UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

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AHMED SHEPPARD, et al., 91 Civ.4148

Plaintiffs, (RPP)

-vs.- DECLARATION OF PLAINTIFFS'

ANDREW PHOENIX, et al., COUNSEL

[FED. R. CIV. P.

23(e)]

Defendants.

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Jonathan S. Chasan declares pursuant to 28 U.S.C. 1746 as follows:

1. I am an attorney with the Prisoners' Rights Project of the Legal Aid Society, and together with my colleagues Sarah Kerr and Dale A. Wilker, represent the fifteen named plaintiffs and the plaintiff class in this action. I execute this Declaration in support of the application to the Court that it approve and enter as an order the Stipulation of Settlement ("the Stipulation") agreed to by the parties, and specifically to provide the Court with an understanding of how and to what extent the Stipulation successfully resolves plaintiffs' claims. First, I have provided the Court with an explanation of how the resolution of this litigation complies with the Prison Litigation Reform Act, 18 U.S.C. § 3626 et seq. Second, I have described the factual basis for the Stipulation--the record designated by the parties. Third, I have set out an outline of the issues raised in the litigation, a summary of the history of the litigation, and a recitation of the relief secured by the Stipulation. I believe that after reviewing the Stipulation and this Declaration, the Court will be satisfied that the interests of the plaintiff class have been protected and substantially advanced by the relief negotiated on its behalf. Assuming defendants' compliance with the terms of the Stipulation, the parties' agreement holds out the substantial likelihood that the culture of uniformed staff brutality and cover-up in the New York City Department of Correction's Central Punitive Segregation Unit ("the CPSU") will be rooted out, and that the Unit will be run consistent with constitutional mandates.

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The Prison Litigation Reform Act

1. The Stipulation is consistent with the terms of the "Prison Litigation Reform Act," 18 U.S.C. §3626 et seq. First, defendants have acknowledged that the relief to which they have agreed is required to redress violations of the plaintiff class' federal rights. Stipulation, page 4. Second, defendants have conceded, and plaintiffs have agreed,

based on the entire record, that the remedies set forth in this Stipulation and Proposed Order are narrowly drawn, extend no further than necessary to correct violations of the federal rights of the plaintiff class, and are the least intrusive means necessary to accomplish redress.

Stipulation, page 4. Third, the parties have agreed that the Stipulation, once approved and entered as an Order of the Court, shall remain in effect for at least two years. After two years, defendants may move the Court to terminate relief, but the motion shall not be granted if the Court makes written findings based on the record that prospective relief remains necessary to correct a current and ongoing violation of the plaintiff class' constitutional rights, extends no further than is necessary to correct the violation of those rights, and the Order is narrowly drawn and the least intrusive means necessary to correct the violation. Stipulation, ¶ 103; and see, 18 U.S.C. § 3626(a), (b) (1), (3).

The Designated Record

1. "The record" documenting violation of the plaintiff class' constitutional rights, and providing the factual basis for the relief the parties agree should be ordered by the Court, has been jointly designated by the parties. This record consists of:
2. excerpts of 72 depositions of: CPSU officers; jail supervisors, including Wardens, Deputy Wardens, Assistant Deputy Wardens and captains; the present Commissioner and three of his predecessors; Deputy Commissioners; Integrity Control Officers; Investigation Division investigators and supervisors;
3. lists of hundreds of inmates injured in the CPSU by staff in use of force incidents between 1990 and 1995;
4. voluminous documentary exhibits including:
5. numerous Department memoranda,
6. facility records of over 626 use of force incidents in the CPSU between 1988 and 1996;
7. 402 investigative files (which include facility use of force files) prepared by the Department of Correction's Investigation Division concerning use of force incidents in the CPSU, as well as 168 records of the Investigation Division's Incident Review Team ("IRT");
8. 67 files reflecting the records of Department discipline prepared in connection with use of force incidents in the CPSU;
9. charts and spreadsheets which summarize voluminous Department of Correction use of force, investigation and disciplinary activity;
10. Department of Correction rules, regulations, orders and directives;
11. videotapes of use of force incidents and photographs of inmates injured by uniformed staff;
12. trial and interview transcripts prepared in connection with criminal investigations and prosecutions of CPSU staff;
13. the Rule 26, F. R. Civ. P. reports prepared by plaintiffs' expert witnesses, Vincent Nathan, Steve J. Martin, Charles Montgomery and Isidore Mihilakis, M.D., which were submitted to defendants on December 1, 1997; and the transcripts of the depositions of Messrs. Nathan, Martin and Montgomery, which were conducted in December, 1997.

The Commencement and Prosecution of the Litigation: 1993--6

1. The amended complaint in this case was filed in February, 1993, asserting damage claims on behalf of fifteen present and former CPSU inmates who alleged that they had been brutally beaten by CPSU staff in separate incidents between June, 1990 and December, 1992. (The original pro se complaint in this case was filed by Ahmed Sheppard in 1991.) The amended complaint also asserted on behalf of the class of inmates then or in the future housed in the CPSU claims for declaratory and injunctive relief "to end a pattern of unconstitutional and excessive force." Defendants in the damage claims included a number of correction officers and captains identified by name (50 officers and 10 captains were identified by name in plaintiffs' second amended complaint, filed on March 10, 1994), as well as the Warden of the jail in which the CPSU was located--the James A. Thomas Center ("JATC" or "HDM")-- the Deputy Warden in charge of the CPSU, the facility's Deputy Warden for Security, who supervised the Unit manager, the Commissioner, the Chief of Department, several of their predecessors in office, and the City of New York. The claims for declaratory and injunctive relief were directed at the supervisory defendants--the Commissioner, Chief of Department, Warden, Deputy Warden for Security and Deputy Warden in charge of the CPSU--who "either authorized the beatings or failed to supervise the CPSU staff in the face of a well-documented history of inmate abuse in the CPSU." Second Amended Complaint, ¶ 1. Plaintiffs' prayer for relief sought an order requiring these defendants to formulate a remedy to "include measures which address the continuing deficiencies in selection, training, evaluation, supervision and command of the uniformed staff in the CPSU, and the Department's investigatory and disciplinary failures."
2. Each of the named plaintiffs alleged that he had been subjected to separate brutal beatings by groups of uniformed staff members, that each of the beatings had been covered up by the preparation of false reports, and that these beatings were manifestations of a pattern and practice of misconduct by uniformed staff in the CPSU. These beatings were examples of a long-standing, deeply embedded and widespread culture of brutality and violence in the Unit which was perpetrated by line staff and supervisors, and sanctioned up the chain of command. Specifically, plaintiffs alleged that:

1. Members of the CPSU uniformed force engaged in a calculated effort to terrorize inmates by misuse of physical force, the infliction of summary punishment, and the withholding of rights and privileges guaranteed by prior orders of the Court (see, Benjamin vs. Malcolm, 75 Civ. 3073), the New York City Board of Correction and the Constitution, including the deprivation of running water in cells, access to the telephone and recreation;
2. Members of the CPSU uniformed force used force without justification against inmates to punish them for minor misconduct or perceived disrespect towards staff, often beating inmates hours or days after the initial contact. Some CPSU captains ordered or participated themselves in beating inmates, some stood by while officers beat inmates; some captains covered up the illegal conduct of their subordinates;
3. Members of the CPSU uniformed force subjected inmates to sadistic initiation rites when they entered the Unit, known as "greeting beatings." Inmates subjected to these beatings were often those who had been sentenced to punitive segregation for having assaulted staff in other jails;
4. Inmates targeted for abuse by members of the CPSU uniformed force were routinely beaten in their cells, or removed from their cells to isolated areas, such as strip search areas or stairwells, and beaten by groups of officers where there were no civilian or inmate witnesses. Many inmates were beaten while naked;
5. Inmates beaten in the CPSU were often severely injured, and many suffered facial and other fractures, perforated eardrums and/or internal injuries;
6. Members of the CPSU uniformed staff routinely falsified documents to cover up inmate beatings, and in some cases simply failed to report any use of force. Some officers injured each other to support false claims that inmates had assaulted staff, and some staff members carried "throw down" weapons which they falsely claimed the inmate possessed in order to justify the use of force. Inmates who were beaten or who witnessed beatings were solicited by staff members to make false statements about incidents, or to refrain from reporting injuries. Some inmates were

offered access to medical care or discharge from the CPSU in exchange for their cooperation.
7. Line officers in the CPSU were drawn disproportionately from recruit classes at the Department's Training Academy;
8. Supervisors in the jail in which the CPSU was located, as well as high-ranking Department supervisors, knew for years from a number of sources--including their own documents, communications from oversight agencies, inmate representatives and the United States District Court's Office of Compliance Consultants--that there was an on-going pattern of physical abuse in the CPSU, but these supervisors failed to take measures to curb the abuse. These supervisors failed to ensure that competent, un-biased investigations of use of force incidents were conducted at both the facility and central office, and they failed or refused to subject staff members whose misconduct was brought to the Department's attention to any meaningful disciplinary measures;
9. The pattern of brutality and cover-up in the CPSU, the Department of Correction's failure to conduct unbiased investigations and to engage in meaningful discipline of staff, and the long-standing failure of the Department to properly supervise the Unit were so institutionalized as to demonstrate a policy or custom that implicitly authorized and permitted the abuse of inmates in the CPSU.

1. Between 1993 and July, 1995, plaintiffs conducted extensive documentary and deposition discovery concerning the damage claims of the fifteen named plaintiffs. Much of the information gathered in this phase of discovery was highly probative of the supervisory failures of the CPSU, JATC and Department managers, and of the systemic character of the staff violence in the Unit. For example, depositions of 42 correction officers who worked, or who had worked in the CPSU, produced evidence of: officers' involvement in substantial numbers of use of force incidents under circumstances strikingly similar to those involving the named plaintiffs; incidents which had been reported falsely; reports officers had signed but which had been written by other staff members; highly suspicious staff injuries; and staff use of "throw down" weapons. The deposition of the facility's Integrity Control Officer, Assistant Deputy Warden Gloria Hunter, similarly yielded significant testimony concerning the long-standing unwillingness of Department supervisors to confront the evidence she had gathered concerning misuse of force in the Unit, and the failure of facility supervisors to monitor staff use of force consistent with Department requirements.
2. Depositions of ten investigators and supervisors in the Department's Investigations Division produced substantial evidence of the Department's long-standing failure to conduct competent, unbiased investigations into use of force incidents. These depositions demonstrated how poorly trained and inadequately supervised most of these investigators were; how the Department's central office had at times actively impeded the conduct of use of force investigations; and how the Division's disorganization and lack of automated resources prevented it from effectively gathering information in any meaningful fashion.
3. In June and September, 1995 defendants requested that the noticed depositions of CPSU and JATC supervisors be adjourned while the City Law Department determined which of these individuals it would decline to represent pursuant to General Municipal Law § 50-k. The statute (§ 50-k(5)) requires the City to represent its employees in civil actions "arising out of any alleged act or omission which the corporation counsel finds occurred while the employee was acting within the scope of his public employment and in the discharge of his duties and was not in violation of any rule or regulation of his agency at the time the alleged act or omission occurred." (The City had declined to represent 21 correction officers at the commencement of the litigation, and these individuals had been represented by counsel retained by their union, the Correctional Officers Benevolent Association ("COBA").) At the Court's suggestion, plaintiffs agreed to defer additional depositions until the representation issue was resolved. In November, plaintiffs moved to disqualify Dienst and Serrins, newly retained counsel to the Correctional Officers' Benevolent Association, which had filed notices of substitution of attorney on behalf of the 21 officers who until then had been represented by COBA's prior counsel. The motion was based on the fact that Richard Koehler, former Commissioner of Correction, was of counsel to the Dienst office, was to be called by plaintiffs as a fact witness, and his testimony was likely to be adverse to that of a number of CPSU officers who were to be represented by the firm. See, Plaintiffs' Motion to Disqualify Counsel (November 28, 1995). Shortly after argument on the motion on January 24, 1996, the Dienst firm withdrew as counsel to these officers.
4. On January 23, 1996 the Law Department advised the Court and plaintiffs' counsel that the City

had declined to represent 23 additional defendants in the case. Plaintiffs' counsel was advised that these defendants included Warden Phoenix, Deputy Wardens Bird and Kozack, Assistant Deputy Warden/CPSU Unit Manager Viera, six captains and twelve correction officers. In their January 23 letter, the Law Department informed the Court that, "in an effort to address the historical problems at the CPSU that are the focus of this lawsuit, the New York City Department of Correction is in the process of implementing a plan to move the CPSU from JATC to the Otis Bantum Correctional Center ["OBCC"]. OBCC is a considerably more modern facility than JATC and the new unit will be completely covered by video cameras. In addition, DOC intends to remove all Sheppard defendants from the CPSU and to screen all new staff to prevent officers with extensive use of force histories from being placed in the unit." Letter, Martha Calhoun to Hon. Robert P. Patterson, Jr., January 23, 1996.

5. In February, 1996 the fifteen named plaintiffs settled their damage claims against the individual defendants and the City for sums totaling $1.6 million, and these claims were dismissed on stipulation. See, Stipulation and Order, April 18, 1996.

The Relocation of the CPSU; The Parties' Abortive Efforts to Settle the Litigation; and the Resumption of Discovery and Scheduling of the Case for Trial

1. On March 9, 1996 the Department of Correction relocated the CPSU from JATC to OBCC. At a status conference later that month, the City advised the Court that it was "actively pursuing" plaintiffs' proposal to settle the remaining injunctive claims, a proposal which addressed the systemic deficiencies with respect to the use of force policy, training, supervision, investigation and discipline of officers who misused force.
2. Plaintiffs' counsel continued to monitor closely staff use of force in the Unit. In late April, plaintiff's counsel advised the Court that, notwithstanding the relocation of the Unit and the replacement of its staff, "we expect to prove that there has been, and still is, a pattern of misuse of force in the CPSU, that this pattern has led to the infliction of serious injuries on large numbers of inmates, and it has persisted through a number of Department of Correction and facility administrations. We likewise expect to prove that the pervasiveness of staff violence in the CPSU is a consequence of systemic deficiencies in staff selection, assignment, training, supervision, investigation and discipline." Letter, Jonathan S. Chasan to Hon. Robert P. Patterson, Jr., April 30, 1996. Plaintiffs' counsel wrote to the Court concerning OBCC again, on May 20, 1996, that there was "no doubt that the infliction of serious injuries on class members, including some who were reportedly beaten over the head while handcuffed and others who were sprayed with chemical agents while cuffed, results from a continuation of the same systemic deficiencies in supervision, training, investigation and discipline of uniformed staff which gave rise to this lawsuit in 1993." Letter, Jonathan S. Chasan to Hon. Robert P. Patterson, May 20, 1996.
3. On May 23 and July 31, 1996, plaintiffs' counsel advised defendants' counsel by letter that a pattern had already emerged in the OBCC CPSU of staff misuse of force: inmates were being beaten while in handcuffs and in areas outside the range of wall-mounted video cameras; a number of inmates had been struck in the head and face and required hospital treatment for their injuries. Line staff and captains, who had been authorized to apply tear gas to inmates in the CPSU shortly after the OBCC Unit opened, were gassing inmates--including inmates being treated by medical staff for asthma-- in situations where the use of chemical agents appeared unnecessary. See, *infra*, ¶¶ 87-96.
4. On April 26, 1996, plaintiffs noticed additional depositions of JATC and Department of Correction supervisory staff, including some which had first been noticed in 1995. Defendants objected to plaintiffs' conducting additional discovery concerning the CPSU at JATC, and continued to trumpet the "bold reforms"--including the transfer of authority to investigate use of force incidents in the CPSU from the Department of Correction to the Department of Investigation--that they had initiated at OBCC as a measure of how unlikely plaintiffs' could successfully litigate the injunctive claims in this litigation: "Defendants submit that the new CPSU represents an improvement over the JATC CPSU by several orders of magnitude. Certainly, taken together, all of plaintiffs' concerns are a far cry from the concerns that led Legal Aid to assume responsibility for the prosecution of Sheppard years ago. Indeed, with all their concerns about the new CPSU, plaintiffs' counsel would be hard-pressed to find any plausible basis upon which to

commence a Sheppard-style lawsuit based upon the conditions of confinement as they exist today." Letter, Jonathan Pines to Hon. Robert P. Patterson, Jr., May 1, 1996.

