STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE

AN EXAMINATION OF CONDITIONS OF CONFINEMENT FOR INCARCERATED/DETAINED LATE ADOLESCENTS AGED 18-21

December 10, 2025

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I. INTRODUCTION

The Office of the Child Advocate (OCA) is an independent state oversight agency directed by law to investigate and report on the efficacy of child-serving systems, investigate unexplained and unexpected child fatalities or critical incidents involving a child, review complaints of persons concerning the actions of any state or municipal agency providing services to children, and "periodically review the facilities and procedures of any and all institutions or residences, public or private, where a juvenile has been placed by any agency or department."[1]

In 2016, Connecticut state law was amended to direct the OCA to regularly review and report to the state legislature regarding conditions of confinement for incarcerated youth aged 15 to 21 in the juvenile and adult criminal justice systems.[2] OCA's 2020 report included findings that older youth, aged 18 to 21 at Manson Youth Institution (MYI), were deprived of adequate care, education, and treatment. In 2021, OCA extended its auditing work to examine conditions of confinement for late adolescent[3] boys aged 18 to 21 in additional DOC facilities. OCA quickly identified serious concerns regarding conditions for 18- to 21-year-olds in restrictive housing across multiple DOC facilities and, as a result, conducted a targeted review on those late adolescents.

This report examines conditions of confinement for late adolescents aged 18 to 21 placed at Manson Youth institution (MYI), York Correctional institution (YCI) and other adult facilities operated by the Department of Correction (DOC). Boys who enter the DOC as youthful offenders are all initially housed at MYI, and may be transferred to other facilities operated by DOC after they turn 18. Late adolescents aged 18 and over also may enter these facilities directly when they are charged as adults and may thereafter be transferred to MYI or to other adult facilities. Most 18- to 21-year-old boys are housed at MYI, and all girls are housed at YCI. This report includes an in-depth examination of late adolescent boys placed in restrictive housing settings at Corrigan, Garner and MacDougall-Walker Correctional Institutions. Examining the conditions for this population, OCA found grave concerns, including lengthy periods of solitary confinement, frequent strip searches, lack of access to minimally adequate mental health services, and limited educational services. OCA's report includes detailed profiles on a cohort of late adolescents who spent months and sometimes years in restrictive housing, often deprived of meaningful services, education, or socialization. DOC records depict stark mental health deterioration of some of these individuals who were often teenagers when they were first

[1] Conn. Gen. Stat. § 46a-13k *et. seq.*

[2] Initial legislation required OCA to analyze conditions of confinement for youth aged 15 to 20. State law was amended in 2022 to extend the age of youth who were subject to the review up to the age of 21.

[3] OCA uses the term late adolescents for those aged 18-21. Research indicates that adolescence begins with the onset of puberty and ends in the mid-20's. National Academies of Sciences, Engineering, and Medicine. (2019). The Promise of Adolescence: Realizing Opportunity for All Youth. Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/25388, at 1. See also Alderman EM, Breuner CC, AAP COMMITTEE ON ADOLESCENCE. Unique Needs of the Adolescent. Pediatrics. 2019;144(6):e20193150 (defining adolescence as age 11 through 21); *See also* Center for Law, Brain & Behavior at Massachusetts General Hospital (2022). White Paper on the Science of Late Adolescence: A Guide for Judges, Attorneys and Policy Makers (January 27th, 2022). https://clbb.mgh.harvard.edu/white-paper-on-the-science - of-late-adolescence/ (defining late adolescence as age 18-21).

incarcerated.[4] OCA is concerned that these findings implicate the legal rights of these late adolescents to adequate care and services.

