33 percent of the population of 16- and 17-year-old youth statewide.¹⁸⁸ The criminalization of youth in the adult justice system has grave consequences for them, their families, and public safety.

As noted above, New York houses 16- and 17-year-olds in adult DOCCS prisons, where they face rape, sexual and physical abuse, and are at elevated risk of suicide. Black and Latino children disproportionately bear the brunt of the weight and trauma of incarceration in adult facilities. As noted by the Governor's Commission on Youth, Public Safety, and Justice, "Black and Hispanic youth receive 82 percent of sentences to confinement statewide. In New York City, Black and Hispanic youth account for more than 95 percent of prison sentences for 16- and 17-year-olds."¹⁸⁹ As highlighted in the discussions of Greene above, these 16- and 17-year-olds, as well as 18-year-olds and young people in their early and mid-twenties face targeted abuse by

¹⁸⁶ See, e.g., William Blake, *Voices from Solitary: A Sentence Worse than Death*, Solitary Watch, Dec. 24, 2014, available at: <http://solitarywatch.com/2014/12/25/voices-from-solitary-a-sentence-worse-than-death-2/>.

¹⁸⁷ See Final Report of the Governor's Commission on Youth, Public Safety and Justice, Jan. 2015, 39, available at: https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/ReportofCommissiononYouthPublicSafetyandJustice_0.pdf.

¹⁸⁸ Final Report of the Governor's Commission on Youth, Public Safety and Justice at 40 *citing* the Division of Criminal Justice Services, *Computerized Criminal History* (Albany: Division of Criminal Justice Services, 2014). Prepared by the New York State Division of Criminal Justice Services on November 18, 2014.

¹⁸⁹ Final Report of the Commission on Youth, Public Safety and Justice at 78 *citing* New York State Division of Criminal Justice Services, *Computerized Criminal History*. Unpublished data prepared by DCJS OJRP for this Commission.

correction officers. In addition to the horrific accounts about CO beatings of young people (reported by young people and older people) and the consistent data noted above, during the CA's most recent monitoring visit to Greene, the sheer terror on the faces of many young people and many people's refusal to even look up or speak to us indicate the great fear that young people face in DOCCS prisons. The legislature must take immediate action this upcoming session and finally raise the age in New York in a meaningful way,¹⁹⁰ as well as address all abuses of young people in DOCCS prisons.

LGBT Persons

Youth and adults who self-identify as or are perceived to be lesbian, gay, bisexual, or transgender (LGBT) face significant risks of being criminalized and mistreated in DOCCS prisons. Furthermore, all youth and people who are LGBT and gender nonconforming are considered especially vulnerable populations for sexual abuse in prison.¹⁹¹ Research shows that

¹⁹⁰ New York's raise the age legislation should include the following key components:

- Ensuring that no 16- or 17 year-olds are placed in adult jails or prisons, including ensuring that 16- and 17-year-olds are not simply moved to separate units or facilities within the adult system.
- Ensuring age-appropriate facilities that provide the services we know work (similar to the Missouri model), are created throughout New York State and operated by child-serving agencies (OCFS, ACS, local Departments of Social Services).
- The cases of at least all 16- and 17-year-olds charged with misdemeanors and non-violent felonies should originate in Family Court.
- For the limited number of cases against a 16- or 17-year-old heard in adult criminal court, the following protections should apply:
 - These cases should be heard in specialized "Youth Parts" by judges who have received special training on working with adolescents.
 - Allow for the use of adjustment services prior to the filing of a case, so that, in appropriate cases, young people may engage in necessary services without ever having a petition filed in court.
 - Expand the dispositional options to include the evidence-driven services (including alternatives to incarceration) that have been proven to reduce recidivism and helping young people succeed.
 - Ensure all youth records are kept confidential or sealed to prevent collateral consequences.
 - Apply sentencing that is age-appropriate and holds youth accountable for their actions.
- Inform parents/caregivers of all children under 18 of their children's arrests.
- Include parents/caregivers of all children under 18 in decisions about the potential waiver of Miranda rights.
- Ensure no Persons in Need of Supervision (PINS) youth, who by definition has not committed a delinquency or crime, be detained in a secure facility.
- Restrict the use of pre-trial detention and post-trial placement for youth who pose no public safety risk and are better served by the services and programs proven to work.
- Allow for retroactive use of record sealing for adults who have records from when they were 16- or 17-years-old.
- Raise the lower age of juvenile delinquency from 7 years old to 12 years old. Children aged 7 to 11 in need of court interventions should instead receive these interventions through the Persons In Need of Supervision and/or child welfare systems, which are better suited to serving their needs and those of their families.
- Establish family peer support and peer support specialists to engage families and youth throughout the justice process, including during the court process, and any detention or placement.

¹⁹¹ Just Detention International, *Incarcerated Youth at Extreme Risk of Sexual Abuse*, fact sheet (Just Detention International, March 2009), http://www.prearesourcecenter.org/sites/default/files/library/94-incarceratedyouthatextremriskofsexualabusemarch2009_0.pdf; National Center for Transgender Equality, *LGBT*

transgender women face substantial risks for sexual abuse; a study of California prisons found that transgender women in men's prisons were 13 times as likely to be sexually abused as other people incarcerated in those prisons.¹⁹² A recent study from the Bureau of Justice Statistics found that LGB incarcerated people are ten times more likely to be sexually abused than heterosexual people.¹⁹³ Consistently, a 2014 investigation of the experiences of transgender women in men's prisons in New York revealed disturbing examples of transgender women facing long-term solitary confinement and suffering sexual assault while in solitary.¹⁹⁴

In 2008 the Office of Children and Family Services (OCFS) developed and released a comprehensive LGBT anti-discrimination policy and set of guidelines. New York should continue to be a leader in this arena and mandate a similar set of protections for all people in the custody of all state prisons. New York should also legislatively mandate that agencies that contract with the State to provide public and social services must have a comprehensive LGBT non-discrimination policy in place and that they provide effective and culturally responsive services in order to maintain their contracts. Such a mandate will increase the number of services for LGBT court-involved youth and adults in New York State, and help LGBT youth and adults achieve successful re-entry, as well as prevent their initial entry into the system. Formal and robust protections at all points along the youth and criminal justice continuum – from policing to community programs to residential placements to aftercare to incarceration to placement in solitary to post-release – are critical to keeping LGBT young people and adults safe and out of incarceration, and ensuring that they receive culturally sensitive treatment and guidance.

Domestic Violence Survivors

Domestic violence affects women in prison in staggering numbers: an estimated 75% of women in New York's prisons suffered serious physical violence by an intimate partner during adulthood, 8 in 10 were severely physically or sexually abused as children and 9 in 10 experienced physical or sexual abuse in their lifetimes. All too often, the criminal justice system's response to domestic violence survivors who act to protect themselves from an abuser's violence is to incarcerate them – often for many years. This represents a shameful miscarriage of justice. Instead of giving survivors who have suffered life-shattering abuse compassion and assistance, we give them harsh punishment and prison, where they too often face additional abuse and re-traumatization. Instead of providing protection, the criminal justice system becomes

People and the Prison Rape Elimination Act (National Center for Transgender Equality, July 2012), http://www.transequality.org/Resources/PREA_July2012.pdf.

¹⁹² Valerie Jenness et al., *Violence in California Correctional Facilities: An Empirical Examination of Sexual Assault* (Center for Evidence-Based Corrections, April 27, 2007), <http://www.justdetention.org/pdf/VJReport2007.pdf>.

¹⁹³ Allen J. Beck et al., *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-12* (Bureau of Justice Statistics, U.S. Department of Justice, n.d.), <http://www.bjs.gov/content/pub/pdf/svpjri1112.pdf>.

¹⁹⁴ Aviva Stahl, *Transgender Women in New York State Prisons Face Solitary Confinement and Sexual Assault*, Aug. 7, 2014, available at: <http://solitarywatch.com/2014/08/07/transgender-women-in-new-york-state-prisons-face-solitary-confinement-and-sexual-assault/>.

one more entity in the continuum of violence in survivors' lives. Our state's mandatory sentencing statutes are responsible for much of the problem. These statutes require judges to dispense long prison sentences to survivors even when they determine that diversion to an Alternative to Incarceration (ATI) program is more appropriate. Because judges lack discretion, ATI programs are possible only if a prosecutor agrees to reduce the charge to a lower-level offense – a rare occurrence.

The Domestic Violence Survivors Justice Act (DVSJA), A. 4409 / S. 2036, would take steps to address this problem.¹⁹⁵ The Act would: (1) allow judges to send certain survivors convicted of crimes directly related to abuse to either shorter prison terms or to ATI programs; and (2) allow certain survivors currently serving long prison terms to petition the courts for resentencing and earlier release.¹⁹⁶ The DVSJA poses absolutely no risk to public safety. The vast majority of survivors convicted of crimes directly related to abuse have no prior felony convictions, no history of violent behavior, and extremely low recidivism rates. For example, 85% of women sent to NYS prisons for a violent felony in 2011 had never before been convicted of a felony. Of the 38 women convicted of murder and released between 1985-2003, not a single one returned to prison for a new crime within three years of release – a 0% recidivism rate. By increasing use of ATIs and shortening the amount of time mothers are away from their children, the DV Survivors Justice Act will save the state funds without compromising public safety, and will take critical steps toward treating survivors who act to protect themselves with the compassion and dignity they deserve.