5. At a conference on May 2, 1996, defendants' counsel advised the Court that the City was unwilling to enter into an enforceable remedial order, but was formulating a "detailed operational plan" in response to plaintiffs' proposals. At a May 21, 1996 conference, Corporation Counsel Paul Crotty informed the Court that notwithstanding the City's unwillingness to enter into a court-ordered remedial agreement, it would shortly share with plaintiffs' counsel an operational plan for the CPSU that included, as its cornerstone, the transfer of authority to investigate misuse of force from the Department of Correction to the Department of Investigation. That transfer was supposed to be effective on July 1, 1996.
6. At the Court's suggestion, the parties attempted, during the spring and summer of 1996, to resolve the injunctive claims. These efforts centered around the Court's proposal that the parties stipulate to facts, agree on the terms of an operational plan, and further agree that if the City refused to comply with the terms of the operational plan, plaintiffs could enforce the plan on motion, relying on the stipulated facts as the record of the litigation. Ultimately, the parties' efforts to resolve the litigation failed, and the City withdrew its prior commitment to transfer authority to investigate use of force in the CPSU from the Department of Correction to the Department of Investigation. On February 7, 1997 the Court set a trial date for November 3, 1997; defendants consented to plaintiffs' proposal that proof at trial concerning incidents and events in the CPSU be limited to those occurring before January 1, 1997.
7. From October, 1996 through October, 1997 plaintiffs conducted depositions of a number of current and former CPSU supervisors (captains and assistant deputy wardens) in JATC and OBCC, Wardens and Deputy Wardens assigned to JATC and OBCC, former Commissioners Koehler and Abate, the current and former Deputy Commissioners for Investigation and Trials, former Directors and Deputy Directors of the Investigation Division's Use of Force Unit, Chief of Department Taylor (now retired), then-first Deputy (now Commissioner) Kerik and then-Commissioner Jacobson. These depositions produced substantial evidence of these supervisors' knowledge, over a period of years, of the pattern of misuse of force in the CPSU and of the inadequacy of their response to the misconduct. Depositions of the OBCC supervisors produced evidence of the degree to which CPSU staff continued to resort to physical abuse as a form of management and control in the Unit. During this period, the defendants turned over a number of videotapes showing use of force incidents in the OBCC CPSU after plaintiffs successfully moved to compel production in September, 1996. See, Memo Endorsement, September 20, 1996.
8. In March, 1997, following the deposition of First Deputy Commissioner Kerik, the parties again entered into protracted negotiations towards a resolution of the injunctive claims. In July, 1997, however, plaintiffs' counsel was advised that defendants' counsel lacked authority to continue to negotiate any resolution of the litigation. Pursuant to the Court's revised scheduling order, a March 1, 1998 trial date was set. Plaintiffs' counsel drafted proposed stipulations of fact, which were submitted to defendants' counsel in October and November, 1997. On October 3, plaintiffs provided counsel with a preliminary list of 33 inmate witnesses, which was modified on December 29, when plaintiffs' counsel designated 18 OBCC inmates as witnesses. Plaintiffs' correctional experts--Vincent M. Nathan, Steve J. Martin and Charles Montgomery--and forensic pathologist, Isidore Mihalakis, M.D., submitted voluminous reports pursuant to F.R.Civ. P. 26(b) in early December, 1997. On December 1, plaintiffs designated for admission at trial videotapes of 78 use of force incidents, all but four of which documented incidents in OBCC between March 9 and December 11, 1996. The correctional experts were deposed later that month. Defendants did not designate any expert witnesses for trial.
9. In December, 1997 and again in January, 1998 defendants requested a two month adjournment of the trial date. Plaintiffs initially opposed any adjournment, but consented after agreement had been reached in mid-January on many of the proposed stipulated facts. At the end of January, defendants advised plaintiffs' counsel that they had been provided with authority to enter into a court-ordered settlement agreement. The parties then negotiated over the following three months the terms of the Stipulation.

1. Voluminous documentary and deposition testimony, much of which contained extraordinary admissions by a number of Department of Correction employees, has been adduced in this

litigation concerning the CPSU at JATC, the CPSU at OBCC, the activities of the Department's central office Investigations Division and the Department of Correction's disciplinary process. There have also been a number of criminal investigations and prosecutions by the United States Department of Justice, the New York City Department of Investigation/Inspector General for Correction and the Bronx District Attorney of CPSU staff for assaults on inmates and falsification of official reports. These criminal proceedings have generated additional admissions and evidence of the pattern of wrongdoing in the Unit. Based on the Department's records, the deposition testimony of current and former Department employees, the reports and depositions of plaintiffs' experts, the anticipated trial testimony of plaintiffs' inmate witnesses, and the other evidence gathered in this litigation, it was plaintiffs' expectation that at trial they would be able to prove all of the allegations set out in the Amended Complaint.

2. Plaintiffs believe that the proof adduced in this litigation would have been sufficient for the Court to find that high-ranking Department of Correction supervisors were deliberately indifferent to the harm visited upon the plaintiff class in the CSPU, and thus violated their 14th Amendment rights to due process. Specifically, the evidence gathered in discovery and the record of this litigation demonstrated that these defendants "failed to act despite [their] knowledge of a substantial risk of serious harm"; moreover, these defendants "knew of a substantial risk" of serious harm "from the very fact that the risk was obvious." Farmer v. Brennan, 511 U.S. 825, 114 S.Ct. 1970, 1981 (1994); and see, Madrid v. Gomez, 889 F.Supp. 1146, 1246-47 (N.D.Cal. 1995) (deliberate indifference found when prison official knows of serious risk and fails to take reasonable measures to abate the risk). That these defendants turned a blind eye towards the overwhelming evidence of a pattern of brutality and cover up in the CPSU, and proclaimed for years that they could never "establish" what others told them existed, and what they "suspected," is no defense. See, Vance v. Peters, 97 F.3d 987, 992-93 (7th Cir. 1996); Boyd v. Knox, 47 F.3d 966, 968 (8th Cir. 1995); Jones v. City of Chicago, 856 F.2d 985, 992-93 (7th Cir. 1988). These defendants could not "escape liability if the evidence showed that [they] merely refused to verify underlying facts that [they] strongly suspected to be true, or declined to confirm inferences of risk that [they] strongly suspected to exist." Farmer, 114 S.Ct. at 1982, n.8; see also, Madrid, 889 F.Supp at 1247; Coleman vs. Wilson, 912 F.Supp. 1282, 1316-17 (E.D. Cal. 1995) ("Moreover, after five years of litigating, the claim of lack of awareness is not plausible.")(citations omitted); McGill v. Duckworth, 944 F.2d 344, 351 (7th Cir. 1991) ("Going out of your way to avoid acquiring unwelcome knowledge is a species of intent.") *cert. denied,* 503 U.S. 907, 112 S.Ct. 1265, 117 L.Ed.2d 493). As we detail below, the overwhelming evidence of a pattern of brutality in the CPSU was over a period of years repeatedly placed before Department Commissioners and jail supervisors, but they made no commitment to undertake reasonable measures to address the misconduct until trial in this case was imminent.
3. The evidence in this case--of a pattern of unnecessary and excessive force directed against CPSU inmates, and that defendants, in permitting the pattern to develop and persist, acted with deliberate indifference-- would have been sufficient to impose liability on these defendants. Madrid, 889 F.Supp. at 1247-8. Defendants' consistent failure, over a period of years, to implement adequate systems in training, investigation and discipline in order to control and regulate the use of force, despite their knowledge that such systems were necessary to ensure that force was controlled in the CPSU, is evidence of their deliberate indifference. Fisher v. Koehler, 692 F.Supp. 1519, 1564 (S.D.N.Y. 1988), *injunction entered,* 718 F. Supp. 1111 (1989), *aff'd.*, 902 F.2d 2 (2d Cir. 1990); Madrid, 889 F.Supp at 1251; Ruiz v. Estelle, 503 F.Supp. 1265

1302 (S.D.Tex.1980) (prison officials encouraged staff to indulge in excessive physical violence by rarely investigating reports of violence and failing to take disciplinary action), *affd in part,* 679 F.2d 1115 (5th Cir. 1982), *amended in part, vacated in part on other grounds,* 688 F.2d 266 (5th Cir. 1982), *cert. denied,* 460 U.S. 1042, 103 S.Ct. 1438, 75 L.Ed.2d 795 (1983).

1. Plaintiffs' claim against the City would also have been successful in this case because the failure to train and supervise CPSU staff was so deficient as to evince a policy of deliberate indifference. Canton v. Harris, 489 U.S. 378, 390, 109 S.Ct. 1197, 1205, 103 L.Ed.2d 412 (1989)("[I]t may happen that...the need for more or different training is so obvious, and the inadequacy so likely to result in the violation of constitutional rights, that the policy makers of the city can reasonably be said to have been deliberately indifferent to the need."); Ricciuti v. New York City Transit

Authority, 941 F.2d 119, 123 (2d Cir. 1991) (municipal policy of deliberate indifference may be shown by "evidence that the municipality had notice of but repeatedly failed to make any meaningful investigation into charges that police officers had used excessive force"); Gentile v. County of Suffolk, 926 F.2d 142, 152-3 (2d Cir. 1991) (county liable based on policy of failure to discipline police officers).

The Pattern of Misconduct in the CPSU and the Systemic Failings Which Caused It

1. From 1988 through 1996 there has been a clear pattern of Department of Correction staff using unnecessary and excessive force against inmates confined in the Department's Central Punitive Segregation Unit, and of staff covering up their misconduct. This pattern began when the CPSU was located at the James A. Thomas Center, between March 1, 1988 and March 9, 1996, and continued after the Unit was relocated to the Otis Bantum Correctional Center on March 10, 1996. Plaintiffs' expert Steve J. Martin, who has over twenty-five years' experience in correctional administration, and has conducted more than 300 site visits to confinement facilities in over 23 states, reported in this case:

The pattern of multiple head injuries in a routine application of force in the CPSU exceeds that observed in any other confinement setting with which I am familiar. This pattern includes serious injuries such as perforated eardrums; fractured noses, teeth and jaws; skull and eye injuries; and rib and back injuries. The sheer number of serious incidents (multiple and serious injuries to inmates) that are disproportionate to the threat of harm to staff (because the inmates are either unarmed, restrained or locked securely in a cell) is unprecedented in my experience...Multiple head injuries sustained by inmates in routine applications of force in the CPSU is so commonplace as to constitute a clear pattern and practice of employing techniques intended to harm rather than restrain and control inmates...The evidence of a pattern and practice of excessive and unnecessary force in the CPSU from 1988 to 1996 represents the most uniform and prodigious body of evidence, from the highest levels of the Department to line level staff in the CPSU, I've encountered in my career.

Report of Plaintiffs' Expert, Steve J. Martin, December 1, 1996 at 11, 16, 81.

1. Scores of inmates in the CPSU suffered significant pain and injury when struck by members of the uniformed force. Fifty three inmates suffered fractured bones (not including fractured teeth) in use of force incidents between 1989 and 1995; 35 inmates suffered confirmed or suspected perforated eardrums between 1989 and 1997. Many others suffered lacerations, major contusions and internal injuries. In many, if not most, of the use of force incidents, there was little or no need for the use of force at all, or the amount of force was far out of proportion to its need. The Department made little or no effort to temper the severity of staff's infliction of force. CPSU staff routinely used force as a means of punishing inmates, enforcing obedience, maintaining order, and as a first resort in reaction to any inmate behavior that might possibly be interpreted as insubordinate or aggressive.
2. From 1988 through 1997, high-ranking supervisory officials in the Department, including Commissioners, Chiefs, CPSU Unit Managers and the Wardens and Deputy Wardens for Security of the jails in which the CPSU was located, knew--or deliberately ignored the overwhelming evidence available to them-- that unnecessary and excessive force was being employed against CPSU inmates on a consistent and frequent basis, that large numbers of inmates were being seriously injured, and that staff conduct in the Unit presented a substantial risk of serious harm to CPSU inmates. These supervisors by their actions, misfeasance and nonfeasance, evidenced a conscious disregard of the continuing risk of harm to inmates in the Unit. They permitted the pattern of unlawful force and its cover-up to develop and persist, and by doing so condoned and implicitly authorized it. These supervisors' actions created an atmosphere in which routine staff brutality in the CPSU was tolerated and encouraged, and thereby enhanced the risk that brutality would continue, which it did. In doing so, these defendants acted with deliberate indifference.
3. Despite their knowledge of the continuing pattern of misuse of force and cover-up in the CPSU, the supervisory defendants' response has been either to take no action, or to make ineffective gestures towards addressing the systemic deficiencies that allowed the culture of brutality in the CPSU to develop and persist. Defendants failed to establish adequate systems for controlling the

use of force by CPSU staff. They knew that as a result of these inadequacies, many inmates in the Unit were suffering serious injuries. The culture of violence in the CPSU created a *de facto* policy of corporal punishment in the Unit.

4. Specifically, defendants failed to: (1) formulate effective policies for when and how physical force should be used by members of the uniformed staff; (2) ensure that staff in the Unit were properly screened before being placed in the CPSU, were properly supervised once assigned there, and that their use of force was monitored and reviewed; (3) ensure that adequate, competent, unbiased and effective investigations of use of force incidents were conducted; (4) ensure that staff who used unnecessary and excessive force, and/or who falsely reported its use, were appropriately disciplined; (5) enforce written policies and procedures requiring the use of video cameras when force was anticipated; and (6) provide effective training to staff in when and how to apply non-injurious force when some force is needed.
5. The Department of Correction's failure to guide and train CPSU staff in the appropriate use of force, and its failure to supervise, monitor, investigate and discipline misuse of force, allowed and made inevitable the pattern of misuse of force and infliction of serious injuries on inmates in the CPSU.

The CPSU at JATC: 1988-1996

The Pattern of Correction Officer Brutality and Cover Up

1. Between March 1, 1988, when the CPSU was officially established, through March 9, 1996, when the Unit was relocated to OBCC, there existed in the unit--by defendants' admissions-- a pattern of misconduct by members of the uniformed staff involving not only staff brutality, but "planned brutality" and cover up. (Deposition of Commissioner Michael Jacobson, October 23, 29, 1997 ("Jacobson deposition") 36.) The Unit was relocated to OBCC in March, 1996 "because of the [Sheppard] litigation and the problem of misuse [of force] and cover up," (Jacobson deposition 97), a pattern of excessive force and falsification of documents. (Jacobson deposition 39-40.)
2. Members of the uniformed staff engaged in a calculated effort to terrorize inmates in the CPSU. Staff beat inmates, often in isolated areas of the unit, including cells, dayrooms, search areas and stairwells, where no other inmates or civilian staff could witness the assault. (Deposition of C.O. Turham Gumusdere, January 26, 1995 ("Gumusdere deposition") 166; Deposition of A.D.W. and Unit Manager of the CPSU in 1995 Robert Dash, February 11, March 3, 1996 ("Dash deposition") 212.) Inmates targeted for assaults by staff were often the last in their housing area to be locked out of their cells to attend a service, such as recreation, so that they could be isolated with a group of officers and beaten. (Gumusdere deposition 311-12.) Many inmates were beaten while naked. Beatings were inflicted to punish inmates for minor misconduct, for verbal complaints, for engaging in behavior which staff perceived as disrespectful (Gumusdere deposition 311-2; trial testimony of former CPSU officer Alex Padilla, People vs. Batista, et al. (Bronx County Supreme Court, 7223/96 (hereinafter "Batista trial testimony," 626-654)); Dash deposition 238) or for no reason other than to maintain a high level of fear in the unit. "If an inmate was a problem, they would take care of business...They would beat his ass." (Dash deposition 212.) Former CPSU officer Alex Padilla described an August, 1994 use of force incident in which Captain Bianchi instructed the officers, "if he [an inmate named Lynch] doesn't want to move, let's do it the Merrill Lynch way, the old fashioned way. Let's beat his ass." (Notes of August 17, 1994 interview with Alex Padilla by FBI and Department of Investigation staff.) CPSU staff were given "the green light" to beat inmates to "to teach them a lesson." (FBI summary of interview with CPSU officer Henry Neil, September 18, 1995). Emotionally disturbed and mentally ill inmates were beaten to punish them for "acting out," exhibiting behavior associated with their psychiatric conditions. (Deposition of Captain David Fullard, July 13, 20 ("Fullard deposition," 422-430.) Commissioner of Investigation Howard Wilson stated at a press conference with Mayor Giuiliani that during at least the two year period 1992--1994, there was a "pattern of deliberate beatings" of inmates by members of the uniformed staff in the CPSU. (Transcript, Press Conference, January 23, 1996.) According to Commissioner Jacobson, "the CPSU and JATC has [sic] been the subject of several criminal trials, a variety of departmental charges and a number of allegations, a lot of which are obviously true....It doesn't surprise me that there was brutality against inmates in JATC because that is sort of a matter of reckoning." (Jacobson deposition 94-5.)