According to national data, young people aged 18 to 24 make up ten percent of the U.S. population but twenty-one percent of people confined in adult prison every year. [5] Black men in this age group are 7 to 9 times more likely than their white peers to be incarcerated.[6]

Research analysis completed by the United States Department of Justice (DOJ) Office of Juvenile Justice and Delinquency Prevention (OJJDP) summarizes:

> "I sit in my cell and try to read and think about staying out of trouble and all I hear is the noise. Other's calling me names, swearing, watching people do crazy things, encouraging us to do the same, and just trying to survive it. I wish there were programs for us to do, teach me something and help me learn about myself so I can do better when I leave here. It all seems like a set up so we stay here. Everything I do I'm in these chains. It just doesn't make any sense. I know there are people in here who are never going to leave, but I am going to leave soon and I need some help."
>
> *Late adolescent inmate in restrictive housing*

> Research findings over the past two decades have underscored the need for a greater emphasis on adolescent development in policies pertaining to the processing and treatment of youth and young adults within the justice system, with more consideration for their level of maturity and other relevant factors.[7] Adolescence is a critical period of growth and development between—and yet distinct from—childhood and adulthood.… Adolescents are more inclined toward risk-taking in part because during adolescence the brain is still developing in areas involving self-control and self-regulation, and the brain may continue to develop even into young adulthood (until an individual is in their mid-20's).[8] … In adolescence, the tendency to engage in sensation-seeking behaviors remains high while the capability to self-regulate remains low; self-regulation continues improving throughout young adulthood.[9] Therefore, problem behaviors such as delinquency or criminal activity can be a result of the developmental immaturity that characterizes adolescence.[10] Research has found that crime rates for individuals who commit crimes during their youth typically peak around

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[4] OCA met with DOC officials in November 2022 to discuss OCA's concerns regarding transfers of late adolescents to facilities other than MYI, lack of adequate mental health treatment, and the isolation of late adolescents in restrictive housing settings without access to programming or education. In October 2023, the DOC issued a Request for Proposals for Restrictive Housing Study, which was subsequently awarded to Falcon Inc. Falcon issued a report, entitled *Comprehensive Study, Program Validation, and Best Practice Recommendations* in November 2024.

[5] Frank, Alex. (2018). *Why Reimagining Prison for Young Adults Matters.* Vera. https://www.vera.org/news/why-reimagining-prison-for-young-adults-matters#:~:text=Young%20people%20ages%2018%20to,compared%20to%20their%20white%20peers.

[6] Id.

[7] https://ojjdp.ojp.gov/model-programs-guide/literature-reviews/age-boundaries-of-the-juvenile-justice-system#2-0. National Research Council, 2013; Cauffman et al., 2018; National Academies of Sciences, Engineering, and Medicine, 2019.

[8] Id. *citing* Steinberg, 2009; National Research Council, 2013; Cohen et al., 2016; Monahan, Steinberg, and Piquero 2015; Cavanaugh, 2022

[9] Id. *citing* Steinberg, 2017.

[10] Id. *citing* Monahan, Steinberg and Piquero, 2015.

> ages 18 to 21; and generally speaking, these individuals will not continue committing crimes in later adulthood as part of the normative developmental process.[11]

Research funded by the National Institutes of Health found that "incarceration during adolescence and early adulthood is independently associated with worse physical and mental health outcomes during adulthood. This relationship holds even when accounting for baseline health and key social determinants of health.[12]

In addition, it is well documented that physical isolation can be detrimental to one's mental health, including "severe exacerbation or recurrence of preexisting illness, or the appearance of an acute mental illness in individuals who had previously been free of any such illness,"[13] an increased likelihood of death after reentry into the community,[14] and increased risk of self-harm.[15] People "with mental illness are particularly vulnerable to the harms of solitary confinement."[16]

The National Commission on Correctional Health Care adopted the following principles in relation to health professionals and the issue of solitary confinement[17]:

> 1. Prolonged (greater than 15 consecutive days) solitary confinement is cruel, inhumane, and degrading treatment, and harmful to an individual's health.
>
> 2. [Youth], mentally ill individuals, and pregnant women should be excluded from solitary confinement of any duration.
>
> 3. Correctional health professionals should not condone or participate in cruel, inhumane, or degrading treatment of adults or [youth] in custody.
>
> 4. Prolonged solitary confinement should be eliminated as a means of punishment.
>
> 5. Solitary confinement as an administrative method of maintaining security should be used only as an exceptional measure when other, less restrictive options are not available, and then for the shortest time possible. Solitary

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[11] Id. *citing* Scott, 2000; National Research Council, 2013.

