STATE OF NEW YORK
SUPREME COURT: COUNTY OF ERIE

In the Matter of the Application of

THE NEW YORK STATE COMMISSION OF CORRECTION,

Petitioner,

For an Order Pursuant to
Article 78 of the CPLR and
NY State Correction Law §§ 46(4) and 48

- against –

TIMOTHY B. HOWARD, Individually and in his capacity of Sheriff of Erie County, New York, and **ERIE COUNTY, NEW YORK,**

Respondents.

Index No.: _____

NOTICE OF PETITION

PLEASE TAKE NOTICE that, upon the annexed Petition of Allen Riley, Chairman of the New York State Commission of Correction ("Commission"), verified on the 15th day of March, 2021, and upon the supporting papers attached hereto, an application will be made to this Court, to be held at the courthouse thereof, located at the New York State Supreme Court, Erie County, 25 Delaware Avenue, Part __, Buffalo, New York, on the 9th day of April, 2021, at 9:00 a.m. of that day, or as soon thereafter as counsel can be heard, for an Order, pursuant to Article 78 of the CPLR and New York State Correction Law §§ 46(4) and 48, to be entered that:

1. Enjoins Respondents from violating the Commission's regulations at 9 NYCRR §§ 7022.1, 7022.2, and 7022.3;

2. Directs Respondents to appoint an independent monitor to conduct retrospective audits of the Sheriff's Office serious incident reporting to the Commission on a yearly basis for a five-year cycle, with the first audit to be completed by the end of the calendar year of the Court's Order;
3. Directs Respondent Sherriff's Office to provide the Commission with proof of training to correctional officers regarding (i) New York's zero-tolerance policy regarding sexual misconduct in correctional facilities, (ii) how to handle inmates who report sexual misconduct, and (iii) the Commission's Reportable Incident Guidelines, on a yearly basis, with the first training to be completed by the end of the calendar year of the Court's Order;
4. Directs Respondent Sheriff's Office to provide specialized training for investigators and/or Office of Professional Standards staff regarding investigating sexual abuse in correctional settings, with the first training to be completed by the end of the calendar year of the Court's Order;
5. To comply with 9 NYCRR § 7022.7 by developing and/or revising procedures "for the review, investigation and assessment of reportable incidents," and to work with the Commission, or any person employed or designated by the Commission, to develop and improve upon such policies and procedures; and
6. For such other and further relief as the Court may deem just and proper under the circumstances.

PLEASE TAKE NOTICE that, pursuant to CPLR 7804(c), these papers have been served on you at least twenty (20) days before the motion is scheduled to be heard. You must serve your answering papers, if any, at least five (5) days before such time. Reply papers, if any, shall be served at least one (1) day before such time.

PLEASE TAKE NOTICE that, pursuant to Section 48 of the Correction Law, any action or proceeding commenced by the Commission pursuant to this article shall have a preference over all other cases, except habeas corpus proceedings, pending before the Court.

Petitioner designates Erie County as the venue. The basis of venue is the place of business of the Respondents.

Dated: New York, New York

March 17, 2021

LETITIA JAMES
Attorney General of the
State of New York

By: /s/ *Jessica Clarke*
Jessica Clarke
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STATE OF NEW YORK
SUPREME COURT, COUNTY OF ERIE

In the Matter of the Application of **THE NEW YORK STATE COMMISSION OF CORRECTION**, Petitioner, For an Order Pursuant to Article 78 of the CPLR and NY State Correction Law §§ 46(4) and 48 - against – **TIMOTHY B. HOWARD**, Individually and in his capacity of Sheriff of Erie County, New York, and **ERIE COUNTY, NEW YORK,** Respondents.	Index No.: _____ **VERIFIED PETITION**

TO THE SUPREME COURT OF THE STATE OF NEW YORK:

The petition of Commissioner Allen Riley respectfully alleges:

1. Your Petitioner serves, pursuant to Correction Law § 41(1), as Chairman of the New York State Commission of Correction, an oversight body consisting of three persons appointed by the governor, by and with the advice and consent of the Senate.

2. The grounds for Petitioner's information and the source of his beliefs to all matters set forth herein are the papers and documents contained in the Commission's files, information he has obtained from the Erie County Sheriff's Department pursuant to Correction Law §§ 44(4) and 46(1), and the Commission's investigation into the facts and circumstances involved herewith.

VENUE

3. Pursuant to CPLR 7804(b) and 506(b), venue in this proceeding lies in Erie County, in the judicial district Respondents' offices are located.

PARTIES

4. Petitioner NEW YORK STATE COMMISSION OF CORRECTION (the "Commission") is an oversight body established by Article 17, Section 5 of the New York State Constitution, and its functions, powers and duties are set forth in Article 3 of the Correction Law.

5. Respondent ERIE COUNTY (the "County") is a governmental subdivision created under the laws of the State of New York. The County is charged by the laws of the State of New York with authority to maintain the Erie County Holding Center and the Erie County Correctional Facility (collectively, the "Facilities"). The Erie County Holding Center in Buffalo, New York is a pretrial facility; many people held there are not convicted of a crime. The Erie County Correctional Facility in Alden, New York houses a population of both pre-trial and sentenced inmates. Both Facilities house male and female adults.

6. Respondent TIMOTHY B. HOWARD is the Sheriff of Erie County, who, as Sheriff, is charged with custody of the Facilities pursuant to New York laws and regulations.

FACTS

I. Background: The Statutory and Regulatory Regime

7. Under Section 45(6) of the Correction Law and 9 NYCRR § 7000.1, the Commission is empowered to 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." *See* N.Y. Correction Law § 45(6). Further, the Commission may "[a]dopt, amend or rescind such rules and regulations as may be necessary or convenient to the performance of the functions, powers and duties of the commission." *See* N.Y. Correction Law § 45(15).

8. Pursuant to this power, the Commission has promulgated rules and regulations regarding the reporting and investigation of serious local correctional facility incidents. *See* 9 NYCRR §§ 7022.1–7022.7.

9. These rules and regulations include the requirement that local correctional facilities, including the Facilities, "internally review and assess all incidents of a serious or potentially problematic nature and report incidents to the commission," *see* 9 NYCRR § 7022.1, according to the requirements in the Commission's *Reportable Incident Guidelines for County Correctional Facilities* (the "Guidelines"), *see* 9 NYCRR § 7022.2(b). The Guidelines are attached herein as **Ex. A**.

10. The chief administrative officer of the Facilities also shall "develop and implement procedures for the review, investigation and assessment of reportable incidents." 9 NYCRR § 7022.7(a). The chief administrative officer and/or other designated supervisory staff must also "regularly review all reports prepared by facility staff resulting from the review and/or investigation of reportable incidents." 9 NYCRR § 7022.7(b).

11. New York has zero tolerance for sexual offenses committed against any incarcerated individual. State law deems persons in the custody of a state or local correctional facility "incapable of consent" to sexual conduct with facility employees, *see* N.Y. Penal Law § 130.05(3)(e)–(f), and subjects guards to criminal liability for such conduct, *see*, *e.g.*, *id.* §§ 130.25(1), 130.60(1). These laws acknowledge that *any* sexual contact between a guard and a prisoner is deemed non-consensual due to the inherent power differential between guards and prisoners.

12. Therefore, both the Commission's Guidelines and regulations require local correctional facilities, including the Facilities, to promptly report serious incidents to the

Commission, including "any degree of rape, criminal sexual act, forcible touching, sexual abuse or sexual misconduct." Ex. A at 6; *see also* 9 NYCRR §§ 7022.1–7022.3. Reports must be submitted within "24 hours of occurrence of a sex offense or initiation of an internal and/or criminal investigation into an alleged sex offense" (Ex. A at 6), "regardless of the time of day or day of the week" (9 NYCRR § 7022.3(a)). Pursuant to State law, the Guidelines and regulations draw no distinction between assaultive and non-assaultive sexual activity in the prison context. The Commission requires reporting of either activity.

13. The Guidelines and the regulations also require local correctional facilities, including the Facilities, to promptly report assaults, including assaults committed by facility personnel on inmates. Ex. A at 4; *see also* 9 NYCRR § 7022.2. An assault is defined as the "intentional or reckless infliction of physical injury upon another person." Ex. A at 4. Any assault (i) requiring "treatment . . . following the incident" or (ii) "which was terminated by the use of . . . mechanical restraints other than for routine inmate movement" must be reported within "24 hours of occurrence or discovery of" the incident. *Id*.

14. The Guidelines and the regulations also require local correctional facilities, including the Facilities, to promptly report incidents of erroneous release, *id.* at 15–16, and attempted suicides, *id.* at 21–22.

15. Reports of serious correctional facility incidents (*i.e.*, "Reportable Incident" reports) are submitted to the Commission through an online submission form, the eJusticeNY Integrated Justice Portal.

16. In submitting a Reportable Incident report, users must include key details such as date and time of incident, location of incident, incident category, and a summary or narrative of the incident. Because an incident may meet the criteria for multiple categories, users must select all

incident categories that apply to an incident. There are distinct incident categories for assault and sex offenses (including personnel/inmate sex offenses). *See* Ex. A at 4, 6.

17. The duty to report is ongoing: "When additional facts of an important or critical nature are discovered about an incident after a facility has submitted a report to the commission pursuant to subdivision (a) of this section, such information shall be forwarded in writing to the commission as soon as practicable, but no later than 14 days following discovery." 9 NYCRR § 7022.3(c).

18. Pursuant to Correction Law §§ 44(4) and 46(1), the Commission may obtain additional information regarding the reporting and investigation of serious incidents.

19. Correction Law § 44(4) empowers the Commission's Chairman to request from officials charged with operating local correctional facilities, including Respondents, "such assistance, information and data as will enable the commission . . . to carry out its functions, powers and duties." Correction Law § 46(1) further requires that any Commission member or designated Commission employee be "granted access at any and all times to any correctional facility or part thereof and to all books, records, inmate medical records and data pertaining to any correctional facility deemed necessary for carrying out the commission's functions, powers, and duties." The Commission "may require from the officers or employees of a correctional facility any information deemed necessary for the purpose of carrying out the Commission's functions, powers and duties." *Id*.

20. Under these books-and-records provisions, the Respondents are therefore statutorily required to provide the Commission a complete set of investigation files regarding serious incidents upon request.

21. Local correctional facilities' compliance with the above statutes and regulations is vital to the Commission's oversight role. In the words of the Commission's regulations, serious incident reports—and the investigation of such incidents—"provide a mechanism by which facility operations, policies and procedures can be monitored, evaluated and improved . . . ." *See* 9 NYCRR § 7022.1. Serious incident reports, and the investigation of such reports, also ensure that the correctional facilities adhere to New York's zero-tolerance policy on sexual misconduct committed against any incarcerated individual.

II. The May 2017 Directives Issued to Respondents

22. In 2017, the Commission learned that the Erie County Sheriff's Office failed to properly report incidents constituting an erroneous release, a significant assault of an incarcerated individual by another inmate, and multiple suicide attempts. (**Ex. B** (Commission's Worst Offenders Report).) These incidents, almost all of which occurred before 2017, were not promptly or accurately reported, as required by the Commission's Guidelines and regulations.

23. Because of these reporting failures, on May 16, 2017, the Commission issued Directives to the Respondents, pursuant to Correction Law § 46(4) (*see* **Exs. C–D** attached).

24. The Directives stated that the Commission found that the Facilities had "failed to report significant facility incidents as required by the Commission's regulations" and were violating the Commission's regulations relating to the management and affairs of a local correctional facility, including 9 NYCRR §§ 7022.1, 7022.2(b) and 7022.3(a). (Exs. C, D at 1.) The Directives ordered that the Respondents "ensure that all significant facility events and incidents are reported to the Commission of Correction consistent with the Commission's *Reportable Incident Guidelines* . . . and Part 7022 of Title 9 NYCRR." (Exs. C, D at 2.) The Directives further ordered the Respondents to submit to the Commission "documentation substantiating compliance" with the Guidelines and

regulations. (Exs. C, D at 2.) The Directives notified the Respondents that non-compliance "may result in an application by the State Commission of Correction to the Supreme Court of the State of New York for an order directing such compliance." (Ex. C at 2; Ex. D at 3.)

25. On May 26, 2017, the Commission met with the Sheriff's Office to discuss the Directives and promote efforts within the Sheriff's Office to achieve compliance.

26. The Erie County Sheriff's Office responded in writing to the Directives on June 2, 2017. (*See* **Ex. E**.) The Sheriff's Office wrote that "in an effort to satisfy the Commission's concerns with respect to Part 7022," the Office had taken, or would take, certain remedial steps, including scheduling additional training regarding the Commission's reporting requirements for its staff. (Ex. E. at 1.) The Office also stated that "Command Level staff are reviewing all incidents electronically within 24 hours of occurrence in order to ensure accuracy, sufficiency of information, and compliance with the Reportable Incident Guidelines." *Id*.

27. The Commission responded on June 7, 2017 (**Ex. F**), noting that the corrective measures that were planned, or had been taken, were acceptable.

28. But, as further detailed below, Respondents did not comply with the Directives.

29. The Commission is aware of at least eight additional instances in which the Facilities failed to timely or properly submit reports of alleged sexual assault or misconduct to the Commission, either because the reports did not contain complete information or were not promptly submitted as required by the Guidelines and regulations. All but one of these reports were submitted only after inquiries were made by the Commission.

30. Furthermore, the Sheriff's Office recently admitted that the "relevant policy and procedure" did not include "language relevant to the Commissioner's reporting requirements" (*see* **Ex. G** at 1). The Office also admitted that, because sexual abuse allegations were not internally

tracked as part of the "normal incident process," such allegations "would not necessarily generate an internal incident report" (*id*. at 3).

31. These practices are in direct violation to the Commission's regulations requiring procedures for the review, investigation, and assessment of reportable incidents (9 NYCRR §§ 7022.1, 7022.7), the Directives' order for Respondents to comply with Part 22, and New York's zero-tolerance policy on sexual misconduct in state and local correctional facilities (N.Y. Penal Law § 130.05(3)(e)–(f)).

32. Respondent Sheriff, as the person who has custody over the Facilities, and Respondent Erie County, as the body that maintains the Facilities, are responsible for ensuring that the Facilities are in compliance with the Directives.

33. Because of the Respondents' repeated failures to comply with Commission regulations, Guidelines, and Directives, Petitioner respectfully seeks the Court's intervention.

III. Respondents' failure to properly submit a reportable incident report in April 2018

34. In April 2018, the Sherriff's Office did not properly submit Reportable Incident reports for an incident involving assault and sexual offense allegations. The reports were incomplete and omitted important details, as compared with the Sheriff's Office own internal reports.

35. On April 13, 2018, Inmate John Doe was booked at the Erie County Holding Center. During the medical intake, staff noted that because of the inmate's substance abuse history, an "urgent" forensic mental health screening was needed.

36. Later that day, a sergeant saw the inmate concealing something in his hand, which the inmate then placed in his mouth. According to an internal incident report (*see* **Ex. H**), the sergeant ordered the inmate to spit out the item, and when the inmate refused, the sergeant forced

the inmate into handcuffs. The internal report also stated that the sergeant "appl[ied] mandibular pressure" to retrieve contraband from the inmate's mouth and that he was "strip searched in his cell with no further contraband found."

37. On that same day, Erie County Holding Center staff submitted a Reportable Incident form to the Commission, categorizing the incident as one involving contraband. (*See* **Ex. I**.) However, unlike the Sheriff's Office own internal report, the Reportable Incident form sent to the Commission did not mention the strip-search and was thereby not in compliance with the obligation that a facility report all facts "of an important or critical nature," *see* 9 NYCRR § 7022.3(c).

38. On April 16, the inmate told his parole officer he had been sexually assaulted by Holding Center staff on April 13.

39. On April 17, four days after booking, the inmate received a mental health screening by Forensic Mental Health staff at the Erie County Holding Center. The inmate told the staff that he had been sexually assaulted on April 13. The inmate was then sent to the hospital for injuries sustained during the incident. During evaluation for a possible jaw fracture, the inmate told staff at the hospital that he might have been sexually assaulted on April 13. The inmate was discharged after undergoing a SANE (sexual assault nurse examiner) evaluation. That same day, the New York State Department of Corrections and Community Supervision informed the Sheriff's Office that the inmate had reported sexual assault allegations to his parole officer.

40. On April 18, a lieutenant interviewed the inmate. During the interview, the inmate again alleged that he had been sexually assaulted during the April 13 incident. Erie County staff submitted a Reportable Incident form that same day. The Reportable Incident form (**Ex. J**) categorized the April 13 incident as relating to a sexual offense but not as an assault, even though

the incident should have been designated as an assault because it was terminated by the use of mechanical restraints (*see* Ex. H at 3) and resulted in treatment at the hospital (Ex. K at 3). (*See also* Ex. A at 4). The form also did not include any mention of a strip-search, unlike the Sheriff's Office's own internal report, *see* Ex. H at 2, thus omitting facts "of an important or critical nature," *see* 9 NYCRR § 7022.3(c).

41. On April 19, a detective interviewed the inmate. The inmate stated that he had been sexually assaulted and asked to see an attorney. The detective then terminated the interview.

42. On April 30, the inmate sent a letter to the Commission regarding the April 13 incident. The inmate wrote that he had been sexually assaulted and not taken to the hospital for treatment until April 18. The inmate alleged that he had been retaliated against for reporting the sexual assault and that officers were depriving him of his glasses. (*See* **Ex. K**.)

43. On May 4, after receiving the letter, the Commission asked Respondent Sheriff Howard to commence an investigation.

44. The Sheriff's Office responded to the Commission's inquiry with a memorandum from the Office of Professional Standards ("OPS"), dated May 10, 2018. The memorandum stated that the Criminal Investigation Bureau had conducted a criminal investigation and that OPS had conducted an administrative investigation. (*See* **Ex. L** at 1.)

45. The memorandum stated that OPS concurred with the findings of the criminal investigation and had determined in its own administrative investigation that the allegations were "unfounded." *Id*.

46. Upon information and belief, the Erie County Sheriff's Office produced to the Commission its investigative file regarding the aforementioned incidents.

47. Upon information and belief, and based on a review of the files sent to the Commission pursuant to Correction Law §§ 44(4) and 46(1), there is no indication that either the Criminal Investigation Bureau or OPS reviewed surveillance footage, interviewed witnesses, or considered the results of the SANE examination before drawing its conclusions. Upon information and belief, and based on a review of the files sent to the Commission pursuant to Correction Law §§ 44(4) and 46(1), the Sheriff's Office failed to document in a written report all the physical and testimonial evidence considered in its investigation and assessment.

48. OPS also found that no policy violations had occurred, despite the incomplete reports sent to the Commission, as detailed in the paragraphs above. *Id.*

IV. Respondents' untimely submission of Reportable Incident forms

49. Despite the clear orders of the May 2017 Directives, Respondents repeatedly failed to ensure proper reporting to the Commission half a dozen times in 2018, 2019 and 2020. (**Exs. M** to **S.**)

50. On October 20, 2020, a reporter contacted the Commission to inquire as to whether the Erie County Holding Center had reported an incident from June 2020, in which a sergeant had allegedly engaged in sexual conduct with an inmate. The Commission followed up with the Sherriff's Office the next day about the incident.

51. In response to the Commission's inquiries, on October 22, the Sheriff's Office submitted Reportable Incident forms (**Exs. M** and **N**) for alleged sexual misconduct between the sergeant, Sgt. Robert Dee, and two different inmates, Jane Doe 1 and Jane Doe 2.

First allegation regarding Jane Doe 1

52. On June 24, 2020, the Sheriff's Office received a report from an inmate who shared a housing unit with Jane Doe 1. The inmate reported to two deputies that she had seen Jane Doe 1

and Sgt. Dee kissing and groping sometime in April after Sgt. Dee had pulled Jane Doe 1 from the housing area to clean. The inmate also reported that Sgt. Dee would come to the housing unit to see Jane Doe 1 expose herself. The inmate stated that many other inmates observed this behavior.

53. The Sheriff's Office promptly started an investigation that was completed by August 13. Upon information and belief, and based on a review of the files sent to the Commission pursuant to Correction Law §§ 44(4) and 46(1), the Sheriff's Office gathered, among other things, voluntary statements from the inmate who had reported and Jane Doe 1 and internal records showing that Jane Doe 1 had been among those Sgt. Dee took to clean elevators and hallways four times from April 14–21.

54. In a voluntary statement taken after her release from custody, the inmate again repeated her allegations that she had seen Stg. Dee and Jane Doe 1 kiss. The inmate also stated that Jane Doe 1 had admitted to performing a sexual act on Sgt. Dee.

55. In a voluntary statement, Jane Doe 1 denied any sexual involvement with Sgt. Dee.

56. The Sheriff's Office memorialized its findings with a memorandum from the Office of Professional Standards, dated August 13, 2020. *See* **Ex. U**.

57. The memorandum stated that the Criminal Investigation Bureau had conducted a criminal investigation and that OPS had conducted an administrative investigation. *Id*.

58. OPI's memorandum stated that it concurred with the findings of the criminal investigation. The memorandum also stated that OPI had conducted an administrative investigation and determined that the allegations were "unfounded." *Id*.

59. Upon information and belief, the Erie County Sheriff's Office produced to the Commission its investigative file regarding the aforementioned incidents.

60. Upon information and belief, and based on a review of the files sent to the Commission pursuant to Correction Law §§ 44(4) and 46(1), there is no indication that either the Criminal Investigation Bureau or OPS gathered voluntary statements from other witnesses. Upon information and belief, and based on a review of the files sent to the Commission pursuant to Correction Law §§ 44(4) and 46(1), the Sheriff's Office also failed to document in a written report all the physical and testimonial evidence it considered in its investigation and assessment.

