

DISABILITY RIGHTS

at University Legal Services



TO: Tammy Seltzer, Lyndsay Niles, Mani Golzari, Lindsay Walter, Emily Gunston, Mark Herzog, and David Ludlow
FROM: Natasha Walls Smith
RE: Safe Cell Report
DATE: March 11, 2020

I. INTRODUCTION

This report discusses violations of occupant rights while in safe cells. Although I documented many varying complaints, the report only focuses on complaints made by two or more individuals that continue to persist. This way, I hope to capture violations of policies and rights that are likely more common. The qualifying complaints are access to showers, water, recreation, and permitted safe cell items. Additionally, I have included a section noting inconsistencies in record keeping, which I witnessed on several occasions.

Even though there are many outstanding complaints to be addressed, District of Columbia Department of Corrections (DC DOC) has resolved several structural and systemic issues as a result of the efforts of Disability Rights DC's safe cell advocacy. These changes are listed in section III of this memorandum.

Over six months, I executed 13 random safe cell inspections with 34 evaluations for a total of 30¹ individuals. 29 of the evaluations are from South 3 occupants, two from DC Central Treatment Facility and three from the infirmary. Most of the complaints are from my interviews in South 3, but I note when the issues apply to other safe cell units. Safe cell inspections took place on [REDACTED].

At the end of the report, I suggest possible solutions or goals that may help align staff practice and behavior with the overall policies and procedures of DC DOC.

¹ Actual names of individuals are used if they signed a release authorizing use of their information. In cases without authorization, a random stream of five alphanumeric characters are used to protect individual identity.

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II. SAFE CELL INSPECTIONS

a. "Pipe" Log Documentation is not Consistent or Accurate

For suicide watch and precaution, COs in South 3 are supposed to document their security checks on a "pipe" log at staggered intervals "not to exceed 15 minutes."² Suicide checks require a CO to touch a pipe to a button-like object on the wall next to each safe cell, which electronically records the time between checks. Next, the CO should fill in the pipe log, which hangs next to each occupant's door. This requires them to document the time of the check and record the number of the associated action of the occupant, such as sleeping, eating, standing at the window, using the bathroom, or etc. The handwritten log is there to make sure COs actually do a visual check on the occupant. At the end of each shift, a white shirt will review and sign the sheet.

However, COs in South 3 usually only complete the electronic component and walk by without logging the time of the check on the sheet or the actions of the occupant. Last year, this meant leaving some logs with large periods of undocumented time on the sheet. For example, a log showed entries for 3 AM, 4:20 AM, and then 4:50 AM.³ Both gaps exceed the 15-minute policy.

Concerningly, I am no longer able to discern if visual checks exceed 15 minutes because of the new method used to fill out the pipe logs. Currently, all units with safe cells are filling the time section on the log at the start of the shift. Thus, when looking at the log, visual checks seem to be documented in precise 15-minute intervals.

For example, if I arrived to check the log around 3:55 PM, I would see logs similar to the one below.⁴ The later times are filled in regardless of the actual time of the check.

Time	3:00	3:15	3:30	3:45	4:00	4:15	4:30	4:45	5:00
Action	6	6	6	5					

This practice makes it more difficult to verify the consistency of visual checks and ignores the "staggered intervals" policy.

Additionally, I witnessed Officer W [REDACTED] falsify pipe logs on two separate occasions. For one occupant,⁵ he filled in the log times from 1:45 to 2:45 all at the same time. In the other instance, Officer W [REDACTED] simultaneously filled the 1:45, 2:00, and 2:15 times on a pipe log.⁶

² District of Columbia Dep. of Corrections, *Policy and Procedure: Suicide Prevention and Intervention*, 6080.2G(23)(6)(e)(1).

³ E.g., [REDACTED].

⁴ This is not a replica of the actual table but is only here as a visual explanation of the issues with the logged time and action. This example does not list all the information available on the actual DOC sheet.

⁵ Alse9, South 3, [REDACTED]

⁶ Gmp6t, South 3, [REDACTED]

b. South 3 COs Restrict Access to Water in Safe Cells.

DOC policy states occupants “shall” have access to running water, but access “may” be denied if the occupant has previously tried to flood their cell or used the running water to facilitate a suicide attempt.⁷ Changes in staffing, procedures, and general communication has resulted in confusion and inadvertent mistreatment of occupants in the safe cells. For example, the safe cell treatment sheets by Unity allow for access to water in certain cases. However, DOC staff are the actual witnesses to incidents of prior flooding. Currently, the Unity records do not reflect flooding incidents reported in DOC records. Unsurprisingly, the lack of procedural reporting/communication causes frustration for occupants, doctors, and DOC staff alike.

