Testimony of

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I am Natalie Fiorenzo, Senior Corrections Specialist at New York County Defender Services (NYCDS). NYCDS is an indigent defense office that every year represents tens of thousands of New Yorkers in Manhattan's Criminal, Family, and Supreme Courts. The NYCDS Corrections Specialist Team provides a direct channel of communication with and advocacy for our clients who are incarcerated.

I. Introduction

NYCDS is horrified to learn of DOCs widespread practice of "deadlocking" mentally vulnerable and virtually defenseless individuals in cells—with no access to prescription medication, medical attention, basic hygiene, or contact with outside world—for days, weeks and even months on end.

The account of Justyna Rzewinski, the former Associate Director of Mental Health under Correctional Health Services ("CHS"), describes an appalling culture of depraved indifference among DOC Officers working in the Mental Observation ("MO") and PACE units at George R. Vierno Center ("GRVC"), which likely extends across all facilities. The dystopian scenario that Ms. Rzewinksi describes confirms horrifying reports that defenders and advocates have heard from our detained clients for years. Indeed, NYCDS testified about clients subjected to similar treatment at the Rose M. Singer Center and Robert N. Davoren Center at the April 29, 2022,

September 13, 2022 and October 18, 2022 Board meetings. Other groups have also documented reports of this practice.[1]

Ms. Rzewinksi's urgent report, in conjunction with NYCDS's independent investigation, corroborates a pattern and practice of organized cruelty far beyond what might be characterized as isolated instances of neglect. In short, Ms. Rzewinski confirms that the most vulnerable population on Rikers Island is being subjected to profoundly inhumane isolation and systematically deprived of access to psychiatric medications, medical treatment, basic hygiene, and humanity.

We are stunned not only at the depths of cruelty exhibited, but also the level of premeditation and logistical planning necessary to operationalize such a widespread system and execute it with secrecy and impunity for so long.

II. Background and History of the MO and PACE Units at Rikers Island.

Over half of the population at Rikers Island is flagged for mental health attention, but those that exhibit more serious needs are placed in specialized units, namely Mental Observation ("MO") units or Program to Accelerate Clinical Effectiveness ("PACE") units, which DOC claims provide a higher level of clinical care than is offered in a general population unit. According to DOC, these specialized units offer on-site access to clinical staff, who are able to assist with the acute mental health needs of those housed there, and Corrections Officers who are specially trained to work with this population. In a jail system that is notorious for denying critical, sometimes life-saving medical and mental health care,[2] such direct access to clinical staff is essential. Most notably, these units are specifically designed to distribute medications within the unit, rather than relying on escorts to receive medications, to ensure more consistent, reliable delivery of medications.[3]

Individuals placed in MO units are generally able to function independently, but suffer from serious mental health issues or are at risk for suicide, and therefore need "structured support and

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[1] *See, e.g.* Columbia University Center for Justice, *Solitary by Many Other Names: A Report on the Persistent and Pervasive Use of Solitary Confinement in New York City Jails* (December 2023), https://centerforjustice.columbia.edu/sites/default/files/content/Solitary%20By%20Many%20Other%20Names%20Report%20Final.pdf.

[2] Meko, Hurubie, *Rikers Inmates Are Routinely Denied Medical Care, Court Filing Says,* NY Times (Aug. 4, 2024) https://www.nytimes.com/2024/08/08/nyregion/rikers-inmates-health-care.html.

[3] Annie McDonough, *Mental Health Care on Rikers: New York's Largest Psychiatric Provider*, City & State New York (Sept. 30, 2022) https://www.cityandstateny.com/policy/2022/09/mental-health-care-rikers-new-yorks-largest-psychiatric-provider/377870/#:~:text=According%20to%20the%20Department%20of,from%20mental%20observation%20units%2C%20PACE.

more frequent observation."[4] According to DOC, "MO units operate under the guidance of a multi-disciplinary team of unit-based mental health providers who conduct daily rounds, provide group programming and individual psychotherapy and also oversee medication treatment. MO units are not punitive and afford the same out-of-cell time as General Population units."[5]

The PACE units were created in 2015 under then-Mayor Bill de Blasio in an effort to provide more robust clinical care to incarcerated individuals "who struggle to function adequately while incarcerated due to chronic mental illness, risk of acute psychiatric decompensation, and/or behavioral disruption."[6] Many of the individuals housed in the PACE units are those who have been determined by a "730" examination to be mentally "unfit" to proceed in their criminal case.[7] These individuals are housed in PACE units while they await placement in a forensic hospital run by the Office of Mental Health (OMH). Due to a growing backlog in OMH placement, these individuals currently spend 4-6 months waiting for a hospital bed to become available.