61. The OPI memorandum also stated there were no policy violations found even though the allegations of sexual misconduct were not timely reported to the Commission, in contravention to Commission regulations and the May 2017 Directives. *Id*.

Second allegation regarding Jane Doe 2

62. On August 18, 2020, shortly after the close of the investigation regarding Jane Doe 1, the Sheriff's Office received a report from Jane Doe 2 who also alleged that she had sexual encounters with Sgt. Dee. Jane Doe 2 said she and Sgt. Dee would kiss and have other sexual contact when she was confined from October 2019 to November 2019.

63. On August 19, 2020, Jane Doe 2 submitted a voluntary statement describing her allegations further.

64. According to a summary of OPS's administrative investigation, Jane Doe 2 stated that she regretted going along with Sgt. Dee's advances, she felt taken advantage of because she was at a vulnerable time in her life, and she did not want other women to go through what she had experienced. *See* **Ex V** at 3–4. Jane Doe 2 further alleged that she feared seeing Sgt. Dee while she was incarcerated. *Id*.

65. Jane Doe 2 alleged that some of the sexual misconduct occurred when Sgt. Dee escorted her to cleaning tasks. Inmates are paid for their work. Jane Doe 2 alleged that she found

more money than she expected in her account and Sgt. Dee told her the extra money was for "you and me stuff." *Id*. at 3.

66. OPS reviewed work logs and commissary records as part of its administrative investigation. OPS found that Jane Doe 2 received an "unusual amount of trustee pay" for a week in October 2019, but OPS could not confirm Jane Doe 2's allegations with any video evidence as surveillance tapes went back only six months. *Id*. at 4.

67. OPS interviewed Sgt. Dee on September 10 who denied having any inappropriate relations with inmates. *Id*. at 4. OPS closed its administrative investigation that same day.

68. The Sheriff's Office memorialized its findings with a memorandum from the Office of Professional Standards. *See* Ex. V.

69. Despite the seriousness of the allegations, the memorandum stated that there was no criminal investigation conducted "due to time lapse between date of supposed incident and reporting of incident and lack of physical evidence." *Id*. at 1.

70. The memorandum did state that OPS had conducted an administrative investigation and determined that the allegations were "unfounded." *Id*.

71. Upon information and belief, the Erie County Sheriff's Office produced to the Commission its investigative file regarding the aforementioned incidents.

72. Upon information and belief, and based on a review of the files sent to the Commission pursuant to Correction Law §§ 44(4) and 46(1), there is no indication that OPS gathered voluntary statements from other witnesses. And as mentioned above, the Sheriff's Office also failed to conduct a criminal investigation regarding Jane Doe 2's allegations.

73. The OPI memorandum also stated there were no policy violations found even though the allegations of sexual misconduct were not timely reported to the Commission, in contravention to Commission regulations and the May 2017 Directives. *Id*.

74. On information and belief, Sgt. Dee returned to work on September 14 with a restriction that Facility Watch commanders were to avoid assigning Sgt. Dee to any areas where female inmates are housed whenever possible.

V. Respondents continue to submit untimely reports despite a prior "audit"

75. On October 23, 2020, the Sherriff's Office sent a letter to the Commission, acknowledging the "error" in not reporting the sexual misconduct allegations involving Sgt. Dee within the required 24-hour timeframe. (*See* **Ex. G**.) In the letter and its attachment, the Sheriff's Office conceded that the "relevant policy and procedure" did not have any "language relevant to the Commission's reporting requirements" (*id*. at 1) and that sexual abuse allegations were not internally tracked as part of the "normal incident process," (*id*. at 3). The Sheriff's Office further advised the Commission that it was conducting an "audit" (*id*. at 1) to make sure there were no other reporting failures.

76. Presumably pursuant to this audit, the Sheriff's Office submitted another Reportable Incident report to the Commission on October 26. (**Ex. O.**)

77. Between October 26 and November 15, the Sheriff's Office submitted no further incident reports, nor did it inform the Commission that additional reports may be forthcoming pursuant to its purported audit.

78. About three weeks later on November 15, the *Buffalo News* published a story, regarding the Sheriff's Office's failure to timely report sexual misconduct. (**Ex. T.**)

79. The Sheriff's Office then submitted three Reportable Incident forms for sexual misconduct in the next several days after the *Buffalo News* article was printed. (**Exs. P, Q, R**.)

80. In December 2020, the Sheriff's Office submitted another untimely Reportable Incident form. (**Ex. S.**)

81. In January 2021, the *Buffalo News* published redacted memoranda from the Sheriff's Office regarding the allegations untimely submitted to the Commission in December 2020. These memoranda are attached hereto. (**Exs. W** and **X**.)

The Sherriff's Office's most recent untimely submissions

82. On March 15, 2018, OPS received a complaint with respect to four corrections officers: Ronald Dolyk, John Valenti, Randy Chavanne and Matthew Reardon. According to an OPS memorandum, the allegations included having "sexual relations with inmates while on duty, bringing contraband into the facility, and associating, and having contact with, former inmates after their release from jail." (Ex. W at 1.)

83. The Sheriff's Office also received reports on March 15, 2018 that Chavanne and an additional corrections officer, Keith Roberts, also had "inappropriate dealing with inmate [*sic*] in and out of the facility." (Ex. S at 2.)

84. On May 26, 2018, an inmate "confided" to a deputy that "she did not want to be housed at the [Erie County Correctional Facility] because she was involved in a 'on and off' relationship with [corrections officer] John Valenti." (Ex. X at 1.)

85. Even though the allegations made in March and May 2018 involved sexual misconduct between inmates and correction officers who were "on duty," none of these allegations were timely reported "within 24 hours of occurrence of a sex offense or initiation of an internal

and/or criminal investigation into an alleged sex offense," as required by the Commission's Guidelines and regulations. (Ex. A at 6.)

86. According to OPS memoranda, Reardon admitted to contacting a former inmate through social media and text messages. He was issued a letter of reprimand on April 19, 2018 but remained on duty. (Ex. W at 3, 9.)

87. According to OPS memoranda, Dolyk admitted to contacting a former inmate and having a sexual relationship with her. He was suspended for 7 days and returned to work after signing a "last chance agreement." (Ex. W at 2, 7.)

88. According to OPS memoranda, Chavanne denied all allegations of having sexual relations with inmates. The Sheriff's Office found "no evidence to support the allegations" against him and exonerated him. (Ex. W at 2.)

89. According to OPS memoranda, Valenti admitted to contacting a former inmate and attempting to arrange a meeting with her. In OPS' initial investigation in April 2018, he denied going through the meeting. After Sheriff's Office issued a letter of suspension to Valenti, his union representative asked that the suspension be kept "on a need to know basis." (Ex. W at 3, 8.)

90. After initially denying meeting with the former inmate, in a subsequent investigation by OPS, Valenti admitted to having sexual relations with the former inmate in a hotel after her release. Valenti resigned before he could be terminated. (Ex. X at 5, 7.)

91. Upon information and belief, Roberts admitted to sexually suggestive contact with female inmates while they were clothed. He was suspended for 30 calendar days in 2018.

92. As mentioned above, none of these incidents were timely reported.

93. The Sheriff's Office finally submitted a Reportable Incident form regarding these allegations over two years later. (Ex. S.)

94. The Reportable Incident form states that OPS's investigation "found [that] [correction officers] Reardon, Valenti and Dolyk had violated facility policy and [had] exonerated [correction officer] Randy Chavanne." (Ex. S at 2.) The Reported Incident form does not mention whether any investigation concerning Roberts was ever completed by the Sheriff's Office. (*Id.*)

Summary table of late Reportable Incident forms

95. The below table demonstrates the untimeliness of these Reportable Incident forms:

Incident No.	**Date of Discovery**	**Date First Reported to Commission**	**Days Between Discovery and Reporting**
129044 (Ex. M)	Aug. 18, 2020	Oct. 22, 2020	65 days
129042 (Ex. N)	June 24, 2020	Oct. 22, 2020	120 days
129472 (Ex. O)	July 18, 2020	Oct. 26, 2020	100 days
131458, 131577 (Ex. P)	Aug. 25, 2020	Nov. 16, 2020	83 days
131848 (Ex. Q)	Jan. 9, 2019	Nov. 19, 2020	680 days
131843 (Ex. R)	Sept. 6, 2019	Nov. 19, 2020	440 days
134126 (Ex. S)	Mar. 15, 2018	Dec. 10, 2020	***1,001 days***

96. All of the Reportable Incident forms described in the chart above were untimely submitted in contravention to 9 NYCRR § 7022.3, the Guidelines, and the 2017 Directives, which require incidents of sexual misconduct to be reported within 24 hours of discovery of the conduct.

97. To date, Respondents have provided the Commission with documentation demonstrating an internal review by the Sheriff's Office for the incidents involving Inmates John

Doe, Jane Doe 1, and Jane Doe 2. In none of these incidents, did the Office of Professional Standards find that any policy violations occurred, despite the clear statutory and regulatory reporting violations described in this Petition. Upon information and belief, it also appears that the Sheriff's Office did not conduct a proper review, investigation, and assessment of the incidents involving Inmates John Doe, Jane Doe 1, and Jane Doe 2.

REQUESTED RELIEF

98. As submitted above, Respondents Erie County and Sheriff Howard have violated and continue to violate New York State Commission of Correction regulations by failing to "internally review and assess all incidents of a serious or potentially problematic nature and report incidents to the commission pursuant to the requirements of [Part 7022. Reportable Incidents]." *See* 9 NYCRR § 7022.1.

99. Respondents also have failed to timely or properly "report incidents to the commission pursuant to the requirements outlined in the commission's *Reportable Incident Guideline for County Correctional Facilities*," *see* 9 NYCRR § 7022.2(b).

100. Such regulatory violations have continued since and despite the Commission's May 16, 2017 issuance of Directives to the County and Sheriff Howard, which notified them of the violations, recommended remedial action, and directed compliance with the requirements of Part 22.

101. Upon the continued failure to comply with a regulation following the Commission's Directive, Correction Law § 46(4) provides that the Commission may "apply to the supreme court for an order directed to such person requiring compliance with such rule, regulation, or law." Upon application, the court may issue an order "as may be just." *Id*.

102. Considering the Commission's mandate in assuring that the Erie County Holding Center and the Erie County Correctional Facility are safe, stable, and humane correctional

facilities—together with the proceeding's statutory "preference over all other cases, except habeas corpus proceedings," *see* Correction Law § 48—Petitioner respectfully requests that the Court schedule and issue a determination in this matter forthwith and at its earliest convenience.

WHEREFORE, Petitioner respectfully requests that an Order, pursuant to Correction Law § 46(4), be entered that:

1. Enjoins Respondents from violating the Commission's regulations at 9 NYCRR §§ 7022.1, 7022.2, and 7022.3;
2. Directs Respondents to appoint an independent monitor to conduct retrospective audits of the Sheriff's Office serious incident reporting to the Commission on a yearly basis for a five-year cycle, with the first audit to be completed by the end of the calendar year of the Court's Order;
3. Directs Respondent Sherriff's Office to provide the Commission with proof of training to correctional officers regarding (i) New York's zero-tolerance policy regarding sexual misconduct in correctional facilities, (ii) how to handle inmates who report sexual misconduct, and (iii) the Commission's Reportable Incident Guidelines, on a yearly basis, with the first training to be completed by the end of the calendar year of the Court's Order;
4. Directs Respondent Sheriff's Office to provide specialized training for investigators and/or OPS staff regarding investigating sexual abuse in correctional settings, with the first training to be completed by the end of the calendar year of the Court's Order;
5. To comply with 9 NYCRR § 7022.7 by developing and/or revising procedures "for the review, investigation and assessment of reportable incidents," and to work with

the Commission, or any person employed or designated by the Commission, to develop and improve upon such policies and procedures; and

6. For such other and further relief as the Court may deem just and proper under the circumstances.

Dated: Albany, New York
March 15, 2021

ALLEN RILEY
Chairman of the New York State
Commission of Correction
Petitioner

VERIFICATION

STATE OF NEW YORK
CITY OF ALBANY
COUNTY OF ALBANY

Allen Riley, being duly sworn, states that he is the Chairman of the New York State Commission of Correction, the Petitioner in this action, and that he is acquainted with the facts underlying this proceeding; that he has read the Petition herein and understand the contents thereof; that the same is true to my knowledge, and to the matters alleged upon information and believe, I believe those matters to be true.

This verification is made under CPLR 3020(d)(2) by deponent because the petitioner is the State of New York and/or a governmental subdivision of the State of New York and is acquainted with the facts.

Allen Riley
ALLEN RILEY

Sworn to me before this
15th of March, 2021

Deborah Slack-Bean
Notary Public

DEBORAH SLACK-BEAN
Notary Public, State of New York
Qualified in Schenectady County
No. 02SL6071809
Commission Expires 3/25/22

Ex. A

NEW YORK STATE | Commission of Correction

Reportable Incident Manual

for

County Jails

and

The New York City Department of Correction

January 2016

Thomas A. Beilein
Chairman

Phyllis Harrison-Ross, M.D.
Commissioner

Thomas J. Loughren
Commissioner

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Incident Reporting via the eJusticeNY Integrated Justice Portal

As directed more specifically below, all significant correctional facility incidents shall be reported to the Commission of Correction via the eJusticeNY Integrated Justice Portal. Faxed and mailed reports will no longer be accepted. For assistance, online tutorials that demonstrate the process of electronically submitting reportable incidents have been published under the “Tutorials” tab of the Commission’s website (www.scoc.ny.gov).

Provided an incident is reported via the portal, consistent with the requirements of this manual, telephone notification is not required. Nevertheless, should the eJusticeNY Integrated Justice Portal be inaccessible for any reason, a facility must contact the Commission of Correction at (518) 485-2466 to report any incident otherwise required by the revised manual to be reported immediately. Upon re-establishment of portal access, the incident report must then be submitted as normal.

For questions and issues regarding the eJustice NY Integrated Justice Portal, please contact the CCC Center via e-mail (portalhelpdesk@ejusticeny.ny.gov) or telephone (888-462-8003).

GENERAL INCIDENT CATEGORY: *ASSAULT*

DEFINITIONS: *Assault* shall mean an intentional or reckless infliction of physical injury upon another person.

Treatment shall mean any specific medical procedure used for the cure or improvement of a disease, injury or pathological condition (e.g. stitches, medicine, splints, sterile dressings, injections). Examination, evaluation (X-rays, blood tests, etc.) and diagnosis do not constitute treatment.

REPORTABLE INCIDENT CATEGORIES:

01. Inmate/Inmate Assault - the perpetrator of the assault is one inmate and victim of the assault is one or more inmates, or the inmate perpetrator and inmate victim are not clearly distinguishable.

02. Inmate/Personnel Assault - the perpetrator of the assault is one or more inmates and victim is one or more facility personnel.

03. Inmate/Visitor Assault - the perpetrator of the assault is one or more inmates and the victim is one or more visitors.

04. Personnel/Inmate Assault - the perpetrator of the assault is one or more facility personnel and the victim is one or more inmates.

05. Visitor/Inmate Assault - the perpetrator of the assault is one or more visitors and the victim is one or more inmates.

06. Inmate/Inmate Group Assault/Gang Assaults - The perpetrators of the assault are **two or more** inmates and the victim of the assault is one or more inmates.

07. Visitor Assault- an assault on a visitor by one or more personnel, visitors or inmates.

COMMISSION OF CORRECTION REPORTING REQUIREMENTS:

Report submitted to the eJusticeNY Integrated Justice Portal within 24 hours of occurrence or discovery of:

1. any assault requiring treatment to one or more inmates, personnel, or visitors at the facility medical unit, hospital or emergency room following the incident.

2. any assault which was terminated by the use of following:

    a. impact weapons;

    b. mechanical restraints other than for routine inmate movement;

    c. electronic devices;

d. chemical agents;

e. canines;

f. firearms; or

g. medication ordered by a physician, physician's assistant or nurse practitioner as an emergency intervention.

3. any Inmate/Inmate Group Assault/Gang Assault.

GENERAL INCIDENT CATEGORY: *SEX OFFENSE*

DEFINITION: *Sex Offense* shall mean conduct constituting an offense as prescribed by Article 130 of the New York State Penal Law, including, but not limited to, any degree of rape, criminal sexual act, forcible touching, sexual abuse or sexual misconduct.

REPORTABLE INCIDENT CATEGORIES:

01. Inmate/Inmate Sex Offense - both the perpetrator and the victim are inmates.

02. Inmate/Personnel Sex Offense - the perpetrator is an inmate and the victim is an employee, as that term is defined by Penal Law §130.05(3)(f).

03. Inmate/Visitor Sex Offense - the perpetrator is an inmate and the victim is a visitor.

04. Personnel/Inmate Sex Offense - the perpetrator is an employee, as that term is defined by Penal Law §130.05(3)(f), and the victim is an inmate.

05. Visitor/Inmate Sex Offense - the perpetrator is a visitor and the victim is an inmate.

COMMISSION OF CORRECTION REPORTING REQUIREMENTS:

Report submitted to the eJusticeNY Integrated Justice Portal within 24 hours of occurrence of a sex offense or initiation of an internal and/or criminal investigation into an alleged sex offense.

GENERAL INCIDENT CATEGORY: *CONTAGIOUS ILLNESS*

DEFINITION: *Contagious illness* shall mean an infectious illness or disease capable of being transmitted by environmental condition or human contact.

REPORTABLE INCIDENT CATEGORIES:

01. Inmate Contagious Illness - only inmates have contracted the illness.

02. Personnel Contagious Illness - only personnel have contracted the illness.

03. Group Contagious Illness - a significant number of inmates and personnel have contracted an illness as a probable result of being exposed to the ailment (e.g., flu, measles, mumps, hepatitis, meningitis).

COMMISSION OF CORRECTION REPORTING REQUIREMENTS:

Report submitted to the eJusticeNY Integrated Justice Portal within 24 hours of discovery or occurrence of:

1. all physician-confirmed cases of communicable diseases listed in 10 NYCRR section 2.1 and reportable to the NYS Department of Health pursuant to 10 NYCRR section 2.10.

2. any quarantine of a facility or portion of a facility by a physician or local, state or federal department of health or other agency.

3. any removal or relocation of an inmate or staff member for quarantine purposes by a physician or local, state or federal department of health or other agency.

GENERAL INCIDENT CATEGORY: *CONTRABAND*

DEFINITION: *Contraband* shall mean any article or substance, the possession of which would constitute an offense under the New York State Penal Law or that is specifically prohibited by facility regulations.

REPORTABLE INCIDENT CATEGORIES:

01. Inmate-Introduced Contraband - when one or more inmates are found to be in possession of contraband, his/her ownership of it has been confirmed, or he/she attempts to bring it into the facility.

02. Personnel-Introduced Contraband - when one or more personnel provides, or attempts to provide, contraband to one or more inmates.

03. Visitor-Introduced Contraband - when one or more visitors deliberately bring contraband into the facility and provide, or attempt to provide, it to one or more inmates and/or personnel.

04. Unknown Source-Introduced Contraband - when ownership or responsibility for contraband found within the facility cannot be determined or presumed. Following an arrest, an update shall be submitted within 14 days.

05. Arrest of Security Staff/Civilian Staff/Volunteer Staff - when any person of authority within the facility is arrested and charged with violating sections 205.20 or 205.25 of the Penal Law.

COMMISSION OF CORRECTION REPORTING REQUIREMENTS:

Report submitted to the eJusticeNY Integrated Justice Portal within 24 hours of:

1. any discovery of the following contraband introduced by an inmate or visitor after the admission procedure has been completed:

   a. a deadly weapon or dangerous instrument, as defined in Article 10 of the New York State Penal Law;

   b. ammunition;

   c. explosive substances and/or fireworks;

   d. quantity of drugs, legal or illegal, the possession of which would constitute an offense under the Penal Law, or which violates facility policy and procedure;

   e. any quantity of alcohol; or

   f. any other contraband capable of endangering the safety or security of the facility or any person therein.

2. any discovery of contraband introduced by personnel.

3. any discovery of the following contraband introduced by an unknown source:

   a. a deadly weapon or dangerous instrument, as defined in Article 10 of the New York State Penal Law;

   b. ammunition;

   c. explosive substances and/or fireworks;

   d. quantity of drugs, legal or illegal, the possession of which would constitute an offense under the Penal Law, or which violates facility policy and procedure;

   e. any quantity of alcohol; or

   f. any other contraband capable of endangering the safety or security of the facility or any person therein.

GENERAL INCIDENT CATEGORY: *DEATH*

DEFINITION: *Death* shall mean the cessation of a person's life.

REPORTABLE INCIDENT CATEGORIES:

01. Inmate Death - the deceased is an inmate.

02. Personnel Death - the deceased is a facility personnel member.

03. Visitor Death - the deceased is a visitor at the facility.

04. Newborn/Infant Death - the death or stillbirth of a child of an inmate.

COMMISSION OF CORRECTION REPORTING REQUIREMENTS:

Report submitted to the eJusticeNY Integrated Justice Portal (under "Inmate Mortality Reporting" tab) **within six (6) hours of death**, followed by **SCOC Form M-187** (available in the "Forms" tab of the SCOC website at www.scoc.ny.gov), which shall be completed by facility health staff and submitted to the Commission within 10 days of death, for:

1. Any inmate death.

Report submitted to the eJusticeNY Integrated Justice Portal, within 24 hours of:

1. any personnel death;

2. any visitor death, which occurs as a result of an act by one or more inmates or by personnel, while on facility property, or in a temporary SCOC-approved facility, hospital or court detention area; and

3. any stillbirth, or perinatal death, or death of an infant who has been housed with its mother at the facility.