4. Failing People with Mental Illness

Due to a lack of community-based mental health services and the criminalization of behavioral manifestations of mental illness, New York State incarcerates large and growing numbers of

¹⁹⁵The DV Survivors Justice Act is supported by a broad coalition of over 125 domestic violence, social service, victims' rights, criminal justice and women's organizations, and by thousands of individuals across the state. Supporters include: the New York State Coalition Against DV, Downstate Coalition for Crime Victims, Erie County Coalition Against Family Violence, Rochester/Monroe County Coalition Against DV, Nassau County Coalition Against DV, Suffolk County Coalition Against DV, Sanctuary for Families, Lawyers Committee Against DV, Men Can Stop Rape, Rockland Family Shelter, Safe Homes of Orange County, Equinox Domestic Violence Services, Family Counseling Service of the Finger Lakes, STEPS to End Family Violence, My Sisters' Place, NYC Bar Association's Domestic Violence and Criminal Operations Committees, and the YWCA of Northeastern New York. In addition, in a PBS poll conducted in 2012, 92% of respondents said they supported reduced sentences for DV survivors convicted of crimes directly related to their abuse.

¹⁹⁶ To be eligible for an alternative sentence or for resentencing under the bill, a judge must find that a survivor meets three specific criteria: (1) that she was, at the time of her offense, a victim of domestic violence subjected to substantial physical, sexual or psychological abuse inflicted by a spouse, intimate partner or relative (either by blood or marriage); (2) that the abuse was a "significant contributing factor" to the crime; and, (3) that a sentence under the law's general sentencing provisions would be "unduly harsh." Individuals convicted of Murder in the First Degree, Aggravated Murder, Sex Offenses and Terrorism Offenses are excluded from eligibility under the bill. It is important to note that the Act's "significant contributing factor" standard has already been recognized by the legislature as a proper standard in assessing mitigating circumstances in sentencing. For example, the recent Rockefeller Drug Law reforms permit diversion if substance abuse is a "contributing factor" to the crime.

people with mental health needs – over 9,500 people are in state prisons alone (18% of the total prison population).¹⁹⁷ Prison is not an appropriate environment for people with mental health needs. The highly regimented, rigid rule-oriented, hyper-punitive, and too commonly abuse-laden environment is often very difficult for people with

COs target . . . mental health patients. For instance, one person with mental health issues will wear his pants backward, and COs will slap the crap out of him, and another person with Tourette Syndrome will get beaten for the noises he makes. –Anonymous

mental illness to manage. The trauma of this environment can exacerbate people's mental illness and create new mental health challenges for any person. DOCCS and OMH have increased and in some cases improved mental health care over the last decade, including expansion of the non-disciplinary residential Intermediate Care Programs (ICP). With only around 1,200 total disciplinary and non-disciplinary residential mental health beds in the whole system, however, the vast majority of people with mental health needs remains in the general prison population. Also, while solitary confinement can exacerbate pre-existing mental illness and create new mental health challenges for any person, around 700 people on the mental health caseload remain in solitary each day in New York prisons. Thanks to the SHU Exclusion Law, on any given day around 200 people with the most serious mental illness are diverted to a disciplinary Residential Mental Health Treatment Units (RMHTUs), where they typically can receive two to four hours a day, five days a week, of out-of-cell mental health programming and treatment.

While many patients have benefited from being in an RMHTU, people are often held in these units for months and years, and too often face excessive disciplinary tickets, denial of out-of-cell programs, staff physical and verbal abuse, and in turn patient program refusals. Also, there has been a major shift in diagnoses in the last six years from schizophrenia and psychoses (35% drop) to adjustment, anxiety, and personality disorders (72% rise). With a related 36% drop in S-designations, less people are eligible for SHU diversion. As one of the most disturbing outcomes of these identified challenges, NYS prisons have a suicide rate 50%-70% higher than the national average for state prisons, roughly two times the suicide rate in the outside community, and suicides are concentrated at Auburn, Attica, Clinton, Elmira, and Great Meadow.

New York must de-criminalize behavioral manifestations of mental illness, and provide greater community mental health care, diversion, and alternatives to incarceration so that prisons and jails are no longer the dumping ground for people with mental illness. Inside prisons, DOCCS and OMH must expand non-punitive residential mental health units, and mental health programs and services for people in general population. NYS should pass A. 1346A / S. 5900 so that people with any mental illness – whether they are S-designated or not – are removed from

¹⁹⁷ For a more in depth analysis of the intersection of the criminal justice system and mental health, see Correctional Association Testimony before the NYS Assembly's Corrections and Mental Health Committees, Nov. 13, 2014, available at: <http://www.correctionalassociation.org/wp-content/uploads/2014/11/Testimony-by-Jack-Beck-11-13-2014-re-Mental-Health-Services-FINAL.pdf>.

isolation, and pass A. 4401 / S. 2659 so that no person is subjected to the torture of solitary confinement, and more humane and effective alternatives are utilized. All current and future alternative units to SHU must be more therapeutic and rehabilitative, and all staff abuse, disciplinary tickets, additional SHU time, and program denials must cease. Further, DOCCS and OMH must enhance assessments, diagnoses, and individualized treatment for all people with mental health needs. In addition, there must be greater suicide, self-harm, and crises prevention and therapeutic responses, including through counseling, treatment, and transfers to an RMHTU or Central New York Psychiatric Center. Further, DOCCS, OMH, and the Justice Center must have greater public reporting, transparency, and accountability, and resources for the Justice Center must be increased so it can adequately monitor the SHU Exclusion Law implementation and prison mental health services.

5. Failing People with Medical Needs

People incarcerated in NY prisons have high rates of chronic medical problems, including HIV, hepatitis C, asthma, diabetes and heart disease. They are totally dependent upon DOCCS to provide that care, which is challenging in a correctional setting where security concerns too often compete with and trump providing care comparable to the standards in the community.

The delivery of healthcare in DOCCS is complex and expensive. The current FY 2015-16 DOCCS budget for medical services is \$347 million and DOCCS employs nearly 1,650 healthcare staff. NY prisons are the epicenter for HIV infections in US prisons, and we have an epidemic of hepatitis C (HCV) in our prisons, with an estimated 6,000 HCV-infected patients needing expensive care.

The CA has focused on healthcare delivery in the prisons for many years and reported our findings to the legislature in reports about system-wide care and in prison-specific reports.¹⁹⁸ We have discussed routine medical care, treatment of chronic medical conditions, access to specialty care services, and medical staffing. The CA has recorded an enormous degree of variability in the quality and efficacy of medical services across different facilities. Some facilities provide incarcerated persons with timely and high-quality care and should be commended for their success. Equally important, however, are the facilities that struggle to administer medical care consistent with community standards. Consequently, medical services are, and continue to be, a source of significant incarcerated person dissatisfaction, with more grievances being filed on the topic of medical care than for any other issue.

In order to gain a complete understanding of how medical care in DOCCS facilities can be brought in line with community standards, its successes and challenges must be examined both on a system- and facility-wide level. Across the Department, patients' complaints include, but

¹⁹⁸ See, e.g., CA, Correctional Association of NY 2013 Comments Concerning DOH Oversight of HIV/HCV Care in NYS Prisons (2013); CA, Healthcare in New York Prisons: 2004-2007 (2009); CA, Health Care in New York Prisons (2000).

are not limited to: delays in access to medical care, difficulties receiving medications, lack of health education, failures to treat chronic medical problems expeditiously, lack of medical confidentiality, providers having negative attitudes and acting in a disrespectful or uncaring nature toward patients, and providers not believing patients' reported medical problems and/or giving pain relievers as a response to any medical ailment rather than thorough and appropriate medical care. Related to these complaints, the number of DOCCS medical staff has declined by 15.8% since 2011, a rate more than two times the overall prison population decline (7.5%) in the same period. In addition, as discussed further below, women face additional barriers to quality health care, particularly reproductive health care. Despite these challenges, the Department has made progress in some arenas by reducing some of the chronic staff vacancies, enhancing auditing protocols by the Department's Division of Health Services to ensure compliance, and instituting more formal guidelines for chronic conditions.

Comprehensive evaluation and monitoring of medical care in these facilities are crucial contributions to responsible public health policy. Oversight is crucial to ensure that all patients are receiving adequate care regardless of the facilities in which they reside, the units where they live or the medical problems they have. With 97% of the prison population returning to their communities and 26,000 people being released each year from DOCCS, the care provided inside and the continuity of care when they are released has a significant impact on the families of formerly incarcerated individuals and the communities in which they reside. As such, the importance of the Department of Health's commitment to oversight of HIV and HCV care cannot be undervalued. Healthcare inside provides an opportunity to address chronic conditions and diseases in a medically high-risk population, educate incarcerated patients about their conditions, and initiate treatment inside, and provide sufficient continuity of care preparation prior to release so that people return home in better health and ready to address their medical needs when accessing services out in the community.