[12] Barnert ES, Dudovitz R, Nelson BB, et al. How Does Incarcerating Young People Affect Their Adult Health Outcomes?. Pediatrics. 2017; 139(2): e20162624, at 7. See PEDS_20162624.pdf (nih.gov)

[13] Stuart Grassian, Psychiatric Effects of Solitary Confinement, 22 WASH. U. J. L. & POL'Y 325 (2006), https://openscholarship.wustl.edu/law_journal_law_policy/vol22/iss1/24, at 333.

[14] "Specifically, our results demonstrate that restrictive housing is associated with a higher likelihood of reincarceration and all-cause mortality, including deaths related to opioid overdose, suicide, and homicide. Importantly, repeated placements and being in restrictive housing for more than 14 days, the threshold of what constitutes torture according to the Mandela Rules, may further exacerbate risk." Association of Restrictive Housing During Incarceration With Mortality After Release. Lauren Brinkley-Rubinstein, PhD1,2; Josie Sivaraman, MSPH3; David L. Rosen, PhD, MD4; et al, October 4, 2019. doi:10.1001/jamanetworkopen.2019.12516

[15] "We found that acts of self-harm were strongly associated with assignment of inmates to solitary confinement. Inmates punished by solitary confinement were approximately 6.9 times as likely to commit acts of self-harm after we controlled for the length of jail stay, SMI, age, and race/ethnicity." Solitary Confinement and Risk of Self-Harm Among Jail Inmates, American Journal of Public Health, March 2014, Vol 104, No. 3.

[16] Position Statement, Solitary Confinement (Isolation), National Commission on Correctional Health Care, April 10, 2016.

[17] In its Position Statement, the NCCHC defines solitary confinement as "housing of an adult or juvenile with minimal to rare meaningful contact with other individuals."

confinement should never exceed 15 days. In those rare cases where longer isolation is required to protect the safety of staff and/or other inmates, more humane conditions of confinement need to be utilized.

6. Correctional health professionals' duty is the clinical care, physical safety, and psychological wellness of their patients.

7. Isolation for clinical or therapeutic purposes should be allowed only upon the order of a health care professional and for the shortest duration and under the least restrictive conditions possible and should take place in a clinically designated and supervised area.

8. Individuals who are separated from the general population for their own protection should be housed in the least restrictive conditions possible.

9. Health staff must not be involved in determining whether adults or [youth] are physically or psychologically able to be placed in isolation.

10. Individuals in solitary confinement, like other inmates, are entitled to health care that is consistent with the community standard of care.

11. Health care staff should evaluate individuals in solitary confinement upon placement and thereafter, on at least a daily basis. They should provide them with prompt medical assistance and treatment as required.

12. Health care staff must advocate so that individuals are removed from solitary confinement if their medical or mental health deteriorates or if necessary, services cannot be provided.

13. Principles of respect and medical confidentiality must be observed for patients who are in solitary confinement. Medical examinations should occur in clinical areas where privacy can be ensured. Patients should be examined without restraints and without the presence of custody staff unless there is a high risk of violence. In situations where this cannot occur, the patient's privacy, dignity, and confidentiality should be maintained as much as possible. If custody staff must be present, they should maintain visual contact but remain at a distance that provides auditory privacy.

14. Health care staff should ensure that the hygiene and cleanliness of individuals in solitary confinement and their housing areas are maintained; that they are receiving sufficient food, water, clothing, and exercise; and that the heating, lighting, and ventilation are adequate.

15. Adults and [youth] in solitary confinement should have as much human contact as possible with people from outside the facility and with custodial, educational, religious, and medical staff.

16. Appropriate programs need to be available to individuals in confinement to assist them with the transition to other housing units or the community, if released from isolation to the community.