GENERAL INCIDENT CATEGORY*: MAINTENANCE/SERVICE DISRUPTION*

DEFINITION: *Major maintenance/service disruption* shall mean an occurrence which disrupts normal facility operations, or the delivery of inmate services required by Chapter I of of Subtitle AA, Title 9 NYCRR (e.g., medical care, food services), or causes a substantial breakdown in the functioning of essential facility utilities and/or infrastructure. This does not include brief power outages scheduled by utility companies for routine maintenance or repair.

REPORTABLE INCIDENT CATEGORIES:

01. Major Maintenance/Service Disruption

COMMISSION OF CORRECTION REPORTING REQUIREMENTS:

Report submitted to the eJusticeNY Integrated Justice Portal **immediately** following:

1. any major maintenance/service disruption that results in one or more of the following:

   a. physical injury requiring one or more inmates, personnel or visitors to be admitted to a hospital; or

   b. essential services or essential facility utilities or infrastructure interruptions extending beyond 8 hours in duration.

GENERAL INCIDENT CATEGORY*:* ***DISTURBANCE***

DEFINITION:

Major disturbance shall mean an occurrence simultaneously and collectively caused by a group of inmates or other individuals which results in a temporary loss of control of any correctional facility, or portion thereof, by the established authority.

Loss of control shall mean a disruption of routine facility activities and functions causing a lockdown of any part of a correctional facility, the vacating of mandated posts, or the necessity of additional responding staff to quell the disruption.

Minor disturbance shall mean an occurrence, caused by inmates or other individuals acting in concert, which does not result in a loss of control by the established authority, but may threaten the safety, security and good order of a correctional facility (not an assault).

Treatment shall mean any specific medical procedure used for the cure or improvement of a disease, injury or pathological condition (e.g., stitches, medicine, sterile dressings, and splints) examination; diagnosis and evaluation (X-rays, blood test, etc.) do not constitute treatment.

Individual inmate disturbance shall mean an occurrence during which an individual inmate exhibits behavior that disrupts the normal operation of a correctional facility.

REPORTABLE INCIDENT CATEGORIES:

01. Major Disturbance

02. Minor Disturbance

03. Individual Inmate Disturbance

COMMISSION OF CORRECTION REPORTING REQUIREMENTS:

Report submitted to the eJusticeNY Integrated Justice Portal **immediately** following:

1. any major disturbance

Report submitted to the eJusticeNY Integrated Justice Portal, within 24 hours of:

1. Any minor disturbance which results in one or more of the following:

   a. treatment provided to one or more inmates, personnel or visitors at the facility medical unit, hospital or emergency room;

   b. property damage that limits the use of a correctional facility, or portion thereof (must involve the closing of more than one cell);

   c. intervention requiring the use of;

(1) impact weapons;
(2) electronic devices;
(3) chemical agents;
(4) canines;
(5) firearms; or
(6) medication ordered by a physician, physician's assistant or nurse practitioner as an emergency intervention.

2. Any individual inmate disturbance that results in one or more of the following:

a. treatment provided to one or more inmates, personnel or visitors at the facility medical unit, hospital or emergency room; or

b. intervention requiring the use of:

1. impact weapons;
2. mechanical restraints other than for routine inmate movement;
3. electronic devices;
4. chemical agents;
5. canines;
6. firearms; or
7. medication ordered by a physician, physician's assistant or nurse practitioner as an emergency intervention.

GENERAL INCIDENT CATEGORY: ***NATURAL/CIVIL EMERGENCY***

DEFINITION: *Natural or civil emergency* shall mean an occurrence, originating outside the facility, of a serious and urgent nature by natural forces or human action resulting in damage, loss, destruction, or injury that requires immediate attention and poses a direct threat to the safety, security, and good order of the facility (e.g., explosions, weather, bomb threats, gas leaks, aircraft accidents, nuclear accidents, assaults on the facility, fire originating outside the facility proper, etc)

REPORTABLE INCIDENT CATEGORIES:

01. Natural/Civil Emergency

02. A declared county state of emergency

03. Evacuation of any portion of a correctional facility

COMMISSION OF CORRECTION REPORTING REQUIREMENTS:

Report submitted to the eJusticeNY Integrated Justice Portal **immediately** upon:

1. any natural/civil emergency;
2. any declared county state of emergency; or
3. an evacuation of any part of the facility.

GENERAL INCIDENT CATEGORY: *ESCAPE / ABSCONDENCE / ERRONEOUS RELEASE*

DEFINITIONS:

Escape shall mean conduct constituting an offense as prescribed by sections 205.05, 205.10 and 205.15 of the New York State Penal Law.

Attempted escape shall mean conduct constituting an attempt to commit an offense as prescribed by sections 205.05, 205.10 and 205.15 of the New York State Penal Law.

Abscondence shall mean conduct constituting an offense as prescribed by sections 205.16, 205.17, 205.18 and 205.19 of the New York State Penal Law.

Erroneous release shall mean the discharge of an inmate in violation of a lawful securing order or commitment.

REPORTABLE INCIDENT CATEGORIES**:**

01. Escape/County Supervision - the escape of an inmate in the custody of a county sheriff's department or county department of correction personnel.

02. Escape/Other Agency Supervision - the escape of an inmate while under the custody of an agency other than the one to which he/she is committed (e.g., NYS Police, Municipal Police, Parole, Probation, etc.) .

03. Attempted Escape

04. Abscondence

05. Erroneous Release

06. Capture/Return to Custody

COMMISSION OF CORRECTION REPORTING REQUIREMENTS**:**

Report submitted to the eJusticeNY Integrated Justice Portal **immediately** following:

1. any escape.

2. any capture/return to custody following an escape.

Report submitted to the eJusticeNY Integrated Justice Portal, within 24 hours of:

1. any attempted escape.

2. any abscondence.

3. any erroneous release.

4. a capture/return to custody following an abscondence or erroneous release.

GENERAL INCIDENT CATEGORY: ***FIRE***

DEFINITION: *Arson* shall mean the intentional damaging of property by intentionally starting a fire or causing an explosion

REPORTABLE INCIDENT CATEGORIES**:**

01. Arson Fire

02.Non-Arson Fire

03.Unknown Origin

COMMISSION OF CORRECTION REPORTING REQUIREMENTS**:**

Report submitted to the eJusticeNY Integrated Justice Portal **immediately** following:

Any fire occurring within a correctional facility that results in any of the following:

a. treatment provided to one or more inmates, personnel or visitors at the facility medical unit, hospital or emergency room;

b. a portion of the facility is deemed unusable by the appropriate authority;

c. transfer of inmates within the facility; or

d. transfer of inmates to another jail (requires substitute jail order).

GENERAL INCIDENT CATEGORY: ***DISCHARGE OF FIREARM***

DEFINITIONS: *Discharge* shall mean the ballistic expulsion of any projectile from a firearm.

Firearm shall mean any pistol or revolver, a shotgun having one or more barrels, a rifle having one or more barrels, any weapon made from a shotgun or rifle whether through alteration or modification, a machine gun or an assault weapon.

REPORTABLE INCIDENT CATEGORIES:

01. Firearm Discharge

COMMISSION OF CORRECTION REPORTING REQUIREMENTS**:**

Report submitted to the eJusticeNY Integrated Justice Portal **immediately** upon:

1. any firearm discharge occurring while one or more personnel are performing official facility-related duties, except those occurring during practice or qualification procedures; or

2. any other firearm discharge occurring on facility property.

GENERAL INCIDENT CATEGORY: *GROUP ACTION*

DEFINITION**:** *Inmate group action* shall mean a temporary stoppage of established activities by two or more inmates acting in concert, for the purpose of disrupting the operation or good order of the facility or obtaining a change in the operation or services provided by a facility.

Personnel group action shall mean any action or inaction by two or more employees that interferes with, or has the potential to threaten, the routine operation of a correctional facility including, but not limited to, a temporary stoppage or slow-down of established job activities**.**

REPORTABLE INCIDENT CATEGORIES:

01. Inmate Group Action

02. Personnel Group Action

COMMISSION OF CORRECTION REPORTING REQUIREMENTS**:**

Report submitted to the eJusticeNY Integrated Justice Portal, within 24 hours of:

1. any inmate group action

Report submitted to the eJusticeNY Integrated Justice Portal **immediately** upon:

1. a personnel group action that threatens the safety, security and good order of the facility;

2. a personnel group action that results in the facility being unable to maintain minimum staffing levels as determined by the NYS Commission of Correction; or

3. a personnel group action that affects scheduled inmate programs and/or services (rescheduled, cancelled or otherwise modified from routine provision).

GENERAL INCIDENT CATEGORY: ***HOSTAGE SITUATION***

DEFINITION**:** *Hostage situation* shall mean the unlawful abduction or restraint of one or more individuals by another.

REPORTABLE INCIDENT CATEGORIES**:**

01. Hostage Situation

COMMISSION OF CORRECTION REPORTING REQUIREMENTS**:**

Report submitted to the eJusticeNY Integrated Justice Portal **immediately** upon:

Any hostage situation, regardless of duration:

1. which occurs within a correctional facility, an SCOC approved temporary facility, hospital prison ward or court detention cell; or

2. involves an inmate and occurs outside the confines of a correctional facility for any reason, including, but not limited to court, work detail, medical or mental health treatment, transport to another facility, etc.

GENERAL INCIDENT CATEGORY: *PHYSICAL INJURY / HOSPITALIZATION*

DEFINITIONS**:** *Physical injury* or *injury* shall mean an impairment of physical condition or substantial pain.

Attempted suicide shall mean an act during which an individual attempts to terminate one's own life by inflicting life-threatening injury upon oneself, or by placing oneself in a life-threatening situation, (e.g., by hanging, setting oneself on fire, ingesting poisonous chemicals or drugs, inflicting lacerations, etc.).

Self-inflicted injury shall mean an act by which an individual intentionally injures oneself which is not considered life threatening and does not represent a highly lethal attempt to terminate one's life. This shall include a refusal to consume food or fluids for a period of forty eight (48) consecutive hours.

Accidental injury shall mean an injury resulting from an unexpected occurrence with no indication of direct intentional involvement of the victim or any other individual.

Treatment shall mean any specific medical procedure used for the cure or improvement of a disease, injury or pathological condition (e.g. stitches, medicine, splints, sterile dressings, injections). Examination, evaluation (X-rays, blood tests, etc.) and diagnosis **do not** constitute treatment.

REPORTABLE INCIDENT CATEGORIES**:**

01. Inmate Attempted Suicide

02. Inmate Self-Inflicted Injury

03. Inmate Accidental Injury

04. Personnel Accidental Injury

05. Hospital Admission of Inmate

06. Release of Hospitalized Inmate From Custody

COMMISSION OF CORRECTION REPORTING REQUIREMENTS**:**

Report submitted to the eJusticeNY Integrated Justice Portal, within 24 hours of:

1. an attempted suicide by an inmate;

2. any self-inflicted injury requiring an inmate to receive medical treatment;

3. any accidental injury requiring an inmate, employee, volunteer or visitor to be admitted to a hospital or facility medical unit as an inpatient;

4. the custodial release of an inmate, while such inmate is admitted to, or otherwise presented for treatment in, a hospital due to:

    a. the revocation or amendment of a court securing order;

    b. the posting of bail; or

    c. the expiration of a sentence; or

5. the transfer or relocation of an inmate to a hospital, as defined by Article 28 of the Public Health Law, for the residential care, medical management or as an inpatient for a period of 24 hours or longer.

Ex. B

NEW YORK STATE | Commission of Correction

THE WORST OFFENDERS

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

February 2018

Thomas A. Beilein
Chairman

Thomas J. Loughren
Commissioner

Allen Riley
Commissioner

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EXECUTIVE SUMMARY

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

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

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

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

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

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

Findings

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

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

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

RIKERS ISLAND FACILITIES

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

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

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

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

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

FACILITIES OVERVIEW

Anna M. Kross Center (AMKC)
Description: Opened in 1978, AMKC houses male detainees in 78 housing areas spread over 40 acres.
Cells: 984 cells
Dorms: 656 beds
Modular (combination cells and dorms): 936
Total capacity: 2,576
12/1/17 population: 1,991 (unsentenced males)

Eric M. Taylor Center (EMTC)
Description: Opened in 1964 and expanded in 1973, was previously designated the Correctional Institution for Men.
Cells: 136 cells
Dorms: 1,468 beds
Total capacity: 1,604
12/1/17 population: 1,230 (males, predominantly sentenced)

George Motchan Detention Center (GMDC)
Description: Opened in 1971 as the Correctional Institution for Women with a capacity of 679, GMDC later became a male detention center.
Cells: 912 cells
Dorms (Modular): 659 beds
Total capacity: 1,571
12/1/17 population: 634 (males, predominantly unsentenced)

George R. Vierno Center (GRVC)
Description: Opened in 1991 as an 850-bed facility for male detainees. A 500-bed addition opened at GRVC in 1993.
Cells: 853 cells
Dorms: 376 beds
Total capacity: 1,229
12/1/17 population: 687 (unsentenced males)

North Infirmary Command (NIC)
Description: Opened in 1932, NIC consists of two infirmary buildings, one of them the original Rikers Island Hospital. The main facility has 281 beds, 84 cells and 197 beds in dorms. The Annex, converted to housing in mid-1980, has 5 cells and 153 dorm beds for housing infirmary care inmates. A 39-bed dorm was closed by the Commission in December 2016 due to inadequate living conditions.
Cells: 89 cells
Dorms: 350 beds
Total capacity:439
12/1/17 population: 244 (sentenced and unsentenced males)

Otis Bantum Correctional Center (OBCC)
Description: Opened in 1985, OBCC includes the Department's 400-bed Central Punitive Segregation Unit.
Cells: 750 cells
Dorms: 950 beds

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

Rose M. Singer Center (RMSC)
Description: Opened in 1988 as an 800 bed facility for female detainees and sentenced inmates. A 650 bed addition opened at RMSC in 1995 increased capacity to its present level.
Cells: 470 cells
Dorms: 978 beds
Total capacity: 1,448
12/1/17 population: 603 (all females, including minors)

Robert N. Davoren Center (RNDC)
Description: Opened in 1972, formerly Adolescent Reception and Detention Center, RNDC houses adolescent male detainees (ages 16-17) and adult male detainees.
Cells: 1,184 cells
Dorms: 50 beds
Modular (dorms): 700
Total capacity: 1,934
12/1/17 population: 663 (minor males and unsentenced adult males)

West Facility (West)
Description: Opened in 1991, as a 940-bed facility constructed of 12 Sprung-rigid aluminum framed structures covered by a heavy-duty plastic fabric. Part of the West Facility was converted into the DOC's Contagious Disease Unit (CDU) center in which 140 air-controlled housing units are reserved for male and female inmates with contagious diseases, such as tuberculosis. Reduced to 98 operational cells inside the sprungs, the remaining sprungs were converted to Central Intake in 2014, but closed a few months later.
Cells: 98 cells
Total capacity: 98
12/1/17 population: 47 (unsentenced males)

COMMISSION EVALUATIONS OF DOC FACILITIES

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

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

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

2016 INDIVIDUAL FACILITY EVALUATIONS

AMKC – *Report issued 3/7/17*

Part 7003 - Security and Supervision

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

   b. Population counts not immediately forwarded to the Chief Administrative Officer and did not consistently document the time of review.

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

Part 7006 - Discipline

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

Part 7008 - Visitation

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

Part 7009 - Food Service

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

Part 7015 - Sanitation

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

Part 7063 - Chemical Agents

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

EMTC – *Report issued 12/14/16*

Part 7003 - Security and Supervision

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

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

Part 7006 - Discipline

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

Part 7007 – Good Behavior Allowances

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

Part 7015 - Sanitation

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

Part 7063 - Chemical Agents

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

GMDC – *Report issued 10/6/16*

Part 7003 - Security and Supervision

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

Part 7006 - Discipline

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

Part 7007 – Good Behavior Allowances

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

Part 7009 – Food Service

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

Part 7015 - Sanitation

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

Part 7063 - Chemical Agents

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

GRVC – *Report issued 12/14/16*

Part 7003 - Security and Supervision

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

Part 7006 - Discipline

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

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

Part 7008 - Visitation

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

Part 7015 - Sanitation

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

Part 7063 - Chemical Agents

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

NIC – *Report issued 12/14/16*

Part 7003 - Security and Supervision

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

Part 7006 - Discipline

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

Part 7007 - Good Behavior Allowances

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

Part 7015 - Sanitation

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

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

Part 7063 - Chemical Agents

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

OBCC – *Report issued 8/3/16*

Part 7003 - Security and Supervision

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

Part 7006 - Discipline

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

Part 7007 - Good Behavior Allowances

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

Part 7008 - Visitation

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

Part 7015 - Sanitation

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

Part 7063 - Chemical Agents

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

RMSC – *Report issued 9/21/16*

Part 7003 - Security and Supervision

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

Part 7006 - Discipline

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

Part 7007 - Good Behavior Allowances

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

Part 7015 - Sanitation

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

Part 7063 - Chemical Agents

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

RNDC – *Report issued 3/7/17*

Part 7003 - Security and Supervision

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

Part 7006 - Discipline

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

Part 7007 – Good Behavior Allowances

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

Part 7008 - Visitation

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

Part 7009 – Food Service

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

Part 7015 - Sanitation

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

Part 7063 - Chemical Agents

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

WEST – *Report issued 9/27/16*

Part 7003 - Security and Supervision

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

Part 7006 - Discipline

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

Part 7015 - Sanitation

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

Part 7063 - Chemical Agents

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

DOC RESPONSE TO 2016 SCOC EVALUATIONS

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

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

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

2017 INDIVIDUAL FACILITY EVALUATIONS

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

AMKC

Part 7002 - Admissions

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

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

Part 7003 - Key Control

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

Part 7005 - Prisoner Personal Hygiene

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

Part 7024 - Religion

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

Part 7028 – Exercise

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

Part 7031 - Legal Services

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

EMTC

Part 7002 - Admissions

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

Part 7005 - Prisoner Personal Hygiene

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

Part 7025 – Packages
- **Inspection of Incoming Prisoner Packages:** The facility is not providing written notices to the inmates when their package is returned to sender or sensor items sent through the mail.

Part 7028 – Exercise
- **Exercise Area Searches:** Facility was unable to demonstrate the completion of exercise yard searches prior and subsequent to each exercise period.

Part 7031 - Legal Services
- Inmates who do not have direct access to legal reference materials are not being provided a list of available legal reference materials to be able to assist in a proper defense.

GMDC

Part 7002 - Admissions
- **Medical Screening**: The Suicide Prevention Screening Guidelines Form required by NYS standard is not being completed on all inmates admitted to the facility.
- **Facility Rules and Information:** The Department's last updated inmate rulebook was completed in 2007. Reviews and necessary revisions are required on an annual basis.

Part 7003 - Security and Supervision
- **Key Control**: The facility Intake Officer maintained a key that would provide inmates a means of egress out of the facility intake area. This lack of key control could allow inmates access to the unsecured portion of the facility.

Part 7005 - Prisoner Personal Hygiene
- **Inmate Clothing**: Issuing of socks and undergarments is not consistently issued to newly admitted inmates.
- **Laundry and Repair of Clothing:** The facility was only providing laundry services for facility issued uniforms and linens. Inmates are required to wash their personal clothing in buckets with soap and water in their cells and hang them to dry.
- **Bedding:** The inmate's population is not consistently issued pillows. Such failure causes tension among inmates.

Part 7013 – Classification
- **Initial Screening and Risk Assessment**: The Suicide Prevention Screening Guidelines Form required by NYS Minimum Standards is not being completed on all inmates admitted to the facility.