3. Inmates were beaten during their admission processing to the CPSU, or threatened with a beating, in order to terrify and intimidate them. These admission beatings were known as "greeting beatings" and were "part of the routine" in the unit. (Letter, Office of Compliance Consultants to Hon. Morris E. Lasker, June 28, 1992; Gumusdere deposition 161, 163; Dash deposition 192-3.) The practice was common knowledge in the unit. (Gumusdere deposition 164.) Officers talked about "greeting beatings" in front of supervisors. (Dash deposition 192-3.) One such beating was described by a former CPSU officer, as follows: "As inmates were brought up to the 1A dayroom for new admission process...Officer Beckford and Officers Casciano and Devito [sic] would read their infraction, and if it was an assault on staff, they would beat up the inmate...[Also present were] Captain Deravin, Captain Bailey and Captain Bianchi...sometimes they would just go in there and add a shot." (Transcript of May 17, 1994 interview with Officer Alex Padilla by FBI and New York City Department of Investigation.)
4. CPSU staff engaged in other sadistic and humiliating conduct. Officers forced some inmates who entered the unit with tobacco, which was prohibited in the segregation areas, to eat their cigarettes. (Gumusdere deposition 158-9.) Officers in the unit held some inmates' heads in toilet bowls and flushed the toilets. (Letter, Mary Jo Mullan, Office of Compliance Consultants, to Judge Lasker, June 28, 1992; Trial Testimony, United States v. Roger Johnson, 96 Cr. 18 (SHS) (hereinafter "Johnson Trial Testimony") 286.)
5. Members of the uniformed staff assigned to the CPSU used force against inmates far in excess of any need to restrain an inmate. (Deposition of JATC Warden Andrew Phoenix, March 25, 26, 27, 1997 ("Phoenix deposition") 645; Gumusdere deposition 341; Dash deposition 189-1.) Force was used for the purpose of inflicting pain (Dash deposition 241-2), ` and not in any good faith effort to restore order. (Gumusdere deposition 341.) Supervisors in the jail knew that many inmates beaten in the CPSU suffered serious injuries, including perforated eardrums, fractured noses, jaws and other bones, and multiple traumatic injuries on a regular basis. (Dash deposition 58; Phoenix deposition 122.) Many inmates required hospitalization for treatment of their injuries. Some inmates suffered permanent injuries from the beatings, including visual impairment and hearing loss. A number of inmates beaten in the CPSU suffered severe internal injuries, such as contused livers and kidneys. Visible abrasions, contusions, and lacerations associated with punches to the face and body were common after a use of force incident. One inmate beaten by CPSU officers died from his injuries. (See, Jacobson deposition 187 (Q: "...[Y]ou know that somebody was [killed in the CPSU] don't you? A: Bryant.")) JATC was known among officers and supervisory uniformed staff in the Department of Correction as "the house of pain" (Fullard deposition, 376, 421; Deposition of C.O. Calixto Herrera, March 23, 1995 ("Herrera deposition") 297; Dash deposition 83-4), and the CPSU staff was known in the Department of Correction as "a bunch of ass kickers." (Fullard deposition 421.)
6. Staff assaults on inmates in the CPSU were routinely documented falsely in the records prepared at the jail as assaults on staff. The officers' use of force was justified as "defensive" no matter how extensive the inmate's injuries, and how minimal the officers' injuries. Alex Padilla, a correction officer who worked in the CPSU from 1990 to 1994, cooperated with the United States Department of Justice and the New York City Department of Investigation ("DOI") investigation into allegations of correction officer brutality and cover-up in the CPSU. Padilla stated to the FBI and DOI investigators under oath on May 17, 1994: "I know that ninety-five percent of the uses of force in HDM are covered up or lied. Everybody lied in their reports, so that it could coincide with the injuries, it could coincide with the guidelines or the directives of the use of force policy, because if they all say what really happened, they would all be arrested....And it's common knowledge, that's common knowledge." (Transcript of May 17, 1994 interview with Alex Padilla by FBI and DOI .)
7. Injuries to inmates inflicted by staff were routinely reported to Department supervisors, including the Commissioner and her senior staff, in daily "24 hour reports," which purported to justify as "self defense" uniformed staff's striking inmates in the face numerous times. (Letter, Assistant Commissioner Toni V. Bair to Commissioner Catherine Abate, April 11, 1992.) The level of force used in the CPSU almost always involved multiple punches to the inmate's face or head, usually administered by more than one officer. Warden Phoenix observed that there was a "common" scenario in which officers reported that they responded to a blow or threat of a blow from an inmate by applying multiple punches to the face and head and then wrestled the inmate to the floor. (Phoenix deposition 419.) If an inmate suffered severe injuries to his face and head, these

wounds were in many cases attributed to his having fallen to the floor face first when restrained with a wrestling hold after one or more officers punched him in the face or head. (Deposition of A.D.W. and former CPSU Unit Manager Jose Viera, January 30-31, February 3, 1997 ("Viera deposition") 200.) Former JATC Deputy Warden for Security Bird testified to another variation of the scenario: a spontaneous, unprovoked attack by a prisoner against an officer. (Deposition of James Bird, April 3-5, 1997 ("Bird deposition") 164, 166.)

8. Uniformed staff assigned to the CPSU routinely falsified official Department documents to mask their involvement in incidents in which inmates were beaten and injured. (Dash deposition 217.) The cover-ups of brutality were "organized" and "patterned." (Jacobson deposition 95.) Some staff members reported their participation in an incident at which they were not present in order to conceal the involvement of a fellow officer whose presence was not reported. Other staff, including supervisors, failed to report their presence and participation in use of force incidents. (Gumusdere deposition 335-6; Johnson Trial Testimony 274-276.) Staff members wrote reports for other officers to sign, or wrote their reports together, to ensure that the reports were consistent. (Deposition of C.O. Efrain Mojica, September 22, 1994, ("Mojica deposition") 184, 139; Deposition of ADW and former CPSU Unit Manager Jose Viera, January 301, February 3, 1997 (Viera deposition) 272, 600, 273, 361; Deposition of JATC Deputy Warden for Security Terrence Skinner, January 10, 16, 17, 1997 ("Skinner deposition") 155-6; Jacobson deposition 411.) Former CPSU Officer Alex Padilla described several beatings that occurred in 1992 after which different captains either gave him a use of force report which had already been prepared and instructed him to copy it in his own handwriting, or instructed him how to prepare a false report. (Transcript of May 17, 1994 interview with Officer Alex Padilla by FBI and DOI 11-14, 15-16.)
9. Officers and captains carried razor blades and other contraband weapons to "throw down" after an inmate was beaten so that staff could falsely claim the inmate assaulted them with a weapon. (Gumusdere deposition 331-4; Fullard deposition 181-2; Phoenix deposition 648.) Officer Roger Johnson told Inspector General Michael Caruso and other law enforcement personnel on May 3, 1995, that when he worked in the CPSU between September, 1991 and October, 1994 he carried razor blades with him on duty like other correction officers. (Johnson Trial Testimony 286-7.) Officer William Spissinger, who was assigned to the CPSU from 1988--1993, testified that he carried razor blades in his memo book, as did other officers in the jail, and that some officers told him they had dropped razor blades at the scene of a use of force incident. (Deposition of Officer William Spissinger, April 27, May 4, 1995 ("Spissinger deposition") 298.)
10. Some officers, after gratuitously beating an inmate, falsely claimed that the inmate struck and injured them so that they could report that they struck the inmate in "self-defense." (Gumusdere deposition 341.) To support these fabrications, officers solicited other officers to punch them in the face to leave an injury that could be documented by medical staff. (Fullard deposition 190-2, 315, 361-3; Gumusdere deposition 353; Johnson Trial Testimony 262-266, 277-9, 160-165; Testimony of Alex Padilla, Batista trial transcript 644-651; Phoenix deposition 433-4, 832 ("recognizes" injuries to officer cheekbones in CPSU use of force packages); Phoenix deposition 610-12 (staff facial bruises an element of use of force "scenario" in CPSU); Bird deposition 560-1 ("substantial number" of conspicuous injuries to officers' cheeks reported in a number of CPSU use of force incidents).)
11. Former CPSU Officers Henry Neil and Roger Johnson provided detailed information to the FBI and the New York City Department of Investigation (DOI) in 1995 concerning the planned beating of a number of CPSU inmates on December 11, 1992, and the elaborate cover-up--involving the infliction of injuries by officers on other officers and the preparation of false reports--which was subsequently orchestrated by CPSU supervisors. Seven inmates were severely beaten by CPSU staff and treated at hospitals for their injuries in this incident.
12. Johnson informed the FBI and DOI that the officers who participated in the beatings were instructed at roll call that day to "beat down" the inmates in Block 1A during a block search. Captain Martinez approached Johnson and Officer Charles Sanacore and instructed them to beat Hector Batista, who was being held in the CPSU after a notorious hostage-taking incident at another jail.
13. Johnson stated that after roll call he and Sanacore proceeded to Block 1A. When they went to Batista's cell, they instructed him to strip. When he was slow in cooperating Sanacore struck him, and Batista tried to hide under his bed. Johnson dragged Batista out from under the bed and held him while Officers Day, Sanacore, and another officer, probably Rodriguez, beat him. Rodriguez

used a baton.

14. After the incident, Johnson went to the jail clinic, where he saw Batista bleeding from the face, handcuffed. Johnson walked over to Batista and punched him twice in the ribs.
15. Officer Johnson stated that he submitted a false report about the incident. After the incident, he asked Captain Martinez how he should write it up. Captain Martinez told him to report that staff had been assaulted with a weapon. A short while later, Captain Martinez showed him a shank which they would say had been used by Batista in the incident. Martinez then wrote out a report, which Johnson copied in his own handwriting, and signed. The report stated that Batista had produced a shank, which was not true. Either Captain Sanchez or Captain Olivari gave Johnson the report Martinez had written. Johnson also reported that Batista had struck him in the face, which also was not true. Johnson asked Officer Moore to strike him in the face with his fist to leave an injury and thereby justify the use of force. Johnson also struck himself in the face. Johnson said that on a prior occasion he had struck Officer Lampe to leave a bruise which could be attributed to an inmate assault. He also said that some officers had rubbed carbon paper on their faces to fabricate evidence of an injury and thereby justify a use of force, and the officer could then go out on compensation leave.

United States v. Roger Johnson, 96 Cr. 18 (SHS), Transcript 262-266, 277-9, 160-165, 652-3.

- Prior to this meeting with prosecutors, Johnson had been recorded by Officer Padilla, who was already cooperating with the FBI and the Department of Investigation, in a conversation in the CPSU about the December 11, 1992 incident. Among other things, Johnson told Padilla: that he and the other officers with him "were still kicking and stomping and hitting [Batista]....He [Batista] didn't know what was hitting him. He was screaming like a bitch"; that Captain Martinez had told Johnson at roll call to "demolish" Batista during the search; that Captain Olivari had asked him if he wanted to participate in the operation before they went into the block; and that "the whole thing was planned for weeks, man. They wanted to do it a week earlier. [It] came from downtown." "That's why we rumbled. They had to make it look good. Made the whole thing up." "Captain Sanchez, Captain Olivari they looked on, that's all they were supposed to do for the report....It was funny, Dep. Bird knew the deal...Sanacore didn't get knifed. He cut his hand. He put it down on the report that he got punctured."

United States v. Roger Johnson, 96 Cr. 18 (SHS) Exhibit ID 77T (Transcript of August 27, 1994 tape recorded conversation between Johnson and Padilla).

- Neil told the FBI that, after the inmates were beaten in the housing area, and while he and other officers were in the CPSU captains' office, "Neil was struck by C.O. Figueroa on his leg, incurring a bruise. Neil inflicted an injury to himself by making a mark on his face...to substantiate the fact that the correction officers were attacked by the inmates. C.O. Santana showed Neil how to properly give himself a mark on his face... [and then] inflicted an injury on himself, and Neil struck Figueroa on the shoulder. Figueroa kicked Neil in Neil's upper left leg....All this was done to legitimize the correction officers' need to exert physical force to subdue alleged hostile inmates.

...Neil rode in an ambulance [from the jail to a hospital] with COs Brophy, Peele, Sanacore, Santana and Figueroa. Neil recalled that they were all laughing and even stopped and got a six pack of beer for the ride to the hospital. The correction officers were all laughing and talking about how much compensatory time they were going to take off...

...Upon returning to Rikers Island [Neil saw] Captain Oliveri in a conference room orchestrating the submission of the use of force and compensation forms required of the correction officers. Neil advised that he totally fabricated C.O. Figueroa's use of force report and that Captain Oliveri approved of Neil's 'report writing.'...Oliveri supervised the bogus report writing to ensure conformity in the COs written version of what transpired."

Memorandum, Special Agent James B. Hughes, September 18, 1995, at 2-3..

1. Members of the uniformed staff often solicited CPSU inmates who were beaten or who witnessed beatings to make or write false statements about the incidents. (Fullard deposition 510-11.) Staff members directed inmates to say they didn't see or hear anything, or told them not to report the incident at all. Inmates were instructed to sign false statements about the source of their injuries as a condition of receiving medical treatment. Some inmates were offered early discharge from the CPSU if they cooperated in covering up a beating (Dash deposition 225); others were threatened with additional beatings or disciplinary charges if they reported the incidents.
2. At least one Department supervisor suspected that CPSU officers used and directed inmates to commit assaults on other inmates. (Memorandum, April 8, 1993, Integrity Control Officer Velez to Deputy Director of Investigations Pagan.) CPSU officers would release an inmate from his cell so that he could fight another inmate. In the CPSU, providing an inmate with an opportunity and location to fight another inmate was known as "giving five minutes" or allowing a "one-on-one." (Phoenix deposition 490.) These incidents were also known as cockfights (Fullard deposition 168-9) because CPSU staff considered them sporting events. "Everybody in Correction heard about it...it's very out in the open." (Gumusdere deposition 71.)
3. Members of the uniformed staff assigned to the CPSU punished inmates by withholding rights and privileges guaranteed by the Minimum Standards of the Board of Correction and by prior orders of the court. (Benjamin v. Malcolm, 75 Civ. 3073.) This punishment took the form of housing inmates in cells without mattresses, operative toilets or light bulbs; denying them telephone calls or access to recreation, law library or medical attention. (Dash deposition 189-91, 100-1, 238.) Denying an inmate a service or entitlement was referred to as "burning him" or "putting him on the burn." JATC Warden Phoenix testified that denying inmates access to mandated services was "part of the operation of the [New York City] jails," including the CPSU, and it was a practice he could not stop. (Phoenix deposition 500-1.) Officer Melvin Ancrum testified that he and other officers had peremptorily denied CPSU inmates access to recreation ("burning an inmate for yard") and phone calls as a means of punishing inmates and exerting informal control. (Deposition of Officer Melvin Ancrum, October 25, December 19, 1994 ("Ancrum deposition") 113-119.) Most CPSU captains were aware of these practices. (Ancrum deposition 120.)

Knowledge of the JATC and CPSU Command

1. The use of force reports generated by CPSU staff--which were reviewed and signed by Unit and jail supervisors--document hundreds of incidents in which inmates suffered severe injuries in incidents in which they were struck in the presence of more than one correction officer, often in isolated areas of the jail. Exhibit 1 to this Declaration is a chart which summarizes 1062 use of force incidents in the CPSU between 1988 and 1995, listing for each month the number of incidents occurring in isolated areas of the jail, and the number in which a CPSU inmate was involved with more than one officer. Exhibit 2 to this Declaration lists injuries to some of the CPSU inmates who were injured by Department of Correction staff members in use of force incidents between 1990 and 1995.
2. The supervisory staff at JATC--the CPSU unit manager, the Deputy Warden for Security and the Warden--had personal knowledge of the pattern of misconduct described in the preceding paragraphs within weeks of the opening of the unit in March, 1988, and continuing thereafter through March, 1996. Over this eight year period, these supervisors turned a blind eye--and a deaf ear--to the evidence of staff brutality. These jail supervisors reviewed the written use of force reports, injury to inmate reports and supervisor's investigative reports concerning virtually every use of force incident that occurred in the CPSU. These supervisors also reviewed the reports which were prepared after an inmate alleged that he was beaten in an unreported incident. Andrew Phoenix, who was the Warden at JATC from 1989 through 1993, testified that: "I just probably knew what was going on... it was obvious things were going on...At least I tried to do something...[The prior Warden, from 1988-89] "ran like a thief" [from the jail] because he didn't have "the nerves" to stay there." (Phoenix deposition 168, 257, 802.)
3. Indeed, Andrew Phoenix stated repeatedly at his deposition that he was aware, through a variety of sources, of the existence or probable existence of a pattern of staff abuse of inmates in the CPSU; that he believed these allegations to be true; that he communicated his belief to other high-ranking Department of Correction officials; and that he failed to address the abuse at the jail:

1. When he was at HDM/JATC from 1989 through 1993, Phoenix couldn't stop the brutality; nor had any other Warden before him. (Phoenix deposition 561.) He believed that JATC had the highest rates of staff-inmate violence during his tenure, and before it. Phoenix testified that "nothing changed much" during his tenure. (Phoenix deposition 201.)

1. He knew, independent of the use of force packages he read, that inmates in the CPSU were being injured seriously and frequently by officers. (Phoenix deposition 122.)

2. From when he took over as Warden (in 1989), to when the complaint in this case was filed (February, 1993), Phoenix heard allegations of staff brutality. (Phoenix deposition 172.) He suspected staff was beating up inmates and getting away with it. (Phoenix deposition 174.)

3. By December, 1989, he had suspicions that there were things going on in the unit he did not know about, and that use of force incidents were not being reported accurately. (Phoenix deposition 194-5.) What he suspected was being covered up was unnecessary and excessive use of force by staff. (Phoenix deposition 195.) Phoenix suspected that there were incidents in the CPSU in which inmates were the victim of excessive or unnecessary force. (Phoenix deposition 655.) Physical abuse of inmates occurred from time to time, "over again." (Phoenix deposition 654.) He suspected the inmate allegations were true because the allegations were consistent over a period of time. (Phoenix deposition 215-6.) Based on the consistency of allegations of which he was aware over a period time, he had suspicions that CPSU bing staff was engaging in unnecessary and excessive force on inmates in the CPSU. (Phoenix deposition 252.)

4. Phoenix suspected that the inmate allegations about beatings, and about denial for services, were true. (Phoenix deposition 502.)

5. Phoenix suspected that inmates were being assaulted by staff and beaten up. (Phoenix deposition 427.) He testified that he did not know if there is a "blue wall of silence" in the Department of Correction. He does know that officers "cooperate with each other very often." (Phoenix deposition 506.) But some "snitch" on other officers to the FBI. (Phoenix deposition 505.)

1. Phoenix suspected that some force was unreported, and that staff "overreacted" in some instances. (Phoenix deposition 643.) He suspected officers used excessive force out of "frustration, and they got out their frustration because inmates "caused them grief." (Phoenix deposition 644.) If an inmate threatens an officer, the officer is supposed to "restrain" the inmate first, "get order, then write an infraction." (Phoenix deposition 644-5.)

2. But Phoenix believed "of course" that some members of the uniformed force used force without justification against inmates in response to inmate misconduct. (Phoenix deposition 645.)

3. He agreed that he heard from some inmates that some officers were engaged in malicious and sadistic beatings of inmates. He heard the same names over and over again. He did not move the officers because, as he testified at his deposition, "I can't just move them because they were beating them up and I can't prove it." (Phoenix deposition 393.)

4. He suspected but could not prove that there were deliberate beatings of inmates in the CPSU. (Phoenix deposition 390.)

5. He was "concerned" about the numbers of inmates being injured in use of force incidents. (Phoenix deposition 117.)

6. He was "constantly conscious" of the issue of brutality and cover-up when he was the Warden. (Phoenix deposition 769.) The issue was raised at federal court conferences, and was in the press. It was "definitely" the subject of frequent complaints from the Legal Aid Society. (Phoenix

deposition 768.)

1. He could not get a grip on the brutality, but he thought he "did some pretty great things there." (Phoenix deposition 410.)

1. He was aware that in 1990 and 1991 there were a number of allegations made to the Investigation Division that inmates had been struck by staff in incidents that went unreported. "I just probably knew what was going on." (Phoenix deposition 168.)

2. At one time he was "desperate" to find out what was going on. "I wanted to find out what was going on." (Phoenix deposition 234-5.)