Below are the individuals with treatment plans that did not allow access to water or were not followed by staff.

- Five individuals’ treatment plans allowed access to running water, but their water was turned off and only turned on when specifically requested for flushing;
- four had treatment plans denying access to water but occupants had access anyway; and
- nine either did not have a treatment plan allowing water access or the treatment plan was not filled out completely and there was not a notation for history of flooding. All nine did not have access to water.

In the five cases where the water was turned off despite the treatment plan, staff said they could not turn off water in adjoining cells for only one occupant and on for the other. Even Lieutenant P [REDACTED] did not know how to turn water on for only one occupant if the occupant in the connected cell is denied access to water. In response, I have told staff about the tool from maintenance that turns off water in one cell while allowing access to the other, but no one ever called maintenance.

Further, occupants who were never incarcerated and were admitted to a South 3 safe cell directly from intake were not allowed access to water by their treatment plan and did not know how to get drinking water. Being admitted straight from intake means occupants do not get a chance to go through orientation, so they are unfamiliar with the policies, procedures, and culture of the jail. For that reason, occupants do not know how to get drinking water and are only given something to drink at meals. Three out of the three occupants⁸ admitted directly from intake reported not knowing how to access drinking water—i.e., by asking COs to bring them water from the water fountain.

c. South 3 Safe Cell Occupants are not Consistently Receiving Showers

⁷6080.2G(23)(6)(e).

⁸

Third shift is responsible for giving showers to those in South 3 safe cells. Occupants in safe cells are supposed to be offered a shower every day,⁹ while all other occupants are given showers every three days. On October 15, 2019 both Lieutenant P [REDACTED] and Major T [REDACTED] directed the staff to ask safe cell occupants everyday if they wanted a shower. Instead, COs are only giving showers when occupants ask for a shower *and* there is enough time to give them showers after dinner, recreation, and showers for the rest of South 3. Out of the eight occupants that resided in a South 3 safe cell for three or more days, all eight¹⁰ reported not having showered since arrival.

In response, some occupants protest the lack of showers by “jacking their slots,” meaning they stick their arm through the slot where they are given food and medication and refuse to remove their arm so that the slot cannot be closed. Jacking their slot usually leads to verbal altercations with the staff and can lead to a cell extraction. In one instance, Mr. [REDACTED]¹¹ jacked his slot in protest and the staff asked me to help resolve the situation. Mr. [REDACTED] told me he was concerned he would not be given a shower once I left. I told him I would stay until he got his shower. Mr. [REDACTED] removed his arm.

COs and White Shirts alike immediately assume the occupant is lying when I bring up the issues of showers. Second shift staff dismiss my complaints by telling me it is not their job to give showers; third shift is supposed to give showers. Third shift says that they do give showers but also will excuse the lack of showers by telling me that they don’t have enough staff to give showers to safe cell occupants. It is often obvious by observation—i.e., smell—that individuals have not received showers for several days.

When I discussed the shower issue with Lieutenant P [REDACTED], he told me that sometimes the occupants lie and say they were not given a shower when they were. I asked Lieutenant P [REDACTED] to talk to the individuals with me. Together, we talked to the individuals, reviewed their sheets, and looked for time indications for showers.

Lieutenant P [REDACTED] said we needed to check the logbook to know for sure. I asked him to show me. We went into the bubble (a small office located in the center of the unit) where he pulled out a green logbook and told me I should check the log book to determine if something really did or did not happen. I asked if he could show me an example of what the shower notation would like in the log. He reviewed log entries for several days and did not see a notation indicating safe cell showers. I asked him what it means if there is not a notation. He told me if there is not a notation in the book, that means it did not happen. He then directed the staff to give them showers.

⁹ The policy does not state a specific number of showers a week. Lt. P [REDACTED], Maj. T [REDACTED], and Elton Jones (prior point of contact and Health Systems Specialist) all stated that safe cell occupants should receive daily showers.