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

Part 7025 – Packages

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

Part 7028 – Exercise

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

Part 7031 - Legal Services

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

GRVC

Part 7002 - Admissions

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

Part 7002 – Security and Supervision

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

Part 7005 - Prisoner Personal Hygiene

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

Part 7024 - Religion

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

Part 7025 – Packages

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

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

Part 7028 – Exercise

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

Part 7031 - Legal Services

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

NIC

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

OBCC

Part 7002 - Admissions

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

Part 7005 – Prisoner Personal Hygiene

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

Part 7024 - Religion

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

Part 7025 – Packages

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

Part 7028 – Exercise

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

RMSC

Part 7002 - Admissions

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

Part 7005 – Prisoner Personal Hygiene

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

Part 7024 - Religion

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

Part 7025 – Packages

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

Part 7028 – Exercise

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

RNDC

Part 7002 - Admissions

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

Part 7005 - Prisoner Personal Hygiene

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

Part 7005 - Sanitation

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

Part 7025 – Packages

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

Part 7028 – Exercise

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

Part 7031 - Legal Services

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

WEST

Part 7002 - Admissions

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

Part 7005 - Prisoner Personal Hygiene

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

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

Part 7024 - Religion

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

Part 7025 – Packages

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

Part 7028 – Exercise

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

Part 7031 - Legal Services

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

DEPARTMENT-WIDE COMPLIANCE ISSUES

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

9 NYCRR Part 7016 - Inmate Commissary

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

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

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

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

9 NYCRR Part 7022 - Reportable Incidents

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

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

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

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

9 NYCRR Part 7039 – Fire Prevention and Safety

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

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

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

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

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

9 NYCRR Part 7040 - Maximum Facility Capacity

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

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

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

COMMISSION-ISSUED DIRECTIVES

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

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

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

Robert N. Davoren Complex (RNDC)

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

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

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

Anna M. Kross Center (AMKC)

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

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

Anna M. Kross Center (AMKC) – Reportable Incidents

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

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

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

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

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

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

REPORTED SIGNIFICANT FACILITY INCIDENTS

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

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

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

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

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

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

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

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

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

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

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

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

INMATE MORTALITY INVESTIGATION FINDINGS

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

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

AMKC

Indidividual 1
DOD: 2013
COD: MEDICAL – OVERDOSE
MOD: ACCIDENT
ISSUES: MEDICAL CARE

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

Individual 2
DOD: 2013
COD: COMPLICATIONS OF DIABETES
MOD: NATURAL
ISSUES: ADMISSIONS AND MEDICAL CARE

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

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

Individual 3
DOD: 2013
COD: DIABETIC KETOACIDOSIS AND SEPSIS
MOD: HOMICIDE
ISSUES: MULTIPLE MEDICAL CARE, SECURITY AND SUPERVISION, AND CIVIL RIGHTS VIOLATION ISSUES

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

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

Individual 4
DOD: 2013
COD: PERFORATED ULCER
MOD: NATURAL
ISSUES: MEDICAL CARE

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

Individual 5
DOD: 2013
COD: SUICIDE
MOD: SUICIDE
ISSUES: SECURITY ISSUES, FAILURE TO FOLLOW POLICY, MEDICAL AND MENTAL HEALTH CARE

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

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

Individual 6
DOD: 2014
COD: ACCIDENT – EXTREME HYPERTHERMIA
MOD: ACCIDENT
ISSUES: MECHANICAL FAILURE OF HEAT REGULATION IN CELL, LEAD TO TERMINAL LIVING CONDITION, FAILURE OF DOC STAFF TO PROPERLY SUPERVISE

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

Individual 7
DOD: 2015
COD: CHRONIC SUBSTANCE ABUSE
MOD: NATURAL
ISSUES: FAILURE TO IDENTIFY FOR DRUG WITHDRAWAL, INADEQUATE FIRST AID AND EMERGENCY RESPONSE

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

GRVC

Individual 8
DOD: 2012
COD: INGESTION OF CAUSTIC CHEMICAL

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

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

NIC

Individual 9
DOD: 2012
COD: HOMICIDE – USE OF FORCE BY OFFICERS
MOD: HOMICIDE
ISSUES: USE OF FORCE. FALSIFIED DOCUMENTATION BY DOC OFFICERS

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

OBCC

Individual 10
DOD: 2013
COD: PERITONITIS DUE TO NECROSIS OF THE STOMACH FROM POSSIBLE INGESTION OF CAUSTIC SUBSTANCE
MOD: NATURAL
ISSUES: FAILURE TO PRODUCE TO MEDICAL AND FOLLOW POLICY

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

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

Individual 11
DOD: 2013
COD: SUICIDE – HANGING
MOD: SUICIDE
ISSUES: SECURITY AND SUPERVISION, POLICY AND PROCEDURE, MENTAL HEALTH CARE

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

Individual 12
DOD: 2014
COD: SEIZURE
MOD: NATURAL
ISSUES: MEDICAL CARE AND SUPERVISION

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

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

RNDC

Individual 13
DOD: 2015
COD: SUICIDE HANGING
MOD: SUICIDE
ISSUES: SUPERVISION AND MENTAL HEALTH CARE

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

SANITATION AND PHYSICAL PLANT CONDITIONS

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

AMKC

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

EMTC

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

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

GMDC

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

GRVC

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

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

NIC

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

OBCC

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

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

RMSC

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

RNDC

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

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

WEST

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

GREENE COUNTY JAIL

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

FACILITY OVERVIEW

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

PHYSICAL PLANT CONDITIONS

2010

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

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

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

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

2013

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

2016

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

FACILITY STAFFING DEFICIENCIES

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

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

VARIANCES AND FACILITY CONSTRUCTION

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

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

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

2016 FACILITY EVALUATION

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

Policies and Procedures

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

Part 7003 - Security and Supervision

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

Correction Law sections 137(6) and 500-k

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

Part 7006 - Discipline

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

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

Part 7008 - Visitation

- **Written Policy:**

a. Last revised in 2011
b. Did not address all required Minimum Standard elements

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

Part 7009 - Food Service

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

Part 7016 - Commissary

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

Part 7030 - Non-Discriminatory Treatment

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

Part 7032 - Grievance Program

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

Correction Law §500-c (Physical Plant)

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

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

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

Part 7041 - Staffing

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

2017 FACILITY EVALUATION

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

Part 7002 – Admissions

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

Part 7005 – Prisoner Personal Hygiene

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

Part 7013 – Classification

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

Part 7016 – Commissary

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

Part 7022 – Reportable Incidents

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

Part 7028 – Exercise

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

Part 7039 – Fire Prevention and Safety

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

COMMISSION-ISSUED DIRECTIVES AND ENFORCEMENT

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

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

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

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

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

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

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

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

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

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

REPORTED SIGNIFICANT FACILITY INCIDENTS

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

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

ERIE COUNTY HOLDING CENTER AND CORRECTIONAL FACILITY

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

FACILITY OVERVIEW

Erie County Holding Center
Description: Opened in 1938, the Erie County Holding Center is a 7-story high-rise facility that houses pre-trial and sentenced inmates in 30 housing areas.
Cells: 528 cells
Dorms: 112 beds
Authorized capacity: 640
12/30/17 population: 347 inmates in-house and 2 inmates boarded out

Erie County Correctional Facility
Description: Opened in 1985, the Erie County Correctional Facility houses pre-trial and sentenced inmates in 42 housing areas.
Cells: 406 cells
Dorms: 388 beds
Total authorized capacity: 794
12/30/17 population: 592 inmates

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

FACILITY STAFFING DEFICIENCIES

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

COMMISSION SPECIAL INVESTIGATIONS

2010 - Escape from Custody
Inmate Brian Collins escaped from the confines of the Erie County Holding Center and gained access to the rooftop of the facility. The escape resulted from the failure of facility management and staff to observe established practices and Minimum Standard regulations. The ECSO

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

2015 - Escape from Custody
Inmate Thomas Walsh escaped from Buffalo City Court while in the custody of the Erie County Sheriff's Office (ECSO). The escape resulted from the failure of ECSO transport officers to supervise Walsh in accordance with Minimum Standard regulations, staff assignment practices, and limitations caused by on-going construction at the Buffalo City Court Building. Actions taken by the ECSO to correct identified deficiencies included revision of policies and procedures, reinforcement of staff expectations, amendment to staff assignment protocols, and enhancement of the department's Field Training Officer Program.

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

INMATE MORTALITY INVESTIGATIONS

ERIE COUNTY HOLDING CENTER

Individual 14
DOD: 2012
COD: SUICIDE - HANGING
MOD: SUICIDE
ISSUES: MEDICAL AND MENTAL HEALTH CARE

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

Individual 15
DOD: 2012
COD: HOMICIDE – TRAUMATIC ASPHYXIA
MOD: HOMICIDE
ISSUES: USE OF FORCE, SUPERVISION, MEDICAL AND MENTAL HEALTH CARE

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

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

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

Individual 16
DOD: 2014
COD: NATURAL – PERFORATED ULCER
MOD: NATURAL
ISSUES: INADEQUATE MEDICAL CARE

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

Individual 17
DOD: 2014
COD: UNKNOWN – AS LISTED
MOD: UNKNOWN
ISSUES: OPEN INVESTIGATION – MULTIPLE MEDICAL MENTAL HEALTH AND MINIMUM STANDARD VIOLATION ISSUES

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

2016 FACILITY EVALUATION

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

Part 7003 - Security and Supervision

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

Part 7006 - Discipline

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

Part 7007 - Good Behavior Allowances

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

Part 7008 - Visitation

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

Part 7009 - Food Services

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

Part 7015 - Sanitation

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

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

Part 7030 - Nondiscriminatory Treatment

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

Part 7032 - Grievance Program

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

Part 7063 - Chemical Agents

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

2017 FACILITY EVALUATION

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

Part 7002 - Admissions

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

Part 7005 – Prisoner Personal Hygiene

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

Part 7013 – Classification

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

Part 7022 – Reportable Incidents

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

Part 7039 – Fire Prevention and Safety

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

COMMISSION-ISSUED DIRECTIVES AND ENFORCEMENT

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

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

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

REPORTED SIGNIFICANT FACILITY INCIDENTS

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

ERIE COUNTY HOLDING CENTER

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

ERIE COUNTY CORRECTIONAL FACILITY

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

DUTCHESS COUNTY JAIL

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

FACILITY OVERVIEW

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

INMATE OVERCROWDING MANAGEMENT

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

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

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

INMATE MORTALITY INVESTIGATIONS

Individual 18
DOD: 2011
COD: SUICIDE
MOD: SUICIDE - HANGING
ISSUES: MEDICAL AND MENTAL HEALTH CARE

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

Individual 19
DOD: 2014
COD: SUICIDE
MOD: SUICIDE (HANGING)
ISSUES: MEDICAL AND MENTAL HEALTH CARE

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

ATTORNEY GENERAL INQUIRY – CORRECTIONAL MEDICAL CARE, INC.

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

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

2016 FACILITY EVALUATION

Part 7070 – Educational Services for Youth

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

2017 FACILITY EVALUATION

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

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

Part 7002 - Admissions

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

Part 7005 - Prisoner Personal Hygiene

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

Part 7008 - Visitation

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

Part 7013 – Classification

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

Part 7016 - Commissary

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

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

Part 7028 - Exercise

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

Part 7031 - Legal Services

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

Part 7039- Fire Prevention and Safety

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

REPORTED SIGNIFICANT FACILITY INCIDENTS

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

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

ONONDAGA COUNTY JUSTICE CENTER AND PENITENTIARY[1]

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

FACILITY OVERVIEW

Onondaga County Justice Center
Description: Opened in 1995, the Onondaga County Jail houses pre-arraigned arrestees and pre-trial and sentenced inmates in 30 housing areas.
Cells: 593 cells
Dorms: 78 beds
Total authorized capacity: 671 beds
12/30/17 population: 537 inmates in-house and 54 inmates boarded out to the Onondaga County Penitentiary.

Onondaga County Penitentiary
Description: Opened in 1983, the Onondaga Penitentiary previously housed only Onondaga County sentenced inmates. In recent years, the facility has also housed unsentenced inmates boarded from the Onondaga County Justice Center. The facility houses inmates in 30 housing areas.
Cells: 190 cells
Dorms: 348 beds
Total authorized capacity: 538 beds
12/30/17 population:

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

FACILITY STAFFING DEFICIENCIES

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

INMATE OVERCROWDING MANAGEMENT

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

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

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

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

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

2016 FACILITY EVALUATION

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

Part 7003 – Security and Supervision

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

Part 7006 – Discipline

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

Part 7032 – Grievance Program

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

2017 FACILITY EVALUATION

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

Part 7002 – Admissions

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

Part 7005 – Prisoner Personal Hygiene

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

Part 7013 – Classification

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

Part 7016 – Commissary

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

Part 7024 – Religion

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

Part 7028 – Exercise

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

Correction Law §611 (Restraint of Pregnant Inmates)

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

CIVIL RIGHTS LITIGATION

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

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

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

COMMISSION-ISSUED DIRECTIVES AND ENFORCEMENT

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

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

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

REPORTED SIGNIFICANT FACILITY INCIDENTS

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

ONONDAGA COUNTY JUSTICE CENTER

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

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

ONONDAGA COUNTY PENITENTIARY

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

Ex. C

IN THE MATTER

OF THE

ERIE COUNTY HOLDING CENTER

Directive Issued by the New York State Commission of Correction Pursuant to Correction Law §46(4)

TO: Timothy B. Howard
Erie County Sheriff
10 Delaware Avenue
Buffalo, New York 14202

Michael A. Siragusa
Erie County Attorney
95 Franklin Street, Room 1634
Buffalo, New York 14202

GREETINGS:

The New York State Commission of Correction, having learned, upon information and belief, that the Erie County Holding Center has failed to report a significant facility incident as required by the Commission's regulations, has determined that the Erie County Holding Center has and is violating the following minimum standard regulations relating to the management and affairs of a local correctional facility:

9 NYCRR §7022.1

In order to provide a mechanism by which facility operations, policies and procedures can be monitored, evaluated and improved, each facility shall internally review and assess all incidents of a serious or potentially problematic nature and report incidents to the commission pursuant to the requirements of this Part.

9 NYCRR §7022.2(b)

Each facility shall report incidents to the commission pursuant to the requirements outlined in the commission's *Reportable Incident Guidelines for County Correctional Facilities.*

9 NYCRR §7022.3(a)

Except in the case of inmate deaths, whenever a reportable incident occurs, each facility shall report such incident to the commission's Albany office, regardless of the time of day or day of the week, pursuant to the following requirements:

(1) all major disturbances, escapes, inmate group actions, personnel group actions, hostage situations, firearm discharges, natural/civil emergencies, and major maintenance/services disruptions shall be reported immediately upon occurrence or discovery, in a form and manner prescribed by the commission, as set forth in the commission's *Reportable Incident Guidelines for County Correctional Facilities*; and

(2) all other reportable incidents shall be reported in a form and manner prescribed by the commission, as set forth in the commission's *Reportable Incident Guidelines for County Correctional Facilities*, within 24 hours of occurrence or discovery.

The Erie County Holding Center, upon information and belief, has and is currently violating the above provisions of the minimum standard regulations relating to the management and affairs of a local correctional facility; in that the Erie County Holding Center failed to report a significant facility incident as required by the Commission's regulations, namely the April 12, 2017 erroneous release of an inmate.

WHEREAS, the State Commission of Correction is an independent body charged by its constitutional and statutory mandates with oversight and regulatory responsibility for all State and local correctional facilities within New York State; and

WHEREAS, pursuant to subdivision (4) of section 46 of the Correction Law, in any case where a minimum standard regulation or statute relating to the management and affairs of a local correctional facility is being or is about to be violated, the State Commission of Correction shall notify the person in control of the facility, recommend remedial action, and direct such person to comply with the statute, rule or regulation; and

WHEREAS, the Erie County Sheriff, upon information and belief, has and is currently violating the above minimum standard regulations relating to the management and affairs of a local correctional facility; it is hereby

RECOMMENDED, that the Erie County Sheriff undertake remedial action at the Erie County Holding Center to ensure that all significant facility events and incidents are reported to the Commission of Correction consistent with the Commission's *Reportable Incident Guidelines for County Correctional Facilities* and Part 7022 of Title 9 NYCRR; and you are further

ORDERED AND DIRECTED to ensure that all significant facility events and incidents are reported to the Commission of Correction consistent with the Commission's *Reportable Incident Guidelines for County Correctional Facilities* and Part 7022 of Title 9 NYCRR; and you are further

ORDERED AND DIRECTED to submit to the State Commission of Correction, by June 6, 2017, documentation substantiating compliance with this **DIRECTIVE**.

PLEASE TAKE NOTICE, that non-compliance with this **DIRECTIVE** may result in an application by the State Commission of Correction to the Supreme Court of the State of New York for an order directing such compliance.

Dated: May 16, 2017
Albany, New York

STATE COMMISSION OF CORRECTION

By: Thomas A. Beilein

Thomas A. Beilein, Chairman

Thomas Loughren

Thomas Loughren, Commissioner

Ex. D

IN THE MATTER

OF THE

ERIE COUNTY CORRECTIONAL FACILITY

Directive Issued by the New York State Commission of Correction Pursuant to Correction Law §46(4)

TO: Timothy B. Howard
Erie County Sheriff
10 Delaware Avenue
Buffalo, New York 14202

Michael A. Siragusa
Erie County Attorney
95 Franklin Street, Room 1634
Buffalo, New York 14202

GREETINGS:

The New York State Commission of Correction, having learned, upon information and belief, that the Erie County Correctional Facility has failed to report significant facility incidents as required by the Commission's regulations, has determined that the Erie County Correctional Facility has and is violating the following minimum standard regulations relating to the management and affairs of a local correctional facility:

9 NYCRR §7022.1

In order to provide a mechanism by which facility operations, policies and procedures can be monitored, evaluated and improved, each facility shall internally review and assess all incidents of a serious or potentially problematic nature and report incidents to the commission pursuant to the requirements of this Part.

9 NYCRR §7022.2(b)

Each facility shall report incidents to the commission pursuant to the requirements outlined in the commission's *Reportable Incident Guidelines for County Correctional Facilities.*

9 NYCRR §7022.3(a)

Except in the case of inmate deaths, whenever a reportable incident occurs, each facility shall report such incident to the commission's Albany office, regardless of the time of day or day of the week, pursuant to the following requirements:

(1) all major disturbances, escapes, inmate group actions, personnel group actions, hostage situations, firearm discharges, natural/civil emergencies, and major maintenance/services disruptions shall be reported immediately upon occurrence or discovery, in a form and manner prescribed by the commission, as set forth in the commission's *Reportable Incident Guidelines for County Correctional Facilities*; and

(2) all other reportable incidents shall be reported in a form and manner prescribed by the commission, as set forth in the commission's *Reportable Incident Guidelines for County Correctional Facilities*, within 24 hours of occurrence or discovery.

The Erie County Correctional Facility, upon information and belief, has and is currently violating the above provisions of the minimum standard regulations relating to the management and affairs of a local correctional facility; in that the Erie County Correctional Facility failed to report significant facility incidents as required by the Commission's regulations, namely inmate attempted suicides on March 23, 2013, April 24, 2013, December 7, 2013 and September 2, 2015, and failed to properly report an incident involving inmate Carl Miller occurring on September 30, 2016.

WHEREAS, the State Commission of Correction is an independent body charged by its constitutional and statutory mandates with oversight and regulatory responsibility for all State and local correctional facilities within New York State; and

WHEREAS, pursuant to subdivision (4) of section 46 of the Correction Law, in any case where a minimum standard regulation or statute relating to the management and affairs of a local correctional facility is being or is about to be violated, the State Commission of Correction shall notify the person in control of the facility, recommend remedial action, and direct such person to comply with the statute, rule or regulation; and

WHEREAS, the Erie County Sheriff, upon information and belief, has and is currently violating the above minimum standard regulations relating to the management and affairs of a local correctional facility; it is hereby

RECOMMENDED, that the Erie County Sheriff undertake remedial action at the Erie County Correctional Facility to ensure that all significant facility events and incidents are reported to the Commission of Correction consistent with the Commission's *Reportable Incident Guidelines for County Correctional Facilities* and Part 7022 of Title 9 NYCRR; and you are further

ORDERED AND DIRECTED to ensure that all significant facility events and incidents are reported to the Commission of Correction consistent with the Commission's *Reportable Incident Guidelines for County Correctional Facilities* and Part 7022 of Title 9 NYCRR; and you are further

ORDERED AND DIRECTED to submit to the State Commission of Correction, by June 6, 2017, documentation substantiating compliance with this **DIRECTIVE**.

PLEASE TAKE NOTICE, that non-compliance with this **DIRECTIVE** may result in an application by the State Commission of Correction to the Supreme Court of the State of New York for an order directing such compliance.

Dated: May 16, 2017
Albany, New York

STATE COMMISSION OF CORRECTION

By: _____
Thomas A. Beilein, Chairman

_____
Thomas Loughren, Commissioner

Ex. E

TIMOTHY B. HOWARD
SHERIFF

MARK N. WIPPERMAN
UNDERSHERIFF

SHERIFF OF ERIE COUNTY

ADMINISTRATIVE OFFICES
TEN DELAWARE AVENUE
BUFFALO, NEW YORK 14202-3913
(716) 858-7618
FAX: (716) 858-7680

POLICE SERVICES
ONE SHERIFF'S DRIVE
ORCHARD PARK, NEW YORK 14127-3700
(716) 662-5554
FAX: (716) 662-8477
WEBSITE: http://www.erie.gov/sheriff

June 2, 2017

Chairman Thomas Beilein
Alfred E. Smith State Office Building
80 South Swan Street, 12th Floor
Albany, New York 12210

RE: Directive Response

Chairman Beilein:

The Erie County Sheriff's Office received two (2) directives from your Agency concerning its perception that the ECSO Jail Management Division was non-compliant with Part 7022 of the NYS Minimum Standards. As you are aware, a meeting was held on 5/26/17 between officials from COC and ECSO in order to discuss the requirements of the directives as well as the circumstances which gave rise to them. We considered this meeting to be very productive; all parties came away with a clear understanding of each entity's position on the matters at hand, as well as a clear understanding of a mutually agreeable path forward.

Sheriff Howard and the entire Jail Management Command Team continue to be committed to full compliance with the Standards, and committed to continuing the collaborative relationship that we have enjoyed with your staff. To that end, in an effort to satisfy the Commission's concerns with respect to Part 7022, and after discussion with COC staff at the aforementioned meeting, ECSO has taken the following actions:

1. Command Level Staff have been fully briefed on the Commission's interpretation of the terms "life threatening injury" and "life threatening situation," and have been advised that the intent of the inmate should not factor into how an incident is categorized;

2. Command Level Staff are reviewing all incidents electronically within 24 hours of occurrence in order to ensure accuracy, sufficiency of information, and compliance with the Reportable Incident Guidelines;

3. Line-Up Training has been scheduled for facility Watch Commanders regarding the above, with additional training for First-Line Supervision (who serve as our report writers) to be scheduled immediately thereafter;

4. In instances where medical and/or mental health determinations determine the categorization of an incident, sufficient information justifying the decision will be provided to COC.

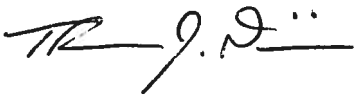
Based on our discussion, the four items listed above will satisfy the actions required by the directives. As a result of the untenable situation created by a third-party bail guarantor, the ECSO has suspended acceptance of bail payments from that company until such time that we are satisfied that sufficient safeguards and procedures are in place on their end. We want to ensure that no county jail in the State of New York will ever again be placed in a situation such as the one which occurred on 4/12/2017.