3. Phoenix testified at his deposition that "a lot of use of force happened the same way" (Phoenix deposition 624.): incidents occurred in search rooms (Phoenix deposition 617.) One "scenario" involved the last inmate to be locked out to go to the yard being alone with staff in a dayroom. After the "use of force incident," staff reported that they sustained facial bruises. The inmate would go to the hospital for treatment of his injuries. There were no inmate witnesses. The incident involving plaintiff Barron Cunningham on October 12, 1990, was an example of that "scenario, " with which Phoenix was already familiar by that date. (Phoenix deposition 619-21.)

4. Even though Phoenix recognized the reports of incidents such as Cunningham's as a "scenario" which he had read in use of force packages a number of times, he continued to rely on the Deputy Warden for Security to investigate these incidents. (Phoenix deposition 625.)

5. Phoenix was aware of a number of incidents in cross over areas, search rooms, bridge areas, and clinic corridors. Phoenix "is sure" that "from time to time" there were incidents in which inmates were victims of excessive force or unreported incidents in areas of the Bing where no other inmates could see, such as search rooms, cross overs, bridge areas. (Phoenix deposition 647.) He suspected that reports of some of these incidents were not truthful, and some incidents were not reported at all. (Phoenix deposition 646-7.) From reading the reports, he could see that "many" incidents took place in areas with no inmate witnesses. (Phoenix deposition 226-7, 413-4.) This created a suspicion that inmates were being targeted for beatings in areas with no inmate witnesses. As a result, he ordered that captains be present in the crossovers when inmates were being searched. "It should be a rare case where the officer sees the inmate in the crossover." (Phoenix deposition 227-8.) In most of the use of force incidents which took place in the crossover areas, however, no supervisor was present.

6. Phoenix testified that there were some incidents that occurred where the inmate involved in the use of force was naked. (Phoenix deposition 415.)

7. There was a "common" scenario in which the officers reported that they responded to a blow or threat of a blow from an inmate by applying multiple punches to the face and head and then wrestled the inmate to the floor. (Phoenix deposition 419.)

8. He thought that if the Investigations Division could not find out what was going on, he could not. (Phoenix deposition 168-9, 214.)

9. Even after he left HDM/JATC in 1993, and after public disclosure of the federal and state criminal investigations into inmate beatings which occurred while he was the Warden, Phoenix was afraid to talk to anybody about the federal investigation of HDM because he thought people were wearing recording devices. (Phoenix deposition 435.)

10. Warden Phoenix testified that correction officer brutality is "ingrained in the culture" of the New York City Department of Correction, and was "part of the overall operations of the jail." (Phoenix deposition 561, 410.) He and other JATC supervisors knew that large numbers of inmates were being severely injured by correction officers in incidents which were falsely reported by the officers and their direct supervisors, the CPSU captains, as self-defense. These jail supervisors

knew that correction officers resented the Department of Correction use of force policy because they perceived it as "tying their hands" and preventing them from punishing difficult inmates by beating them. These supervisors tolerated the practice of CPSU officers beating inmates, and thereby encouraged the practice to develop into a *de facto* policy of using deliberate beatings as a management tool.

11. Robert Dash, who was a tour commander in the CPSU and was Unit Manager in 1995 "saw" a pattern of inmates being beaten in isolated locations of the jail (Dash deposition 106), and "knew" that inmates were sustaining broken bones, perforated eardrums, and multiple trauma to their faces and heads on a monthly basis. (Dash deposition 59-60.) He "believed" that inmates were singled out and beaten, and that these incidents were covered up between 1989 and 1996. (Dash deposition 185.) He "overheard" officers talk about "initiation rites" and he "heard" officers talking about "taking care of business," which he understood to mean, "they would beat his [inmate's] ass." (Dash deposition 212.) Although he heard from inmates and staff that inmates "got their behinds whipped," he did nothing in response: "These are rumors--I didn't do anything about it. They were people talking." (Dash deposition at 388-9.)
12. Some jail supervisors, including the CPSU unit manager in 1988, the facility Deputy Warden for Security in 1989, and unit captains, ordered CPSU officers to beat and injure inmates to punish them. (Fullard deposition, 221-228, 229-34, 446-9; Johnson Trial Testimony 262-266 (direction from captain to "demolish" an inmate); see also, Memorandum, Investigator Peter Brookins to Deputy Director of Investigations Ralph Mierzejewski, December 9, 1988 ("Three uses of force that I am investigating or have knowledge of have occurred in an area in the front of the housing area out of sight of other inmates with two of these having allegations made to the effect that the Captain signaled the Officers giving them a green light to use force on the inmates.").
13. The City has produced in discovery in this case hundreds of reports prepared by CPSU staff and approved by the unit and jail supervisors for the period 1988--1996. Many, if not most, of these reports utilized boilerplate language to document and justify "uses of force" in which officers repeatedly struck inmates to the face, head and body, inflicting serious injuries. Unit and jail supervisors knew that many of the officers' reports were written collusively by the officers involved in the incidents. (Phoenix deposition 400-403; Dash deposition 217; Skinner deposition 155-60, 335-8; Gumusdere deposition 241-2.) Many of these reports included descriptions of inmate assaults on officers with weapons, many of which the supervisors knew or suspected were introduced to the scene of the incident by staff. (Dash deposition 215-6, 228.) Other reports purported to document injuries to officers which had been inflicted by inmates, but were known by the supervisory staff to have been inflicted by the officers themselves. (Dash deposition 213-4.)
14. Deputy Warden Terrence Skinner was assigned as the Deputy Warden for Security at JATC in December, 1994, and remained there until October, 1995. At least during the first part of his tenure at JATC, Skinner considered the jail, including the CPSU, to be "out of control." (Skinner deposition 648.) Skinner believed that staff needed to be disciplined and re-trained. (Skinner deposition 648.) Staff failed to provide documentation of incidents; there were pervasive security breaches in housing areas, including the storage of broom and mop sticks in officers' stations and some shanks in desk drawers. (Skinner deposition 652.) Skinner believed that officers were stealing, or were permitting inmates to steal, inmate property that was supposed to be kept in locked lockers. (Skinner deposition 180, 654-5.) "At times," Skinner knew, there were a number of officers off-post in the CPSU. (Skinner deposition 247.) Skinner observed officers wearing unauthorized gloves, cut-off gloves. (Skinner deposition 248-9.)
15. According to Skinner, one of the reasons why JATC was "out of control" when he arrived there was the quality of the facility supervisors-- captains and assistant deputy wardens, and when Skinner was first assigned there, the Unit Manager of the CPSU. (Skinner deposition 653-4.) Skinner had concluded by January, 1995, that the failure to provide CPSU inmates with programs and services at that time--failures of which he had learned through personal observation and inmate complaints (Skinner deposition 115)--was caused by inadequate supervision of line officers by captains and assistant deputy wardens. (Skinner deposition 117.) Skinner believed the CPSU Unit Manager was indifferent to whether CPSU inmates received the services to which they were entitled. (Skinner deposition 122.)
16. Other measures of the jail being "out of control" were the number of uses of force and inmate stabbings and slashings. (Skinner deposition 656.) During his tenure at JATC, Skinner received complaints from inmates that they had been housed in cells without light bulbs for more than a

day. (Skinner deposition 585.)

17. The use of force reports prepared by the CPSU and JATC staff were reviewed and approved by the unit and jail commanders, and forwarded to the Commissioner and Chief of Department. These reports consistently demonstrated a fundamental bias towards exonerating the staff of any misconduct, and finding that the use of force, no matter how severe the injuries, was an appropriate response to assaultive inmate conduct. In fact, these reports were written for the very purpose of absolving Department staff of any liability for injuries the inmates sustained when they were struck by correction staff. A few attempts by Department staff to conduct independent investigations into use of force incidents in the CPSU were met with threats by CPSU and JATC supervisors. (Fullard deposition 306-313.)
18. The facility reports demonstrated a double standard in evaluating inmate and correction officer accounts. (Viera deposition 590-1.) They characterized the officers' reports as credible if they were consistent; but they dismissed as collusive and fabricated inmate statements which were consistent with each other. At the same time, they rejected an inmate's allegation that he was the subject of unnecessary or excessive force in the absence of corroborative statements from other inmates. The facility reports minimized the inmate injuries, and credited the officers' accounts because the injury was always consistent with the description of the force used by staff. The reports often described the officers' injuries in ways that were not consistent with medical findings, or relied on clinical findings of officer injuries made long after the inmate allegedly inflicted the injuries.
19. From the time the unit was opened until it was moved out of JATC, the supervisory staff of the CPSU and JATC--with the exception of the unit manager during the period October, 1988 through May, 1989--took no meaningful steps to curb the abuse of inmates in the unit. These supervisors consistently failed to conduct independent, thorough and unbiased investigations of incidents in which correction staff struck inmates. Jail and unit supervisors refused to interview staff members after they had used force, and instead relied on their written reports in preparing the facility investigation. These supervisors failed to review the records of officers' use of force history, even though a Department directive required such review. The supervisors failed to require that CPSU staff video tape incidents in which force was anticipated, such as whenever an inmates' cell was opened, even though this was required by an institutional order. The supervisors consistently rejected inmate allegations of unreported beatings, even when the inmate had obviously been injured by blunt force trauma and there was no reasonable explanation to account for his injuries other than to credit his allegation. The refusal of these supervisors to acknowledge the pattern of brutality which they knew existed, and to take any steps to curb it, were substantial factors in the continuation of the staff violence and other misconduct.
20. Indeed, the pattern of staff misconduct in the CPSU was so blatant, the number of inmates severely injured so great, and the number and frequency of incidents so consistent over the period 1988--1996 that the failure of supervisors at the jail to acknowledge and address the problem demonstrates that these supervisors deliberately chose to allow officers to brutalize inmates as a means of exercising management and control.
21. This inference is consistent with evidence in the record that some supervisors, including the CPSU Unit Manager Danny Trapp, and the Deputy Warden for Security William Kozack, ordered captains to have inmates beaten by officers to punish them for minor misconduct and to falsify Department reports concerning the incident. (Fullard deposition 221-4, 446-5.) Other captains ordered inmates to be beaten, and orchestrated the cover-up of the beating by advising officers how to write their reports, and that they should falsely claim inmates attacked staff with weapons. (Johnson Trial Testimony 262-6, 277-9, 160-5.)

Participation and Acquiescence of Department Managers

1. Some Department officials with knowledge of the CPSU knew or believed that a pattern of excessive and unnecessary force by staff existed there. Other Department officials suspected that such a pattern existed but took no effective action to verify whether it in fact existed.
2. Department supervisors tolerated the practice of CPSU officers beating inmates and falsely reporting the incidents as the use of force to defend themselves. These supervisors thereby encouraged the brutality and cover-up to develop into a *de facto* policy in the CPSU of using deliberate beatings as a management tool. The reliance on misuse of force and its cover up in the CPSU were the direct consequences of decisions made between 1988 and 1990 by Commissioner

Koehler, and his successor, Commissioner Sielaff. Koehler assigned Danny Trapp as the first Unit Manager of the CPSU in 1988. Trapp was known in the Department of Correction as a "head knocker," someone who beat inmates or approved of their beating as a management technique. (Memorandum, Assistant Commissioner Colon to Chief of Department Mitchell, May 30, 1990.) In July, 1988, Trapp stated publicly that his management philosophy in administering the Unit was: "We try to control with respect, but there are those you control with fear." (*New York Newsday*, July 31, 1988.) Trapp generated fear by directing officers and captains to "take care of inmates" who acted disrespectfully to Department employees, by which he meant, "if [an inmate] gets out of line, fuck him up." (Fullard deposition 222, 225.)

3. Howard Robertson was assigned as the Unit Manager of the CPSU in October, 1988. With the knowledge of the Commissioner, he took successful steps to reduce unnecessary and excessive force in the Unit. (See, Memorandum, "New York City House of Detention for Men/Central Punitive Segregation Unit," Ralph Mierzejewski to Bonnie Nathan, November 29, 1988; Memorandum, Bonnie Nathan to Richard Koehler, December 12, 1988.) CPSU staff became resistant to Robertson's initiatives, and in May, 1989 demanded--and were afforded--a meeting with the Commissioner and the Chief of Department. At the meeting, these officers demanded that Robertson be removed because he would not "back" his officers and allow them to use force as a "legitimate reprisal" to punish inmates who violated facility rules. (Deposition of Prof. Robert J. Kelly (Commissioner Koehler's consultant on the CPSU), September 30, 1994 ("Kelly deposition") 99; Kelly Memorandum, Impressions of the Commissioner's Meeting With the Correction Officers of the CPSU, May 12, 1989 ("Problems start and end with the Unit Commander, the ADW who has failed to support his COs.").) Immediately after the meeting, Robertson was removed from his position as CPSU Unit Manager.
4. Following Robertson's removal, inmate injuries in use of force incidents in the Unit were more frequent and more severe. According to Department records, there were 13 reported use of force incidents in the CPSU in the 19 days following the Commissioner's meeting with CPSU officers, which was more than there had been in the previous three months.
5. When Allyn Sielaff became Commissioner he instituted a number of measures that signaled a relaxation, if not a repudiation, of the Department's formal use of force policy. These steps included: (1) issuing a public statement to a newspaper that he was terminating the Assistant Commissioner for Investigation and Discipline, Bonnie Nathan, because she had been "unduly harsh" in her approach to disciplining officers who violated Department policies, *The Chief-Leader,* July 27, 1990, pp. 1, 8; (2) withdrawing authority from the Investigation Division to charge officers with violating the use of force policy, and assigning that responsibility to the wardens of the jails; (3) re-assigning half of the Investigation Division's use of force unit to other duties and removing resources from ID, including cars, which impaired the ability of ID staff to respond to incidents, and to conduct interviews of inmates injured by uniformed staff and of witnesses to these incidents; and (4) declaring that the Department would significantly expand the CPSU from 300 beds to over one thousand, converting the entire James A. Thomas Center to the CPSU.
6. During Commissioner Sielaff's administration, the Department reduced the number of excessive force cases it prosecuted at OATH from 79 cases brought between January and July, 1990, to 28 brought from July through December, 1990, and to 2 cases brought between December, 1990 and July, 1991.
7. These decisions were made in response to the perception that officers throughout the Department, including the CPSU, were suffering from low morale because, *inter alia*, they believed the Department's use of force policy was too restrictive.
8. During the eight years the CPSU operated at JATC, supervisors in the Department's central office knew of the number, frequency and severity of staff use of force in the CPSU, and that these incidents, over time, clearly constituted a pattern of brutality and other misconduct that was on-going and widespread in the unit. CPSU personnel submitted written reports of every use of force incident and allegation of unreported force which occurred in the CPSU between March 1, 1988 and March 9, 1996 for review by supervisors at the highest level of the Department of Correction, including the Commissioner, Chief of Department, Chief of Security, Investigation Division and Division Chief (later "Assistant Chief"). These reports included both "use of force reports," detailed reports submitted pursuant to Department policy after every use of force, and daily summaries of use of force activity ("24-hour" or "CCC" [Communications Control Center]

reports). From these written reports, as well as from other sources, senior Department officials in the Commissioner's office knew as early as December, 1988 that CPSU inmates were being subjected to physical force in exceptionally high numbers, that there were repeated, consistent allegations of brutality and cover-up by uniformed staff in the jail, and that the brutality appeared to represent a calculated decision by facility personnel to manage the unit through fear, intimidation and the infliction of serious injury. (See, Memorandum, Ralph Mierzejewski to Assistant Commissioner Bonnie Nathan, December 12, 1988 ("[T]aking into consideration that the inmates are locked into their cells most of the time except for mandated services and hygienic reasons, there appears to have been an extraordinary amount of assault on staff/use of force reports since its conception [sic].. . .").)