As soon as they opened, DOC began touting the PACE units' success, claiming they would "dramatically increase our delivery of therapeutic interventions for those at risk of further decompensation, self-harm and hospitalization, thereby reducing negative health outcomes."[8] According to the DOC website, the PACE units "are considered national models for therapeutic treatment of seriously mentally ill inmates."[9]

For years, NYCDS staff, relying on DOC's representations outlined above, have advocated for our clients with mental health needs to be placed in these units. Believing these units to be a vast improvement to the conditions and care in general population units at Rikers, our attorneys and corrections specialists have spent untold hours of persistent advocacy petitioning DOC and criminal court judges to place our clients in these units. As a result, at any given time, our office represents dozens of individuals housed in these units across NYC jail facilities.

III. The "Deadlocking" of NYCDS Clients.

NYCDS has heard reports about 24-hour lock-ins for years. In October 2022, for example, we submitted the following written account from a client at RMSC to this Board:

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[4] Department of Correction testimony before the New York City Council Committees on Justice Systems, Criminal Justice, and on Mental Health, Disabilities and Addiction (June 17, 2019) https://www.nyc.gov/site/doc/media/mh-hearing.page.
[5] Id.
[6] NYC Dept. of Correction, CAPS and PACE Backgrounder, https://www.nyc.gov/site/doc/media/caps.page.
[7] C.P.L. Article 730.
[8] Press Release. NYC Office of the Mayor. Mayor de Blasio to Triple Intensive-Care Mental Health Units on Rikers Island (April 26, 2016) https://www.nyc.gov/office-of-the-mayor/news/394-16/mayor-de-blasio-triple-intensive-care-mental-health-units-rikers-island.
[9] NYC Dept. of Correction, CAPS and PACE Backgrounder, https://www.nyc.gov/site/doc/media/caps.page.

> "Good morning, I just saw the news [quoting then-Commissioner Molina announcing that there was no solitary confinement at Rikers], and it's very disturbing to me how the Commissioner was talking. I need you to know that Buildings 10 and 12, where they're housing the mental health patients, they are keeping them locked in their cells 24 hours a day. They have not come out of their cells for at least over a month. Their cells are like living with a bunch of pigs, and if somebody comes here to take a look at those cells they could see that they are very unhealthy and very unlivable conditions. The women who are housed there in that area will get sick; the trash, the food is all over the place in their cell. They don't shower, they don't let them out for any type of activity. Video tape will show that. They will not let them out, the officers won't, and I don't know why. This is in Buildings 10 and 12, the mental health units. This needs to be investigated as soon as possible."

More recently, our staff have noticed increasingly alarming conditions affecting our clients in MO and PACE housing. In particular, several attorneys representing "730-ed" clients have noticed that when these individuals return back to Rikers from OMH facilities (after being "restored to competency"[10]), they severely decompensate within weeks.

Just last month, our office received a report that one of our clients in the GRVC MO unit was "deadlocked" for approximately one week. When this client was able to reach out directly to our corrections specialist unit, he recounted that he was locked inside his cell for 24-hours a day and denied access to his medication, a shower, and the phones. We were disturbed to notice that he was even denied a counsel visit with his assigned attorney during this week (under the auspices, of course, of a "refusal").

These accounts, in addition to others over the years, have alerted all NYC defender offices to DOC's proclivity towards locking down vulnerable clients. What we did not know, and are only now beginning to uncover, was just how widespread and pernicious the practice of deadlocking has become. In Ms. Rzewinksi's firsthand experience as a CHS clinician, our own worst fears regarding our clients' conditions of confinement, particularly in the PACE and MO units, have been realized.

When we heard Ms. Rzewinksi's harrowing account for the first time, we were appalled beyond words. As dedicated advocates, we were also called to action. Our first order of business was to begin conducting additional wellness checks on all of our clients housed in MO and PACE units and, to the extent possible, to independently investigate and confirm the information shared by Ms. Rzewinksi.

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[10] Pursuant to CPL 730.50.

We have recently interviewed several incarcerated clients directly impacted by deadlocking. We are saddened and horrified to share that our clients' experiences corroborate the following:

- The term "deadlock" is routinely used by DOC staff, and appears to have a universal definition among staff and incarcerated individuals. Unsurprisingly, we have found no written reference to deadlocking in any publicly available DOC policy, procedure, or manual. But consistent with Ms. Rzewinksi's account, there was no confusion or hesitation when we asked our clients whether they had heard the term "deadlock," and what it meant to them. Every single client immediately knew what deadlocking was, and defined it in a remarkably consistent way: in sum and substance, being locked down in their cell and being unable to leave for any reason.