In conclusion, the ECSO maintains that the incidents in question were documented and reported correctly, and were based upon: 1) our reasonable interpretation of the Reportable Incident Guidelines; 2) input from Medical and Forensic Mental Health leadership; and 3) a review of the totality of the circumstances surrounding the incident. However, it is in no one's best interest to prolong a dialogue on the directives. That would detract from the continued progress and improvement that the ECSO has made within the Jail Management Division with respect to staffing, training, inmate rehabilitative programs, technology, and infrastructure improvements.

Sheriff Howard and I both feel that a speedy and mutually agreeable resolution to your concerns is what is best for all. We will continue to work with your staff to ensure that this takes place.

Please feel free to call if you have any questions, or if you require further remedial action on our part to satisfy your concerns.

Sincerely,



Thomas Diina
Superintendent

cc: Hon. Timothy B. Howard, Sheriff
Undersheriff Mark Wipperman

Ex. F

NEW YORK STATE | Commission of Correction

THOMAS A. BEILEIN
Chairman

THOMAS J. LOUGHREN
Commissioner

June 7, 2017

Sheriff Timothy B. Howard
Erie County Sheriff's Office
10 Delaware Avenue
Buffalo, New York 14202

Re: Response to SCOC Directives

Dear Sheriff Howard:

The Commission is in receipt of Superintendent Diina's response to the two Directives issued to the Erie County Sheriff's Office on May 16, 2017. Both Directives outlined areas of non-compliance with 9 NYCRR Part 7022 at the Erie County Holding Center and Erie County Correctional Facility, and ordered corrective action to be taken.

In response to noted violations of 9 NYCRR §7022.1, §7022.2(b), and §7022.3(a), Superintendent Diina offered the following actions that have been or will be taken:

1. Command level staff have been fully briefed on the Commission's interpretation of the terms 'life threatening injury' and 'life threatening situation', and have been advised that the intent of the inmate should not factor into how an incident is categorized;

2. Command level staff are reviewing all incidents electronically within 24 hours of occurrence in order to ensure accuracy, sufficiency of information, and compliance with the Reportable Incident Guidelines;

3. Line-up training has been scheduled for facility Watch Commanders regarding the above, with additional training for First-Line Supervision (who serve as our report writers) to be scheduled immediately thereafter;

4. In instances where medical and/or mental health staff determinations determine the categorization of an incident, sufficient information, sufficient information justifying the decision will be provided to SCOC.

The Commission finds Superintendent Diina's corrective measures to be acceptable. On-site verification by Commission staff will occur during future visits.

Sincerely,

Thomas A. Beilein
Chairman

cc: Superintendent Thomas Diina

Ex. G

TIMOTHY B. HOWARD
SHERIFF

JOHN W. GREENAN
UNDERSHERIFF

SHERIFF OF ERIE COUNTY

ADMINISTRATIVE OFFICES
10 DELAWARE AVENUE
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POLICE SERVICES
48 ELM STREET
BUFFALO, NEW YORK 14203
(716) 858-7618
FAX: (716)858-3277
WEBSITE: http://www.erie.gov/sheriff

October 23, 2020

Chairman Allen Riley
Alfred E. Smith State Office Building
80 South Swan Street, 12th Floor
Albany, New York 12210

RE: Alleged Incident at the Erie County Holding Center

Dear Chairman Riley:

Be advised that that all documentation responsive to your October 21, 2020 letter has been transmitted electronically along with this response. Video relevant to this investigation was too large to send electronically, so a thumb-drive containing same has been sent via U.S. Mail.

We fully acknowledge our error in not reporting within twenty-four (24) hours the commencement of an investigation into allegations concerning staff sexual misconduct with an inmate. A Reportable Incident on this investigation was submitted to the Commission yesterday, October 22nd (RI #129042). While investigating this error, I discovered an additional investigation that commenced into a similar allegation that came to light on August 18, 2020 that also went unreported. Director Moran was contacted immediately, and a reportable incident was submitted (RI #129044). All information relevant to this second incident is being submitted electronically and thumb-drive via U.S. Mail. Please note that in both cases, our investigation determined the allegations to be unfounded and the accused staff member was exonerated.

As a result of these errors, a directive was issued by me to all Jail Management Division Command Staff to reduce the risk of this mistake occurring again. A copy has been attached to this letter, and submitted along with the rest of the material you requested. We are also reviewing relevant policy and procedure with the intent to add language relevant to the Commission's reporting requirements. Additionally, Director Moran and I confirmed that appropriate safeguards were in place within the reporting e-JusticeNY Integrated Justice Portal system to ensure that the integrity of any internal or criminal investigation is not compromised. Finally, an audit of all incidents of sexual misconduct allegations is taking place to ensure that there are no other occurrences of failure to report. I assure you that the ECSO Jail Management Division takes such allegations seriously along with our obligation to report required information to the Commission of Correction.

Please let me know if you have any further questions or require any additional information or documentation.

Sincerely,

Thomas Diina
Superintendent

Cc: Sheriff Timothy B. Howard
Undersheriff Mark Wipperman

ERIE COUNTY SHERIFF'S OFFICE

MEMORANDUM

TO: All JMD Command Staff

FROM: Superintendent Thomas Diina

DATE: October 22, 2020

RE: Reportable Incidents Order

The NYS COC Reportable Incident Guidelines require notification within twenty-four(24) hours for the following categories that may not arise through our normal incident process:

Sex Offense (02):
Notification within 24 hours of occurrence or initiation of an internal and/or criminal investigation into an alleged sex offense.

Contraband (04):
Notification within 24 hours when any person of authority (security, civilian, or volunteer staff) is arrested and charged with violating sections 205.20 or 205.25 of the Penal Law.

Natural/Civil Emergency (08)
Notification within 24 hours for all natural/civil emergencies and all declared county state of emergencies.

Discharge of Firearm (11)
Notification within 24 hours of any firearm discharge that occurs on facility property.

Any of the above categories could involve circumstances that outside of normal operations, and as such would not necessarily generate an internal incident report (i.e. a sexual abuse allegation). Any time that occurs, it is imperative that Command Staff ensure that the reportable incident guidelines are met. In circumstances where a criminal and/or administrative investigation is initiated, it may become necessary for

Command Staff to personally submit the reportable incident so as to not compromise that investigation.

Be reminded that there is no margin for error with respect to any reportable incidents and that we are under a COC directive to report incidents appropriately and timely. **It is an essential function of all JMD Command Staff duties to be 100% fluent in all local, state, and federal regulations governing our facilities and operations.**

Thomas J. Dlina
Superintendent

Cc: Sheriff Timothy Howard
Undersheriff John Greenan

Ex. H

ERIE COUNTY SHERIFF'S OFFICE
JAIL MANAGEMENT DIVISION
INCIDENT REPORT

INC #: 18 - 202
CL#: 028-758

Incident: Inmate-Introduced Contraband*

INCIDENT

Incident Code:	Date of Incident:	Time of Incident:	Inmates Involved:	PREA Incident:	Force Used:	Inmate Mental Health Issue?
0 4 0 1	4/13/2018	19:30	0 1	No	Yes	[redacted]

Facility Name:	ORI#:	Facility Code:	Facility Class:
Erie County Holding Center	N Y 0 1 4 0 2 3 C	1 4 0 3	0 4

Location Code:	Specific Incident Location:
I N	Bravo Long Low-Side

INMATE(S) INVOLVED

[redacted]

INCIDENT DISCOVERED BY

Discovered By:	Date Discovered:	Time Discovered:
Sgt. Christopher Slimak	4/13/2018	19:35

RESPONDING SUPERVISOR

Title:	Last Name:	First Name:	Badge No:	Telephone:
Sgt.	Smaczniak	Jason	S-73	7 1 6 - 8 5 8 7 0 1 5 X X X X X

S-73
SIGNATURE OF RESPONDING SUPERVISOR

Time Called:	Time Responded:
7:35:00 PM	7:36:00 PM

INJURIES

Injuries to Staff: ☐ **Injuries to Inmates:** ☐ **Injuries to Others:** ☐

ACTION TAKEN

- ☑ Use of Force Form filed
- ☑ NYS-COC - 011 Report form
- ☐ C-2 Injury Report filed
- ☐ Exposure Incident Report filed
- ☐ Liability waivers filed
- ☐ QET Team used
- ☐ Video taken
- ☐ Housing referrals made
- ☑ Medical EvaluationINFIRMARY
- ☐ Medical Evaluation HOSPITAL
- ☐ OC SPRAY Deployed
- ☐ Decontamination BLOOD/B.F.
- Pictures taken #: 12
- ☐ Housing Area Evacuated
- ☑ Admin. Segregation ordered
- ☐ Keep Away orders issued
- ☑ Disciplinary charges filed
- ☑ Criminal charges filed
- ☐ Interview of VICTIM (S)
- ☐ Interview of SUSPECT (S)
- ☐ Interview of WITNESS (S)
- ☑ Evidence collected
- ☐ H.A. K/L pending Invest.
- ☐ Other (see Narrative)

FOLLOW-UP / REVIEW

Lt. D Fanandez Intered

Patrol Services Notified ☑
Deputy: Dispatch
Date: 04/13/2018 Time: 20:30
Investigative Services Notified ☐
Detective:
Date: Time:

Watch Commander's Review: [signature] Date: 4/13/2018
Second Review: [signature] Date: 4/16/18
Superintendent's Review: [signature] Date: 4/17/18

rptInmateData1

PERSON'S INVOLVED

Person 01 Information

Last Name: [redacted] First Name: [redacted] MI: Housed in: [redacted]

Street Address: [redacted] C/T/V: [redacted] State: [redacted] Postal Code: [redacted]

Inmate #: [redacted] NYSID #: [redacted] Date of Birth: [redacted] Age: [redacted]

Sex: [redacted] Race: [redacted] Eth. Org.: [redacted] Date of Admission: 04 13 18 Status Code: AUXX Med Code: F Role: P

Charge: Parole

Law: P V Section: SubDivision: Attempt: Category: Bail: 0.00

Instrument Code: NA Type of Force Used : MRBHXX Other:

Did inmate have any PRIOR KNOWN HISTORY of: check all that apply)

- ☐ Mental Health Treatment
- ☐ Physical handicap
- ☐ Sex Offenses
- ☒ Disciplinary Problems [redacted]
- ☐ Victimization
- ☐ Escape
- ☐ Assaultive Behavior
- ☐ Attempted Escape
- ☐ Suicide Attempts
- ☐ Self-injury
- ☐ Arson

Administrative action taken: Yes ☑ No ☐ If yes, check all that apply

- ☑ Administrative Segregation
- ☐ Constant Supervision [redacted]
- ☐ Transfer to General Housing unit
- ☐ Transfer to Another Facility
- ☐ Other
- ☐ Restraint Chair [redacted]
- ☐ Stun Device
- ☐ Impact Weapon
- ☐ Chemical Agent
- ☐ Medical Restraint
- ☐ Suicide Smock
- Taken To Emergency Room:

rptStaffData1

STAFF INVOLVED

Title:	Last Name:	First Name:	MI:	Sex:	Med:
Dep	Irwin	Robert		M	N
Sgt	Slimak	Christopher		M	N

Summary:

On 13 Apr 2018, at approximately 19:35 hours, I responded to Bravo Long to a call via radio of escorts needed on Bravo long. Upon arrival I witnessed [redacted] Inmate [redacted] lying facedown on his bunk. Sgt. Slimak was standing next to Inmate [redacted] and applying mandibular pressure to the right side of Inmate [redacted]'s jaw while ordering him to spit out the item he had in his mouth. Inmate [redacted] then spit several plastic bags onto his bunk. Sgt. Slimak took control of the suspected contraband and secured the items in evidence locker #4. Inmate [redacted] was strip searched in his cell with no further contraband found. Inmate [redacted] was then escorted to the Infirmary for evaluation by medical who noted that Inmate [redacted] had no injuries, his vitals were stable, and he could return to his housing unit. Sgt. Slimak states that while he was waiting for elevator #5 on Bravo Level, he heard a commotion in the low-side shower area. Sgt. Slimak approached the area and witnessed Inmate [redacted] with his hands in the buttocks area of his pants. Sgt. Slimak then ordered Inmate [redacted] to step up to the sallyport gate and show him his hands. Inmate [redacted] then turned and walked toward his cell with something concealed in his hand. Sgt. Slimak then ordered Dep. Robert Irwin to lock the low-side of his housing unit in and open the sallyport gates. Sgt. Slimak entered the Bravo Long housing area and witnessed Inmate [redacted] place the item in his mouth. Sgt. Slimak ordered Inmate [redacted] to spit the item out and Inmate [redacted]

refused. Sgt. Slimak guided Inmate [redacted] onto his bunk by applying pressure to his right arm and applied handcuffs. Sgt. Slimak then again ordered Inmate [redacted] to spit the item out of his mouth. Inmate [redacted] refused to comply. Sgt. Slimak then applied mandibular pressure with his right index and middle finger to Inmate [redacted]'s right jaw and ordered him to spit the item out of his mouth. Inmate [redacted] then spit the item out of his mouth onto the bunk. Dep. Robert Irwin states that while he was standing at the Bravo Long high-side sallyport gate with nurse for medication pass, Sgt. Slimak walked up to his low-side gate and ordered him to lock his low-side in and open the sallyport gates. Dep. Irwin further states that Sgt. Slimak then entered his housing unit and ordered him to call for escorts to respond via his radio. Dep. Irwin called for escorts via his radio and myself and response arrived on the housing unit. Inmate [redacted] was reasssigned to cell #15 per classification. Thorough search conducted on housing unit for any other contraband with none found. Administrative segregation order was issued. Criminal and disciplinary charges pending. Patrol services contacted for criminal charges and collection of evidence. CL#18 028-758

Ex. I

SCOC Reportable Incident

Incident # 45486

Facility Incident Number	ORI	Agency Name	Agency Type
18-202	NY014023C	Erie County Jail	County Jail
Date/Time Reported	**Date/Time of Incident**	**Location of Incident**	**Specific Location**
April 13, 2018 10:36 PM	April 13, 2018 7:35 PM	Multiple Occupancy Housing Unit	[redacted]

Incident Category Per Manual

Incident Category	Incident SubCategory
Contraband	Inmate-Introduced Contraband

Staff Involved

Rank	Name	Sex	Shield/ID
Sergeant	Slimak , Christopher	Male	S79
Sergeant	Smaczniak , Jason	Male	S73

Inmate Information for #5742

NYSID	Name	Sex	Birth Date
[redacted]	[redacted]	[redacted]	[redacted]
Race/Ethnicity	**Admission Date**	**Commitment Type**	**Most Serious Charge**
[redacted]	April 13, 2018	[redacted]	[redacted]
Inmate Classification	**Role in Incident**	**Was Inmate boarded in ?**	**Transferred Out**
[redacted]	Instigator	No	No

Inmate PRIOR KNOWN History

Discipline
[redacted]

Staff Action In RESPONSE TO THE INCIDENT

Administartive Segregation Initiated
Criminal Action Initiated
Disciplinary Action Initiated
Medical/Mental Health Evaluation On Site
[redacted]

Additional Notes

On 13 Apr 2018, at approximately 19:35 hours, [redacted] Inmate [redacted] was attempting to conceal contraband in his mouth while on his housing unit. Sgt. Christopher Slimak entered the housing unit and ordered Inmate [redacted] to spit the items out of his mouth. Inmate [redacted] refused to comply. Sgt. Slimak guided Inmate [redacted] onto his bunk by applying pressure to his right arm and applied handcuffs. Inmate [redacted] again refused multiple orders to spit the items out of his mouth. Sgt. Slimak then applied mandibular pressure to the right side of Inmate [redacted]s jaw and ordered him to spit the items out and Inmate [redacted] complied. The items were several baggies containing several orange pills, orange powder, several blue pills and blue powder believed to be narcotics. The items were placed in evidence locker #4 at the Erie County Holding Center. Inmate [redacted] was escorted to the infirmary for evaluation by medical who noted no injuries, that he was stable, and that he could be returned to his housing unit.

Ex. J

New York State Commission of Correction
AE Smith Building, 12th Floor
80 South Swan Street
Albany, NY 12210
Attn: RI

(518) 485-2466 24 Hr On Call
(518) 485-2467 Fax Machine

Reportable Incident Form

Reporting Agency: Erie CJ | Agency ORI: NY014013C | Date Reported: 4/18/2018 | Time Reported: 12:46 PM

Incident Category Per Manual: Sexual Offense | Incident Subcategory: Inmate/Personnel

Location of Incident: Bravo Long | Date of Incident: 4/13/2018 | Time of Incident: 5:00 PM

Agency Contact Information

Title: Sgt | Last Name: Lodestro | First Name: Anthony

Agency Contact Person: Watch Commander | Agency Contact Number: 716-858-7015

SCOC-011 1/2014

Inmate Information

Last Name [redacted] First Name [redacted] Middle Initial

Inmate Facility Number [redacted] NYSID Number [redacted] Date of Birth [redacted]

Race Sex Date of Admission 4/13/1970

Charge [redacted] Category [redacted]

Facility Classification Category [redacted] Role in Incident Undetermined

Was Inmate boarded In? No If so, from where

Staff action taken in response to the incident: (Check all that apply)

☐ Transfer to Another General Housing Unit ☑ Administrative Segregation Initiate ☐ Constant Supervision Initiate ☑ Medical Evaluation On Site

☐ Mental Health Referral ☐ Transfer to Another Facility ☐ Use of Suicide Smock ☐ RestraintChair ☐ Stun Device

☐ Impact Weapon ☐ Chemical Agent ☐ Medicinal Restraint ☑ Taken to Emergency Room Treated and Released

Did Inmate have any PRIOR KNOWN HISTORY of: (Check all that apply)

[redacted] ☐ Gang Affiliation ☐ Self-Injury ☐ Suicide Attempts ☐ Attempted Escape ☐ Physical Handicap

☐ Sex Offenses ☑ Discipline Problems ☐ Victimization ☐ Escape ☐ Arson ☐ Assaultive Behavior [redacted]

[redacted]

Staff Information

Rank	Last Name	First Name	Middle Initial	Sex	Medical Treatment
Lt	Lodestro	Anthony		M	N

Incident Narrative

On April 17th, 2018 at approximately 1630 hours, First Deputy Superintendent John Rodriguez received a phone call from Chief Tom Degal of the Department of Corrections, that Inmate [redacted] had informed his Parole Officer, [redacted] that he had been sexually assaulted by Holding Center staff on Friday April 13th 2018. Inmate [redacted] was interviewed by Lt. Anthony Lodestro on 4/17/18 at approximately 2200 hours, while at ECMC waiting for an evaluation of his jaw.

[redacted] was evaluated at Erie County Medical Center following Lt. Lodestro's interview by an ECMC Certified Sexual Assault Nurse Examiner. SANE examiner stated that [redacted] claimed the assault happened Friday April 13, 2018 at approximately 1500 hours.

Inmate [redacted] was admitted into the ECHC on Friday April 13, 2018 at 1335 hours. At 1935 hours, Inmate [redacted] was involved in an incident documented in JMD Incident 18-202, Patrol Services under CL#18-028758, and under NYSCOC RI-45486. The reported summary of that incident is as follows:

"On 13 Apr 2018, at approximately 19:35 hours, [redacted] Inmate [redacted] was attempting to conceal contraband in his mouth while on his housing unit. Sgt. Christopher Slimak entered the housing unit and ordered Inmate [redacted] to spit the items out of his mouth. Inmate [redacted] refused to comply. Sgt. Slimak guided Inmate [redacted] onto his bunk by applying pressure to his right arm and applied handcuffs. Inmate [redacted] again refused multiple orders to spit the items out of his mouth. Sgt. Slimak then applied mandibular pressure to the right side of Inmate [redacted] s jaw and ordered him to spit the items out and Inmate [redacted] complied. The items were several baggies containing several orange pills, orange powder, several blue pills and blue powder believed to be narcotics. The items were placed in evidence locker #4 at the Erie County Holding Center. Inmate [redacted] was escorted to the Infirmary for evaluation by medical who noted no injuries, that he was stable, and that he could be returned to his housing unit."

All members of the Sexual Abuse Response Team have been notified and PSD #18-026 has been assigned to this case. Inmate [redacted] is currently being housed at the ECHC in [redacted].

SCOC-011 1/2014

Ex. K

NEW YORK STATE | Commission of Correction

ALLEN RILEY
Chairman

THOMAS J. LOUGHREN
Commissioner

May 4, 2018

Timothy Howard, Sheriff
Erie County Sheriff's Department
10 Delaware Avenue
Buffalo, New York 14202

Re: Complaint # 92162

Dear Sheriff Howard:

Enclosed please find a copy of a correspondence received at the Commission from Mr. [redacted] Mr. [redacted] makes allegations in his complaint letter that he was physically assaulted and sexually abused by a staff member which he is claiming to have occurred at the Erie County Holding Center. Mr. [redacted] also wrote that he constantly fears for his safety.

It is requested that an investigation be made of this complaint and the Commission be apprised of your findings by July 10, 2018. If an investigation has already been completed, please advise the Commission of your findings.

Thank you for your cooperation in this matter.

Sincerely,

Terrence W. Moran
Director of Operations

cc: Deborah Clark, Supervisor
Christopher Ost, Supervisor
Enclosed

1.

MAY 04 2018

m.c. to C.

RECEIVED
Executive Director
NYS COC

[redacted]

4-30-18

Re: Sexual Assault - Misconduct

Sir(s);

Please be Advised and TAKE NOTICE THAT I am The Above Named At said facility. ON 4-13-18 I was ASSAULTED by inmates. ~~and~~ Sexually and Physically ASSAULTED by Erie County Sheriffs deputy Sgt. Christopher Slimak, as he did insert an object or objects into my rectum. He kept jamming is fingers into my mouth and down my Throat.

He kept Telling me To Spread my ASShole open for him", but I wouldent. He kept shoving something up into my rectum inside my Anus. I did suffer bleeding from The rectum after That.