17. In systems that do not conform to international standards, health care staff should advocate with correctional officials to establish policies prohibiting the use of solitary confinement.

The research outlined above has important implications for policy planning. In particular, policy makers must recognize the "the diminished culpability of adolescent offenders and their potential responsiveness to preventive interventions based on evidence-based risk- and needs-assessments."[18] Conditions of confinement must also be viewed in the context of its impact on the developing brain and future well-being of adolescents.

In recognition of the detrimental effect of isolation, in 2022, the legislature passed Public Act 22-18, An Act Concerning the Correction Advisory Committee, the Use of Isolated Confinement and Transparency for Conditions of Incarceration. Several provisions of this law are relevant to this report.

State Law Prohibition on Isolated Confinement

In 2022, the legislature passed Public Act 22-18, which defines the term "isolated confinement" to mean "any form of confinement of an incarcerated person within a cell, except during a facility-wide emergency, lockdown or for the purpose of providing medical or mental health treatment, with less than the following time out-of-cell:

(A)For all incarcerated persons, four hours per day, on or after July 1, 2022;
(B) For all incarcerated persons in general population, four and a half hours per day, on or after October 1, 2022; and
(C) For all incarcerated persons in general population, five hours per day, on and after April 1, 2023.

The new law also provides various guidelines and limitations on the use of isolated confinement.

First, the law defines "isolated confinement" to mean "any form of confinement of an incarcerated person within a cell, except during a facility-wide emergency, lockdown or for the purpose of providing medical or mental health treatment, with less than the following time out-of-cell:

(A) For all incarcerated persons, four hours per day, on or after July 1, 2022;
(B) For all incarcerated persons in general population, four and a half hours per day, on after October 1, 2022; and
(C) For all incarcerated persons in general population, five hours per day, on and after April 1, 2023.

The law establishes guidelines for the use of isolated confinement including the following:

[18] The Promise of Adolescence: Realizing Opportunity for All Youth. https://doi.org/10.17226/25388, at 11.

- Any use of isolated confinement shall maintain the least restrictive environment necessary for the safety of incarcerated persons and staff, and the security of the facility.
- If holding an incarcerated person in isolated confinement, the department shall:
  (1) Not later than twenty-four hours after initiating the process of holding such person in isolated confinement, ensure that a medical professional conducts a physical examination, and a therapist conducts a mental health evaluation of such person;
  (2) Ensure regular monitoring to ensure such person's safety and well-being, including a daily check-in from a therapist;
  (3) Continue de-escalation efforts when applicable and appropriate to the situation; and
  (4) Provide to such person access to the following:
    (A) Reading materials, paper, and a writing implement;
    (B) Not less than three showers per week;
    (C) Not less than two hours out-of-cell per day, including at least one hour for recreational purposes.

Further, the law limits the use of isolated confinement to instances where less restrictive measures have been considered and limits the length of time in isolated confinement to fifteen consecutive days or thirty total days within a sixty-day period.

As discussed in the conclusion of this report, some changes have occurred as a result of Public Act 22-18. Even with these changes, placement in restrictive housing settings is particularly detrimental to late adolescents and OCA recommends that long term restrictive housing be prohibited for this age group.

II. METHODOLOGY

This investigation included the following activities:

- Meetings and correspondence with state agency/s personnel.
- Review of child-specific education, mental health, and custodial records from DOC.
- Review of child-specific child protection records from DCF.
- Review of monthly data provided by DOC.
- Site visits to facilities run by DOC.
- Meetings with incarcerated youth.
- Examination of applicable state and federal statutes and regulations.
- Examination of DOC policies, practices, and procedures.
- Review of best practices/promising practices for individuals confined in adult correctional facilities.

The period under review (PUR) for this report includes calendar years 2022, 2023, and 2024. For the small cohort review discussed in Section IV of this report, OCA selected individuals who were incarcerated during the PUR, reviewed records for a one-year time period within the PUR, reviewed certain records for a period prior to the PUR, and conducted site visits throughout the PUR.[19] OCA also conducted limited site visits in 2025.