- Deadlocked clients are denied access to showers, phone calls, recreation time, or any time out of their cell, for the duration of the deadlock. Each client we spoke to confirmed that individuals who are deadlocked lose access to basic hygiene and essentially all connection with the outside world.

- Being deadlocked critically impacts our clients' access to medication and medical treatment. Because they cannot leave their cells, deadlocked clients are prevented from receiving their prescribed medications in the usual manner. Some clients reported that, when deadlocked, prescriptions that come in pill form were specially delivered to them at their cell, though without the usual accompanying supervision to ensure they actually took those medications. Prescribed injectable medications, in contrast, were never delivered to clients' individual cells. And most shockingly of all: **some clients reported receiving none of their prescribed medications while deadlocked.**

- Deadlocking happens "all the time." Deadlocking is so commonplace that our clients reported it is not unusual for one or more people to be deadlocked every single day on their unit. More than one client described deadlocking as "happening all the time."

- Deadlocking can last hours, days, or even longer. Several of our clients reported being deadlocked themselves, or seeing others deadlocked, for varying periods of time. Some reported being deadlocked for two or three days individually. One reported a deadlock period of two weeks. Even others reported witnessing a fellow detainee on their unit who was deadlocked, while in crisis, for months.

- Deadlocking can be individual, or involve entire units. Our clients reported that while individuals are often deadlocked alone in their own cell, on multiple occasions, entire units have been deadlocked for a period of hours or days. In other words, it is reportedly not uncommon for DOC employees to lock down entire MO or PACE units, without

> warning, and for unspecified reasons—trapping *every single person* housed on a unit in their cell for hours or days without access showers, phones, rec time, and without consistent access to medication or medical care, psychiatric and otherwise.

While every new detail we learn about deadlocking shocks our office to the core, we are compelled to expand on a few key issues here.

First, the lack of access to medication and medical treatment for individuals in deadlock is especially cruel and inhumane *given the specific needs of the client population on MO and PACE units*. It is well-established that locking a person in a cell 24/7 is incredibly damaging to mental or physical wellness. This is infinitely more true for those clients diagnosed as having serious mental health issues, or who have suicidal ideations. To exacerbate matters, individuals subjected to "deadlocking" are not only dealing with the trauma of isolation, but also have to suffer the serious physical and psychological effects of a sudden withdrawal from their prescription medications. The direct harm to these deadlocked individuals is frankly incalculable.

Of course, the deterioration of these individuals' mental health can, in turn, have deleterious effects on others in their immediate vicinity. Several of our clients endorsed seeing others being deadlocked, including while in significant psychiatric distress. For example, one report involved a deadlocked individual, likely in the throes of a psychiatric episode, who continuously banged on the walls of their cell, screamed, covered themselves in feces, and threw human excrement. This is obviously a traumatic incident for both the individual in deadlock and the witnesses to his condition.

Second, and specifically concerning to us as legal advocates, is the use of deadlocking as a depraved form of "punishment" without any semblance of due process. According to the clients we interviewed, deadlocking is commonly considered a punitive measure taken by DOC employees against incarcerated individuals. Deadlocking plainly falls outside of the scope of legally permitted disciplinary procedures and is applied entirely arbitrarily by DOC staff, who decide who gets deadlocked and for how long, with impunity. At a minimum, we believe this practice to be profoundly violative of due process, local and federal law, and basic tenets of human decency. In every respect, this is a punishment that is cruel and unusual.

We note here the particular concern that deadlocking is a punishment most often meted out to individuals who may have trouble advocating for themselves, and who do not always have family or friends in their life, or anyone beyond legal counsel, to advocate for them. Even for those that do have those connections, some of these individuals may not have the awareness to reach out and explain what is happening to them given their mental and physical condition. We are aware of anecdotal evidence that individuals who lack close community

connections—especially those who do not often have visitors beyond legal counsel—are more likely to be deadlocked more often, and for longer periods of time.

Finally, we feel it is appropriate to emphasize the high level of consistency in the stories our clients shared with us about the practice of deadlocking. Our clients' own stories, combined with the detailed report by Ms. Rzewinski, reveal a chilling truth that DOC and CHS have gone to great pains to keep out of the public eye for years.

IV. Conclusion

There is still so much we do not know about deadlocking as a practice on Rikers Island. But we have no doubt of its traumatic and dehumanizing impact on our clients. The conspiracy to deprive the most vulnerable detainees on Rikers Island of medication, medical attention, basic hygiene, and contact with the outside world must end.

We urge the Board to investigate this practice extensively and immediately, so the public can see the full extent of the unspeakable horrors that the most vulnerable New Yorkers have endured at the hands of DOC staff.

If you have questions about this testimony please email me at nfiorenzo@nycds.org.