6. Shackling of Pregnant Women and Reproductive Injustice¹⁹⁹

Women incarcerated in New York State prisons continue to face serious barriers in obtaining access to quality reproductive health care. Based over a five-year period on interviews with 950 incarcerated women, 20 visits to prisons housing women in New York, data from over 1,550 surveys, and reviews of medical charts, the CA's recent *Reproductive Injustice* report reveals a shockingly poor standard of care, the routine denial of basic reproductive health and hygiene items, and the continued egregious practice of shackling pregnant women during labor and childbirth despite a 2009 law prohibiting it.

¹⁹⁹ For more information about the barriers to reproductive health care faced by women in NYS prisons, see *Reproductive Injustice: The State of Reproductive Health Care for Women in New York State Prisons*, a report of the CA's Women in Prison Project, available at: <http://www.correctionalassociation.org/wp-content/uploads/2015/02/Reproductive-Injustice-FULL-REPORT-FINAL-2-11-15.pdf>.

Highlights of the report's key findings about reproductive health care in DOCCS include: 1) Virtually no oversight of reproductive health care, substandard written policies, and inadequate data collection and analysis; 2) Violations of NY's 2009 anti-shackling law and routine shackling of women throughout pregnancy; 3) Poor conditions of confinement for pregnant women, including insufficient food and damaging childbirth experiences; 4) Substandard reproductive health care and serious delays in accessing gynecological services for many women; 5) Routine denial of basic reproductive health items, including contraception and sufficient sanitary supplies; and 6) Women in solitary confinement facing egregious conditions, and pregnant women placed in solitary, a dangerous setting for them and their babies.

New York must take serious steps to, among other actions: 1) Expand funding for gender-specific, community-based alternative-to-incarceration and reentry programs, including programs that allow mothers to live with their children. 2) Guarantee incarcerated women access to timely and quality reproductive health care. 3) Amend the 2009 Anti-Shackling Law to include mechanisms to ensure compliance, and expand the law to ban the shackling of women during all stages of pregnancy and during trips for babies to receive medical care outside of the prison; 4) Allow women who complete Bedford's nursery program to finish serving their sentences with their children in community-based programs; 5) Allocate funds for DOCCS to hire sufficient GYN staff, raise salaries for DOCCS clinical providers and create an electronic medical records system; 6) Allocate funds for DOCCS to create a women's health education program and to expand domestic violence and trauma programming, particularly the Female Trauma Recovery Program; and 7) Eliminate the use of solitary confinement for pregnant women, women in postpartum recovery, and women in the nursery program.

7. Repeated Unfair Denials of Parole²⁰⁰

Although the Parole Board itself is purportedly independent of DOCCS, the merger of DOCS and Parole into DOCCS in 2011, and the interconnected impact of people's experiences in DOCCS prisons with Parole Board decisions and vice versa requires that discussions about oversight of DOCCS should include discussions of oversight and investigations of the Parole Board. Thousands of people each year are denied parole in New York State.²⁰¹ Worse still, thousands of people are repeatedly denied parole, sometimes as many as ten or more times, thereby remaining in prison for decades longer than they should. Indeed, only one out of every five people who appears before the Parole Board for a general assessment of eligibility for parole is released, whether appearing for the first time or as someone previously denied parole.²⁰² All of

²⁰⁰ For more information regarding the failures of the Parole Board, the negative impact on people's perception of the fairness of the criminal justice system, and the need for fundamental reform, see Correctional Association Testimony before the NYS Assembly Corrections Committee re Board of Parole, Dec. 4, 2013, available at: <http://www.correctionalassociation.org/wp-content/uploads/2013/12/CA-Parole-Testimony-12-4-13-Hearing-FINAL.pdf>.

²⁰¹ CA analysis of data provided by the Board of Parole for 2011, 2012, and 2013.

²⁰² *Ibid.*

those individuals who have been denied have already served at least the minimum sentence deemed appropriate by the judiciary and the legislature for their crimes of conviction and past criminal history. Yet, the Board repeatedly denies parole based on the nature of applicants' crimes of conviction or their past criminal history, in the process failing to adequately consider or give sufficient weight to what people have accomplished while incarcerated, their current readiness for reentry, or their risk to the community as measured in an objective manner. Although a risk assessment is now conducted for each person appearing before the Parole Board, the Board often ignores the assessment and frequently denies people determined to be at very low risk of committing an offense upon release.

The repeated denials of parole, particularly when coupled with DOCCS programming that is lacking and insufficiently supported, is an inhumane form of persistent punishment and a form of violence. In particular, elderly people and/or people serving long sentences who are denied parole even when they have completed required prison programming and demonstrated rehabilitation are left to languish with little positive opportunities and little hope. In addition to this human cost, this system of parole denials also is a tremendous drain on taxpayer funds. Each denial of parole to the 10,000 people denied each year generally results in an additional two years in prison, and the annual cost per incarcerated person in NYS prisons is approximately \$60,000. Even if one looked solely at the Board appearances for a general assessment of eligibility for parole and increased the rate of release in those categories to only 50% in a single year, there would be approximately an additional 4,000 people released and thus, potential savings of hundreds of millions of dollars per year. Moreover, when the state fails to abide by the rule of law, the resulting demoralization from repeated parole denials can lead some people to become less willing to engage in beneficial activities, to instead carry out problematic or disruptive behavior, or to lose respect for the rule of law or society as a whole. Perhaps most importantly, repeated parole denials deprive families and communities of valuable and contributing members. Many people who are denied parole are parents, children, or grandparents; have transformed their lives or self-actualized; have attained GEDs or college degrees; and are genuinely cognizant of the harms they have caused others and deeply committed to doing something positive in the community to help repair the harms caused. For them and our communities, New York needs to let them return home to be contributing members of our society.

8. Overall Lack of Investigations and Oversight, and Interconnected Use of Mechanisms as Cover-Up

What makes things worse related to all of the above failures and abuses of the incarceration system, the failed mechanisms of investigations and oversight described in Part I do not help prevent or effectively respond to the abuses and too often serve as a cover-up instead. Far too often staff abuse follows a repeated pattern of: (a) brutality or some other abuse by staff, (b) issuing incarcerated people who were beaten up or otherwise mistreated false disciplinary tickets

and sending them to long solitary confinement sentences; (c) other methods of cover-up through false documentation of UIRs and other reports and insufficient medical documentation of injuries; (d) denial of grievances filed for the incident and possible further retaliation for raising complaints; (e) failure of OSI investigations of the incident to lead to any positive outcomes; (f) failure of any remedial action taken against officers even when substantiated staff abuse is found; (g) significant barriers faced in pursuing litigation; (h) ultimately no redress whatsoever for the incarcerated person who suffered the assault; and (i) the public, the media, and policy-makers are unaware of the incident or other systemic abuse taking place. In other words, officers severely beat a person up. Instead of accountability for the staff, the person beaten gets sent to solitary confinement for months or years, and any attempts to complain or seek redress do not lead to any positive outcomes and only lead to possible further abuse as retaliation, and the public and policy-makers are left in the dark about what has happened behind the prison walls. All of the various mechanisms described in Part I are essential to help shine a light on what is happening in NY State prisons and bring meaningful levels of accountability and preventative measures to stop abuses taking place.

IV. The Need for Broader Changes to Fundamentally Transform the Culture and Environment

While enhancing oversight and investigations is a necessary step to address all of the above and other fundamental human rights violations, these changes must be part of a broader package of reforms aimed at creating a fundamental cultural shift across DOCCS prisons. The culture of brutality, violence, excessive punishment, dehumanization, intimidation, fear, and abuse must end. It must be replaced by a culture that prioritizes mutual respect and communication between staff and incarcerated persons; conflict resolution, transformation, and de-escalation; and individual autonomy, support, programs, empowerment, and personal growth for incarcerated persons.²⁰³ Promoting the latter type of culture can improve relations between staff and incarcerated persons, increase safety and security for all, and improve staff morale and job performance,²⁰⁴ not to mention improving the lives of people while they are incarcerated and increasing their chances of success upon return to their home communities.²⁰⁵

1. Cultural Changes

The current culture of brutality, violence, torture, and abuse at DOCCS prisons self-perpetuates by creating violence, a fear of violence, or real/perceived misconduct by incarcerated persons, which in turn leads to further brutality, torture, and abuse by correction officers, continuing a downward spiral of violence and abuse. As renowned psychiatrists, former prison administrator/staff, and experts on violence and incarceration, Dr. James Gilligan and Dr. Bandy

²⁰³ See, e.g., *Report of the Commission on Safety and Abuse* at 66.

²⁰⁴ *Ibid.* at 66-67.

²⁰⁵ See Byrne at 88 (noting that “improvements in the everyday quality of life of staff and [incarcerated persons] will ultimately affect the ‘moral performance’ of incarcerated persons when they return to the community.”).