III. GENERAL REVIEW

POPULATION

OCA obtained census data for individuals 18-21 the first day of the calendar year for 2022, 2023, and 2024. This provides a snapshot of the population. On any given day, there are approximately 400-500 incarcerated 18–21-year-olds, 94 to 97 percent of whom are boys.

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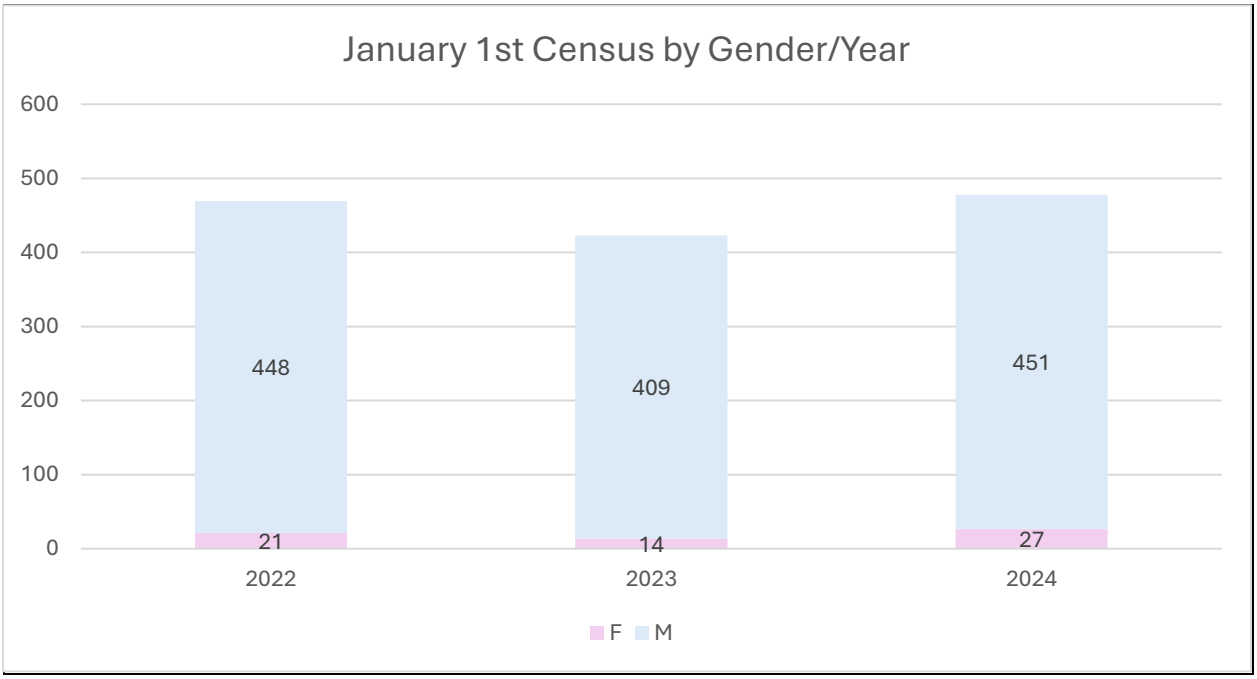
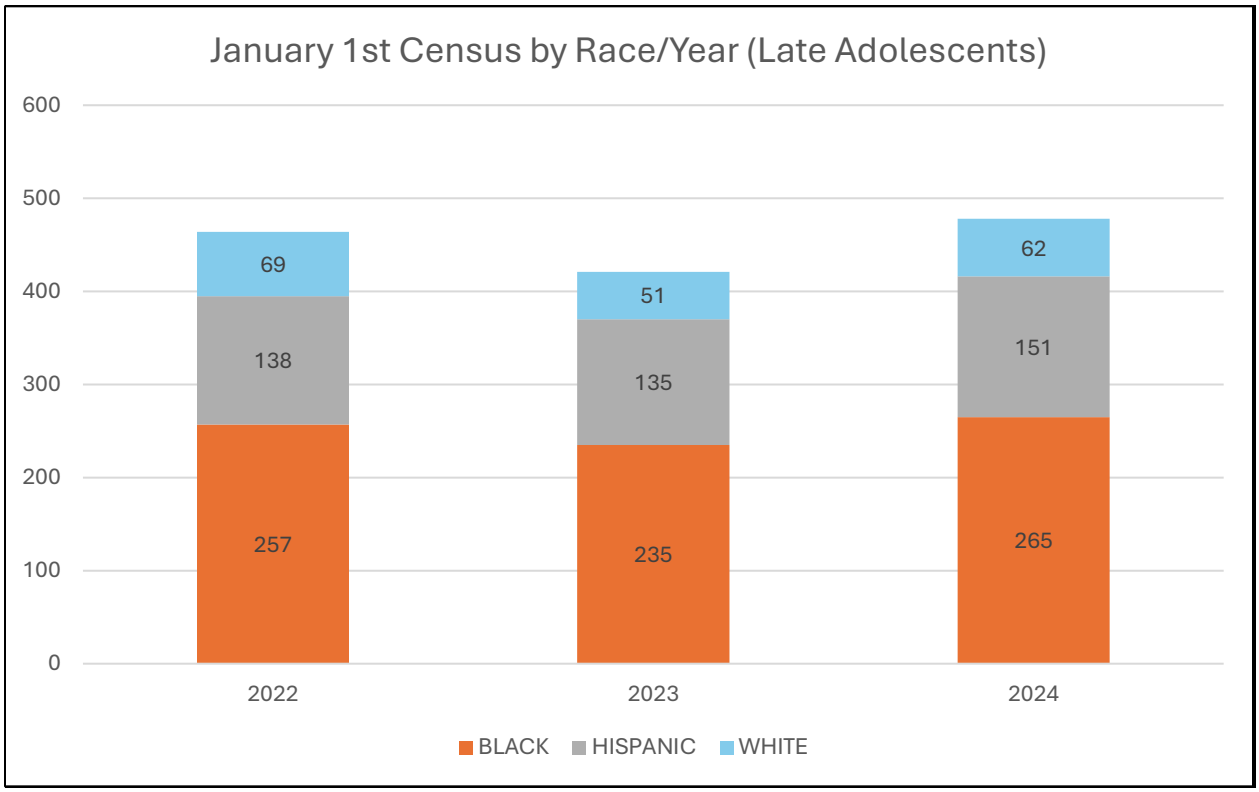