¹⁰ [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

to Dr. Wo [REDACTED], the regular psychiatrist responsible for Mr [REDACTED] case, he also stated he believed the doctor changed his status as retaliation and immediately changed Mr [REDACTED] status back to precaution when he arrived at CDF Monday morning.

f. South 3 COs Do Not Always Give Mattresses to Occupants

DOC policy states that occupants “will” be given a safety mattress if it is not a safety hazard designated on their treatment plan.¹⁵ Yet, two occupants who were allowed mattresses by their treatment plan were not given mattresses.¹⁶ In both cases, South 3 experienced a lot of safe cell turnover. On October [REDACTED] 2019, Mr. [REDACTED] was the only new safe cell occupant and had been in cell [REDACTED] since 1:46 PM (second shift). I checked on him between 7:30 and 8 PM (third shift) and found he was approved for a mattress. I talked to Officer Y [REDACTED], the CO in charge of third shift that evening, about getting a mattress for Mr. [REDACTED]. When I asked why he did not have a mattress, I was told they do not have enough mattresses for all the safe cells. Officer Y [REDACTED] told me Mr. [REDACTED] had to wait until the next day to receive a mattress because all the other mattresses were dirty. I had to contact Lieutenant P [REDACTED] to get a mattress. He also did not know where to get a mattress but searched and eventually found one. None of the other staff on South 3 were willing to search for a mattress.

Additionally, two safe cell occupants¹⁷ received dirty mattresses. One occupant used his blanket to cover his mattress because it had feces on it. I contacted a white shirt and told him about the dirty mattresses. He told me he would find a mattress for the occupant that received a mattress with feces on it but was unsure if he could find one for the other occupant.

III. ISSUES RESOLVED BY ADVOCACY

- The infirmary safe cell occupants were making all their legal calls on speakerphone, which allowed the CO making the call and any other person in the vicinity to hear the entire conversation. I contacted Lieutenant F [REDACTED] and showed him the phone was not appropriate for legal calls and asked him to have the phone fixed as soon as possible. He put in an order for the phone to be fixed while I was standing there. The phone was fixed.
- Only three out of the nine infirmary cameras for the safe cells worked. The rest had not worked for months. I talked to Lieutenant F [REDACTED] about the problem, and now, eight cameras work out of nine.
- CTF safe cell [REDACTED] used a paper towel sheet as a curtain. I told the COs that it needed to be an actual curtain. The paper towel did not properly cover the window. I asked the CO to put in a request for it to be fixed as I was standing there. It was fixed by my next visit.
- After the November CO rotation, each safe cell area started using sheets that said checks were to be done every 30 minutes instead of in staggered intervals not to exceed

¹⁵ See 6080.2G(23)(6)(f).

¹⁶ [REDACTED]

¹⁷ [REDACTED]

15 minutes. I spoke with the COs and officers in charge in each unit, the head of nursing who spoke to her boss about the issue, and Mr. Reid, the mental health coordinator. They replaced the sheets and the new sheet has the correct language.

- CTF safe cell ■ had a light that continuously flickered, and in safe cell ■, the light could not be dimmed. A CO put in work orders for both, and they were fixed by my next visit.
- None of the lights on the acute block in South 3 worked, including the main lights and the individual cell lights. The lack of electrical lighting meant occupants on the acute unit sat in the dark starting around 4:00 PM. COs said they submitted work orders, but the lights did not get fixed. I asked them to submit another work order. The OIC was absent that day, but I spoke to her about the lighting issue when I saw her again. The issue was that the COs did not know how to properly work the lights. She showed the other COs how to work the lights. Instructions to operate the lights are taped to the window of the bubble.
- The psychiatrists did not know they could allow property and out of cell time. I showed them the policy and treatment plans now include these privileges.

IV. RECOMMENDATIONS

1. Training on the meaning and expectation of staggered interval security checks ■ needed immediately.
2. Supervisors need to re-train and address issues related to water access. This should be a priority and disobeying should have consequences.
 - a. Occupants should be briefed on how to access drinking water when access to water is denied by the treatment plan.
 - b. A method for comprehensive flooding documentation that allows both doctors and DOC staff to access the information.
 - c. Give South 3 staff the maintenance tool needed to turn off only one cell's water at a time. Staff should be trained on using the tool.
3. All shifts in South 3 should be educated on where to find mattresses.
4. Recreation should be made a priority and procedures need to be developed to guarantee occupants are given their recreation time.
5. Schedule a joint meeting with ULS, Warden, doctors and officers on the purpose and implementation of treatment plans. Treatment plans are created by Unity doctors but executed by DOC staff. This results in tension between the two. In most disagreements the occupants become collateral damage as privileges are repeatedly taken away and reinstated.