Lee, conclude, “the more severely [incarcerated persons] are punished by the prison authorities, the more violent they become, and the more violent they become, the more severely they are punished, until they become so enraged and bitter that they do not care whether they themselves live or die, if only they can get back at their tormentors, or at any other target on whom they can vent their rage.”²⁰⁶

At the psychological root of this downward cycle, Gilligan and Lee find “punishment stimulates feelings of shame and diminishes feelings of guilt, and those are precisely the conditions that stimulate violent behavior.”²⁰⁷

“[D]epriving someone of his freedom is likely to be experienced by most people as a form of punishment in itself, no matter how humanely it is done, and no matter how many efforts are made to mitigate the cruelty of it. To add further punishments to that,

gratuitously, is not only needlessly cruel, but is also counterproductive: it only stimulates more violence on the part of the person who is subjected to it.”²⁰⁸ Similarly, many other experts and scholars espouse a similar “deprivation model” that emphasizes that “the prison environment and loss of freedom cause deep psychological trauma so that for reasons of psychological self-preservation [incarcerated persons] create a deviant prison subculture that promotes violence.”²⁰⁹

To change the downward spiral, the paradigm, and in turn the outcomes, requires a fundamental change in culture and environment. Gilligan and Lee conclude that prisons can never provide

Violence and abuse, and an institutional culture that condones abuse, are truly deadly to the purposes of a correctional facility. There are prisons and jails where officers too often use weapons and force instead of words and where [incarcerated persons] lash out at each other and at officers. But this is not the fate of all correctional facilities. In some institutions, officers maintain safety for everyone—in part by directly engaging with [incarcerated persons] and, in some cases, bridging race, culture, and class differences to make those connections. -- Report of the Commission on Safety and Abuse at 20.

If [prisons'] purpose had been to increase the frequency and severity of crime and violence to the highest possible level, they could hardly have been more successful. – Gilligan and Lee at 310.

²⁰⁶ James Gilligan and Bandy Lee, *Beyond the Prison Paradigm: From Provoking Violence to Preventing It by Creating “Anti-Prisons” (Residential Colleges and Therapeutic Communities)*, Ann. N.Y. Acad. Sci. 1036: 300-324, 307 (2004) (“Gilligan and Lee, *Beyond the Prison Paradigm*”).

²⁰⁷ *Ibid.* at 309-310.

²⁰⁸ *Ibid.* at 306.

²⁰⁹ See Ross Homel and Carleen Thompson, *Causes and prevention of violence in prisons*, *Corrections Criminology*, p. 101-108, at 1 (2005) (citing Farrington & Nuttal, 1980; Sykes, 1958; Wortley, 2002).

the appropriate environment for positive change and reducing violence.²¹⁰ Still, their ideas for what should replace abusive institutions can also serve as models for what DOCCS prisons should move toward so long as they exist. As Gilligan and Lee describe:

*If we want to facilitate the ability of violent people to regain their humanity, or to gain it for the first time, so that after their return to the community they will behave constructively rather than destructively, it is essential that the setting in which they are temporarily separated from the community at large be as dignified, humane, and homelike as possible, and that it be a kind of microcosmic example of the kind of health-promoting and non-violent community that we would hope they could help create and maintain after they return to the community.*²¹¹

Enhancing oversight and investigations of DOCCS prisons can themselves help to promote a changed and improved culture. These enhanced transparency and accountability mechanisms, however, must also coincide with broader changes to the approach and purposes of incarceration and the criminal justice system more generally, including related to changing the attitudes and practices of staff as well as creating opportunities for the empowerment of people who are incarcerated.

Changes to Staff

A major component of transforming the culture at DOCCS prisons involves changing the attitudes, practices, and cultural norms of staff. One part of this component requires a clear desire and articulation of this shift from top DOCCS and state officials.²¹² The Governor, the DOCCS Commissioner, and other state officials, must strongly convey a new emphasis, including at a minimum the above recommended no tolerance policy for abuse and strengthened limitations on the use of force. DOCCS administrators and state officials must work toward creating a culture that prioritizes resolving conflict and supporting and respecting incarcerated persons, does not tolerate staff violence and abuse, and holds staff accountable.²¹³ High level DOCCS administrators, and more elected representatives and state officials, should make periodic unannounced visits to NYS prisons to assess conditions. In addition, DOCCS Central Office

²¹⁰ *Ibid.* at 310-311 (finding that prisons “are so irredeemably flawed, their most basic premises are so incorrigibly mistaken, that they can only be abolished and replaced with a qualitatively different kind of approach.” They term their alternative approach an “anti-prison”, which would be “reserved exclusively for those who have committed (or credibly threatened) a serious act of violence”; would aim to be a “human development center,” “behavioral health center,” or “comprehensive education center”; and would start the process of habilitation and socialization from the beginning).

²¹¹ *Ibid.* at 311.

²¹² See, e.g., *Report of the Commission on Safety and Abuse* at 70 (“efforts to improve the institutional culture must come from the top.”).

²¹³ See, e.g., DOJ 2014 Report at 62, Remedial Measures H(9), J(1).

should develop a system for tracking, identifying, and appropriately responding to patterns of misconduct.²¹⁴

Moreover, the legislature should require that DOCCS create and fully implement alternative mechanisms to the use of force, physical abuse and punishment/discipline to resolve conflicts that arise between staff and incarcerated persons, as well as among incarcerated persons. For instance, utilizing counseling, de-escalation techniques, crisis intervention methods, and restorative justice circles or panels could provide more effective means of addressing conflicts and in turn reduce use of force, if properly established and built into prison operations.²¹⁵

Additionally important, the legislature could require that DOCCS prioritize recruiting, hiring, and retaining staff – including correction officers, captains, lieutenants, superintendents, and deputy superintendents for security – with higher levels of qualifications and experience, as well as racial, cultural, and gender diversity.²¹⁶ According to a Human Rights Approach to Prison Management handbook,

*It is essential that the staff should be carefully selected, properly trained, supervised and supported. Prison work is demanding. It involves working with men and women who have been deprived of their liberty, many of whom are likely to be mentally disturbed, suffer from addictions, have poor social and educational skills and come from marginalized groups in society.*²¹⁷

The legislature could require, for instance, that security staff qualifications focus more on skills related to communication, resolving conflicts, empathy, and de-escalating difficult situations.²¹⁸ DOCCS should limit the number of inexperienced security staff at prisons known to have documented levels of violence, and should instead provide incentives for more experienced officers and those specialized in counseling, conflict resolution, and de-escalation to work in these prisons and areas.²¹⁹ Of course, a truly effective prioritization of hiring of the most

²¹⁴ See, e.g., DOJ 2014 Report at 63, Remedial Measures J(3-4).

²¹⁵ See, e.g., Byrne at 82, (citing K. Edgar for the proposition that “building mechanisms” in prisons such as restorative justice panels “to resolve conflicts” is one method for promoting social order in prisons, along with “fulfilling [incarcerated persons’] basic human needs; working to ensure personal safety; providing opportunities to exercise personal autonomy”).

²¹⁶ See, e.g., *Report of the Commission on Safety and Abuse* at 15, 70-72 (concluding that “correctional facilities cannot operate safely and effectively without a qualified, stable, and diverse corps of officers”); Byrne at 83 (linking higher levels of prison violence and disorder with staffing levels, quality, and experience); Homel and Thompson, at 9 (summarizing support for “approaches to recruitment and training to screen out inappropriate staff, to equip staff to recognize and deal with conflict, and to improve supervision.”)

²¹⁷ Andrew Coyle, *A Human Rights Approach to Prison Management*, Handbook for prison staff, 2nd ed., p. 15 (2009).

²¹⁸ See, e.g., *Report of the Commission on Safety and Abuse* at 147 (noting that in an alternative model, “[n]egotiation and communication become more important staff skills than brute strength”).

²¹⁹ See, e.g., DOJ 2014 Report at 49, Remedial Measures F(10, 12, 13).

qualified and diverse staff would likely require shifting the current locations of many DOCCS prisons from primarily white, rural communities in many parts of upstate NY.²²⁰

Beyond recruitment, the legislature should mandate additional and enhanced periodic training of staff throughout the DOCCS system. Such training should utilize interactive and realistic role plays and demonstrations of specific skills and techniques.²²¹ These skills and techniques should focus on alternatives to the use of force, conflict resolution, crisis intervention, and de-escalation techniques, along with training on use of force policies, reporting requirements, and investigations.²²² All security staff should also receive additional and enhanced interactive training on mental illness and working with people with mental health and medical needs.²²³ Moreover, staff should undergo additional training on how to work respectfully and effectively with people of different races, cultures, and backgrounds.²²⁴ At many DOCCS prisons, where the vast majority of incarcerated persons are Black and Latino and the vast majority of security staff are white, it is essential that staff participate in anti-oppression workshops in order to better understand and navigate the racial dynamics at the prison.²²⁵ Especially since most DOCCS prisons will never have substantial numbers of people of color working in them, extensive and effective training around issues of race, gender, and power must be a crucial part of staff training in order to begin to address the pervasive racism at prisons like Attica.