9. Over the next seven years, the Department's senior officials continued to receive daily reports summarizing the incidents in which CPSU inmates were repeatedly struck and seriously injured by correction officers who claimed to be using force in self defense. In addition, these officials received a number of complaints from inmates in the unit, as well as letters and communications from the Legal Aid Society and the Board of Correction beginning in 1989, alleging deliberate beatings of inmates in the unit. In 1990 and 1992 written reports prepared by the Office of Compliance Consultants for Judge Lasker confirmed a pattern of beatings and physical abuse of inmates in the unit. Based on interviews with approximately 20 inmates and observations of injuries to inmates, OCC concluded in 1990 that "there is a basis to the charges that inmates have been beaten and subjected to humiliating acts by officers working in the CPSU." OCC also reported that there was a widespread fear of reprisals for reporting misuse of force among the CPSU population. OCC staff shared its assessment of staff brutality and intimidation with the JATC Warden and CPSU Unit Manager, Jose Viera. (Letter, Mary Jo Mullan to Hon. Morris E. Lasker, October 16, 1990.) In June, 1992, OCC again reported to Judge Lasker and to the Department of Correction that, based on interviews with inmates and Department staff, it had found a pattern of inmate abuse in the CPSU. This pattern included "greeting beat-up[s] administered to inmates who have been admitted to the CPSU for striking an officer or who display an attitude that offends officers. In some cases the beat-up will involve acts that do not leave scars (e.g., perforated ear drums). . . Another practice involves holding an inmate's head in the toilet bowl while flushing the toilet." (Letter, Mary Jo Mullan to Judge Lasker, June 28, 1992.) Both the October, 1990 and June 1992 OCC reports were the subject of lengthy court conferences attended by high-ranking officials from the Department of Correction, including the Commissioner, Deputy Commissioners, Division Chiefs and JATC Warden.
10. Commencing shortly after the CPSU was opened, central office supervisors were repeatedly placed on notice of the existence of a pattern of excessive and unlawful force by correctional staff not only through the official reports of use of force incidents routed to them, but through information provided by Department staff members, most notably the reports prepared between 1992 and 1995 by the Integrity Control Officers ("ICO") assigned to the CPSU; by Assistant Commissioner Toni V. Bair, whose April, 1992 memorandum to Commissioner Abate read in part: "I know of no other system in the country where there are daily occurrences of inmates being struck in the face numerous times and the correctional officers and captains justifying this behavior by stating that 'they were defending themselves.' Hardly without exception the morning 24-hour reports chronicle inmate assaults. Legal Aid uses these documents as well as others to bring suit against the Department similar to the one at C-76 in 1987. GMDC and JATC are likely targets"; by the reports in 1990 and 1992 by the federal court's Office of Compliance Consultants; and by outside agencies, including the Legal Aid Society and the New York City Board of Correction.
11. In December, 1988 Assistant Commissioner Bonnie Nathan was advised by the Department's Deputy Director of Investigations, Ralph Mierzejewski, that one CPSU captain, Vinogroski, had been involved in 19 use of force incidents between November, 1987 and December, 1988 in the CPSU (and in JATC's punitive segregation area, which had been made part of the CPSU in March, 1988). Mierzejewski concluded that Vinogroski was not properly supervising the Unit officers assigned to him, and "possibly condoning unnecessary use of force incidents against inmates." (Memorandum, Mierzejewski to Nathan, December 9, 1988, Re: Captain Edward Vinogroski.)
12. During the first six months an ICO was assigned to JATC, the position was filled by two experienced Correction supervisors, first Assistant Deputy Warden Gloria Hunter, and then her successor, Assistant Deputy Warden Melvin Fieramosca. Hunter and Fieramosca reported to

central office and, in some cases, to the facility warden: (1) inconsistencies between the force reported by officers and the injuries found by medical staff (Memo, Hunter to Suite, October 28, 1992); (2) that a CPSU inmate who protested the way his property was being handled during a search was thrown on the ground and struck in the back by Officer Spissinger, after which an unidentified captain told the inmate to "shut up before they send you to Bellevue" (Memo, Hunter to Suite, November 10, 1992); (3) a serious absence of supervision of facility "probe teams" when these groups of officers responded to force incidents; (4) that probe team members were wearing utility gloves, which were prohibited by Department rules and which inmates alleged were used when officers beat them; (5) that CPSU officers were working without name plates, contrary to Department policy; (6) that captains were absent during admission processing and inmate searches (Memo, Hunter to Phoenix, November 20, 1992); (7) that an inmate's allegation that he was punched and struck in a closed room after an inmate worker was ordered to lock into a janitor's closet was true (Memo, Fieramosca to Rodriguez, December 15, 1992); (8) that in 11 days in December, 1992 there were "fourteen uses of force, which in the opinion of this writer appears to be a strong reliance on force. It appears that the command's reliance on force is quite significant." (Id.)

1. The Department of Correction installed wall-mounted, time lapse cameras in JATC, and later in OBCC, pursuant to the Stipulation and Order of February 21, 1995 in Benjamin v. Jacobson, 75 Civ. 3073 (MEL). JATC and central office supervisors knew that CPSU staff sabotaged the surveillance cameras in JATC by pointing the cameras at the floor or ceiling, but essentially remained passive in the face of this staff subversion. (See, Skinner deposition 165-7, 596-8) (Deputy Warden for Security made sure the cameras were properly aligned before leaving the jail, and returned the next morning to find that they had been moved; Chief of Security Abruzzo "reamed" him because of the vandalism); Dash deposition 80-3 (CPSU commanding officer knew cameras were pointing to floors and ceilings).)

1. Even before the CPSU was opened in 1988, the Department of Correction was on notice through federal court litigation of allegations of widespread misuse of force among correctional staff. During the three years immediately before the CPSU was established, litigation was being pursued against the Department challenging systemic correction officer brutality in three of its jail facilities. Fisher v. Koehler, 692 F. Supp. 1519 (S.D.N.Y. 1988), *injunction entered*, 718 F. Supp. 1111 (1989), *aff'd.*, 902 F.2d 2 (2d Cir. 1990) [Correction Institution for Men], Jackson v. Montemagno, CV 85-2384 (AS) (Order Approving Stipulation for Entry of Judgement, November 26, 1991) [Brooklyn House of Detention], Reynolds v. Ward, 81 Civ. 101 (PNL), Order and Consent Judgement, October 1, 1990) [Bellevue Prison Psychiatric Ward]. In response to the Fisher litigation, Richard Koehler, then the Commissioner of Correction, represented in early 1987 that the Department would adopt a number of remedial measures to curb the unnecessary and excessive use of force by officers in the jails. Specifically, Koehler represented to Judge Lasker that the Department would, throughout its jails, carefully monitor the use of force by staff through a computer tracking system devised pursuant to Directive 5003; impose severe discipline, including suspension and termination, on those staff members involved in misuse of force; communicate the intent to impose such discipline to jail staff; hold jail commanders responsible for monitoring their subordinates' use of force, and promote supervisors who reduce use of force in their commands; improve training of correction staff in alternatives to use of force and techniques of non-injurious use of force; and extend officers' probationary periods with review of probationary evaluations by the Commissioner himself. (See, testimony of Richard J. Koehler, Fisher v. Koehler, transcript, 3341, 3579, 3600, 3439, 3469, 3566, 3349, 3354, 3376, 3501.)
2. During the period 1988--1996, none of these measures, except the lengthening of the probationary period, was ever implemented or utilized in the CPSU. Despite their knowledge of misuse of force and their own promises and their agents' recommendations of remedial measures, defendants failed to do what they knew needed to be done at the CPSU from its inception. This failure persisted even after an obvious pattern of excessive and unlawful force had emerged at the CPSU.
3. Defendants failed adequately to screen and select officers suitable for assignment to the environment of the CPSU. Former CPSU officer Alex Padilla described his recruitment to the CPSU by the Unit Manager, Deputy Warden Jose Viera, at the Department's Training Academy: "Upon interview, Dep. Viera asked me what am I going to do if an inmate punches me in the face,

and I told him I would kick his ass to make sure he doesn't punch me in the face anymore, and Dep. Viera said all right, you're in, and the next thing you know, sure enough, I was in the CPSU." (Transcript of May 17 interview at 38.) The Department assigned officers to the CPSU because of their imposing size (Deposition of C.O. Marvin Williams, November 1, 1994 ("Williams deposition") 9), so that they could be intimidating to inmates. (Viera deposition 182-3.)

4. The Department officials' failure to adopt meaningful and effective measures to curb the abuse of inmates was a substantial cause of the continuation of the pattern of staff brutality in the unit. Indeed, the pattern of staff misconduct in the CPSU was so often brought to the attention of Department supervisors between 1988 and 1996, and their failure to implement measures to curb the abuse of inmates so consistent over this period as to support a finding that this continuing failure reflected a deliberate choice by them to allow inmates to be brutalized in order to control them.
5. Specifically, the Department's central office supervisors failed to ensure that the Investigation Division competently and effectively investigated use of force incidents in the CPSU, and that the few staff members charged with violating the Department's use of force and reporting directives were adequately disciplined.
6. The Department not only failed to effect meaningful discipline on CPSU staff members for misusing forces; it rewarded some. Central office supervisors promoted individuals known to have been involved in questionable or suspicious use of force incidents, or suspected of having allowed inmates under their supervision to be beaten. These supervisors staffed the CPSU in part with officers and captains whose employment histories documented their refusal to conform their conduct to the Department's use of force policy, and/or to report their conduct truthfully. These transfer and promotion decisions led CPSU staff to realize that violating the use of force policy would have no adverse career consequences. These transfer and promotion decisions were a substantial factor in perpetuating the pattern of staff misconduct in the Unit.
7. Moreover, probationary officers and captains in the CPSU who were disciplined for violations of the Department's use of force and reporting directives were allowed to remain with the Department and become tenured employees. Several supervisors who were charged with violating Department policies in connection with use of force incidents in the CPSU were subsequently promoted.

1. Even though Department supervisors knew as early as 1989 that certain officers and captains were frequently and repeatedly involved in use of force incidents in the CPSU in which inmates were seriously injured, it was not until late 1995--in response to this litigation--that the Department transferred staff members from the Unit because of their use of force activity, and thereafter relocated the Unit to OBCC.

Lack of Use of Force Training

1. Staff members assigned to the CPSU relied on "street fighting" techniques, primarily punches, strikes and blows, when they applied force to inmates. Although its written policy purports to require staff to restrain inmates using holds and other non-injurious force, the Department of Correction does not adequately train its uniformed staff in how to restrain inmates without resorting to injurious force, i.e. punches, strikes and blows. This failure to ensure that line staff used force properly and in compliance with DOC policy was consistent with the more general pattern of failure to supervise line staff and enforce DOC policy in the operations of the CPSU which I have described above.
2. It is common knowledge in the supervisory ranks of the Department of Correction that uniformed staff are inadequately trained in how to restrain inmates utilizing non-injurious force. Moreover, the City of New York has refused to budget sufficient funds to enable the Department of Correction to provide adequate training to uniformed staff in how to restrain inmates utilizing non-injurious force.
3. Chief of Department Eric Taylor, the Department's highest ranking uniformed officer, testified that the Department's training in non-injurious use of force, such as body holds and restraining techniques, is inadequate to allow officers to use holds spontaneously without first resorting to punches. (Deposition of Chief Eric Taylor, May 2, 1997 ("Taylor deposition") 97.) Taylor had been told that there is no money to provide regular, on-going training to uniformed staff in using

non-injurious force, and for that reason it had not been provided to CPSU staff. (Taylor deposition 100, 102-6.)

4. Deputy Warden Dash, who was the CPSU's commanding officer in 1995, testified that Department of Correction staff are not adequately trained in using non-injurious force, although the Department's formal use of force policy discourages them from striking inmates in the head or face. (Dash deposition 178.) Dash agreed with plaintiffs' counsel that more likely than not, the reason why CPSU officers punched and struck inmates as frequently as they did was because they received inadequate training in non-injurious forms of self-defense. (Dash deposition 179-180.) In Dash's opinion, the "'few hours' training" that officers receive in non-injurious self defense is not "realistic" preparation for jail experience. (Dash deposition 178, 180-1.) He agreed that the Department of Correction does not provide consistent training in non-injurious forms of self-defense; nor does it consistently hold staff responsible when they violate its policies. (Dash deposition 182-3.) Effective training could have an impact on curbing brutality, but "it's not the training alone, it's the mindset." (Dash deposition 182.)
5. Dash's predecessor as the CPSU commanding officer, Deputy Warden Walter Johnson, testified that it was his belief that the training provided to New York City correction officers in applying non-injurious force is not adequate. (Deposition of Walter Johnson, February 6, 19, 1997 ("Johnson deposition") 437.) That inadequacy is in part the reason why officers used force as frequently and severely as they did in the CPSU. (Johnson deposition 438.)
6. Terrence Skinner, the Deputy Warden for Security at JATC in 1994-5, testified that he "did not have properly trained officers" in the CPSU when he was assigned to JATC. (Skinner deposition 413.)
7. At his deposition, Skinner testified to his belief that the uniformed staff in the Department had to be closely monitored and trained; they had to be guided "all the time." "You can't guide them today, because tomorrow if you don't tell them to turn left they're going to go straight. They have to turn left every day, but if you don't tell them to turn left, they're not going to turn left." (Skinner deposition 123.) "Things have been happening for years, so you have to drill things in and change the mentality." (Skinner deposition 170.)

The CPSU at OBCC: March 10, 1996--present

The Continuation of the Pattern of Misuse of Force

1. After the relocation of the CPSU to OBCC, the pattern of misuse of force continued. Indeed, videotapes of a number of incidents in 1996 established that staff initiated the application of force (see, *e.g.*, UOF 621/96 [Cpt. Trinidad/inmate Escalante], UOF 712/96 C.O. Britt/inmate Anderson], UOF 1811/96 [inmate Pemberton] and/or falsely reported the incident (see, *e.g.*, UOF 1011/96 [Wayne Gardine], UOF 1171/96 [Alberto Muniz], UOF 1747/96 [inmate Smalls]). The scenarios in which force was misused in OBCC were different from those which had been employed at JATC. Four factors contributed to the change in the manner in which force was misused. First, the CPSU housing areas were subject to video surveillance by wall-mounted cameras located in the nine housing areas of the Unit and in the elevators. Significantly, no cameras were installed in the elevator lobbies. A number of incidents in which staff misused force occurred in areas removed from view of the cameras, such as the elevator lobbies, inmates' cells and facility receiving rooms. Second, beginning shortly after the Unit's relocation, all CPSU inmates were rear-cuffed whenever they left their cells. A number of inmates were struck in the face and head while cuffed, or pushed head-first into the walls while rear-cuffed (see, *e.g.*, videotapes of UOF 438/96 [baton blows on handcuffed inmate in yard], UOF 512/96, 939/96 1171/96 [cuffed inmates pushed violently into wall], UOF 1141/96 [cuffed inmate pushed into cell and then struck off-camera]. Third, all OBCC CPSU staff were authorized to administer tear gas, and were equipped with hand-held aerosol gas dispensers. A number of CPSU inmates were gassed while cuffed, in their cells, or under other circumstances in which the use of chemical agents was abusive. Fourth, at OBCC captains were directly involved in striking inmates, supervising incidents in which blatant security breaches (e.g. inmates moving cuffed hands from the rear to the front with no preventive action by staff) precipitated the use of force, and in failing to utilize the hand-held video camera to record applications of force that were clearly anticipated, as required by Department policy.

2. Between March 9 and December 31, 1996 there were 264 reported use of force "incidents" or allegations of use of force reported to DOC staff involving CPSU inmates in OBCC. This number was far in excess of the yearly totals of use of force incidents in the CPSU when it was housed in JATC. Some of the 264 reported use of force incidents involved the application of force to more than one inmate. Altogether, there were 373 inmates involved in use of force incidents in the CPSU between March 10 and December 31, 1996.
3. At OBCC, CPSU staff continued to routinely employ unwarranted, unnecessary and excessive force as a means to punish and control inmates, and to retaliate against them for perceived wrongdoing. The routine misuse of force was wholly beyond, and out of proportion to, that needed to maintain order in the CPSU. The misuse of force routinely and inevitably inflicted serious injury and pain on inmates confined to the Unit. A list of some of the CPSU inmates who were injured by Department of Correction staff in use of force incidents in the OBCC CPSU is attached to this Declaration as Exhibit 3. There were 101 use of force incidents--almost forty percent of the total number of "use of force incidents" in the CPSU in 1996--in which, according to Department of Correction records, staff reported striking or punching an inmate with their fists, or with a baton, or the inmate alleged to Department staff that he was struck by fists, feet or a baton. Many of these incidents occurred during "cell extractions" which in other correctional systems are effected with techniques that are intended to gain quick control of an inmate with minimal injurious force.
4. Evidence of this pattern was manifest both in the institutions's records (use of force packages, videotapes) and in the sheer number of incidents and the frequency and severity of inmate injuries, especially injuries to the face and head. Indeed, multiple head injuries sustained by inmates in routine applications of force in the CPSU was so commonplace as to constitute a clear pattern and practice of the utilization of techniques intended to harm and punish, rather than restrain and control, inmates.
5. At OBCC there was a conspicuous pattern of inmates being struck in the face and head while in handcuffs and of inmates being struck in the face and head in locations that could not be observed by inmate witnesses and were not subject to video surveillance, *e.g.*, cells, elevator lobbies and intake areas. Staff evaded and sabotaged the surveillance cameras that were installed precisely for the purpose of helping to control the misuse of force. In at least fifty use of force incidents in the CPSU in 1996, inmates were struck or otherwise injured (*e.g.*, pushed to the floor) by correction staff while they were handcuffed, almost always with their hands behind their backs.
6. Staff used force when none was needed, *e.g.*, initiating force in response to verbal misconduct or other acts of defiance. A number of inmates suffered head and face injuries in the CPSU when struck by staff in the course of cell extractions performed to remove inmates from their cells under circumstances in which they could and should have been allowed to remain in the cell, or should have been removed without being struck repeatedly in the face and/or head. In other incidents, when some force may have been justified, staff used excessive force that was intended to cause pain and injury rather than in a good faith effort to maintain order.
7. Staff manufactured occasions for the use of force by creating security breaches, *e.g.* allowing inmates to move their cuffed hands from the rear to the front; entering cells of defiant inmates who had not been restrained; escorting inmates after incidents without adequate restraints; opening cells and allowing the inmate to walk unescorted on the tier. There were a number of use of force incidents in the CPSU which reportedly began when the inmate freed himself from cuffs, attacked groups of staff, and was then restrained with multiple punches to the face, head and body. Most of these incidents were reported in areas of the facility not covered by video surveillance cameras.
8. CPSU staff used chemical agents frequently. In a five-month period between April and August, 1996, there were 118 Class A use of force incidents in the CPSU, 96 of which (81%) involved the use of mace. (Memorandum, Warden Ortiz to Chief Haughton, September 4, 1996, Statistics for March through August, 1996 Re: Class A Use of Force.) In OBCC, staff used chemical agents under highly questionable circumstances: on inmates whose hands were cuffed behind their backs; to "effect a transfer" of an inmate; in response to verbal abuse; on inmates in locked cells; on an inmate with a cane who refused to wear leg shackles or to return to his cell; and on an asthmatic inmate locked in his cell.
9. Staff continued to cover up their misconduct. Staff submitted false reports, and frequently used rote and specious reasons to justify the applications of force in which multiple and serious injuries resulted. Most commonly, they reported that they used minimal force to restrain an inmate in

defense of themselves when, in fact, they initiated force to assault the inmate, and to inflict pain and injury. In a number of cases, the fraudulent and dishonest nature of the staff use of force reports was obvious when the videotape of the incident was viewed. In some cases staff failed to report the use of force at all.