Black and Hispanic young people are disproportionately represented, with Black individuals consistently representing 55% or more and Hispanic individuals consistently representing approximately 30% of incarcerated 18–21-year-olds.[20]

[19] The specific year of record review of the cohort is not being released to protect the privacy of the individuals in the cohort.

[20] In Connecticut, according to the 2020 U.S. Census, people who are "White alone" represent 61.6% of the population; "Black alone" represent 12.4%; Hispanic represent 18.7%; "Asian alone" represent 6%; American Indian and Alaska Native alone represent 1.1%; Native Hawaiian and Other Pacific Islander alone represent 0.2%; Some Other Race alone 8.4%; and Two or More Races 10.2%.See https://www.census.gov/library/stories/state-by-state/connecticut-population-change-between-census-decade.html.



MENTAL HEALTH SCORING

Pursuant to DOC policies, all individuals entering a DOC facility must be assessed to determine specific needs for treatment.[21] Mental health needs are identified by assigning a Mental Health Need Score. Upon inquiry, DOC indicated that there is no uniform standardized tool used for determining mental health score. Instead, the determination is a clinical determination made by a qualified mental health professional. The policy indicates that the Mental Health Need Score should be determined by mental health professionals "whenever possible."[22] A Mental Health Need Score of 3 or above may only be scored by mental health staff.[23] The Mental Health Need Scores indicate the following:

Score	Description
MH 1	No mental health history or current need; characterized as emotionally stable
MH 2	History of mental health disorder that is not currently active or needing treatment; or current mild mental health disorder, not requiring treatment by a mental health

[21] Department of Corrections Classification Manual, at 28, available at https://portal.ct.gov/-/media/DOC/Pdf/PDFReport/ClassificationManualLibraryCopypdf.pdf.
[22] Id.
[23] Id.