Empowerment of Incarcerated Persons

In addition to transforming the staff component of the culture at DOCCS prisons, part of the necessary changes in prison culture must also involve greater empowerment of incarcerated persons to help build a more effective culture and environment. Incarcerated persons themselves can play a powerful role to

The more coercive the prison environment, the greater the potential for violence . . . Conversely, prisons that provide for [incarcerated persons] participation in education and vocational programs and promote self-efficacy generally report reduced levels of rule violations and violence. – Homel and Thompson at 10.

²²⁰ See *Report of the Commission on Safety and Abuse* at 35 (calling for officials to “reexamine where prisons are located and where [incarcerated persons] are assigned” for purposes of promoting family and community ties.).

²²¹ See *Report of the Commission on Safety and Abuse* at 33 (“officers need guidance, inspiration, and a repertoire of effective, non-forceful responses so that the use of force is naturally limited to those rare situations where it is required to prevent serious harm.”).

²²² See, e.g., DOJ 2014 Report at 59-60, Remedial Measures G(1, 3, 5); *Report of the Commission on Safety and Abuse* at 11 (“teaching and modeling non-forceful ways for officers to resolve conflict is crucial because the unnecessary or excessive use of force and weapons provokes broader violence”).

²²³ See, e.g., DOJ 2014 Report at 60, Remedial Measure G(7).

²²⁴ See, e.g., *Report of the Commission on Safety and Abuse* at 33 (finding that “careful screening of staff at the time of employment and ongoing, in-depth training are necessary to ensure that an understanding of and respect for cultural differences shapes how staff relate to [incarcerated persons]”).

²²⁵ See *Ibid.* at 69 (noting that “where there are stark differences in race and culture between officers and [incarcerated persons], it takes real effort on the part of corrections staff to understand and effectively communicate . . . pre-service and ongoing training are critical. That training must dig deep into ingrained conceptions about people from different races, cultures, and neighborhoods.”).

decrease violence and abuse inside the prison by affecting the culture of the prison, reducing violence by incarcerated persons, empowering incarcerated persons about their rights and ability to raise complaints, and more generally serving as peer leaders, mentors, and facilitators of peer-led programs. Providing greater autonomy to incarcerated persons and fostering a sense of community among incarcerated persons and staff has been proven to help reduce prison violence.²²⁶ As one part of this component, joint training of staff and incarcerated persons can help empower both, and improve relationships between staff and incarcerated persons.²²⁷ Similarly, increasing use of the so-called “direct supervision” model, whereby staff and incarcerated persons have constant and continuous direct interaction in common, non-cell areas, can help reduce violence if implemented properly and effectively with adequately skilled, trained, racially diverse, and culturally competent staff.²²⁸

In addition, the legislature must create a renewed focus at DOCCS prisons on programs, habilitation, and transformation. It has long been demonstrated that providing meaningful program opportunities will reduce idleness, which itself can help decrease confrontations among incarcerated persons and between incarcerated persons and staff.²²⁹ As Gilligan and Lee suggest, “To the all-too-limited extent to which prisons simply restrain people without punishing them, treat them with respect rather than contempt, and make available to them the tools (such as education, psychotherapy, employment, treatment for alcoholism, and so on) that can enable them to gain sufficient self-respect to outgrow their need to commit violent acts, prisons could (and sometimes do) actually prevent violence.”²³⁰

In the name of fighting crime and supporting law and order, the politicians who claim to support those goals most vociferously have systematically dismantled what may be the most effective means we have yet discovered [college] for enabling the most violent men in our society to abandon their lives of crime and violence. – Gilligan and Lee at 315.

College programs have long been documented to reduce violent behavior among participating students and empower those individuals.²³¹ The limited number of small college programs in

²²⁶ See Homel and Thompson, at 9 (citing the example of the Barlinnie Special Unit for people convicted of violent offenses in Scotland as a successful example of violence reduction based on “a sense of community involving both [incarcerated persons] and staff, greater than usual [incarcerated person] autonomy, and distinctive incentives and disincentives.”); Coyle, at 15 (noting that “the key to a well managed prison is the nature of the relationship between [staff and incarcerated persons]”).

²²⁷ *Ibid.* at 9 (citing example of a “Pennsylvania conflict resolution program that jointly trains officers and [incarcerated persons and] is successful in improving staff-[incarcerated person] relationships”).

²²⁸ See, e.g., *DOJ 2014 Report*, at 52; Gilligan and Lee, *Beyond the Prison Paradigm*, at 150; *Report of the Commission on Safety and Abuse* at 29-31.

²²⁹ *DOJ 2014 Report* at 58, Remedial Measure F(8).

²³⁰ See Gilligan and Lee, *Beyond the Prison Paradigm*, at 307.

²³¹ See, e.g., Jack Beck, *Correctional Association Testimony*, Educational and Vocational Programs in NY Prisons, p. 27, Nov. 29, 2012, available at: <http://www.correctionalassociation.org/wp-content/uploads/2013/02/testimonu-prison-ed-voc-progs-nov-2012.pdf> (“Beck, *Educational and Vocational Testimony*”). Gilligan and Lee, *Beyond the Prison Paradigm*, at 314-316; *Education From The Inside, Out: The Multiple Benefits of College Programs in*

DOCCS prisons need to be expanded, and the NYS legislature must restore access to Tuition Assistance Program (TAP) grants in order to expand college opportunities for people incarcerated across the state. In addition, expanding general academic and vocational programs – through additional resources from the legislature – to address the ongoing waitlists at DOCCS prisons will help to reduce idleness and in turn confrontations with staff.²³² Moreover, the legislature should require and provide resources for DOCCS to enhance and expand specialized programs aimed at reducing violence that help staff and incarcerated persons better address some of their underlying issues and help them grow, including anti-violence programs like the Alternatives to Violence Project (AVP), Aggression Replacement Training (ART), and cognitive behavioral therapy.²³³

College as a Chance to Become Builders of the Community

I am fortunate to be enrolled in [a college program] – it’s saved my life. . . . Individuals who want to, and one day will, reenter society want to produce fruitful gains for the community. The [people in the program] are grateful for a second chance to live as builders of their community and not destroyers. . . . This program has given me the confidence to reach for my lost potential and achieve my dreams. . . . Because of this program, [people] such as myself have the necessary tools to go home and live lawful, productive lives. I’d rather read Plato than sell drugs; explore history than commit [a crime]. . . . I guarantee if you ask the inhabitants of Brownsville, East New York, Bed-Stuy, Jamaica, Queens, Harlem, Far Rockaway, and the South Bronx who would they rather have back into these communities: individuals without an education who have done nothing more than mop floors and clean windows during their entire prison stint? Or would they rather have individuals, like myself, who have participated in and facilitated notable self-help classes. What happened to all of the rehabilitative programs? – Anonymous.

Moreover, incarcerated persons can play an important role in expanding program opportunities, empowering other incarcerated persons, and in turn reducing peer violence and confrontations with staff. Given that roughly 60% of the people incarcerated in DOCCS already have their high school diploma or equivalency, a small but substantial number of people have a college degree, and many others have a wealth of other forms of relevant knowledge, experiences, and expertise, incarcerated persons can be an invaluable resource.²³⁴ Unfortunately, a decline in DOCCS support for peer-led initiatives, such as incarcerated person organizations and peer-led classes

Prisons, Correctional Association of New York, 2009; Laura E. Gorgol, Brian A. Sponsler, *Unlocking Potential: Results of a National Survey of Postsecondary Education in State Prisons*, May 2011.

²³² See, e.g., Homel and Thompson, at 7-8 (finding that “academic and vocational education help decrease prison rule violations and violence”); *Report of the Commission on Safety and Abuse* at 27-28.

²³³ See, e.g., Homel and Thompson, at 7 (finding that the literature tentatively concludes that “programs that implement violence alternative training or other forms of treatment such as drug rehabilitation within a supportive and ‘opportunity enhancing’ environment of a specialist or rehabilitative unit are more likely to be effective in reducing . . . violence”); *Report of the Commission on Safety and Abuse*, at 28.

²³⁴ See, e.g., Beck, *Educational and Vocational Testimony*, at 22-23.

and workshops, has made opportunities for peer leadership more difficult and limited.²³⁵ The legislature should provide support and expand peer-led programs in DOCCS prisons.