I also Suffered head Trauma AS I have Significant memory loss AS TO days After ~~This~~ These events. He did Smash me in The mouth Several Times breaking TEETH and dental work That was Cemented in Since 2005.

I was brought in on 4-13-18, [redacted] I was PUT on A unit with Drugs and gang members. They Thought They Knew me And I was ASSAULTED By Two inmates on B Unit on Said date.

As the record reflects, I have a past history with deputies and personnel at the Erie County holding center. I've been assaulted physically in the past here.

This is the first sexual assault I've ever experienced at this facility. [redacted] I was given 190 days keeplock without due process as all of this is a form of retaliation for numerous complaints made against this facility and specific personnel.

I am and was defrived of medical treatment after said assault. I was not taken to the hospital until 4-18-2018.

I have acute and chronic medical conditions that continue to go untreated and am defrived of my medications to manage my conditions.

I am deprived of access to medical and mental health care as my conditions are legitimate.

Please see Corr. Law 137, as I am in Daccs custody held here in this facility. Please advise.

Thank you for your time and consideration in this matter. I am in danger at this facility.

Respectfully Submitted,

[redacted]

c/c: file

2.

This letter is to inform You of The Continuing reprisal and misconduct AS I was sexually assaulted by The aforementioned.

He did kiss my head, while choking me and Putting objects in to my anus for extended Periods of time.

I Lost ~~consciousness~~ Conscienceness and was denied any medical attention for this until 4-18-18. 4-13-18 was the date of incident.

I Now have acute injuries related to this That are maliciously and intentionally Neglicted.

[redacted] I am held in The shu with nothing - no medical care for 190 days. [redacted] I am not receiving Adequate meds or care in any Respect.

I do not want to go back to what drove me to break at the bend like last time.

This is serious and I constantly fear for my safety at this facility.

Please advise and explain. Why these People here can get away with this and do whatever they want to me.

This is a moral outRage and disgusting. I have more details of the Gruesome events That Transpired on 11-13-18.

I am deprived of my Glasses so I cant read or write properly and Suffer continual Psychological Trauma.

I absolutely need help here as These Conditions Jeopardize my overall Health and well being.

Please Respond At your earliest Convenience. Thank You for your time And consideration in this matter

Respectfully Submitted,

[redacted]

c/c: file

Ex. L

ERIE COUNTY SHERIFF'S OFFICE

MEMORANDUM

TO: Sexual Abuse Coordinator

FROM: Undersheriff Mark N. Wipperman

DATE: 5/10/18

SUBJECT: PSD Case # 18 - 26 ALLEGATION OF SEXUAL ABUSE [redacted]

The Office of Professional Standards has reviewed the investigation conducted by the Criminal Investigation Bureau and:

☒ Concurs with the findings of the Criminal Investigation.

☐ Has returned the file to the Criminal Investigation Bureau for further investigation:

NOTES: _____

The Office of Professional standards has conducted an administrative investigation into this matter and has determined the allegations to be:

☒ UNFOUNDED ☐ SUBSTANTIATED ☐ INCONCLUSIVE

The Office of Professional standards has conducted an administrative investigation into that matter and has determined that the following policy violations have occurred:

☒ NO VIOLATIONS FOUND

☐ VIOLATIONS FOUND:

Policy violated	Responsible Party	Status

The Office of Professional Standards makes the following administrative recommendations:

Ok to close
no Evidence

PSD Confidential Case Report is ☐ ATTACHED ☐ NOT ATTACHED

Signature: V/S Mk Wipperman

Ex. M

New York State Commission of Correction

Reportable Incident

Incident # : 129044
Agency Name : Erie County Jail
Agency Type : County Jail
Date/Time of Incident : 08/18/2020 16:57
Date/Time Reported : 10/22/2020 12:29
Location of Incident : Other
Specific Location : ECHC
Status : New

Incident Category(s)

Sex Offense

Inmate/Personnel Sexual Offense

Staff(s) Involved

Staff Info # 1

Rank Sergeant
Name : Dee , Robert
Sex : Male

Staff Info # 2

Rank Chief
Name : Harris , Alphonso
Sex : Male

Staff Info # 3

Rank Chief
Name : Hartman , Jeffery
Sex : Male

Inmate Information # 1

Name : [redacted]
Date Of Birth : [redacted]
NYSID : [redacted]
Sex : Female
Race : [redacted]
Ethnicity : [redacted]
Role in Incident : Undetermined
Commitment Type : Criminal Commitment
Date of Admission in Facility : 01/28/2020

Most Serious Charge : [redacted]

Inmate ID : [redacted]

Inmate Classification : Level 1

Was Inmate boarded in ? : No

Inmate Prior Known History

Discipline

[redacted]

Staff action in response to the incident

Criminal Action Initiated

Additional Notes On August 18, 2020, Erie County Correctional Facility (ECCF) Chief of Operations Alphonso Harris did receive information that ECCF Inmate [redacted] was making allegations of sexual misconduct towards Erie County Holding Center Sergeant Robert Dee. Chief Harris did then interview Inmate [redacted] who stated that Sergeant Dee subjected her to repeated sexual encounters over the length of her incarceration from October 8th, 2019 to November 20th, 2019. At approximately 1657 hours, Chief Harris emailed the Office of Professional Standards and Prison Rape Elimination Act (PREA) coordinator Chief Hartman, regarding her accusations. After an administrative review, it was discovered that this incident was not reported to the New York State Commission of Correction (NYSCOC). On September 10th, 2020, following investigations by the Office of Professional Standards, the accusations cannot be substantiated and are considered unfounded.

Incident Summary On August 18, 2020, Erie County Correctional Facility (ECCF) Chief of Operations Alphonso Harris did receive information that ECCF Inmate [redacted]) was making allegations of sexual misconduct towards Erie County Holding Center Sergeant Robert Dee. Chief Harris did then interview Inmate [redacted] who stated that Sergeant Dee subjected her to repeated sexual encounters over the length of her incarceration from October 8th, 2019 to November 20th, 2019. At approximately 1657 hours, Chief Harris emailed the Office of Professional Standards and Prison Rape Elimination Act (PREA) coordinator Chief Hartman, regarding her accusations. After an administrative review, it was discovered that this incident was not reported to the New York State Commission of Correction (NYSCOC). On September 10th, 2020, following investigations by the Office of Professional Standards, the accusations cannot be substantiated and are considered unfounded.

Ex. N

New York State Commission of Correction

Reportable Incident

Incident # : 129042
Agency Name : Erie County Jail
Agency Type : County Jail
Date/Time of Incident : 06/24/2020 20:20
Date/Time Reported : 10/22/2020 12:16
Location of Incident : Other
Specific Location : ECHC
Status : New

Incident Category(s)

Sex Offense

Inmate/Personnel Sexual Offense

Staff(s) Involved

Staff Info # 1

Rank Lieutenant
Name : Franckowiak , David
Sex : Male

Staff Info # 2

Rank Chief
Name : Hartman , Jeffrey
Sex : Male

Staff Info # 3

Rank Sergeant
Name : Scanio , Mark
Sex : Male

Staff Info # 4

Rank Sergeant
Name : Dee , Robert
Sex : Male

Staff Info # 5

Rank Deputy
Name : Friedman , Jill
Sex : Female

Inmate Information # 1

Name : [redacted]
Date Of Birth : [redacted]
NYSID : [redacted]
Sex : Female
Race : [redacted]
Ethnicity : [redacted]
Role in Incident : Undetermined
Commitment Type : Criminal Commitment
Date of Admission in Facility : 01/28/2020
Most Serious Charge : [redacted]
Inmate ID : [redacted]
Inmate Classification : Level 1
Was Inmate boarded in ? : No
Inmate Prior Known History

[redacted]

Staff action in response to the incident

Criminal Action Initiated

Inmate Information # 2

Name : [redacted]
Date Of Birth : [redacted]
NYSID : [redacted]
Sex : Female
Race : [redacted]
Ethnicity : [redacted]
Role in Incident : Undetermined
Commitment Type : Criminal Commitment
Date of Admission in Facility : 03/13/2020
Most Serious Charge : [redacted]
Inmate ID : [redacted]
Inmate Classification : Level 2
Was Inmate boarded in ? : No
Inmate Prior Known History

[redacted]

Staff action in response to the incident

Criminal Action Initiated

Additional Notes On June 24th, 2020 at approximately 2020 hours, Deputy Jill Friedman informed Sergeant Mark Scanio that inmate [redacted]

[redacted] was making allegations of sexual abuse. Inmate [redacted] stated that she witnessed Sergeant Robert Dee kissing and fondling Inmate [redacted] Prison Rape Elimination Act (PREA) coordinator, Chief Hartman was then notified by Lieutenant David Franckowiak at approximately 2312 and subsequently notified the Office of Professional Standards, on the morning of June 25th, 2020, to initiate a formal investigation. On July 21st, 2020, following investigations by both Erie County Sheriffs Detectives and the Office of Professional Standards, the accusations cannot be substantiated and are considered unfounded.

Incident Summary

On June 24th, 2020 at approximately 2020 hours, Deputy Jill Friedman informed Sergeant Mark Scanio that inmate [redacted] as making allegations of sexual abuse. Inmate [redacted] stated that she witnessed Sergeant Robert Dee kissing and fondling Inmate [redacted] Prison Rape Elimination Act (PREA) coordinator, Chief Hartman was then notified by Lieutenant David Franckowiak at approximately 2312 and subsequently notified the Office of Professional Standards, on the morning of June 25th, 2020, to initiate a formal investigation. On July 21st, 2020, following investigations by both Erie County Sheriffs Detectives and the Office of Professional Standards, the accusations cannot be substantiated and are considered unfounded.

Ex. O

New York State Commission of Correction

Reportable Incident

Incident # : 129472
Agency Name : Erie County Correctional Facility
Agency Type : County Jail
Date/Time of Incident : 07/18/2020 09:55
Date/Time Reported : 10/26/2020 14:22
Location of Incident : Single Occupancy Housing Unit
Specific Location : Bravo-101
Originating Incident # : 120736
Status : Closed

Incident Category(s)

Sex Offense

Personnel/Inmate Sexual Offense

Staff(s) Involved

Staff Info # 1

Rank Chief
Name : Hartman , Jeffrey
Sex : Male
Shield/ID : N/A

Inmate Information # 1

Name : [redacted]
Date Of Birth : [redacted]
NYSID : [redacted]
Sex : Male
Race : [redacted]
Ethnicity : [redacted]
Role in Incident : Instigator
Commitment Type : Criminal Commitment
Date of Admission in Facility : 04/10/2020
Most Serious Charge : [redacted]
Inmate ID : [redacted]
Inmate Classification : 2
Was Inmate boarded in ? : No
Inmate Prior Known History

Assaultive Behavior

Discipline

[redacted]

Staff action in response to the incident	Take to Emergency Room
Incident Summary	On 7/18/2020 Inmate [redacted] [redacted] made allegations of a sexual assault by staff when his clothes were removed after he was placed into the restraint chair. Per Chief Jeffrey Hartman inmate [redacted] recanted his statement of being sexually assaulted when he was asked by medical professionals at ECMC. After an investigation Inmate [redacted] allegations were found to be unfounded. Reference NYSCOC Incident #120736

Ex. P

New York State Commission of Correction

Reportable Incident

Incident # : 131458
Agency Name : Erie County Jail
Agency Type : County Jail
Date/Time of Incident : 08/25/2020 09:30
Date/Time Reported : 11/16/2020 09:56
Location of Incident : Program Area
Specific Location : Gulf Recreation
Status : Closed

Incident Category(s)

Sex Offense

Inmate/Personnel Sexual Offense

Staff(s) Involved

Staff Info # 1

Rank Deputy
Name : Barnas , James
Sex : Male

Inmate Information # 1

Name : [redacted]
Date Of Birth : [redacted]
NYSID : [redacted]
Sex : Male
Race : [redacted]
Ethnicity : [redacted]
Role in Incident : Undetermined
Commitment Type : Criminal Commitment
Date of Admission in Facility : 02/11/2019
Most Serious Charge : [redacted]
Inmate ID :
Inmate Classification : [redacted]
Was Inmate boarded in ? : No
Inmate Prior Known History

Assaultive Behavior

Discipline

Gang Affiliation

[redacted]

[redacted]

Additional Notes	On 8/25/20 at approximately 0930 hours, while on Gulf Recreation, Inmate [redacted] spoke up and said he wanted to speak to me about how he was sexually assaulted by staff. He went on to state that he was assaulted by Deputy James Barnas on 7/22/20 while he was housed on [redacted]. The watch commanders were notified as was the PREA coordinator, Chief Hartman. The claim was documented and forwarded through Chief Hartman and Professional Standards Division.
Incident Summary	On 8/25/20 at approximately 0930 hours, while on Gulf Recreation, Inmate [redacted]) spoke up and said he wanted to speak to me about how he was sexually assaulted by staff. He went on to state that he was assaulted by Deputy James Barnas on 7/22/20 while he was housed on [redacted]. The watch commanders were notified as was the PREA coordinator, Chief Hartman. The claim was documented and forwarded through Chief Hartman and Professional Standards Division.

New York State Commission of Correction

Reportable Incident

Incident # : 131577
Agency Name : Erie County Jail
Agency Type : County Jail
Date/Time of Incident : 07/22/2019 09:30
Date/Time Reported : 11/17/2020 09:49
Location of Incident : Multiple Occupancy Housing Unit
Specific Location : Gulf East
Status : Open

Incident Category(s)

Sex Offense

Personnel/Inmate Sexual Offense

Staff(s) Involved

Staff Info # 1

Rank Deputy
Name : Barnas , James
Sex : Male

Inmate Information # 1

Name : [redacted]
Date Of Birth : [redacted]
NYSID : [redacted]
Sex : Male
Race : [redacted]
Ethnicity : [redacted]
Role in Incident : Undetermined
Commitment Type : Criminal Commitment
Date of Admission in Facility : 02/11/2019
Most Serious Charge : [redacted]
Inmate ID :
Inmate Classification : [redacted]
Was Inmate boarded in ? : No
Inmate Prior Known History

Assaultive Behavior

Discipline

Gang Affiliation

[redacted]

[redacted]

Additional Notes On 8/25/20 at approximately 0930 hours, while on Gulf Recreation, Inmate [redacted] spoke up and said he wanted to speak to me about how he was sexually assaulted by staff. He went on to state that he was assaulted by Deputy James Barnas on 7/22/20 while he was housed on [redacted]. Upon preliminary investigation and additional questioning, the inmate later clarified that this claimed incident occurred on 7/22/19. The watch commanders were notified as was the PREA coordinator, Chief Hartman. The claim was documented and forwarded through Chief Hartman and Professional Standards Division for investigation. This submission is a correction of RI#131458

Incident Summary On 8/25/20 at approximately 0930 hours, while on Gulf Recreation, Inmate [redacted]) spoke up and said he wanted to speak to me about how he was sexually assaulted by staff. He went on to state that he was assaulted by Deputy James Barnas on 7/22/20 while he was housed on [redacted]. Upon preliminary investigation and additional questioning, the inmate later clarified that this claimed incident occurred on 7/22/19. The watch commanders were notified as was the PREA coordinator, Chief Hartman. The claim was documented and forwarded through Chief Hartman and Professional Standards Division for investigation. This submission is a correction of RI#131458

Ex. Q

New York State Commission of Correction

Reportable Incident

Incident # : 131848
Agency Name : Erie County Jail
Agency Type : County Jail
Date/Time of Incident : 01/07/2019 11:15
Date/Time Reported : 11/19/2020 10:07
Location of Incident : Other
Specific Location : Gulf Level
Status : New

Incident Category(s)

Sex Offense

Personnel/Inmate Sexual Offense

Staff(s) Involved

Staff Info # 1

Rank Sgt
Name : Lewandowski , Kyle
Sex : Male

Staff Info # 2

Rank Dep
Name : Imhof , Christopher
Sex : Male

Staff Info # 3

Rank Dep
Name : Wendling , Daniel
Sex : Male

Staff Info # 4

Rank Capt
Name : Hartman , Jeffrey
Sex : Male

Inmate Information # 1

Name : [redacted]
Date Of Birth : [redacted]
NYSID : [redacted]
Sex : Male

Race : [redacted]

Ethnicity : [redacted]

Role in Incident : Undetermined

Commitment Type : Criminal Commitment

Date of Admission in Facility : 08/21/2018

Most Serious Charge : [redacted]

Inmate ID : [redacted]

Inmate Classification : [redacted]

Was Inmate boarded in ? : No

Inmate Prior Known History

Assaultive Behavior

Discipline

Gang Affiliation

[redacted]

[redacted]

Staff action in response to the incident

Medical/Mental Health Evaluation on Site

Additional Notes On January 9, 2019, Inmate [redacted] reported to Forensic Mental Health that he was being sexually harassed by staff on the [redacted] Housing Area of the Erie County Holding Center. When interviewed by investigators, inmate [redacted] alleged that on January 7, 2019, during a routine search of his person, Deputy Imhoff, grabbed his [redacted] genitals. Inmate [redacted] further alleged, that on January 8, 2019, during a routine search of his person, Deputy Wendling grabbed his [redacted]) genitals. These allegations were thoroughly investigated at the time, including a review of facility surveillance video of the areas in which the events allegedly occurred, and were definitively determined to be UNFOUNDED. An internal audit of Sexual Abuse investigations, found that this allegation was not properly reported to the NYS Commission of Correction, consistent with the Reportable Incident Guidelines. This matter is being reported now to ensure that it is properly reported and to correct that error.

Incident Summary On January 9, 2019, Inmate [redacted] reported to Forensic Mental Health that he was being sexually harassed by staff on the [redacted] Housing Area of the Erie County Holding Center. When interviewed by investigators, inmate [redacted] alleged that on January 7, 2019, during a routine search of his person, Deputy Imhoff, grabbed his ([redacted]) genitals. Inmate [redacted] further alleged, that on January 8, 2019, during a routine search of his person, Deputy Wendling grabbed his ([redacted]) genitals. These allegations were thoroughly investigated at the time, including a review of facility surveillance video of the areas in which the events allegedly occurred, and were definitively determined to be UNFOUNDED. An internal audit of Sexual Abuse investigations, found that this allegation was not properly reported to the NYS Commission of Correction, consistent with the Reportable Incident Guidelines. This matter is being reported now to ensure that it is properly reported and to correct that error.

Ex. R

New York State Commission of Correction

Reportable Incident

Incident # : 131843
Agency Name : Erie County Jail
Agency Type : County Jail
Date/Time of Incident : 08/15/2019 08:55
Date/Time Reported : 11/19/2020 09:41
Location of Incident : Multiple Occupancy Housing Unit
Specific Location : Delta Long
Status : New

Incident Category(s)

Sex Offense
Inmate/Inmate Sexual Offense
Personnel/Inmate Sexual Offense

Staff(s) Involved

Staff Info # 1
Rank Capt
Name : Hartman , Jeffrey
Sex : Male

Staff Info # 2
Rank Dep
Name : Hicks , Jason
Sex : Male

Staff Info # 3
Rank Sgt
Name : Kadryna , Donald
Sex : Male

Staff Info # 4
Rank Sgt
Name : Weyand-Garrett , Jennifer
Sex : Female

Staff Info # 5
Rank Sgt
Name : Kozlowski , Joseph
Sex : Male

Inmate Information # 1

Name : [redacted]
Date Of Birth : [redacted]
NYSID : [redacted]
Sex : Male
Race : [redacted]
Ethnicity : [redacted]
Role in Incident : Undetermined
Commitment Type : Criminal Commitment
Date of Admission in Facility : 05/03/2019
Most Serious Charge : [redacted]
Inmate ID : [redacted]
Inmate Classification : [redacted]
Was Inmate boarded in ? : No
Inmate Prior Known History

Discipline
[redacted]
[redacted]

Inmate Information # 2

Name : Hamilton , Derrick
Date Of Birth : 01/30/1961
NYSID : 6165491K
Sex : Male
Race : Black
Ethnicity : Not Hispanic
Role in Incident : Undetermined
Commitment Type : Criminal Commitment
Date of Admission in Facility : 08/07/2019
Most Serious Charge : Unauthorized Use Vehicle
Inmate ID : 4588
Inmate Classification : [redacted]
Was Inmate boarded in ? : No
Inmate Prior Known History

[redacted]
[redacted]

Staff action in response to the incident

Medical/Mental Health Evaluation on Site

Additional Notes On August 15, 2019, [redacted]r inmate [redacted] assaulted inmate Derrick Hamilton (#4588, DLG-9), causing contusions and lacerations. (REF NYSCOC RI # 87956). When interviewed by facility staff and detectives after the assault, inmate [redacted] stated that she hit that crazy old may because he has been talking shit about me and calling me a Fag since he got here. Inmate [redacted] was subsequently charged with Assault 2nd. On September 6, 2019, after being arraigned on those charges and being informed that this was her third violent felony, inmate [redacted] filed a complaint stating that the August 15th incident occurred because inmate Derrick Hamilton had been grabbing and groping at inmate[redacted] breasts and buttocks. On September 8, 2019, Inmate [redacted] submitted a second complaint, alleging that she had been having a sexual relationship with Sgt. Donald Kadryna, both in the facility and when she [redacted] was out of the facility. These allegations were thoroughly investigated by the facility and the Office of Professional Standards at the time and were definitively determined to be UNFOUNDED. An internal audit found that these additional allegations were not properly reported to the NYS Commission of Correction, consistent with the Reportable Incident Guidelines. This matter is being reported now, to ensure that it is properly reported and to correct that error.