MH 3	Mild or moderate mental health disorder (or severe mental disorder under good control); may or may not be on psychoactive medication
MH 4	Mental Health disorder severe enough to require specialized housing or ongoing intensive mental health treatment; usually on psychotropic medications.
MH 5	Crisis level mental disorder (acute conditions, temporary classification). Requires 24-hour nursing care.

DOC policy requires that "[o]nce it is determined that an inmate shall receive ongoing mental health services, a treatment plan shall be written by a qualified mental health professional following the first encounter and shall be reviewed every 90 days and revised as needed."[24] In addition, DOC requires that "all inmates have access to mental health services consistent with community standards of care regardless of gender, physical disability or cultural factors."[25] Services are delivered as indicated by their Mental Health Score, or as otherwise indicated and requested.[26] Mental health scores of incarcerated individuals fluctuate as scores are based on how an individual presents at a given point in time.

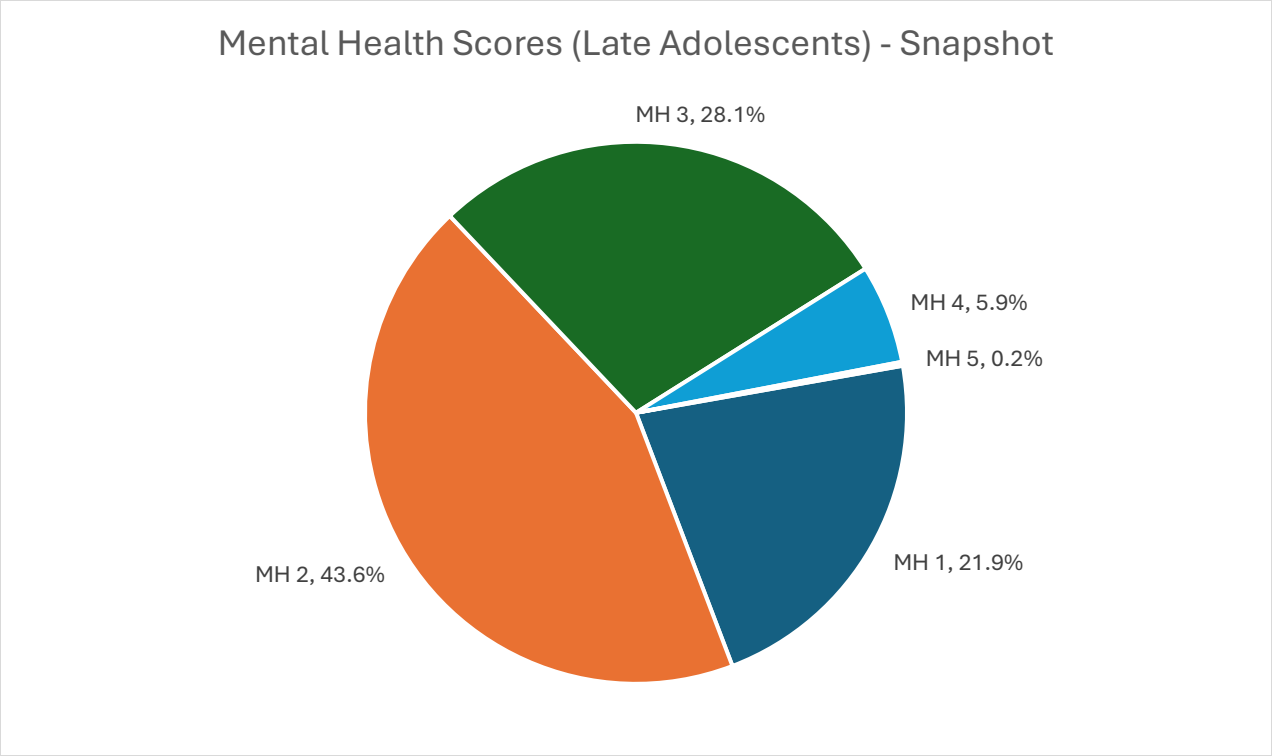
To review mental health scores, OCA reviewed DOC census data for a specific date within the PUR.[27] On this date, there were 424 late adolescents aged 18 to 21 in DOC custody. Of those, more than 65% were classified as Mental Health 1 or 2, meaning that they were deemed to have no history of mental health treatment needs or no current need. Twenty-eight percent of late adolescents were classified as Mental Health 3, and 6% as Mental Health 4. This is significant as it means the majority of 18– to 21-year-olds are not provided with regular scheduled mental health treatment.