In a related manner, individuals who participate in programs, demonstrate growth, and transform themselves inside, and/or no longer pose a substantial risk to the outside community should be granted parole release. As discussed above, repeated parole denials to people who complete a large number of programs, have transformed their lives, and/or have received low risk scores on evidence-based risk assessments can have devastating impacts on those denied parole, and on other incarcerated persons who observe these repeated denials.²³⁶ In turn, these denials can increase violence in prisons because some people who are denied may act out as a response; and others who are denied or who observe people being denied may become demoralized, view program participation or efforts at personal transformation as worthless, and/or lose complete faith in the rule of law or the system and thus lose the will or desire to contribute positively.²³⁷

2. Examples of an Alternative Prison Culture and Environment

Nationally

Some prisons and jails in various parts of the country – including certain individual facilities in California, Oklahoma, Oregon, Maryland, and Massachusetts – as well as those in other countries have received praise for reportedly making substantial efforts at transforming their institutional culture and experiencing successful outcomes.²³⁸ According to the Commission on Safety and Abuse in America’s Prisons (*hereinafter* “*Commission on Safety and Abuse*”), the correction systems “leading those reforms understand that an ‘us versus them’ mentality endangers [incarcerated persons] and staff and, over time, harms the families and communities to which [incarcerated persons] and staff belong.”²³⁹

One powerful example of the positive impact of a shift in culture and an emphasis on programs comes from a system developed and tested in a project at the San Francisco County Jail called the Resolve to Stop the Violence Project (RSVP). RSVP aimed to reduce violent behavior of people while held in jail and after returning home by changing the culture of the jail and changing the interrelated character of the individuals in the jail. RSVP utilized “an intensive, 12-hours-a-day, 6-days-a-week program consisting of group discussions, academic classes (including some emphasizing nonviolent forms of self-expression, such as art and creative writing), theatrical enactments and role-playing, counseling sessions, and presentations by and

²³⁵ *Ibid.*

²³⁶ See, e.g., Scott Paltrowitz, *Correctional Association Testimony, Board of Parole*, p. 30-33, Dec. 4, 2013, available at: <http://www.correctionalassociation.org/wp-content/uploads/2013/12/CA-Parole-Testimony-12-4-13-Hearing-FINAL.pdf>.

²³⁷ *Ibid.* at 32-33.

²³⁸ See, e.g., *Ibid.* at 65.

²³⁹ *Ibid.* at 15.

discussions with victims or survivors of rape, murder, and other serious violence.”²⁴⁰ Three main components of RSVP include: 1) group discussions utilizing a cognitive behavioral approach; 2) a victim impact program where survivors of extreme violence participate in sessions in which they describe the pain they have endured; and 3) a process in which each participant writes and acts out a play based on a traumatic or turning point event in his life.²⁴¹ The program showed dramatic declines in violence in the jail. Specifically, after the program was initiated, there was only one violent incident in the first quarter of the program and zero violent incidents for the subsequent year, representing a 96.5% decline in violent incidents from the period prior to the program.²⁴² The program also led to greater reductions in recidivism, as RSVP participants were “significantly less likely to be rearrested on violent charges, remained longer in the community before being re-arrested, and spent less time in custody during follow-up.”²⁴³ This type of intensive program could be incorporated by DOCCS, particularly for working with groups of individuals who have engaged in violent conduct in the past or while incarcerated.

New York

Even within New York State prisons, there are strong examples that have demonstrated the positive effects of an alternative institutional culture on the levels of violence and abuse. For example, Eastern Correctional Facility for a long time was recognized as having a very different institutional culture than other maximum security DOCCS prisons, and as having much less reported violence and abuse by security staff and among the people incarcerated.²⁴⁴ Eastern is a maximum security facility, and the profile and crimes of conviction of incarcerated people at Eastern are similar to those of people incarcerated at prisons like Attica, Clinton, or Great Meadow. Yet, the CA found, based on its visit to Eastern in 2005, that “Eastern’s program-rich environment of mutual respect among staff and incarcerated persons to be a rare example of a maximum security prison that cultivates a rehabilitative culture, promotes safety within the facility and prepares incarcerated persons for a successful return to the community.” More specifically, the CA found at Eastern in the past a “constructive environment of mutual respect and personal responsibility” and “a broad array of educational and rehabilitative programs” with “extensive opportunities for incarcerated persons to learn and enhance their skills” and “minimal complaints about staff throughout the facility.” In turn, the CA found that this culture and program focus “have helped . . . keep violent and disruptive incidents at a comparatively low

²⁴⁰ Gilligan and Lee, *Beyond the Prison Paradigm*, at 316.

²⁴¹ *Ibid.* at 317-319.

²⁴² Bandy Lee and James Gilligan, *The Resolve to Stop the Violence Project: Transforming an in-house culture of violence through a jail-based programme*, *Journal of Public Health*, Vol. 27, No. 2, p. 149-155, at 152 (“Lee and Gilligan, *RSVP: In-House Culture*”).

²⁴³ James Gilligan and Bandy Lee, *The Resolve to Stop the Violence Project: Reducing Violence in the Community Through a Jail-Based Initiative*, *Journal of Public Health*, Vol. 27, No. 2, p. 143-148, at 145 (2005).

²⁴⁴ See, e.g., *Eastern Correctional Facility*, Correctional Association of New York, visit conducted in May 2005, available at: http://www.correctionalassociation.org/wp-content/uploads/2012/05/Eastern_5-25-05.pdf. The CA has subsequently visited Eastern in October 2005, June 2007, and July 2014.

level.”²⁴⁵ While a 2014 CA visit to Eastern raises concerns about whether this positive culture and environment continues to operate at the prison,²⁴⁶ Eastern’s history presents a powerful example of how a fundamentally different culture can lead to a fundamentally different environment with much less brutality, violence, and abuse.

As another example within New York State prisons, the now closed Merle Cooper program at Clinton Correctional Facility had a positive program-focused culture and environment with little violence and abuse by staff or incarcerated persons.²⁴⁷ Merle Cooper – prior to its closure in the fall of 2013²⁴⁸ – was a 216-bed residential program for persons at high risk of recidivism that was completely separated from the rest of the prison. While Clinton generally has some of the highest reported levels of staff brutality of CA-visited prisons, in the midst of that violent and oppressive prison environment, the Merle Cooper program was able to create a safe therapeutic space. Group sessions and community meetings were held to help participants address the harm they have caused others and delve deeply into the underlying reasons for their behavior that led to incarceration. The program also allowed participants to work toward greater freedom and responsibility, including ultimately having single cells with unlocked doors and being able to run peer-led programs. In turn, because of this environment and focus on support and growth, participants were able to self-actualize and become better equipped to return as successful members of our communities. Indeed, Merle Cooper had lower levels of violence and greater feelings of safety than most other CA-visited prisons. The program was one of the few the CA has seen that received near universal praise from participants, staff, and administrators. Although the program closed, it again provides an example of how a transformed environment, focused on empowerment and effective programming, can lead to more positive outcomes, and as such should be replicated across DOCCS prisons.

Other Countries

An example in the international context comes from the Norwegian prison system, where there are no life sentences, a maximum sentence of 21 years, and a relatively recently adopted focus on rehabilitation and reintegration. The purpose of incarceration at the Halden prison, for example, is “wholly focused on helping to prepare [people] for a life after they get out.”²⁴⁹ Prior to release, the Norwegian Correctional Service secures people going home with housing, employment, and

²⁴⁵ *Ibid.* at 1.

²⁴⁶ Unfortunately, based on the CA’s most recent visit to Eastern in July 2014, there are preliminary concerns – that will be explored further in its thorough investigations of the prison – that Eastern’s culture may be shifting away from one of empowerment and mutual respect to one more centered on security and control.

²⁴⁷ See *Clinton Correctional Facility*, Correctional Association of New York, 2014 report, visit conducted in July 2012, available at: <http://www.correctionalassociation.org/pp/prison-visit-2004-present>.

²⁴⁸ Unfortunately, despite the near universal praise for Merle Cooper, DOCCS closed the program after 36 years in the fall of 2013.

²⁴⁹ Jessica Benko, *The Radical Humaneness of Norway’s Halden Prison*, New York Times Magazine, March 26, 2015, available at: http://www.nytimes.com/2015/03/29/magazine/the-radical-humaneness-of-norways-halden-prison.html?_r=0. (hereinafter “*Radical Humaneness*”).

a supportive social network prior to release; and Norway provides formerly incarcerated persons – as it does for all citizens – health care, education, and a pension.²⁵⁰ Also, while incarcerated the prison architecture itself at Halden was “designed to ease psychological pressures, mitigate conflict, and minimize interpersonal friction.”²⁵¹

Moreover, the prison system in Norway explicitly and primarily relies upon a so-called “dynamic security” of interpersonal relationships between staff and people incarcerated to maintain safety. People incarcerated at Halden have freedom of movement without officer escorts, and officers socialize with incarcerated people every day, including sharing meals together. The isolated confinement cell has never been used at the prison.²⁵²

Similarly, at another Norway prison, Bastoy, incarcerated people have their own room and share kitchen facilities, are provided only one meal a day in a dining hall, earn around \$9 a day (for jobs including farming, bicycle repair shop, timber workshop, horse stables), are additionally given a \$107 food allowance per month to buy groceries to make their own meals; and have opportunities for weekly visits in private living areas with their families. The intent, according to an officer, is for people to “get used to living as they will live when they are released.”²⁵³

People incarcerated in prisons like Halden and Bastoy include people convicted of the most serious crimes, such as murder and killing rampages. Nearly half of the people incarcerated at Halden were convicted of violent crimes such as murder, assault, or rape. Yet, these individuals live under conditions aimed primarily at rehabilitation and promoting autonomy and responsibility rather than punishment, control, torture, and abuse. In the end, Norway is documented to have the lowest rates of people returning to prison after release across Europe, and rates lower than in New York or the rest of the United States.²⁵⁴ Additionally of note, around 40% of the people incarcerated in Norway’s prisons are immigrants who are not Norwegian citizens and come from more than 30 other countries (primarily Eastern Europe, Africa, and the Middle East), debunking arguments that there is something unique with respect to homogeneity of people in Norway’s prisons that would allow for its practices to somehow be more successful.²⁵⁵ Also, the Norway prison system’s shift from a focus on punishment and control to a focus on rehabilitation did not begin until the late 1990s and the intense focus on reintegration did not begin until the 2000s.²⁵⁶

²⁵⁰ *Ibid.*

²⁵¹ *Ibid.*

²⁵² *Radical Humaneness.*

²⁵³ See Erwin James, *The Norwegian prison where [incarcerated people] are treated like people*, The Guardian, Feb. 25, 2013, available at: <http://www.theguardian.com/society/2013/feb/25/norwegian-prison-inmates-treated-like-people> (documenting conditions at Bastoy prison) (*hereinafter* “*Treated like People*”).