Incident Summary On August 15, 2019, [redacted] inmate [redacted] assaulted inmate Derrick Hamilton (#4588, DLG-9), causing contusions and lacerations. (REF NYSCOC RI # 87956). When interviewed by facility staff and detectives after the assault, inmate [redacted] stated that she hit that crazy old may because he has been talking shit about me and calling me a Fag since he got here. Inmate [redacted] was subsequently charged with Assault 2nd. On September 6, 2019, after being arraigned on those charges and being informed that this was her third violent felony, inmate[redacted] filed a complaint stating that the August 15th incident occurred because inmate Derrick Hamilton had been grabbing and groping at inmate [redacted]breasts and buttocks. On September 8, 2019, Inmate [redacted] submitted a second complaint, alleging that she had been having a sexual relationship with Sgt. Donald Kadryna, both in the facility and when she [redacted] was out of the facility. These allegations were thoroughly investigated by the facility and the Office of Professional Standards at the time and were definitively determined to be UNFOUNDED. An internal audit found that these additional allegations were not properly reported to the NYS Commission of Correction, consistent with the Reportable Incident Guidelines. This matter is being reported now, to ensure that it is properly reported and to correct that error.

Ex. S

New York State Commission of Correction

Reportable Incident

Incident # : 134126
Agency Name : Erie County Correctional Facility
Agency Type : County Jail
Date/Time of Incident : 03/15/2018 08:22
Date/Time Reported : 12/10/2020 11:58
Location of Incident : Other
Specific Location : Conference Room
Status : Closed

Incident Category(s)

Sex Offense

Personnel/Inmate Sexual Offense

Staff(s) Involved

Staff Info # 1

Rank Chief
Name : Harris , Alfonso
Sex : Male

Inmate Information # 1

Name : [redacted]
Date Of Birth : [redacted]
NYSID : [redacted]
Sex : Female
Race : [redacted]
Ethnicity : [redacted]
Role in Incident : Witness
Commitment Type : Criminal Commitment
Date of Admission in Facility : 10/31/2017
Most Serious Charge : 140.25.02
Inmate ID : 79619
Inmate Classification : 2
Was Inmate boarded in ? : No
Inmate Prior Known History

Discipline

[redacted]

Victimization

Staff action in response to the incident

Other Action

Incident Summary On 3/15/2018 I forwarded to the intelligence unit allegations of staff impropriety I got from Inmate [redacted]. [redacted] alleged that COs Randy Chavanne and Keith Roberts had inappropriate dealing with inmate in and out of the facility. The intelligence unit gathered addition information from listening to inmate phone calls that they turned over to our Professional Standards Division. The PSD concluded their investigation into the allegations with a confidential case report dated 4/18/2018. The investigation found COs Matthew Reardon, John Valenti, and Ronald Dolyk violated facility policy and exonerated CO Randy Chavanne.

Incident Review # 1

Method of Review : Reviewed/Closed

Assigned To : Christian, Brielle

Reviewed By : christianb2

Reviewed Date : 01/14/2021

Reviewed Notes : [redacted]

Incident Review # 2

Method of Review : Inquiry

Assigned To : Christian, Brielle

Reviewed By : cdiaz4

Reviewed Date : 12/10/2020

Reviewed Notes : Alleged sex offense- Reported outside of timeframes

Ex. T

https://buffalonews.com/news/inmates-accuse-jail-sergeant-of-sexual-contact-investigations-end-as-unfounded/article_10e0a11a-1a1a-11eb-a38d-d76025b7f23e.html

Inmates accuse jail sergeant of sexual contact; investigations end as 'unfounded'

Matthew Spina
Nov 15, 2020

Erie County Sheriff's Office Sgt. Robert Dee, on right, wheels inmate Richard A. Metcalf Jr. on a gurney to a stretcher in 2012 after Holding Center deputies tightly tied a spit mask over Metcalf's head. A state commission later blamed deputies for Metcalf's death. Dee was accused in recent months of sexually abusing female inmates. Both investigations ended as "unfounded."

Erie County Sheriff's Office security camera

Matthew Spina

Two female inmates in recent months have made serious allegations against Robert Dee, an Erie County Holding Center sergeant who once married a woman he met behind bars.

Both of the inmates told Sheriff Timothy B. Howard's internal investigators that Dee made sexual advances as he monitored inmate cleaning crews, according to documents obtained by The Buffalo News.

One woman said she saw Dee kissing and fondling one of her acquaintances. Weeks later, the other told them she and the sergeant would flirt, have adult conversations and sexual contact in private moments.

Dee denied to investigators ever touching any female inmate inappropriately.

Both cases were closed in September as "unfounded" because of a lack of evidence. Dee's forced leave, with pay, then ended, and he returned to the job that in 2019 paid him more than $100,000.

Commanders, however, are to avoid assigning him to women's units, a top jail official said.

Federal and state laws treat sexual contact between a corrections officer and an inmate as a crime. The state penal law notes that because of the power imbalance, inmates in New York's jails and prisons are **incapable of consenting to sex** with guards.

"There is never consent under those circumstances," said Janine Kava, a spokeswoman for the state Commission of Correction, which regulates local jails and, she said, gives heightened scrutiny to sex offenses. Jails have 24 hours to file a report with the agency after finding out about sexual contact or beginning an investigation.

Howard's team did not report the Dee-related matters to the commission, neither upon hearing the allegations or completing the investigations. Said Jail Management Superintendent Thomas Diina: "We simply made an error in not reporting it. I am taking appropriate action to reduce the risk of this same mistake occurring again."

In 2017, the commission **warned the sheriff to report serious incidents** or face legal action. The commission has since received documents about the Dee investigations from Erie County – after The News asked about the matter – and is determining its next steps, Kava said.

Sheriff's deputies are usually blocked from talking to the news media without permission, but Diina said he would let the sergeant comment for this article. Dee, however, did not respond to The News' attempts to reach him by phone, text and email. The union that represents him and other Holding Center deputies, Teamsters Local 264, also did not respond to a request for comment on his behalf.

In an interview with the internal investigators, Dee defended himself by saying he is always professional in dealing with inmates, and he follows jail policies and procedures when picking female workers, or "trusties."

Dee once married a former inmate he met while on the job. Her mother, his former mother-in-law, says he's an attentive father from a good-hearted family.

"I think he's a good dad," said Sandra Gandy.

She is the mother of Jennifer Chudzinski, who met Dee more than 15 years ago while she did time behind bars. The two married and had three children, Gandy said, before splitting in 2012. When Jennifer Chudzinski died from an overdose in 2019, Dee and his parents were a source of support for her survivors, her mother said.

Four inmate lawsuits

Dee has been named as a defendant in four inmate lawsuits alleging mistreatment. The most publicized of the four stems from the 2012 homicide of Richard A. Metcalf Jr. While the Erie County medical examiner at the time said Metcalf died of heart failure brought on by stress, the Commission of Correction's Medical Review Board said **he died because deputies tied the strings of a spit mask** tightly around his neck, asphyxiating him.

According to the investigators' timeline, Metcalf is either struggling for breath or in full cardiac arrest as Dee, recorded on video, pulls Metcalf's gurney to a waiting ambulance. The medics later said in sworn testimony that jail deputies barred them from examining the patient until he reached their vehicle. By then it was too late to save him.

Metcalf's body displayed an array of bruises, and the commission wanted the sheriff to discipline Dee for failing to supervise a proper use of force. Howard refused to do so.

Because Dee's new wife, Sara Dee, worked for District Attorney John J. Flynn as an assistant, the decision on whether to place criminal charges went to a prosecutor in a neighboring county. No criminal charges were filed in Metcalf's death.

Robert and Sara Dee are now in the middle of divorce proceedings. She stated in legal papers that she's the victim of domestic violence. Meanwhile, pages from her private journal were placed on a Dee family Facebook page, and the **compromising information cost her her job**. Robert Dee's father, James, has been charged with criminal contempt and disobeying a court order in the matter. He has pleaded not guilty.

The first allegation

On June 24 of this year, a female inmate told jail deputies she had seen Dee kissing one of her acquaintances, and his hands were on the woman's breasts, according to a summary of the investigation. But the summary also showed the acquaintance

denied any involvement with the sergeant.

The News obtained the summary through the Freedom of Information Law. The sheriff's staff blacked out inmate names before providing it.

Dee's accuser said she witnessed the kissing in April but told the staff about it in June, after deputies asked her to explain why she and the acquaintance were fighting. They fought, the accuser told them, because she had confronted the sergeant over what he was doing, and while he denied it, her fellow inmate's work assignments dried up, the report said.

Other inmates in the housing unit told deputies that the woman said to have kissed Dee would expose herself to him and talk about how they would kiss, the report said.

The sheriff's internal Office of Professional Standards found she had been among those Dee took to clean elevators and hallways four times from April 14-21. Interviewed again after her release from jail, the accuser insisted she had seen the two kiss, and added that the woman had admitted performing a sexual act on Dee, the internal report says.

But the inquiry ground to a halt when the woman who reportedly kissed Dee said it never happened.

"I swear that I never had sex with anyone, absolutely nothing,'' she told them in a written statement. "I can only say that the sergeant used to pass by very often at the beginning, when I got to my cell #5 and that is why rumors of the inmates started."

On July 21, Deputy Denise York of the Professional Standards staff completed a report calling the allegations unfounded.

The second case

Weeks later, on Aug. 18, a Holding Center chief sat down with another inmate

accusing Dee of sexual misconduct. Another internal investigation began.

The inmate said she and Dee would kiss and do other things during a prior period of confinement – October and November of 2019.

According to a summary of the investigation, again with inmate names blacked out, the woman said she regretted going along with Dee's advances; she felt taken advantage of because she was at a vulnerable time in her life; she didn't want other women to go through what she experienced; and she feared seeing Dee while behind bars again.

She told internal investigators that the contact in 2019 started with Dee asking her if she had a bra, and that she would need one in order to work, according to their report. In time, Dee was asking if her breasts were real or fake and if he could feel them, the report continued.

While the two never had intercourse, she told them "she would be bent over trying to clean up something on the floor and he would come up behind her, grab her hips" and simulate intercourse, the report said.

One day, when he took her to do some work preparing for a painting job, she invited him to touch her in a private place, and he did, according to the internal report. She stated she then undid his belt, but he stopped her, saying they would have to wait until she was "on the outside" to go further, the report said. They never did see one another after her release, she said for the report.

Inmates are paid for their work, and one day she found more money than she expected in her account, she told the Professional Standards team. Dee, she said, told her the extra money was for the "you and me stuff," and she shouldn't mention it to other inmates, according to the report.

Deputy York found the inmate received "an unusual amount" of pay one week – $34 – and records showed Dee authorized it. But logs for the women's unit did not

show Dee signing her out for work details, as the inmate asserted. The jail's surveillance tapes only went back six months, so no video evidence was available from October and November 2019. While the inmate said Dee touched her between her legs on a day when she was preparing for a painting job, York's report noted that a male inmate did the painting. York mentioned no effort to contact inmates who had been housed with the woman.

Assignments restricted

Dee insisted to the Professional Standards team he had never touched a female inmate in an inappropriate manner, and all he ever did was make sure their basic needs were met. He went on to say he would help trusties receive their pay if they did the work and something held up the money, according to the summary.

Dee made those statements on Sept. 10. Later that day, York summed up her report for Undersheriff John W. Greenan: "There is a lack of evidence to corroborate the allegations."

Dee returned to work Sept. 14 – with a restriction.

"Facility watch commanders have been instructed," Diina explained, "to avoid assigning Sgt. Dee to any areas where female inmates are housed whenever possible."

Matthew Spina
Buffalo News reporter
Incurable reporter: baseball fan; eternal Buffalo Bills optimist

Ex. U

ERIE COUNTY SHERIFF'S OFFICE

MEMORANDUM

TO: Sexual Abuse Coordinator

FROM: Undersheriff Mark N. Wipperman

DATE: Aug. 13, 2020

SUBJECT: PSD Case # 20 - 59 **ALLEGATION OF SEXUAL ABUSE**

The Office of Professional Standards has reviewed the investigation conducted by the Criminal Investigation Bureau and:

☒ Concurs with the findings of the Criminal Investigation.

☐ Has returned the file to the Criminal Investigation Bureau for further investigation:

NOTES: _____

_____

The Office of Professional standards has conducted an administrative investigation into this matter and has determined the allegations to be:

☒ UNFOUNDED ☐ SUBSTANTIATED ☐ INCONCLUSIVE

The Office of Professional standards has conducted an administrative investigation into that matter and has determined that the following policy violations have occurred:

☒ NO VIOLATIONS FOUND

☐ VIOLATIONS FOUND:

Policy violated	Responsible Party	Status

The Office of Professional Standards makes the following administrative recommendations:

_____

_____

_____

PSD Confidential Case Report is ☒ ATTACHED ☐ NOT ATTACHED

Signature: _____ 8/13/2020

Ex. V

ERIE COUNTY SHERIFF'S OFFICE

amd 9/25/20 Diina Hartman

MEMORANDUM

TO: Sexual Abuse Coordinator

FROM: Undersheriff John Greenan

DATE:

SUBJECT: PSD Case # 20 - 83 **ALLEGATION OF SEXUAL ABUSE**

The Office of Professional Standards has reviewed the investigation conducted by the Criminal Investigation Bureau and:

N/A ☐ Concurs with the findings of the Criminal Investigation.

☐ Has returned the file to the Criminal Investigation Bureau for further investigation:

NOTES: No criminal case conducted due to time lapse between date of supposed incident and reporting of incident and lack of physical evidence CL#20-051311.

The Office of Professional standards has conducted an administrative investigation into this matter and has determined the allegations to be:

☒ UNFOUNDED ☐ SUBSTANTIATED ☐ INCONCLUSIVE

The Office of Professional standards has conducted an administrative investigation into that matter and has determined that the following policy violations have occurred:

☒ NO VIOLATIONS FOUND

☐ VIOLATIONS FOUND:

Policy violated	Responsible Party	Status

The Office of Professional Standards makes the following administrative recommendations:

PSD Confidential Case Report is ☐ ATTACHED ☐ NOT ATTACHED

Signature:

ERIE COUNTY SHERIFF'S OFFICE

OK to close
9/15/2020
cm'd: Diina
Evans
Harris
Kuppel

MEMORANDUM

Confidential Case Report

TO: **Undersheriff John Greenan**

FROM: **Deputy Denise York**

DATE: **September 10, 2020**

RE: **PSD Case #2020-83 –Allegations of Sexual Abuse;** [redacted]

CASE FINDINGS: **UNFOUNDED**

Synopsis: On August 18, 2020, at 1657 hours, Chief Harris emailed the Office of Professional Standards regarding an interview he had conducted with Inmate [redacted] concerning her allegations of sexual misconduct by Sergeant Robert Dee. Inmate [redacted] had stated to Chief Harris that Sergeant Dee subjected her to repeated sexual encounters over the length of her stay from October 8, 2019 to November 20, 2019. A formal investigation was initiated by the Office of Professional Standards on August 19, 2020.

After a thorough investigation by the Office of Professional Standards, we concluded that there was insufficient evidence to support the allegations. The allegations of sexual abuse towards Inmate [redacted] by Sergeant Robert Dee are considered **UNFOUNDED**.

Details: On August 18, 2020, Chief Harris received information from the Forensic Mental Health staff at the Erie County Correctional Facility that Inmate [redacted] was alleging to have been sexually mistreated by an employee at the Holding Center. Chief Harris proceeded to interview Inmate [redacted] in regards to these allegations and who had allegedly been the perpetrator. Inmate [redacted] told Chief Harris that for approximately a month and a half, between October and November of 2019, Sergeant Robert Dee had subjected her to several sexual encounters. These encounters allegedly included kissing, groping, dry-humping, and masturbating for Sgt. Dee. Inmate [redacted] also informed Chief Harris that she gave Sgt. Dee her phone number but never had any contact with Sgt. Dee outside of the Holding Center. Chief Harris then compiled a list of bullet points from the interview and forwarded them to the rest of the command staff. After receiving orders from Superintendent Diina, Chief Harris forwarded the same list of bullet points to the Office of

Professional Standards on August 18, 2020 at 1657 hours to initiate an investigation into the alleged sexual misconduct of Sgt. Robert Dee against Inmate [redacted] (A copy of the email from Chief Harris has been included in the case folder.)

A video recorded interview with Inmate [redacted] was conducted at the Erie County Correctional Facility on Wednesday, August 19, 2020, at 1000 hours to gather more information regarding the allegations. Inmate [redacted] explained that the contact started with Sgt. Dee asking if she needed a bra and how he told her that she would need a bra to work. She stated that it escalated when he started making comments about her chest, asking her if her boobs were fake and if he could feel them. Inmate [redacted] continued to explain how she would be bent over trying to clean up something on the floor and he would come up behind her, grab her hips and start to dry-hump her. Inmate [redacted] also made allegations that Sgt. Dee would tell her how he would masturbate so hard just thinking about her and that he wanted her to swallow all of his juice. She stated that when Sgt. Dee pulled the cleaning crew out to clean that they would grab at each other when no one else was looking. Inmate [redacted] stated that they kissed and that Sgt. Dee did kiss her chest. Inmate [redacted] did state that they never had sex but that Sgt. Dee did pull her out of her cell to "prep for paint" alone. She continued to explain how she masturbated while he watched. She admitted to asking him to touch her and said that he "swiped" his fingers on her vaginal area, rubbed the secretion between his fingers and then sniffed it. Inmate [redacted] stated that she undid Sgt. Dee's belt buckle and the button of his pants before he stopped her saying that they had to wait until she was on the outside to go further. Inmate [redacted] stated that she would get paid for buffing floors when all she did was use the squirt bottle to dampen the floor for the buffer to go over. Inmate [redacted] stated that she never used the floor buffer and that she does not know how to operate it. She claims that Sgt. Dee told her that the extra money was for the "you and me stuff" and not to mention to the other inmates what she was receiving in trustee pay. Inmate [redacted] explained how during 2 separate incarcerations she had slipped her phone number to Sgt. Dee saying it was her bra size but that she never seen him anywhere except for when she was incarcerated. She said she never talked to him on the phone because when a strange number called the phone and a man would ask for [redacted] her mother would tell him that she wasn't home [redacted]. Inmate [redacted] also has claimed to have gotten a friend request from him on Facebook but that it wasn't under his name and that the profile picture was that of a headshot of a man with dark hair and sunglasses on with a beach in the background. When asked if she might still have the friend request on her account, Inmate [redacted] stated that she may have deleted it.

Inmate [redacted] stated that she had not come forward until now because she was in a bad place and feels that she needs to get it out in order to move on with her life. She stated that she felt embarrassed, like it was her fault, and that at the time she wanted it to happen. Inmate [redacted] stated that she would come in and start to detox and that she enjoyed the attention that she was receiving from Sgt. Dee. Inmate [redacted] stated that she was afraid of [redacted] because of what transpired and that she feels as though Sgt. Dee took advantage of the fact that she was lonely and weak. Inmate [redacted] stated that she is not being vindictive, nor is she exaggerating what happened. She is just embarrassed and feels as though Sgt. Dee used the fact that she was at a vulnerable point in her life/incarceration. Inmate [redacted] also stated that she did not want this to happen to any

other female in her position and that she fears running into Sgt. Dee while she is incarcerated.

[redacted]

After interviewing Inmate [redacted] the Office of Professional Standards, attempted to gather information to prove or disprove her story. After reviewing her cell movement log, it showed that Sgt. Dee did change her cell on October 16, 2019 due to her being the new floor clean-up. Inmate [redacted] Resident Account Summary shows that she was getting paid for cleaning floors at that time and that one week she did receive an unusual amount of trustee pay ($34) for the week of October 19-25, 2019. According to the Erie County Holding Center Trustee Payroll Program report, Inmate [redacted] received extra pay per Sgt. Dee with the note that she was owed for the prior week. After reviewing Alpha Long's Destination Forms and Log Book for October and November 2019, no information was logged that she ever left the housing unit to clean or that Sgt. Dee removed her from the housing unit by herself. Alpha Short's Log Book for the same time period was reviewed, showing that the housing unit was open and had inmates housed on both sides of the housing unit. The Alpha Short Log Book also had an entry dated October 26, 2019 at 1920 hours that states "[redacted] on unit to buff floors". This entry was odd due to the fact that there is an entry at 1540 hours on October 26, 2019 stating "Deputy Kirkpatrick on unit for (Alpha Short) #47 Velez to buff floors". The Trustee Detail Log Book for 2019 was reviewed and showed that 1 female was taken from Alpha Short to sweep, mop, and buff floors on Alpha Short on October 26, 2019 at 1530 hours to 1630 hours and 1830 hours to 2000 hours. The Trustee Detail Log Book for 2019 also showed that the only painting that was done on Alpha during that time frame was performed by a male trustee who painted the trim in the Alpha Hallway by the elevators (November 2, 2019 at 1900 hours). An attempt was made to obtain video footage from Elevator 5, the Alpha Atrium, and the Alpha Hallway to verify if Sgt. Dee may have pulled Inmate [redacted] off the housing unit by herself at any point during her October/November 2019 incarceration, however, the video logs only go back approximately 6 months. (This information was obtained from Lt. Usinski after verifying with Black Creek that the video could not be recovered at all.)

[redacted]

Conclusion: There is a lack of evidence to corroborate the allegations of Inmate [redacted] that there was any sexual misconduct against her by Sgt. Robert Dee. The Office of Professional Standards has found no evidence of inappropriate contact between Sgt. Dee and Inmate [redacted]

After careful consideration of the facts and evidence presented, this Office found that there was insufficient evidence to support the allegations. The allegations of sexual abuse towards Inmate [redacted] by Sergeant Robert Dee cannot be substantiated and thus considered **UNFOUNDED**.

It is the opinion of this Office that the investigative part of this complaint should be considered **CLOSED**.