10. At OBCC staff flouted or subverted Department orders requiring the use of hand-held video cameras to record anticipated use of force incidents, such as cell extractions. At OBCC there was a consistent failure to utilize a hand-held video camera to record incidents in which the use of force was reasonably anticipated. When a hand-held camera was brought to the scene of a use of force, staff routinely failed to record the actual use of force by delaying the filming until the force had already been utilized, or using the camera improperly, or obstructing the view of the camera. Even after the CPSU Unit Manager advised his subordinates in May, 1996 of the requirement that a hand-held camera be used to videotape anticipated uses of force, neither the CPSU Tour Commanders nor other staff complied with the order. Between May 10 and August 1, 1996, Department of Correction records reflect that CPSU staff entered inmates' cells, or used force elsewhere, under circumstances when force could reasonably have been anticipated, but no video camera was utilized. It was not until after a second memorandum from the CPSU Unit Manager, issued on August 6 , 1996-- after the Legal Aid Society advised the Commissioner that unit and facility staff were continuing to violate the video taping directive-- that CPSU staff began to utilize the hand-held video camera to tape cell extractions.

The Role of OBCC and Central Office Supervisors

1. As they had at JATC, CPSU and OBCC supervisors, as well as central office administrators, routinely and consistently approved the use of punches and blows to inmates' faces and heads--including many inmates who were handcuffed when struck-- whenever staff justified the application of force as necessary in "self defense." CPSU and jail supervisors, as well as central office administrators, also knew that officers continued to prepare their use of force and witness reports collusively. These same supervisors routinely credited the officers' accounts of use of force incidents because their reports were "consistent."
2. Although the transfer of the CPSU to OBCC was prompted by this litigation and the acknowledged existence of a pattern of misuse of force, and its cover up, at JATC, neither supervisory staff in OBCC nor executive staff in DOC's central office made any significant efforts to determine whether that pattern had been ended by the transfer to OBCC. After the CPSU was moved to OBCC, the pattern of supervisory knowledge of, acquiescence in, and "turning a blind eye" towards the misuse of force continued.
3. OBCC and CPSU supervisors reviewed the "preliminary reports" of use of force incidents in the CPSU, and the Commissioner read the "CCC" or "24 hour reports" documenting use of force in the Unit. These sketchy reports identified the location of the incidents and summarized the sequence of events leading to the application of force, as well as the participants' injuries. Supervisors who read these reports knew that in 1996 numerous CPSU inmates were being punched and struck in areas not covered by the wall-mounted video cameras, such as elevator lobbies and inside cells; struck and punched while they were handcuffed and being moved from their cells; struck with batons in the head and face; and punched and struck after freeing themselves from handcuffs. They also knew of the number of inmates maced by officers in the CPSU to whom hand-held gas canisters had been distributed shortly after the Unit was relocated.
4. Yet the OBCC Warden and CPSU Unit Manager, astonishingly, refused to read the actual reports of "Class A" use force incidents and to routinely review videotaped use of force incidents, although the Commissioner expected them to; the Commissioner only learned some time later that they were not reading the reports and viewing the tapes. (Jacobson deposition 29-30, 55-6.) Similarly, although the Commissioner expected the Integrity Control Officer assigned to the CPSU to routinely review use of force incidents and view the videotapes, he only learned after the fact that she was not doing so. (Jacobson deposition 434, 57.) The Division Chief, who had oversight responsibilities with respect to the CPSU, also did not read the use of force packages, and the Commissioner was not informed of this. (Jacobson deposition 32, deposition of Division Chief Milton Haughton, August 28, 1997 ("Haughton deposition") 73-77.)
5. The fact that the OBCC Warden and CPSU Unit Manager refused to routinely read the use of force reports--although they each signed them--and view the videotaped incidents underscored yet

again how willing high-ranking Department officials were to turn a blind eye towards events in the CPSU. Warden Robert Ortiz had been informed shortly after he assumed his position, by then-Deputy Commissioner Kerik, of the pattern of staff misconduct in the CPSU which led to the Unit's being relocated to his command. (Deposition of then-First Deputy Commissioner Kerik, February 27, 1997 ("Kerik deposition") 157.) Assistant Chief Milton Haughton, Ortiz' immediate supervisor, rebuked Ortiz in June, 1996, for recent "violent incidents among staff and inmates which raised questions concerning proper leadership within the facility." (Memo, Haughton to Ortiz, June 17, 1996.)

6. Central office supervisors, who reviewed the "24 hour reports" from the jails, had general knowledge of the frequency and severity of injuries sustained by CPSU inmates after being struck by staff (as they had during the years the CPSU was located at JATC; see, Memorandum, Assistant Commissioner Toni V. Bair to Commissioner Catherine Abate, April, 1992 [discussed at ¶ 68, *supra*]. However, no one in the Commissioner's or Chief of Department's office routinely and consistently reviewed the use of force packages--which contained more detailed information about the inmate injuries and the course of the incidents--until September, 1996, when Division Chief Haughton, the Warden's immediate supervisor, had the reports sent to him. (This followed the Legal Aid Society's detailed letter of July 31, 1996 to Commissioner Jacobson, in which we advised the Commissioner of a number of use of force incidents in the CPSU in which handcuffed inmates were struck in the face and head, often outside the view of wall-mounted cameras. See, ¶ 103.) The failure to review the contents of the packages appeared to reflect a deliberate intention to avoid knowledge of the contents of the reports.
7. Although the formal reports of use of force incidents were routed both to supervisory staff in OBCC and executive staff in the Department's central office, nobody reacted or responded to the patterns in which force was being used in the Unit until plaintiffs' counsel wrote to the Commissioner on July 31, 1996. In that letter, the Commissioner was advised of a number of inmates who had suffered head and face injuries when struck by CPSU staff, many of them in handcuffs and in areas not covered by the wall-mounted surveillance cameras. The Commissioner was also advised that there had emerged in the CPSU an identifiable group of captains and officers frequently involved in use of force incidents in which inmates were seriously injured. Prior to his receipt of the July 31 letter, the Commissioner was not aware of the fact that CPSU inmates had been struck by staff while handcuffed behind their back. (Jacobson deposition 45.)
8. Throughout 1996 and continuing into 1997, OBCC and central office supervisors ignored obvious patterns of staff practices which warranted review, investigation and follow-up. These patterns of use of force were readily discernible from at least a review of the 24 hour reports, as well as a review of the use of force packages and videotapes. These patterns included: the frequency of serious head and face injuries inflicted on inmates in use of force incidents; reported blows to inmates being escorted out of their cells, who were presumably handcuffed pursuant to Department policy; the use of the poly-carbon shield used in cell extractions to strike inmates in the face and head; unexplained multiple inmate injuries; frequent incidents of force involving the same personnel; frequent incidents involving locations in the jail outside of camera range; and frequent administration of chemical agents on inmates in locked cells who had refused or defied orders.
9. Had the facility Integrity Control Officer, CPSU Unit Manager and OBCC Warden been reviewing videotapes of use of force incidents in the CPSU and reading use of force reports, they would have confronted a number of instances of false reporting of use of force incidents by captains and officers. They would also have become aware of a number of incidents in which staff struck handcuffed inmates to the face and head.
10. Central office officials received information in 1996 regarding continuing violations of use of force investigation policies. The Commissioner, Chief, and Division Chief knew in the spring of 1996 that CPSU staff were failing to use the hand-held video camera to film use of force in inmates' cells; from a review of the "24 hour reports" they knew that several captains and a group of correction officers were involved in a disproportionate number of use of force incidents in which inmates suffered serious injuries; they knew that staff used force in areas of the CPSU that were not covered by the wall-mounted video cameras and that staff struck and punched inmates, whose hands were cuffed behind their backs, in the face and head. Yet they took no reasonable or meaningful steps to protect CPSU inmates from the continuing infliction of injury at the hands of Unit staff.

11. Commissioner Jacobson had become aware of the pattern of excessive force and falsification of documents, and of the more general breakdown in supervision and oversight, in the JATC CPSU in August or September, 1995 (Jacobson deposition 39-40). He, like his predecessors, continued thereafter to rely on his subordinates to deal with the use of force issue in the CPSU. He assumed that these subordinates would ensure that the misuse of force and its false reporting would not recur, although he failed to hold them accountable for what actually occurred in the CPSU. Like his predecessors, he failed to ensure that these subordinates provided him with a regular flow of accurate information concerning the indicia of unnecessary and excessive force. He continued to fail to provide the level of personal attention and commitment to reform the misuse of force problem warranted; he failed to take decisive action in the face of what he knew were serious violations of the Department's use of force policy; he ignored readily available evidence that unnecessary and excessive force continued to pervade the Unit's operations.
12. Although the Commissioner and members of his executive staff met regularly with facility and Unit supervisors to discuss the CPSU, they focused their attention on the numbers of use of force incidents, and not on the officers' conduct and the inmate injuries. OBCC and Unit staff who met with the Commissioner and his executive staff did not inform the central office supervisors of the type and severity of force that was being utilized in the CSPU, and with what consequences. As a result of the Commissioner's and his staffs' unwillingness to confront how force was being used in the unit, and what injuries were being inflicted on inmates, CPSU staff continued to use force to injure inmates under the same circumstances as they had consistently done.
13. When he testified at his deposition in October, 1997, Commissioner Jacobson characterized the CPSU as a "very well run unit." (Jacobson deposition 173.) But, he was unaware as late as October, 1997 how many CPSU inmates were subjected to force while in handcuffs. (Jacobson deposition 214 ("It's not my practice to essentially micromanage the unit.").) Nor did he know who in central office or at the jail read the use of force packages. For some time he had not known that the former Warden and Unit manager had not routinely read the class A use of force packages; Jacobson had assumed that they had. (Jacobson deposition 27-32, 97-8.) The Commissioner assumed that the successor Warden was reading the use of force packages and reviewing the videotapes. (Jacobson deposition 28, 57.) He was unaware that inmates in the CPSU in 1996 and 1997 continued to suffer perforated eardrums (four inmates were reported to have suffered perforated eardrums in use of force incidents between November, 1996 and April, 1997), although he believed that he should have been informed of this; he did not know that a perforated eardrum sustained from the application of force necessarily reflected a targeted blow to the ear although he recognized that injury as having been "associated" with use of force in the JATC CPSU. (Jacobson deposition 207-10.) The Commissioner was not informed of the nature of the injuries inmates sustained in cell extractions and other use of force incidents in the CPSU; he was not informed of whether incidents took place in view of the wall-mounted cameras. (Jacobson deposition 60-62.) The Commissioner did not know how members of the Emergency Response Unit were screened before being selected to work in that unit, but knew that the ERU included some members of the uniformed staff who had not been allowed to work in the OBCC CPSU because of their prior assignment to the CPSU at JATC. He did not know whether staff members were allowed under Department policy to confer with each other when writing use of force reports. (Jacobson deposition 84-6, 412.)
14. Although he believed that any staff member who falsified a use of force report should receive some form of discipline for this "serious violation," this was not the agency practice, and the Commissioner was unaware of it. (Jacobson deposition 424.) Nor was the Commissioner aware--until his deposition in October, 1997-- that a number of videotapes showing captains and officers using and observing force in the CPSU in 1996 demonstrated that the staff members' reports had been falsified. (Jacobson deposition 427-431 (UOF# 1747/96, Samuel Small, 12/11/96); *Id.* 141-2 (UOF# 621/96, Reynaldo Escalante, 5/3/96); *Id.* 245 (UOF# 1171/96, Alberto Muniz, 8/12/96).)
15. The Commissioner never heard of the incident on May 24, 1996 (UOF# 752/96) in which two inmates were maced while chained to a fence. (Jacobson deposition 176-8.)
16. The Commission knew in August, 1996, that Warden Ortiz had written a memorandum, describing an incident captured on videotape, which was inconsistent with the events depicted on the tape. (Jacobson deposition 195-8 (UOF# 1011/96, Wayne Gardine, 7/10/96).) That false report was a factor in the Commissioner's decision to replace Ortiz as the Warden, although he was in

fact not replaced until six months later. When Ortiz was replaced, he was transferred to another jail, lost no pay, and suffered no adverse consequences, even though he had prepared a false report about a use of force incident. (Jacobson deposition 198-203.)

17. Another factor in the decision to remove Ortiz from OBCC was the information conveyed by the Legal Aid Society to First Deputy Commissioner Kerik in late February, 1997: that some CPSU inmates were being forced to pay extortion money to inmate food service workers in order to eat, and others were being robbed of property stored in lockers in their housing areas. (Jacobson deposition 201.)
18. Commissioner Jacobson believed that it is the responsibility of facility and Unit managers to address management and supervision issues with respect to use of force. The Commissioner testified in October, 1997, that he was "totally convinced" that OBCC and CPSU supervisors managed use of force appropriately and adequately, and that they properly monitored and supervised staff use of force since the relocation of the Unit. (Jacobson depo 440.)
19. Although the Commissioner believed that it was unsatisfactory for an Investigation Division investigator to close a case without reviewing the videotape (Jacobson deposition 126-7), that was done routinely, and he was not aware of it. Although he believed that Investigation Division investigators should interview staff members involved in force incidents "most of the time" (Jacobson deposition 231), they seldom did. The Commissioner was unaware that at the time of his deposition, all of the over one hundred 1996 use of force incidents that had been closed by the Investigation Division had been closed without any staff interviews. (Jacobson deposition 239.)
20. Although the Commissioner testified in October, 1997, that he had "a tremendous amount of confidence in the Investigation unit and the person and the people who head it" (Jacobson deposition 377-8), he fired the unit supervisor two weeks after the deposition.
21. The Commissioner was unable or unwilling to ensure that decisions he made with respect to the management of force in the CPSU were actually complied with. For example, he decided in July or August, 1997 that cell extractions performed by the Emergency Response Unit should be videotaped by officers capable of recording the events. (There is an institutional order requiring that cell extractions be videotaped, which OBCC staff did not begin to comply with until late summer, 1996; however, ERU staff were not videotaped pursuant to this order when they conducted extractions in the CPSU.) Subsequently, he was told by his subordinates that the extractions were being videotaped, but in fact they were not. (Jacobson deposition 333-350, 368, 384-5.) The Commissioner in 1996 was at first not made aware that facility staff were not using the hand-held video camera; he was then told that it was being used consistent with policy, when it was not. (Jacobson deposition 49-50, 52,150.) Nor was the Commissioner informed that OBCC staff, even in August and September, 1997, continued to fail to use the hand-held video camera in situations when they were required to. (Jacobson deposition 313-4.)

The Department of Correction's Use of Force Policy

1. The Department's Directive 5005 prohibits the use of force to punish, discipline or retaliate against an inmate, and requires the use of graduated force by staff in responding to inmate misconduct.
2. But while force may not be used to discipline an inmate for failing to obey an order, the Directive on its face permits force to be used to "enforce Department/facility rules and court orders." As plaintiffs' expert Vincent Nathan reported, "this is a generalization through which CPSU staff have driven an engine of terror, as the standard response to an inmate's failure to obey an order is the use of unnecessary or excessive force." (Report of Plaintiffs' Expert Vincent Nathan, December 1, 1997 at 20.) And while deadly force, defined as force readily capable of causing "serious injury or death," is prohibited by the Directive except as a last resort, the Department tolerated multiple blows to the face and head--which are obviously capable of causing serious injury or death--as a normal, routine application of force in the CPSU for close to a decade.

1. Nothing in the Department's use of force reporting requirements, which are also included in Directive 5005, required officers to prepare use of force reports independently. (In fact, in 1990, when it negotiated with rioting correction officers who had seized the Rikers Island Bridge in protest against the Department's use of force policy, the City entered into the so-called "Bridge Agreement" and agreed that "correction officers shall be allowed the assistance of fellow employees and union representatives when writing reports. . . The Department has agreed to allow

delegates to assist correction officers when they are ordered to write reports.") The practice in the CPSU was for staff to prepare the reports collusively, thus ensuring their consistency. (See, Mojica deposition 184; Viera deposition 272-3, 361, 600; Skinner deposition 155-6; Hunter deposition 129-30, 373-4; deposition of Captain Richard Pagan, October 13, 1994 ("Pagan deposition") 126-7 (former Director of Investigations testified that identical reports are "normal" and essentially fabricated).)

1. The Department's Directive 4510RR, governing the use of chemical agents, including mace, failed to provide sufficient guidance to line staff concerning the use of hand-held aerosols. As written, this directive explicitly permits staff to gas an inmate if he refuses an order from a Department staff member: "to enforce Department rules, facility regulations and court orders where necessary to promote the good order and safety of the facility."

Failure to Monitor Use of Force

1. Department Directive 5003, promulgated in November, 1986, requires facility supervisors to identify in a computer database all staff members involved in three or more use of force incidents in the preceding calendar quarter. The Directive at IV.C.1 requires that facility commanders "review the investigative reports of the pertinent incidents and interview the individual involved to ascertain whether the force used was necessary to control the environment or whether a pattern of inappropriate behavior has emerged."

1. Throughout the CPSU's existence, facility commanders at JATC and OBCC largely ignored Directive 5003. At JATC, the computer database did not contain all of the information pertaining to use of force incidents that had occurred. Many officers involved in repeated use of force were not interviewed; when interviews were conducted, the task was at times assigned to captains who themselves had used inappropriate force; and the interviews, when they were conducted, were consistently perfunctory and undertaken without any reference to the written reports concerning the force incidents. (See, Herrera deposition 67, 117-8; deposition of Officer Alvan Ramsey, March 16, 1995 ("Ramsey deposition") 91-2; deposition of Officer Eddie Vasquez, June 21, 1994 ("Vasquez deposition") 58, 61-2, 91-2, 108-9 (no interviews conducted); Skinner deposition 143-4, 236 (delegating interviews to captains in spite of the fact that "there wasn't a captain in the jail who wasn't" involved in repeated use of force); deposition of Deputy Warden and CPSU Unit Manager (1996) Albert Rodriguez, December 3-4, 1996 ("Rodriguez deposition") 164 (interviews conducted without utilizing videotapes of the incidents being reviewed).) Supervisors failed to utilize the information available from the Directive 5003 review process to order re-training of CPSU staff, to transfer staff from the CPSU, and in making assignments in the CPSU, and failed to utilize the information available from the Directive 5003 review process in selecting staff to work in the CPSU.
2. In 1994 and 1995, the CPSU Integrity Control Officer repeatedly made central office supervisors aware of the fact that the JATC administration was not in compliance with Directive 5003. (See, Memoranda, Hunter to Suite, March 11, 1994; Hunter to Kerik, May 26, 1994; Hunter to Rigby, June 29, 1994; ICO monthly reports, Thomas to Loconsolo (May through November, 1995).)