²⁵⁴ *Treated like People.*

²⁵⁵ *Radical Humaneness.*

²⁵⁶ *Ibid.*

Of course Norway is just one example. Other countries, including the Netherlands and Germany, have vastly different approaches to incarceration than in New York and across the United States.²⁵⁷ As in Norway, the incarceration systems in both Germany and the Netherlands are focused primarily on “resocialization and rehabilitation,” with German law for instance indicating that “the *sole* aim of incarceration is to enable [incarcerated people] to lead a life of social responsibility free of crime upon release, requiring that *prison life be as similar as possible to life in the community*” (emphasis added).²⁵⁸ As a result, according to a Vera Institute of Justice report, prison is used far less as a punishment for crime with much greater diversion even for very serious crimes; prison sentences are far shorter (with 75% of sentences in Germany being one year or less and 92% two years or less); the primary focus of incarceration is to prepare people to successfully return to the outside community; people retain their right to vote and receive social welfare while incarcerated; solitary confinement and other disciplinary measures are rarely used (on the order of a few days a year); and people maintain greater connections with family through home leaves from the prison.²⁵⁹ In Sweden, there are “open prisons,” where incarcerated people serving time for anything from drug trafficking to murder, wear their own clothes, eat together with officers, and are allowed to leave the prison to spend time with their family in the community.²⁶⁰ According to the head of the prison system in Sweden, “Our role is not to punish. The punishment is the prison sentence: they have been deprived of their freedom. The punishment is that they are with us. . . . It has to do with whether you decide to use prison as your first option or as a last resort It has to be a goal to get [incarcerated people] back out into society in better shape than they were when they came in.”²⁶¹

3. Specific Legislative Measures to Help Transform Culture and Environment

In light of this need for a fundamental cultural change, there are several specific legislative measures – in addition to those discussed above related to oversight and investigations – that the NYS legislature should pursue. These measures would serve as important steps toward transforming the culture across DOCCS prisons by demonstrating the seriousness of the state in

²⁵⁷ See, e.g., Ram Subramanian and Alison Shames, *Sentencing and Prison Practices in Germany and the Netherlands: Implications for the United States*, p. 13, Oct. 2013, available at: <http://www.vera.org/sites/default/files/resources/downloads/european-american-prison-report-v3.pdf>; Maurice Hammah, *Prison Without Punishment*, The Marshall Project, Sept. 25, 2015, available at: https://www.themarshallproject.org/2015/09/25/prison-without-punishment?utm_campaign=newsletter&utm_source=features&utm_medium=email&utm_term=germanprisons#.uDStMYSgp.

²⁵⁸ *Sentencing and Prison Practices in Germany and the Netherlands*, at 7.

²⁵⁹ *Ibid.* at 9-13; Nicholas Turner and Jeremy Travis, *What We Learned from German Prisons*, The New York Times, Aug. 6, 2015, available at: http://www.nytimes.com/2015/08/07/opinion/what-we-learned-from-german-prisons.html?_r=0.

²⁶⁰ Doran Larson, *Why Scandinavian Prisons are Superior*, The Atlantic, Sept. 24, 2013, available at: <http://www.theatlantic.com/international/archive/2013/09/why-scandinavian-prisons-are-superior/279949/>.

²⁶¹ Zeeshan Aleem, *Sweden’s Remarkable Prison System has done what the U.S. won’t even Consider*, Policy.MIC, Jan. 27, 2015, available at: <http://mic.com/articles/109138/sweden-has-done-for-its-prisoners-what-the-u-s-won-t-#.HkvoKaaOH>.

ending staff brutality and abuse; shifting away from a punishment paradigm toward a model premised on effective rehabilitation, treatment and growth; and reducing the number of people incarcerated to allow for implementing a more empowering culture with a smaller number of people in prison while providing greater support and opportunities in outside communities.

In order to bring more fairness to DOCCS prisons and build the foundations for safe and successful communities, New York must address the racial injustice and punitive approach embedded not only in the policing and prosecution systems, but also in sentencing, incarceration, and release after incarceration. The same racial injustice and excessive emphasis on punishment and social control that drives police brutality also drives New York State to send children to adult prisons and to incarcerate survivors of domestic violence rather than provide them with support. It is what allows for continued use of the torture of solitary confinement, the infliction of staff brutality, and the shackling of pregnant women. It is the same racialized punishment paradigm that allows for the denial of widespread access to college despite the well-known positive benefits for students and for everyone's safety, or the continuous denial of parole to individuals who do not pose any risk to others. These individual policies and practices must be addressed, as well as the underlying systems, cultures, attitudes, and approaches fueling them. Among other necessary policy changes, the legislature and the Governor could make significant strides in that direction by implementing the following:

Demonstrate the Seriousness toward Ending Abuse and Transform Environment Inside:

- 1. Close Attica and End Violence and Abuse across NYS Prisons:** End the brutality at Attica by closing the prison. For other prisons, so long as they continue to operate, state policymakers must change DOCCS policies and practices to end violence, increase transparency and accountability, and fundamentally transform the culture from punishment, brutality, and abuse to communication, de-escalation, and empowerment.
- 2. End the Torture of Solitary Confinement:** Pass A. 4401 / S. 2659 to ensure that no person is subjected to the torture of solitary confinement beyond 15 days and to create more humane and effective alternatives. The Senate and the Governor should also enact two bills that have already passed the Assembly and would reduce solitary: A. 1346A / S. 5900, which among other limitations would prohibit solitary for all people with mental illness and any person under the age of 21, and A. 1347, which would prohibit solitary confinement for women who are pregnant, have recently given birth, or who have infants in the prison nursery program.
- 3. End Shackling of Pregnant Woman and Promote Reproductive Justice:** Take a comprehensive approach to ensure access to quality reproductive health care for all incarcerated women. Urge the Governor to sign and pass into law A. 6430-A / S. 983-A, amending NY's 2009 anti-shackling law to ensure compliance and expand anti-

shackling protections to all stages of pregnancy and during trips for babies to receive medical care.

4. **Expand General Academic Programs and Reinstate TAP:** Expand funding for general and college-level academic programs, support peer-led initiatives, provide intranet learning opportunities, and reinstate NYS's Tuition Assistance Program (TAP) to allow widespread college participation by people incarcerated. NYS should also pass the Fair Access to Education Act, A. 3363 / S. 0969, to ensure colleges do not discriminate against previously incarcerated people in admissions.
5. **Support People with Mental Health Needs:** Provide greater community mental health care, divert people with mental illness from incarceration, and so long as people with mental health needs are incarcerated, improve mental health care and programs for persons with mental health needs, end all staff abuse of mental health patients, and stop placing people with mental illness in solitary confinement.
6. **Apply a Justice Agenda to Incarceration:** Adopt an appropriately modified version of the Governor's 7-point Justice Agenda for policing to DOCCS prisons, including: a) create a statewide reconciliation commission on incarceration; b) recruit more Black and Latino staff in facilities across the state; c) provide race and ethnicity data on incarceration and correction officer actions; and d) appoint an independent monitor to review staff brutality allegations inside prisons, jails, and youth facilities.

Reverse the Punishment Paradigm Outside and Decrease the Number of People in Prison in order to Focus on Rehabilitation and Treatment Inside and in the Community:

7. **Raise the Age:** Pass comprehensive legislation to: meaningfully raise the age in NYS to 18; raise the bottom age of juvenile jurisdiction to 12; keep 16- and 17-year-olds out of adult prisons and jails; and increase opportunities, including alternatives to incarceration, for young people in both the Family Court and adult justice systems.
8. **Release Aging People from Prison and Adopt Meaningful Parole Reform:** Pass the SAFE Parole Act, A. 2930 / S. 1728, or other comprehensive reform to allow the release of all people who have demonstrated their accomplishments or transformation while in prison, current low risk of harm to others, and/or readiness for reentry.
9. **Protect Domestic Violence Survivors:** Pass the Domestic Violence Survivors Justice Act, A. 4409 / S. 2036 to allow judges to sentence survivors convicted of crimes directly related to abuse to shorter prison terms or ATI programs; and allow survivors currently serving long prison terms to petition courts for resentencing and earlier release.