Respectfully submitted,

Deputy D. York #1206

Ex. W

em'd 5/1/18 4/27/18

ERIE COUNTY SHERIFF'S OFFICE

MEMORANDUM

Confidential Case Report

5/1/06 Ensure discipline was imposed. copies to PSD CJ2

TO: Undersheriff Wipperman

FROM: Correction Officer Ernest Hey

DATE: 04/18/18

SUBJECT: **PSD CASE #18-25: Off/On Duty Conduct: CO Ronald Dolyk, CO John Valenti, CO Randy Chavanne and CO Matthew Reardon**

SYNOPSIS:

On or about March 15, 2018, the Office of Professional Standards received a complaint in regards to the On/Off Duty Conduct of the following Corrections Officers: Ronald Dolyk, John Valenti, Randy Chavanne and Matthew Reardon.

The allegations included having sexual relations with inmates while on duty, bringing contraband into the facility, and associating, and having contact with, former inmates after their release from jail.

After a thorough investigation, and considering the facts and evidence, this Office finds CO Randy Chavanne did not violate the ECSO JMD Policy & Procedure and should be considered **EXONERATED** of all allegations.

After a thorough investigation, **and by his own admission**, this Office finds CO Ronald Dolyk did violate the ECSO JMD Policy & Procedure Manual and this complaint should be considered **SUSTAINED.**

After a thorough investigation, **and by his own admission**, this Office finds CO Matthew Reardon did violate the ECSO JMD Policy & Procedure Manual and this complaint should be considered **SUSTAINED**.

After a thorough investigation, **and by his own admission,** this Office finds CO John Valenti did violate the ECSO JMD Policy & Procedure Manual and this complaint should be considered **SUSTAINED.**

CO Randy Chavanne:

On 04/17/18, I conducted an interview with CO Randy Chavanne in regards to this complaint. Before any questions were asked, I read CO Chavanne his Garrity Rights. CO Chavanne stated he understood his rights and signed the form. Sergeant Marc Priore and CO Nick Hendel were present during this interview as union representatives.

When asked, CO Chavanne denied the allegations of having sexual relations with any inmates during his career as a Corrections Officer. CO Chavanne denied bringing contraband into the Correctional Facility. CO Chavanne denied any association with former inmates outside of the facility.

This Office finds no evidence to support the allegations against CO Chavanne.

CO Chavanne provided a written statement, which is included in the case folder.

Conclusion:

After a thorough investigation, and considering the facts and evidence, this Office finds CO Randy Chavanne did not violate ECSO JMD Policy & Procedure and should be considered **EXONERATED** of all allegations.

CO Ronald Dolyk:

On 04/17/18, I conducted an interview with CO Ronald Dolyk in regards to this complaint. Before any questions were asked, I read CO Dolyk his Garrity Rights. CO Dolyk stated he understood his rights and signed the form. Sergeant Marc Priore and CO Nick Hendel were present during this interview as union representatives.

When asked, CO Dolyk denied having sexual relations with any inmates while on duty during his career as a Corrections Officer. CO Dolyk denied bringing contraband into the facility for any inmates. CO Dolyk did admit to contacting, and having a sexual relationship with, a former inmate on two occasions during the summer of 2017.

CO Dolyk provided a written statement, which is included in the case folder.

Conclusion:

After a thorough investigation and by his own admission, this Office finds CO Ronald Dolyk violated the ECSO JMD Policy & Procedure Manual and this complaint should be considered **SUSTAINED**.

CO Matthew Reardon:

On 04/17/18, I conducted an interview with CO Matthew Reardon in regards to this complaint. Before any questions were asked, I read CO Reardon his Garrity Rights. CO Reardon stated he understood his rights and signed the form. Sergeant Marc Priore and CO Nick Hendel were present during this interview as union representatives.

When asked, CO Reardon denied having sexual relations with any inmates while on duty during his career as a Corrections Officer. CO Reardon denied bringing contraband into the facility for any inmates. CO Reardon did admit to contacting a former inmate through social media and then continuing to send text messages and photos to this inmate after her release from jail. This contact occurred from April 3, 2018 until April 11, 2018, at which point, CO Reardon ended the contact.

CO Reardon provided a written statement, which is included in the case folder.

Conclusion:

After a thorough investigation, and by his own admission, this Office finds CO Reardon violated the ECSO JMD Policy & Procedure Manual and this complaint should be considered **SUSTAINED**.

CO John Valenti:

On 04/17/18, I conducted an interview with CO John Valenti in regards to this complaint. Before any questions were asked, I read CO Valenti his Garrity Rights. CO Reardon stated he understood his rights and signed the form. Sergeant Marc Priore and CO Nick Hendel were present during this interview as union representatives.

When asked, CO Valenti denied having sexual relations with any inmates while on duty during his career as a Corrections Officer. CO Valenti denied bringing contraband into the facility for any inmates. CO Valenti did admit to providing an inmate with a contact phone number and then contacting that former inmate by text messages.

CO Valenti did admit to making arrangements to meet with this former inmate but instead got cold feet and did not go through with the arrangement. CO Valenti said he has ceased any further contact with this former inmate.

CO Valenti provided a written statement, which is included in the case folder.

Conclusion:

After a thorough investigation, and by his own admission, this Office finds CO Valenti violated the ECSO JMD Policy & Procedure Manual and this complaint should be considered **SUSTAINED.**

CO Ronald Dolyk:

Personnel
Code of Conduct

Policy # 03-00-01

Regulations:

1) Violation of Rules:

Personnel shall not commit any acts or omit any acts which constitute a violation of any of the rules, regulations, directives, Policies and Procedures, or orders of the Office, whether stated in this manual or elsewhere.

2) Unbecoming Conduct:

Personnel shall conduct themselves, at all times, both on and off duty, in such a manner as to reflect most favorably upon the Office. Conduct unbecoming an employee shall include that which brings the Office into disrepute or reflects discredit upon the employee as a member of the Sheriff's Office, or that which impairs the operation or efficiency of the Office or of the employee.

28) Associations:

Personnel shall avoid regular or continuous associations with any persons whom they know, or should know, to be under criminal investigation or indictment, or who have a reputation in the community or in the Sheriff's Office for present involvement in felonious or criminal activity, except as necessary to the performance of official duties, or where unavoidable because of other personal relationships of the Personnel.

Further, Personnel shall not engage in any conversation, communication, dealing, transaction, association, or relationship with any inmate, former inmate, parolee, or former parolee, or any visitor, friend or relative of same in any manner or form which is not necessary or proper for the discharge of the employee's duties. Any such contact or attempt to contact an employee by any of the aforementioned persons shall be promptly reported to the Sheriff, JMD Superintendent or Division Chief.

CO Matthew Reardon:

Personnel
Code of Conduct

Policy # 03-00-01

Regulations:

1) Violation of Rules:

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CO John Valenti:

Personnel
Code of Conduct

Policy # 03-00-01

Regulations:

1) Violation of Rules:

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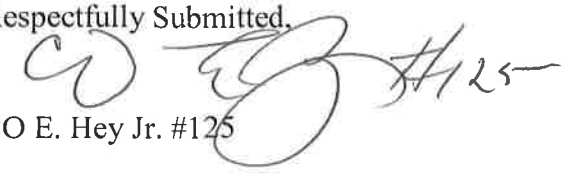
Further, Personnel shall not engage in any conversation, communication, dealing, transaction, association, or relationship with any inmate, former inmate, parolee, or former parolee, or any visitor, friend or relative of same in any manner or form which is not necessary or proper for the discharge of the employee's duties. Any such contact or attempt to contact an employee by any of the aforementioned persons shall be promptly reported to the Sheriff, JMD Superintendent or Division Chief.

It is the opinion of this Office that the investigative part of this compliant should be considered **CLOSED.**

Respectfully Submitted,



CO E. Hey Jr. #125

TIMOTHY B. HOWARD
SHERIFF

MARK N. WIPPERMAN
UNDERSHERIFF

SHERIFF OF ERIE COUNTY

ADMINISTRATIVE OFFICES
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FAX: (716) 858-7680

POLICE SERVICES
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BUFFALO, NEW YORK 14203
(716) 858-7618
FAX: (716) 858-3277
WEBSITE: http://www.erie.gov/sheriff

April 17, 2018

Corrections Officer Ronald Dolyk
Erie County Correctional Facility
11581 Walden Avenue
Alden, NY 14004

RE: *LETTER OF SUSPENSION*

Dear Officer Dolyk:

The Erie County Sheriff's Office Professional Standards Division was made aware of information suggesting that you were involved in an inappropriate relationship with a former inmate. Subsequent investigation, interviews and collection of evidence led this Office to conclude that, in fact, you violated the below-mentioned ECSO Policies and Procedures:

- JMD 03.00.01 Personnel Code of Conduct III, 01 Violation of Rules
- JMD 03.00.01 Personnel Code of Conduct III, 02 Unbecoming Conduct
- JMD 03.00.01 Personnel Code of Conduct III, 28 Associations

On the above date and time, you were interviewed by the Professional Standards Division in the presence of your Union leadership. During the interview, you did admit to having an inappropriate relationship with a former female inmate. Due to your honesty and admittance to said conduct, you will not be terminated. However, in lieu of termination, you will be suspended for seven calendar days beginning on April 23, 2018 through and including Sunday, April 29, 2018. You will also voluntarily sign a 12-month Last Chance Agreement pledging not to engage in same and/or similar conduct. Any future incidents of this conduct will result in your immediate termination.

Sincerely,

Mark N. Wipperman
Undersheriff

MNW:jma

cc: Sheriff Timothy B. Howard
Superintendent Thomas Diina
Deputy Superintendent Paul Evans
Chief John Greenan
CSEA President Marc Priore
File

Adymy, Joanie

From: Priore, Marc
Sent: Thursday, April 19, 2018 3:08 PM
To: Davis, Anne; Howard, Timothy; Wipperman, Mark; Diina, Thomas; Evans, Paul; Rodriguez, John; Greenan, John; Harris, Alfonso; Priester, Peter; Whalen, Alan; Stribing, Michael; Whalen, Gerald; Adymy, Joanie
Subject: RE: Letter of Reprimand & Letter of Suspension

As previously discussed, Officer Valenti will serve his 1 day on Thursday 4/26 and be listed on "DPA" as vacation as to keep this on a need to know basis, correct?

Respectfully,

Marc

From: Davis, Anne
Sent: Thursday, April 19, 2018 2:26 PM
To: Howard, Timothy; Wipperman, Mark; Diina, Thomas; Evans, Paul; Rodriguez, John; Greenan, John; Harris, Alfonso; Priester, Peter; Whalen, Alan; Stribing, Michael; Whalen, Gerald; Priore, Marc; Adymy, Joanie
Subject: Letter of Reprimand & Letter of Suspension

Anne Davis
Jail Management Division
716-937-5502

TIMOTHY B. HOWARD
SHERIFF

MARK N. WIPPERMAN
UNDERSHERIFF

SHERIFF OF ERIE COUNTY

ADMINISTRATIVE OFFICES
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ORCHARD PARK, NEW YORK 14127-3700
(716) 662-5554
FAX: (716) 662-8477
WEBSITE: http://www.erie.gov/sheriff

April 19, 2018

Officer Matthew Reardon
Erie County Sheriff's Office
11581 Walden Ave.
Alden, New York 14004

Re: **Letter of Reprimand**

Officer Reardon,

On or about March 15, 2018, the Office of Professional Standards received a complaint against you regarding on/off duty conduct. The allegations in this matter violate the follow Erie County Sheriff's Office Policy and Procedures:

- JMD 03-00-01, III, 01) Violation of Rules
- JMD 03-00-01, III, 02) Unbecoming Conduct
- JMD 03-00-01, III, 28) Associations

The investigators of the Office of Professional Standards conducted a thorough investigation and were able to sustain the allegations against you through their findings and you own admissions. Therefore, I am issuing you this **letter of reprimand.**

Be forewarned that future occurrences of a similar nature may result in further and more severe disciplinary action, up to and including termination of your employment.

Sincerely,

Thomas Diina
Superintendent

By: Alfonso Harris
Chief of Operations

Cc: Sheriff Timothy B. Howard
Undersheriff Mark Wipperman
Superintendent Thomas Diina
1st Deputy Superintendent Paul Evans
1st Deputy Superintendent John Rodriguez
Chief John Greenan 201 File
Chief Alfonso Harris
Captain Peter Priester
Captain Alan Whalen (Scan)
Lieutenant Kevin Trapper
Lieutenant William Whalen
Sergeant Marc Priore CSEA Local #815
Joanie Adymy (PSD file)
File

Ex. X

6/4/18 Employee will be terminated o/c to close C/L

ERIE COUNTY SHERIFF'S OFFICE

MEMORANDUM

Confidential Case Report

TO: **Undersheriff Wipperman**

FROM: **Correction Officer Ernest Hey**

DATE: **06/01/18**

SUBJECT: **PSD CASE #18-41 Off Duty Conduct <CO John Valenti>**

Synopsis:

On 06/01/18, CO John Valenti admitted that he was less than truthful when interviewed under Garrity on 04/17/18 in regards to PSD Case #18-25 and his Off Duty relationship with former Inmate [redacted]

When asked, CO John Valenti admitted that he did meet with former Inmate [redacted] on or about 04/07/18 for drinks and then he took her to a hotel and they did have sex.

Details:

On 05/26/18, Inmate [redacted] confided in Dep. J. Friedman that she did not want to be housed at the ECCF because she was involved in a "on and off" relationship with CO John Valenti. I/M [redacted] stated she thought it would be weird and awkward seeing him.

Dep. J. Friedman:

Deputy J. Friedman reported this information to her immediate supervisor. A copy of her statement is included in the case folder.

Sgt. C. Slimak:

Sgt. C. Slimak notified his Watch Commander immediately. Capt. Botello informed Supt. T. Diina of this information, Supt. Diina contacted PSD and an investigation was opened.

A copy of Sgt. Slimak's memo is included in the case folder.

Inmate [redacted]

On 05/29/18, Dep. A. Giglio and I conducted an interview of I/M [redacted] in regards to her relationship with CO John Valenti. When asked, I/M [redacted] admitted that they met initially during her incarceration at the ECCF. I/M [redacted] stated she did not know CO Valenti prior. I/M [redacted] told me that she and CO Valenti flirted and he did give her his phone number while he was on duty at the ECCF working Joliet Unit.

When asked, I/M [redacted] stated that at no time did they have sexual relations or sexual contact during her incarceration.

I/M [redacted] told me that CO Valenti contacted her by phone immediately after her discharge from jail. I/M [redacted] stated they made arrangements to meet at the Creek view Restaurant on Main Street in Williamsville but that CO Valenti never showed.

I/M [redacted] told me that they continued to have contact by text message and phone calls. I/M [redacted] stated they did meet at Santoras Pub on Transit. I/M [redacted] told me they had dinner and then went to her home. I/M [redacted] admitted that she had sex with CO John Valenti. I/M [redacted] said that CO Valenti confided to her that he was going to have an interview with PSD.

I/M [redacted] told me that after 04/17/18 she had no further contact with CO John Valenti.

A copy of her statement is included in the case folder.

It should be noted:

CO John Valenti was questioned about having a relationship with I/M [redacted] during an interview on 04/17/18 in reference to **PSD Case 18-25.**

When questioned about the extent of their relationship, CO John Valenti stated the following.

CO John Valenti:

On 04/17/18, I conducted an interview with CO John Valenti in regards to this complaint. Before any questions were asked, I read CO Valenti his Garrity Rights. CO Valenti stated he understood his rights and signed the form. Sgt. Marc Priore and CO Nick Hendel were present during this interview as union representatives.

When asked, CO Valenti denied having sexual relations with any inmates while on duty during his career as a Corrections Officer. CO Valenti denied bringing contraband into the facility for any inmates. CO Valenti did admit to providing an inmate with a contact phone number and then contacting that former inmate by text messages.

CO Valenti did admit to making arrangements to meet with this former inmate but instead got cold feet and did not go through with the arrangement. CO Valenti said he has ceased any further contact with this former inmate.

On 06/01/18, I conducted an interview of CO John Valenti in regards to this new evidence of his relationship with I/M [redacted] Before any questions were asked, I read CO Valenti his Garrity Rights. CO Valenti stated he understood his rights and signed the form. Sgt. Marc Priore and CO Nick Hendel were present during this interview as union representatives.

When asked, CO John Valenti admitted that he met with I/M [redacted] at Santoras Pub for drinks. CO Valenti admitted to taking I/M [redacted] to a hotel and that they did have sex. CO Valenti stated he then drove I/M [redacted] to her residence.

When asked, CO Valenti did confirm that he sent text messages and did have at least one phone call with her after they met. CO Valenti confirmed that I/M [redacted] did advise him that she had contact with PSD by telephone. CO Valenti stated he did not ask her for details of her conversation with PSD.

When asked, CO Valenti did admit that he was less than truthful during his initial interview and on his written statement which was given on 04/17/18 in regards to the extent of his relationship with I/M [redacted]

CO Valenti provided a written statement in regards to this interview which is included in the case folder.

Conclusion:

After a thorough investigation and by his own admission, this Office finds CO Valenti violated the ECSO JMD Policy & Procedure Manual this complaint should be considered **SUSTAINED.**

Personnel
Code of Conduct

Policy # 03-00-01

Regulations:

1) Violation of Rules:

Personnel shall not commit any acts or omit any acts which constitute a violation of any of the rules, regulations, directives, Policies and Procedures, or orders of the Office, whether stated in this manual or elsewhere.

2) Unbecoming Conduct:

Personnel shall conduct themselves, at all times, both on and off duty, in such a manner as to reflect most favorably upon the Office. Conduct unbecoming an employee shall include that which brings the Office into disrepute or reflects discredit upon the employee as a member of the Sheriff's Office, or that which impairs the operation or efficiency of the Office or of the employee.

3) Immoral Conduct:

Personnel shall maintain a level of moral conduct in their personal and business affairs which is in keeping with the highest standards of the law enforcement profession. Personnel shall not participate in any incident involving moral turpitude which impairs their ability to perform as law enforcement Personnel or causes the Sheriff's Office to be brought into disrepute.

10) Truthfulness:

Upon the order of the Sheriff, or the Sheriff's designee or a superior officer, Personnel shall truthfully answer all questions specifically directed and narrowly related to the scope of employment and operations of the Office which may be asked of them.

28) Associations:

Personnel shall avoid regular or continuous associations with any persons whom they know, or should know, to be under criminal investigation or indictment, or who have a reputation in the community or in the Sheriff's Office for present involvement in felonious or criminal activity, except as necessary to the performance of official duties, or where unavoidable because of other personal relationships of the Personnel.

Further, Personnel shall not engage in any conversation, communication, dealing, transaction, association, or relationship with any inmate, former inmate, parolee, or former parolee, or any visitor, friend or relative of same in any manner or form which is not necessary or proper for the discharge of the employee's duties. Any such contact or attempt to contact an employee by any of the aforementioned persons shall be promptly reported to the Sheriff, JMD Superintendent or Division Chief.

It is the opinion of this Office that the investigative part of this compliant should be considered **CLOSED.**

Respectfully Submitted,

CO E. Hey Jr. #125

TIMOTHY B. HOWARD
SHERIFF

MARK N. WIPPERMAN
UNDERSHERIFF

SHERIFF OF ERIE COUNTY

ADMINISTRATIVE OFFICES
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June 5, 2018

Corrections Officer John Valenti
Erie County Correctional Facility
11581 Walden Avenue
Alden, NY 14004

RE: *LETTER OF TERMINATION*
PSD Case #18-41

Dear Officer Valenti:

The Erie County Sheriff's Office Professional Standards Division was made aware of information suggesting that you were involved in an inappropriate relationship with a former female inmate. Subsequent investigation, interviews and collection of evidence led this Office to conclude that, in fact, you violated the below-mentioned ECSO Policies and Procedures:

- JMD 03.00.01 Personnel Code of Conduct III, 01 Violation of Rules
- JMD 03.00.01 Personnel Code of Conduct III, 02 Unbecoming Conduct
- JMD 03.00.01 Personnel Code of Conduct III, 03 Immoral Conduct
- JMD 03.00.01 Personnel Code of Conduct III, 10 Truthfulness
- JMD 03.00.01 Personnel Code of Conduct III, 28 Associations

On April 17, 2018, you were interviewed by the Professional Standards Division in the presence of your Union leadership. During the interview, you did admit to having communications with, and scheduling a place and time to meet, her. After receiving your Garrity warning, you testified that this scheduled meeting never took place because you had second thoughts and left the restaurant. When further questioned by myself, you stated that this was **the one and only time** you attempted to meet this former inmate. I advised you not to leave my office unless you were totally forthcoming about **any and all meetings, relationships, and/or communications** with former female inmates. You assured me that there were no other encounters and that you were being completely honest.

On May 30, 2018, the Professional Standards Office was made aware of, and confirmed, that you did, in fact, have another meeting/date with this former female inmate on or about Saturday, April 14, 2018 at a restaurant in the Amherst area. After meeting her at this restaurant, you both left and engaged in a sexual encounter at a nearby hotel.

Therefore, due to your untruthfulness under Garrity during the meeting on April 17, 2018, and your clear failure to disclose all of your misconduct, you are hereby terminated immediately from your employment with the Erie County Sheriff's Office.

Sincerely,

Mark N. Wipperman
Undersheriff

MNW:jma

cc: Sheriff Timothy B. Howard
Superintendent Thomas Diina
Deputy Superintendent Paul Evans
Chief John Greenan
CSEA President Marc Priore
File

NOTE: CO VALENTI SUBMITTED A LETTER OF RESIGNATION PRIOR TO SERVICE OF TERMINATION.

I John Valach resign my position as a Corrections Officer with the Erie County Sheriff Department as of Today June 5, 2018.

Marc Shore
CSEA
Erie Corrections Unit

John Valach