Investigation Division Use of Force Investigations

1. Correction officer investigators and civilian investigators assigned to the Department's central office Investigations Division conducted investigations of use of force incidents in the CPSU pursuant to case-opening criteria set out in the Department's "Manual on the Conduct of Use of Force Investigations." This investigation was done either simultaneous with or (more often) after the facility conducted its investigation. According to the documents provided in discovery, the Investigations Division reviewed 46% (492 out of 1062) of the use of force incidents in the CPSU between 1988 and 1995. After the Unit was relocated to OBCC, all use of force incidents, then all class A use of force incidents (those involving more serious injuries and those in which chemical agents were deployed) in the CPSU were investigated solely by the Investigation Division; later in 1996, the Investigation Division again assumed responsibility for investigating all use of force incidents in the Unit and the facility was no longer responsible for any investigations.

2. From 1988 through 1997, investigations conducted by the Department of Correction's Investigation Division ("ID") were consistently deficient. Plaintiffs reviewed approximately 678 investigative files prepared by ID in connection with use of force incidents in the CPSU, as well as 264 Incident Review Team reviews of facility investigations. These documents clearly establish that there was a long-standing failure to conduct professional, competent investigations of use of force incidents in the Unit: investigations often parroted the facility investigations and failed to evaluate fairly inmate witness statements. ID investigations rarely challenged officers' assertions that the force applied was "reasonable" or "minimal" or in "self defense." ID investigations were routinely closed based on a "finding" that the force reported was consistent with the injuries to the inmate, even when there was no substantive information in the investigation file concerning how an injury, such as a perforated eardrum or fracture, could have been inflicted. (It was not the practice in the Investigation Division to obtain an opinion from a medical professional to determine what type or amount of force would explain an injury.) So long as the facility staff reported that they used force in a type and quantity that the investigator believed--based on no medical or forensic information--was sufficient to explain the injury, the "investigation" was almost always closed without charges. In those cases where the use of some force may have been justified, ID routinely failed to address whether the force used was excessive. In numerous incidents in which CPSU officers reported that they responded "spontaneously" with punches to the inmate's face, head or body, the officer's version of events was accepted unless there was incontrovertible evidence, such as a bootprint on an inmate's face, to the contrary.

1. Specifically, ID investigations of use of force incidents in the CPSU demonstrated the following deficiencies: (1) inadequate or biased assessment of medical evidence by investigators, including failures to note the presence of serious injuries inflicted on inmates, the absence of injuries to staff consistent with their account of events, and the prevalence of head injuries to inmates; (2) failure by investigators to pursue obvious leads, *e.g.*, the involvement of staff members whose presence is not acknowledged in the reports, and the occurrence of prior incidents which an inmate suggested motivated the 'beat-up,' and failures to identify and interview inmate witnesses; (3) failure by investigators to note patterns in the locations where uses of force occurred, failure to note the repeated use of force by certain CPSU officers and the repeated use of force on tours supervised by certain captains, and an egregious failure to note the unmistakable pattern of perforated eardrums sustained by inmates injured in use of force incidents in the CPSU (35 perforated eardrums reported in Department of Correction or New York City Correctional Health Services medical records between August, 1989 and April, 1997); (4) the use of different standards by investigators when evaluating inmate statements and correction officer reports (there was a conspicuous unwillingness by ID investigators to credit inmate statements, and an equally conspicuous failure to note contradictions, omissions of detail and suspicious similarities in officers' reports) and when interpreting the presence or lack of injuries to inmates and staff; (5) justification of uses of force with boilerplate language stating that force was "minimal and necessary" or "within Department guidelines" without ever pursuing whether there was an alternative to force, or whether the force used was excessive or otherwise did not comply with Department policy; (6) adoption of staff written reports without learning, through staff interviews, the details surrounding an incident; (7) failure to watch the videotape of an incident to determine what occurred and whether it was reported truthfully; and (8) failure to complete investigations within the required time limit or within any reasonable amount of time.

1. In some cases, the unwillingness of the Investigation Division to confront

obvious evidence of staff misuse of force produced ludicrous results. In one case, involving an incident in April, 1994, an ID investigator personally witnessed one officer kick an inmate in the head while the inmate was lying supine on the floor, and witnessed other officers have to restrain the offending officer. The investigator assigned to prepare the ID "investigative report," formulated the following version of the incident: "Based on a statement from Dr. Delacruz, Officer Merrit may have lost temporary control of his faculties as a result of the incident he was involved in which eventually led him to having seizures and as staff reported, being found in an unconscious state at the scene. . . Officer Merrit may have, in fact, kicked an inmate as reported by Investigator Isaac yet not in control of his actions" [sic]. (ID file, UOF# 451/94, Jose O'Neal, 4/13/94.) In a 1991 incident involving named plaintiff Carl Brown, the

investigator concluded that the inmate's injuries were not consistent with an allegation of an unreported beating. (ID file, UOF# 990/91, Carl Brown, 7/9/91.) Mr. Brown, in addition to a perforated eardrum, suffered bruises to his face, ear and ribs, orbital tenderness, a fractured nose, and other injuries.

1. In some cases in which CPSU inmates were seriously injured by staff members, the Investigation Division failed to conduct any investigation at all. On February 1, 1996 in JATC, nineteen CPSU inmates were forcibly extracted from their cells, and a number of them suffered multiple contusions and lacerations. Later that day, Warden Fraser suspended the Tour Commander, ADW Caliendo, for "failing to make proper notification in a proper time frame and calling in the unusual incident erroneously and omitting pertinent facts of the incident. He also failed to control the proper dispatch and monitoring of injured staff to hospitals." (Memorandum, William J. Fraser to Commissioner Michael P. Jacobson, February 2, 1996.) No facility unusual incident or use of force package was prepared in connection with this incident, and the Department's Investigation Division had not completed an investigation of the incident as of June, 1998. Similarly, no ID investigation was ever conducted concerning the March 23, 1995 incident in which Pedro Diegues suffered extensive facial trauma and was hospitalized for several weeks thereafter.
2. Throughout the history of the CPSU there has been a substantial backlog of investigations of uses of force, and an inability or unwillingness by the Investigations Division to complete investigations in a timely manner. Since 1992 the delay in completing investigations cases has worsened. In 1996 approximately a third of the investigations were at least 60 days late, and remained open 3 months after the date of the incident. As of June, 1998 there were still 1996 ID investigations that are uncompleted; all of the these are now at least 15 months late.
3. The Department of Correction did not complete its investigations of many of the most egregious 1996 cases-- in which OBCC CPSU supervisors and officers used unnecessary and/or excessive force, and then prepared false reports--until a year or more after the incident, even though videotapes existed which corroborated the inmates' accounts and/or discredited the officers'. See, for example, disciplinary files in connection with:
4. inmate Hubert Carey incident, April 17, 1996, UOF 512/96; three officers seen on tape striking and kicking inmate; staff not charged until October, 1997;
5. inmates Shane Tate and Tony Starks incident, UOF 605/96, May 2, 1996; officers seen on tape initiating assault on each inmate (contrary to their written reports); not charged until April, 1997;
6. inmate Melvin Anderson incident, May 20, 1996, UOF 712/96; officer seen on tape assaulting inmate, assault then joined by two other officers; charges filed August, 1997 against staff for impermissible force and false reporting;
7. inmate Wayne Gardine incident, July 10, 1996, UOF 1011/96; staff seen on videotape surrounding inmate dumped from laundry cart, charges filed August, 1997;
8. inmate Alberto Muniz incident, August 12, 1996, staff seen on videotape initiating assault, contrary to written report, charges approved January, 1998.

1. On May 12, 1998 the Investigation Division closed its investigation of a June 25, **1996** use of force incident in which two CPSU inmates suffered blunt force trauma when Unit captains and officers struck Jerome Johnson repeatedly in the head, and punched Robert Elliot, who was handcuffed in the rear, about the face and head and then slammed him face-first into an elevator door. Johnson sustained two lacerations to the left brow and swelling of the jaw, and when examined in a hospital emergency room had blood in both ear canals. Elliot had bruising over the head, face, neck and both shoulders, and loose teeth. Johnson alleged that Captain Labruzzo, the CPSU Security Captain, had broken a baton over his head; video tapes reviewed by the Investigation Division showed Labruzzo carrying a baton, and an officer carrying a broken baton after Johnson had been removed from the housing area. (The broken baton was never recovered during the investigation.) Video tape also showed Elliott's face striking the inside of the elevator door. Three CPSU captains--Labruzzo, Lanza and Ferraiuolo--and three CPSU officers were charged with using impermissible force and filing false reports in this incident. This June 25, 1996 incident was one of the many incidents which plaintiffs' counsel had, by letter of July 31, 1996, brought to the Commissioner's attention. See, ¶ 103, *supra.*
2. Other systemic failings which characterized ID activity persisted after the CPSU was relocated to OBCC, and after the Investigations Division was assigned exclusive authority to investigate all use of force incidents in the CPSU. Out of the 185 ID files produced for the year 1996, in only

forty one were staff interviews conducted, and in only 112 was there an indication that the ID investigator watched the videotape. (Commissioner Jacobson testified at his deposition that "investigators should always interview staff members involved in the use of force. . . There may be cases where for some reason it's not necessary because the outcome or the evidence on the videotape or something is so clear that they're rendered unnecessary. But I think most of the time that they should." (Jacobson deposition 231).) In three of the 185 incidents was there an indication that medical personnel were questioned by ID concerning the medical evidence. Out of the 185 use of force incidents, thirty eight involved reports that an inmate possessed a weapon. In only one of these cases was an evidence voucher used to secure the weapon. In eleven of those thirty eight cases, there was a photocopy of contraband in the ID file that was apparently provided to ID along with the use of force package. In seven of the thirty-eight the facility reports indicate that no weapon was recovered. In the remaining eighteen cases the facility reported that a weapon was recovered yet there is no supportive documentation of any kind in the ID file. In twenty five of the 1996 ID investigation files in which ID recommended disciplinary charges against staff, the 22R (Employee Performance Service Report) is included in the file. In only two of the other files is there any evidence that the ID investigator considered the use of force history of the officers involved in the incident while conducting the investigation. However, the infraction history of the inmate involved was usually included in the file and commented on in the ID closing memorandum.

3. In 81 of the 185 files the ID investigator made no effort to locate inmate witnesses. In thirty two of those 81, the Investigation Division did not view the videotape.
4. In 1996 there continued to be extensive delays in completing ID investigations. These delays were unexplained by the contents of the ID file, and occurred even in those cases in which there was videotaped evidence of staff misconduct, and the tape made it clear that staff had submitted false reports.

1. Throughout 1996, there was a consistent failure by the Investigation Division to note the absence of hand-held video cameras in use of force incidents in OBCC that staff should have anticipated, and were therefore required to tape.

1. The Department of Correction did not implement a computerized system for tracking correction officer use of force in the CPSU. The system that was installed during Commissioner Abate's tenure included information derived only from preliminary "24 hour" reports, not from the investigative reports. (Deposition of Investigator Daniel Isaac, August 22 and November 29, 1994 ("Isaac deposition") 84-85; Deposition of Use of Force Unit Director Andre Suite, April 21-22, 1997 ("Suite deposition") 50.) Investigators were not required to use the computer system, and they did not have direct access to any use of force computer systems; they had to request permission. (Deposition of Deputy Commissioner for Investigations Laura Rigby Barbieri, January 24, March 4, 1997 ("Rigby Barbieri deposition") 227-228.) Some of the investigators assigned CPSU cases were unaware that any information existed in a database. (Deposition of Investigator Anthony Fussa ("Fussa deposition") 142.)
2. Plaintiffs' expert Vincent Nathan, who for twenty years has served as a court-appointed special master or court monitor in a number of institutional reform cases involving jails and prisons, reviewed 79 ID files for the period 1988-1995, and 119 cases opened in 1996. He concluded that:

[T]he sheer volume of vicious assaults against inmates in the CPSU is mind-numbing, and the failure of ID investigators to conduct *bona fide*, let alone thorough, investigations of these incidents is appalling to me. Rather than serving as an external control on the continuing use of unnecessary and excessive force throughout the CPSU, ID investigators acted as aiders and abetters to officers who perpetuated a reign of terror throughout the facility on a day-to-day basis. This is true because the quality of ID investigations assured officers and senior staff in the CPSU that they could engage in the most egregious forms of inmate abuse without any appreciable risk that investigators would bring staff misconduct to light.

Nathan Report at 92.

Failure to Discipline Officers Who Misused Force in the CPSU

1. There was a conspicuous failure during the period 1988-1997 to utilize Department of Correction disciplinary measures effectively against staff who misused force in the CPSU. ID investigators and facility supervisors failed to recommend charges in many cases where consistent inmate statements and the injuries to the inmate on whom force was used clearly suggested that the force was unnecessary and/or excessive. In some cases, Trial Division attorneys elected to dismiss charges that had been recommended by the ID investigators. When sanctions were imposed--most often by plea, and in some cases by an administrative law judge--they were almost always insignificant.

1. In the over 1300 use of force cases reported from the CPSU between March, 1988 and December, 1996, only 76 incidents (forty of which occurred in 1996) resulted in disciplinary charges being lodged against 155 CPSU staff members in 194 separate complaints. (Some staff members were the subject of repeated complaints.) Out of the total of 194 complaints issued, 115 have been resolved: 60 resulted in plea negotiations, often to reduced charges, with a penalty of a minimal loss of vacation/suspension time and/or a period of probation; one resulted in a negotiated plea for dismissal after the staff member was convicted of misdemeanor charges in state court (the misdemeanor charges arose from the use of force incident); thirty three resulted in outright dismissal of all charges in the form of an "administrative filing" of the charges; six resulted in the minimal penalty of a command discipline; and thirteen officers went to trial at OATH. The OATH trials resulted in eleven findings of no guilt, and two findings of guilt . Seventy-nine complaints remain open; as of June 18, all of the open cases are at least seventeen months old, four are over three years old.
2. The level of disciplinary action directed at CPSU staff in connection with the use of force varied over the years, but from 1990 through 1996 it was consistently low. Between March, 1989 and January, 1990--while Bonnie Nathan was the Assistant Commissioner for Investigations and Discipline--14 complaints were filed against CPSU staff members for violations of use of force policies. Commissioner Sielaff fired Nathan in July, 1990--because, he claimed, she had been "unduly harsh" in her approach to disciplining uniformed staff--and the utilization of Department discipline with respect to the CPSU declined in lock-step with Sielaff's "hands off" approach. No disciplinary charges were filed against CPSU staff between January, 1990 and September, 1991. One incident resulted in charges being filed in 1991 (a 1991 incident); four incidents resulted in charges being filed in 1992 (all were 1992 incidents); seven incidents resulted in charges being filed in 1993 (4 were 1992 incidents, 3 were from 1993); five incidents resulted in charges filed in 1994 (one 1993 incident and four from 1994); two incidents resulted in charges being filed in 1995 (one 1994 incident and one from 1995); three incidents resulted in charges being filed in 1996 (one 1994 incident and two from 1996).
3. There were seventeen incidents which resulted in charges being filed in 1997 (one incident from 1992 and 16 from 1996). There were twenty two additional 1996 incidents which resulted in charges being filed in 1998. After 1996--as this case was proceeding to the date for trial-- there was a marked increase in filing administrative charges against CPSU staff. However, thirty three of the forty 1996 incidents which resulted in charges remain unresolved as of June 18, 1998. Twenty nine of the forty 1996 incidents which resulted in the filing of administrative charges were filed after July, 1997, when the City first determined not to settle but to proceed to trial.
4. The charges that were filed against CPSU staff for violations of the use of force policy did not follow from a professional assessment of the participants' credibility or of the medical evidence. The few cases in which charges were brought rested on overwhelmingly persuasive evidence: ID staff personally witnessed staff misconduct in the CPSU; the CPSU staff members' inconsistent reports or statements were highly probative of the misconduct and/or cover-up; medical evidence demonstrated conclusively that staff had lied (*e.g.* a bootprint on an inmate's face matched the bootprint of the officer who denied kicking him); or a videotape showed clearly that staff initiated force and then filed false reports.

The Need for a Court Order

1. The evidence in the record of this case demonstrates not only the long-standing tolerance by Department officials of the pattern of misuse of force in the CPSU, but the extraordinary lengths to which Department personnel, over several administrations, went to subvert, evade, avoid and

circumvent remedial measures which were proposed, and in some cases adopted, as means of curbing the use of unnecessary and excessive force.

1. The Department of Correction ignored the recommendations for improved and enhanced training set out in the report of its training consultant, Michael Gilbert, in 1987.

2. The Department of Correction failed to adopt most of the recommendations set out in the report of the Committee on Use of Force (1988) chaired by Professor Gerald Lynch.

3. Department staff failed to utilize the information required to be gathered and reviewed pursuant to Directive 5003.

4. Department supervisors failed to ensure that accurate information concerning staff members' use of force was collected and entered into a retrievable database.

5. Department supervisors failed to interview staff members who had been involved in repeated use of force.

6. When staff members who had been involved in repeated use of force were interviewed, Department supervisors conducted superficial interviews and did not undertake any substantive review of the staff members' conduct in the incidents.