- 10. Stop the Over-criminalization and Abuse of LGBT Persons:** Adopt formal protections for LGBT persons at all points along the youth justice and criminal justice systems in order to keep LGBT persons out of incarceration, protect LGBT persons' safety, and ensure LGBT persons receive culturally sensitive treatment and guidance.
- 11. Adopt Racial Impact Studies for New Criminal Justice Policies:** Require that a comprehensive racial impact analysis be done prior to the enactment of any proposed legislation or executive policy that would expand penalties or extend sentencing, and prohibit the passage of any legislation that would exacerbate racial disparities.

Ultimately, ending abuses within DOCCS and bringing fairness to the DOCCS system requires a fundamentally different approach both in outside communities and behind the walls. New York must address the long and ongoing racial injustice and paradigm of punishment infusing the criminal justice system. The above-outlined goals will help the state reduce the ineffective use of incarceration as a response to socio-economic problems facing our communities; better ensure that conditions in prisons are humane and that the rights of incarcerated people and their families are protected; and promote transparency, oversight, and accountability in the justice system. Such changes will help ensure fairness in the DOCCS system and end abuses taking place, promote greater respect for the rule of law and societal institutions by staff, incarcerated people, and the public, empower healthier and more successful people who have been incarcerated, and ultimately make us all safer and more enriched.

I thought it was the duty of our elected officials to correct the wrongs within the Justice and Correctional systems and rid it of its deeply rooted corruption and institutionalized racism. --Anonymous

Appendix A - Summary of Annual Grievances and Rates/1000 for 2009-13

Gender	Security	Prison	Ave Pop	Totl Griev	Tot G Rate	Medical	Med Rate	Staff Con	Staff Rate	Housing	Hous Rate	SHU	SHU Rate
Female													
	Maximum												
		Bedford Hills	769	493	640.6	57	73.8	58	75.9	73	94.9	21	27.3
TOTALS	Maximum		769	493	640.6	57	73.8	58	75.9	73	94.9	21	27.3
	Medium												
		Bayview	121	68	562.5	16	133.6	23	191.3	1	4.9	0	0.0
		Taconic	299	90	300.3	16	53.5	23	76.3	6	18.7	0	0.7
		Albion	858	190	221.4	32	37.8	64	75.0	6	7.0	7	7.7
TOTALS	Medium		1,279	348	272.2	65	50.5	110	86.4	12	9.5	7	5.3
	Minimum												
		Beacon	138	33	241.5	3	23.3	10	69.8	3	23.3	0	1.5
TOTALS	Minimum		138	33	241.5	3	23.3	10	69.8	3	23.3	0	1.5
TOTALS	Female		2,185	874	400.0	125	57.0	178	81.6	88	40.5	28	12.8
Male													
	Maximum												
		Southport	868	2,400	2764.2	564	649.4	355	408.6	205	236.6	20	23.0
		Upstate	1,271	3,069	2415.1	764	600.9	851	669.4	1	0.9	369	290.7
		Wende	883	1,819	2059.8	295	334.5	233	263.6	225	254.4	90	102.2
		Shawangunk	534	783	1466.7	165	308.6	70	131.1	46	86.1	39	73.4
		Auburn	1,702	2,138	1256.5	295	173.5	411	241.5	71	41.7	91	53.5
		Great Meadow	1,631	1,930	1183.3	386	236.8	265	162.6	175	107.1	146	89.4
		Five Points	1,363	1,561	1144.9	225	165.0	231	169.7	78	57.2	78	56.9
		Sullivan	504	574	1138.9	116	230.6	87	172.6	37	74.2	18	35.7
		Green Haven	2,030	1,958	964.4	300	147.7	206	101.6	239	117.7	69	33.8

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Gender	Security	Prison	Ave Pop	Totl Griev	Tot G Rate	Medical	Med Rate	Staff Con	Staff Rate	Housing	Hous Rate	SHU	SHU Rate
		Elmira	1,770	1,328	750.4	192	108.5	187	105.5	137	77.6	67	38.1
		Attica	2,153	1,561	725.0	297	138.0	196	90.9	77	35.8	99	46.0
		Sing Sing	1,667	1,207	724.1	280	167.9	150	90.1	166	99.6	30	17.8
		Clinton	1,969	1,302	661.0	295	149.9	165	83.7	51	25.8	53	26.7
		Coxsackie	1,003	648	646.5	88	87.3	206	205.4	38	37.9	3	3.2
		Eastern	1,000	489	489.1	75	74.6	49	49.0	21	21.0	18	17.8
		Clinton Annex	809	244	301.0	40	48.9	59	72.7	12	14.6	0	0.0
		Downstate	1,154	342	296.3	42	36.4	62	53.7	19	16.1	6	5.0
	TOTALS	Maximum	22,312	23,352	1046.6	4,418	198.0	3,782	169.5	1,598	71.6	1,195	53.6
	Medium												
		Collins	880	733	833.0	179	203.0	37	41.8	8	9.5	51	57.5
		Marcy	1,060	795	750.2	220	207.6	106	100.2	47	44.7	13	12.6
		Gouverneur	825	560	679.2	103	124.9	96	115.9	16	19.4	58	70.6
		Orleans	813	538	662.4	85	104.3	56	68.7	19	23.6	56	68.4
		Fishkill	1,549	849	547.9	147	94.8	178	114.8	21	13.7	96	62.1
		Otisville	524	217	413.9	52	99.7	27	50.8	10	18.7	0	0.0
		Woodbourne	801	321	400.5	81	101.2	33	41.2	13	16.0	2	2.7
		Bare Hill	1,626	598	367.7	110	67.7	183	112.6	15	9.2	0	0.1
		Altona	436	144	329.2	18	40.8	31	70.1	7	16.0	0	0.0
		Livingston	803	261	325.5	33	40.8	36	45.1	29	35.6	8	10.2
		Groveland	1,023	320	312.9	87	85.4	62	60.8	12	11.9	7	7.0
		Cape Vincent	821	255	310.5	35	42.4	66	80.9	11	12.9	2	2.4
		Riverview	826	245	296.3	52	63.2	47	56.7	8	9.7	2	2.4
		Mid-State	1,404	405	288.4	129	91.6	83	59.3	26	18.4	13	9.4
		Wallkill	562	160	285.4	32	56.9	25	44.8	13	22.8	0	0.0

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Gender	Security	Prison	Ave Pop	Totl Griev	Tot G Rate	Medical	Med Rate	Staff Con	Staff Rate	Housing	Hous Rate	SHU	SHU Rate
		Cayuga	881	241	274.1	35	39.5	65	73.3	3	3.2	26	29.1
		Hale Creek	345	83	240.3	29	85.3	30	86.5	0	1.2	0	0.0
		Franklin	1,643	373	227.2	92	56.2	121	73.5	17	10.6	2	1.3
		Wyoming	1,609	329	204.4	84	52.0	54	33.8	11	6.8	6	3.9
		Mohawk	1,162	236	203.3	54	46.6	70	60.4	9	7.6	3	2.4
		Watertown	533	105	197.0	19	34.9	20	36.8	4	7.1	1	1.5
		Gowanda	1,531	270	176.2	46	30.3	75	49.3	10	6.5	3	1.7
		Mt. McGregor	435	74	170.3	10	22.6	22	50.6	1	3.2	0	0.0
		Hudson	378	57	152.1	6	15.9	18	46.6	1	2.1	0	0.0
		Adirondack	405	61	150.8	13	32.6	18	44.5	2	4.0	0	0.5
		Greene	1,644	218	132.9	40	24.2	63	38.6	2	1.2	10	6.3
		Washington	755	99	130.9	14	19.1	35	46.7	4	5.6	0	0.0
		Ulster	708	92	129.9	11	15.5	45	63.8	4	6.2	0	0.3
		Ogdensburg	374	40	106.9	11	29.9	6	15.0	1	3.2	0	0.0
		Chateaugay	224	12	53.6	2	7.1	6	25.9	0	0.9	0	0.0
	TOTALS	Medium	26,574	8,691	327.0	1,828	68.8	1,713	64.5	325	12.2	360	13.5
		Minimum											
		Queensboro	352	378	1075.4	7	19.9	32	90.5	1	4.0	0	0.0
		Rochester	66	3	39.5	0	3.0	0	0.0	0	0.0	0	0.0
	TOTALS	Minimum	417	381	912.2	7	17.3	32	76.2	1	3.4	0	0.0
	TOTALS	Male	49,303	32,424	657.6	6,254	126.8	5,527	112.1	1,924	39.0	1,555	31.5
		DOCCS TOTALS	51,488	33,298	646.7	6,378	123.9	5,706	110.8	2,012	39.1	1,583	30.7