7. Staff members who had been involved in repeated misuse of force, or suspected misuse of force, were not removed from the CPSU (until 1995.) even though their identities were well-known.

8. The Integrity Control Officers, as well as Unit and other Department supervisors, failed to regularly and routinely review videotapes of use of force incidents. This failure permitted staff members who misused force and/or falsely reported events surrounding the use of force to remain in the CPSU until the incidents were investigated, and the tapes reviewed, in some cases many months later.

9. Department supervisors failed to enforce the requirement, set out in institutional orders, that a hand-held video camera be utilized to record anticipated uses of force, including cell extractions.

10. Department supervisors failed to follow up and take adequate measures in response to a number of communications calling their attention to evidence of a pattern of staff brutality in the CPSU including: letters and phone calls from the Legal Aid Society and the Board of Correction; reports prepared in 1990 and 1992 by the federal court's Office of Compliance Consultants; the memorandum from Assistant Commissioner Toni V. Bair to Commissioner Abate; the memoranda from the Unit's Integrity Control Officers from 1992 through 1995.

11. The Commissioner's transfer of Unit Manager Howard Robertson in response to officers' complaints that he would not "back them" in dealing with CPSU inmates, and after Robertson had succeeded in reducing dramatically staff use of force in the Unit, communicated to Unit staff that they would have a free hand in managing inmates through brute force and intimidation.

12. Even after the Unit was relocated in 1996 because of this litigation and the evidence of egregious staff misconduct in the CPSU, OBCC and CPSU managers refused to read use of force reports, view videotaped use of force incidents, and monitor staff involved repeatedly in use of force incidents. Staff members in a number of incidents struck handcuffed inmates outside the view of surveillance cameras, but the Warden and Unit Manager avoided reading reports of these incidents.

13. After the Unit was relocated and investigative authority assigned to the Investigation Division, its staff failed in large numbers of cases to interview staff members, view the videotapes or interview inmate witnesses, and continued to fail to complete investigations within a reasonable time frame.

The Stipulation of Settlement

1. The Stipulation presented to the Court represents the parties' efforts to resolve the issues in this litigation in a manner which addresses both the operational deficiencies which have plagued the CPSU since its inception, and the culture of brutality and cover up which were so evident in the Unit. The Stipulation is the product of arduous negotiations between the parties over a period of three months; indeed, considering the prior attempts to resolve the litigation in 1996 and 1997, the Stipulation represents the culmination of close to a year's negotiation. The agreement reflects, in our view, substantial success in addressing the deficiencies in defendants' policies and practices which were plead in the complaint and identified during the course of extensive discovery in this case. The parties have assigned significant responsibility to the expert consultants--each of whom has extensive experience in reforming correctional institutions and systems-- to assist the Department in formulating written policies and procedures required under the Stipulation. The following summarizes how the relief secured by the Stipulation addresses the systemic issues raised in the pleadings and established during the litigation.

Use of Force Policy

1. The Stipulation requires that the Department direct and train CPSU staff to respond to inmate misconduct without force, or if force is necessary, to utilize control techniques that minimize injuries to both inmates and staff. Force techniques that carry a high risk of injury, such as punches and blows, are restricted to escapes, similarly serious breaches of security, serious risk of physical injury, or property damage which would immediately endanger the safety of staff, inmates, or others.

Use of Force Training

1. No officer or captain can be assigned to the CPSU unless the staff member has been trained in the utilization of control holds and other forms of self-defense, and has demonstrated a working knowledge of and thorough familiarity with these techniques. All uniformed staff assigned to the Unit must demonstrate annually that they have a working knowledge and familiarity with these techniques. The failure to train adequately CPSU staff in less injurious techniques has been identified as a cause of the pattern of excessive force.
2. The Stipulation requires that the Department, with the parties' expert consultants, formulate a training curriculum and written standards and procedures governing the use of force by correction staff in the CPSU. The training will include control techniques, nature of minimal force, nature of alternatives to force, means for avoiding the unnecessary use of force, when and how gas, batons, shields and stun equipment may properly be used, a policy on inmate movement, a policy requiring the use of the hand-held video camera, and when and how to conduct a cell extraction. The Stipulation requires that staff receive no less than two weeks' training prior to their assignment to the Unit in the utilization of use of force techniques and procedures, including techniques intended to minimize injuries to staff and inmates. As a condition of their continued assignment to the Unit, CPSU officers will receive an additional forty hours of training annually on a quarterly basis, or more frequently as determined by the Department in consultation with the expert consultants. The Stipulation further requires that on an annual basis CPSU staff members' skills will be reassessed. This requirement addresses the apparent ineffectiveness of the Department's existing training program, as shown by staff's own statements as well as their behavior.

CPSU Operating Manual: Written Policies and Procedures for CPSU Staff

1. The Stipulation requires that the Department, with the parties' expert consultants, create a revised CPSU Operating Manual. The Operating Manual will include the use of force policy for the CPSU, a description of how medical, mental health and other mandated services are to be provided to CPSU inmates, and the policy governing the use of mechanical restraints. Interaction between staff and inmates in connection with the delivery of mandated services, including

restraint and escort of inmates to and from the Unit, have been "flash points" leading to confrontations and use of force. Clarifying the rules and procedures should mitigate this problem.

Mental Health Services and the Removal of Disturbed Inmates from the CPSU

1. A significant number of injuries have been inflicted upon inmates in incidents stemming from behavior that appears to reflect emotional disorder. The Stipulation requires that the Department maintain a written plan for the provision of mental health services to CPSU inmates. Inmates deemed by mental health staff to present a risk of mental or emotional deterioration if placed or continued to be confined in the CPSU shall be removed and placed in alternative housing. Observation aides are required to be assigned to each housing area; all inmates in the CPSU shall be seen by medical staff daily so that referrals to mental health services may be made. The Stipulation also requires that mental health staff shall review any punitive segregation time imposed on an inmate in a mental observation housing area, and prohibits the transfer of an inmate from a mental observation area to the CPSU without authorization of mental health staff. Mental health staff must also interview and review the medical records of any inmate receiving mental health services who is to be placed in the CPSU before such placement.

Prohibition of Denying Services as Punishment ("Burning")

1. The Stipulation requires that uniform staff shall not withhold access to any service or program in the CPSU in retaliation for misconduct or perceived misconduct, and that no CPSU inmate shall be housed in a cell which lacks an operable sink with running water, a flushable toilet, and appropriate bedding. Uniformed staff shall supervise food delivery and shall ensure that food is delivered to each inmate in a housing area.

CPSU Time-Lapse Video Coverage

1. The Stipulation reflects the parties' agreement that a properly implemented videotaping system will help keep use of force within lawful bounds by assisting in enforcing accountability. The Stipulation requires that the wall mounted video cameras in the CPSU will continue to be maintained, and that additional cameras will be added to designated areas. ERU (now "ESU" (Emergency Services Unit)) vests will have visible identifying numbers which can be read by the cameras and staff will be required to record the number of the vest that they wore during an operation. Searches conducted of inmates transferred to the CPSU shall be conducted with a supervisor present in an area subject to continuous video-taped surveillance.

CPSU Hand Held Video Cameras

1. The Stipulation requires that hand-held cameras be used to record anticipated uses of force, including facility and ESU searches, as well as all non-routine movement of an inmate from their cell to an area not covered by a wall-mounted video camera. The hand-held tape must provide continuous coverage throughout the incident and the escort of the inmate from the area.

Screening and Selection of CPSU Staff

1. Discovery in this case demonstrated that the CPSU's distinctive culture was in part caused by the fact that its staff--both line offices and supervisors--was drawn disproportionately from the ranks of the newly hired and newly promoted. These individuals had no on-the-job experience in exercising their responsibilities in other, less violent jail settings. The Stipulation sets out requirements to ensure that experienced staff are assigned to the unit: half of the correction officer staff assigned to the CPSU must have completed their two year probationary period; one quarter must have completed one year of their probationary period; and no housing area shall be staffed solely by probationary correction officers. No probationary captains or assistant deputy wardens shall be assigned to the CPSU. In addition, the Stipulation screens out staff whose history of use of force suggests a risk of misconduct in the CPSU. No staff with pending disciplinary charges arising from a use of force incident, or who have in the prior ten years been found guilty or

pleaded guilty or no contest in satisfaction of charges of excessive, impermissible, or unnecessary force; failure to supervise in an incident that resulted in serious injury to an inmate; false reporting or false statements; or failure to report a use of force may be assigned to the CPSU. The Stipulation requires that the disciplinary history, as well as the use of force history, of all staff to be assigned to the unit be subject to extensive and detailed review before their approval for assignment.

Transfer of Staff from the CPSU Upon Documentation of Involvement in Misuse of Force

1. The Stipulation requires that any CPSU staff charged with excessive, impermissible, or unnecessary force, false reporting or false statements, failure to supervise, failure to employ an alternative to force, or failure to report a use of force, shall be transferred from the CPSU. The conduct of staff charged with other misconduct shall also be reviewed for possible transfer from the Unit.

Review of Staff Use of Force

1. The Stipulation requires that the facility supervisory staff review and evaluate the conduct of staff members who have been involved in repeated applications of force. This review will utilize the information gathered about the staff members' conduct by the Investigations Division, and it is expected that this review will be consistent with the policy underlying Directive 5003. The failure to carry out this policy was one of the deficiencies identified in the course of discovery.

Use of Force Reporting: Eliminating Collusion and Requiring Prompt Preparation of Reports

1. The lack of honest and prompt reporting of use of force incidents has been a major factor limiting accountability of staff for misuse of force. The Stipulation includes requirements for staff report writing designed to eliminate collusion between officers, and to ensure accuracy of reporting: reports shall be written directly after an incident; they shall include detailed information from the staff member's personal knowledge; and reports shall be written independently in separate areas under supervision. Staff who cannot write a report due to injury shall give an oral statement to a supervisor who was not a witness or participant in the incident.
2. The Stipulation requires that staff who claim injury be offered the opportunity to be examined in the facility clinic. Staff refusal of treatment shall be recorded and included in the documentation of the incident. A logbook in the clinic shall record the time that inmates and staff arrive in the clinic for treatment. Medical examination reports shall include the time that the individual was treated by medical personnel. This provision is intended to eliminate the characteristic excessive delays between inmate's being removed from the scene of a use of force incident and their being seen by a medical professional.
3. The Stipulation requires that an inmate involved in a use of force incident shall be escorted to the clinic after the incident by staff who were not involved in the incident as either a participant or as a witness.
4. The Stipulation requires that the "use of force package" (use of force reports, use of force witness reports, injury to inmate reports and all other documents and physical evidence pertaining to a use of force) shall be compiled by a Captain who was neither a participant nor a witness to the incident and that the package shall be provided to the CPSU Use of Force Unit of the Investigation Division within 7 days after the incident. The Stipulation also provides that the Investigation Division staff may get copies of reports as soon as they are prepared.

Physical Evidence; Photographs

1. The Stipulation includes requirements to collect, and safeguard physical evidence including photographs, videotapes, and contraband. Photographs of staff and inmates will be taken by staff who were not witnesses or participants in the incident. The Department will utilize wall-mounted and hand-held video cameras to record staff-inmate confrontations.

CPSU Use of Force Unit - Investigations

1. Central to the Stipulation are the requirements for investigations of use of force incidents which occur in the CPSU. The Department will continue to use a dedicated group of investigators and attorneys--assigned to the Investigation Division and outside the facility chain of command--to investigate CPSU use of force incidents. The CPSU Use of Force Unit ("CPSU-UFU"), a section of the DOC Investigation Division, shall investigate all uses of force and allegations of uses of force in the CPSU, as well as allegations of staff misconduct in connection with incidents in which CPSU inmates are injured. The Stipulation sets forth the minimum staffing level for CPSU-UFU, including the requirement that there be an Integrity Control Officer (ICO) assigned to the facility; requirements governing the supervision of CPSU-UFU; time frames for completing investigations; and requirements for how to conduct investigations. The Stipulation requires that investigators assigned to CPSU-UFU undergo a 40 hour training course that will include: interviewing skills and techniques; basic medical terminology; evaluating evidence; writing analytic reports; operating procedures in the CPSU; history of the poor investigations previously conducted in the CPSU; video reviewing; handling physical evidence; use of computer database; and other CPSU-UFU procedures. The Stipulation requires that UFU investigators receive a minimum of 40 hours of investigatory training each year.
2. The Stipulation requires that the CPSU-UFU be notified after each use of force that occurs in the CPSU.
3. The requirements in the Stipulation for conducting investigations include: preliminary review of evidence and videotapes; careful review of all videotapes; obtaining and reviewing reports from medical facilities; use of medical experts to assist in interpreting the cause of injuries; identification of inmate and staff participants and witnesses; interviews with inmate participants and witnesses; staff interviews; review of inmate and staff prior involvement in uses of force; and staff members' prior disciplinary history.

CPSU Integrity Control Officer - ICO

1. The Stipulation sets out specific duties and responsibilities for the Integrity Control Officer assigned exclusively to the CPSU, who will operate as the "eyes and ears" of the Investigation Division in the Unit itself. These responsibilities include: report writing; conducting unscheduled tours of the Unit; maintaining the integrity of the video recording system and evidence room; reviewing all videotapes of use of force incidents; responding to alarms, anticipated uses of force and ESU operations to observe activities; and assisting CPSU-UFU investigators.

Case Tracking System: The Requirement of Computerized Record Keeping

1. A critical provision of the Stipulation requires that the Department of Correction's Investigation and Trials Division utilize computerized databases with searching and reporting capabilities, a resource that has never been consistently available to the Department of Correction in the past. The databases will include every use of force incident which occurs in the CPSU and every disciplinary action against CPSU staff. Information in the databases will be used for the supervision of UFU (maintaining compliance with time frames for completing investigations, tracking caseloads, reviewing investigative efforts), for the purpose of retrieving information useful in investigations (officers' repeated use of gas or other force, groups of officers repeatedly involved in uses of force together), and for the resolution of disciplinary charges against staff (formulating plea offers and making recommendations for penalty at OATH). The Stipulation designates data that must be in the program including: injuries to inmate, injuries to staff, type of force used, location of incident, was a weapon recovered, was a weapon alleged and not recovered, names of staff and inmates involved, UFU investigator, date of incident, date of investigation closing, result of investigation, and use of force number.

Disciplinary Charges

1. The Stipulation sets out time frames for the service and resolution of disciplinary charges against CPSU staff intended to minimize the lengthy delays which have historically plagued the process. The Stipulation requires that the Department and the joint expert consultants formulate penalty

guidelines so that, in a break from the past, staff will be appropriately disciplined for specific violations of the Department's use of force and reporting requirements. The Stipulation requires that the penalty guideline will be used by the Trials and Litigation Division in formulating plea agreements and in making recommendations to the Administrative Law Judges.

The Parties' Expert Consultants

1. To assist in the implementation of the remedial plan set out in the Stipulation, the parties have jointly retained two nationally recognized corrections experts for a period of two years, or longer if the parties agree. Norman Carlson is the retired Director of the United States Bureau of Prisons, and Steve J. Martin, who was one of plaintiffs' experts in this litigation, has served as a consultant and expert witness in connection with investigations and litigation with respect to scores of correctional facilities. Mr. Martin throughout his career has focused on use of force issues and the implementation of remedial plans to curb unnecessary and excessive force in correction institutions.
2. The Stipulation requires that, shortly after the Court approves the agreement as an order, the consultants will assist the Department in formulating: written standards and procedures governing the use of force in the CPSU; a training curriculum for CPSU staff and a plan for continued, in-service training; and a revised CPSU Operating Manual. Thereafter, the consultants will conduct site visits, document reviews, interviews with Department staff and CPSU inmates to assess the Department's compliance with the Stipulation.
3. The scope of the consultants' responsibilities include periodic reviews of all activity addressed by the remedy: use of force incidents in the CPSU, the investigation of those incidents by the Investigation Division, and the discipline of staff members against whom charges have been recommended; and the formulation and implementation of policies and procedure which are, or should be, operative in the CPSU. In addition, the consultants will "assess the adequacy of defendants' use of force policy, staffing and supervision practices, training programs, and any other practices addressed by [the] Stipulation and Order which are intended to insure that the plaintiff class is reasonably safeguarded from injury." See, Stipulation ¶ 91. The consultants will submit written reports to the Court and parties every 90 days for the first year, and thereafter every 120 days, assessing defendants' compliance with the Stipulation and Order and reporting to them "any other matters which affect the security and safety of the plaintiff class." See, Stipulation ¶ 92.
4. The City will provide the expert consultants, as well as plaintiffs' counsel, with relevant records and documents on an agreed-upon schedule, either bi-weekly or monthly.

Monitoring, Enforcement, Continuing Jurisdiction

1. Pursuant to the Prison Litigation Reform Act ("PLRA"), the Stipulation will remain in effect for two years after which the defendants may move to terminate. The PLRA requires a district court to terminate a decree unless the Court makes written findings that the relief "remains necessary to correct a current and ongoing violation" of the federal right, extends no further than necessary to correct such a violation, and is narrowly drawn and the least intrusive means to correct such violation." The Stipulation adopts this language in ¶ 103.
2. The parties have agreed that in any contested proceeding arising under the Stipulation, stipulated facts may be submitted to the court "summarizing the record in this action." Thus, in the event plaintiffs' move to enforce the Stipulation or seek further relief, or contest the defendants' motion to terminate under ¶ 103, they can submit to the court the stipulated facts referred to in ¶ 102.

Conclusion

1. We believe that the foregoing summary demonstrates that the Stipulation of Settlement negotiated by the parties reflects the successful achievement by the plaintiff class of

the goals of the litigation, and will--if complied with--adequately protect the constitutional rights of the members of the plaintiff class. We therefore request that the Court approve the Stipulation and order the

relief set out in the Stipulation.

JONATHAN S. CHASAN (jsc 9018)

Dated: New York, New York

June 26, 1998