[24] DOC Administrative Directive 8.5. In response to a draft of this report in March 2025, DOC reported that "the current Health Services Unit policy states 120 days. The agency is actively working to reconcile the number of days to reflect both in the A.D. and the policy."

[25] Id.

[26] Prior to November 2022, DOC required mental health treatment as follows: "An inmate with a current mental health service needs score of 3 shall be seen no less frequently than once every 30 days by a qualified mental health professional (social worker, therapist, psychologist) for scheduled individual psychotherapy sessions. An inmate with a mental health services needs score of 4 shall be seen by a qualified mental health professional (social worker, therapist, or psychologist) for individual psychotherapy sessions no less frequently than once every 7 days and will also be regularly scheduled for appropriate group psychotherapy treatment as identified on their individualized treatment plan." In November 2022, DOC amended its policy to change these requirements as follows: "An inmate with a current mental health score of 3 shall be seen for regularly scheduled individual psychotherapy sessions no less frequently than biweekly or for weekly group psychotherapy sessions, by a qualified mental health professional (social worker, professional counselor, psychologist) unless clinically indicated otherwise (ex. Psychotropic management only). An inmate with a mental health service needs score of 4 shall be seen by a qualified mental health professional (social worker, professional counselor, or psychologist) for individual clinical contacts no less frequently than biweekly and will also be regularly scheduled for appropriate weekly group psychotherapy sessions as identified on their individualized treatment plan."

[27] The specific date of the census is not being released to protect the privacy of the individuals in our cohort.



PHYSICAL RESTRAINT AND UTILIZATION OF CHEMICAL AGENT

Pepper spray, otherwise known as aerosolized oleoresin capsicum or "OC spray," is a chemical agent used by correctional facility staff as part of a continuum of population management/facility security strategies. Chemical agent immediately impairs a person's ability to see or breathe.

Connecticut law authorizes officials of the DOC to use physical force "as is reasonable and authorized by the rules and regulations of the Department of Correction," in order to maintain order and discipline.[28] Connecticut's statutory scheme limiting the use of restraint for persons at risk (including children and adults) specifically excludes anyone in the custody of the Commissioner of Corrections.[29]

DOC Directives[30] defines various types of restraint. For purposes of this report, the following definitions are used:

Chemical Agents: "Chemical agent devices consist of two (2) categories: i. Category I devices are hand held aerosol dispensers; and, ii. Category II devices consist of all methods of administration other than hand held aerosol devices."

Full Stationary Restraint: "Securing an inmate by the four (4) points of the arms and legs to a stationary surface."

[28] Conn. Gen. Stat. § 53a-18(a)(2).
[29] Conn. Gen. Stat. § 46a-150, *et seq*.
[30] DOC Administrative Directive 6.5, Use of Force.

In-cell Restraint: "Restraint within a cell of an acutely disruptive inmate utilizing one or more of the following restraining devices as appropriate: handcuffs, leg irons, security (tether) chain, belly chains, flex cuffs and/or black box."

Therapeutic Restraints: "Full stationary restraints that are ordered by a psychiatrist or physician as part of a medical or mental health treatment."

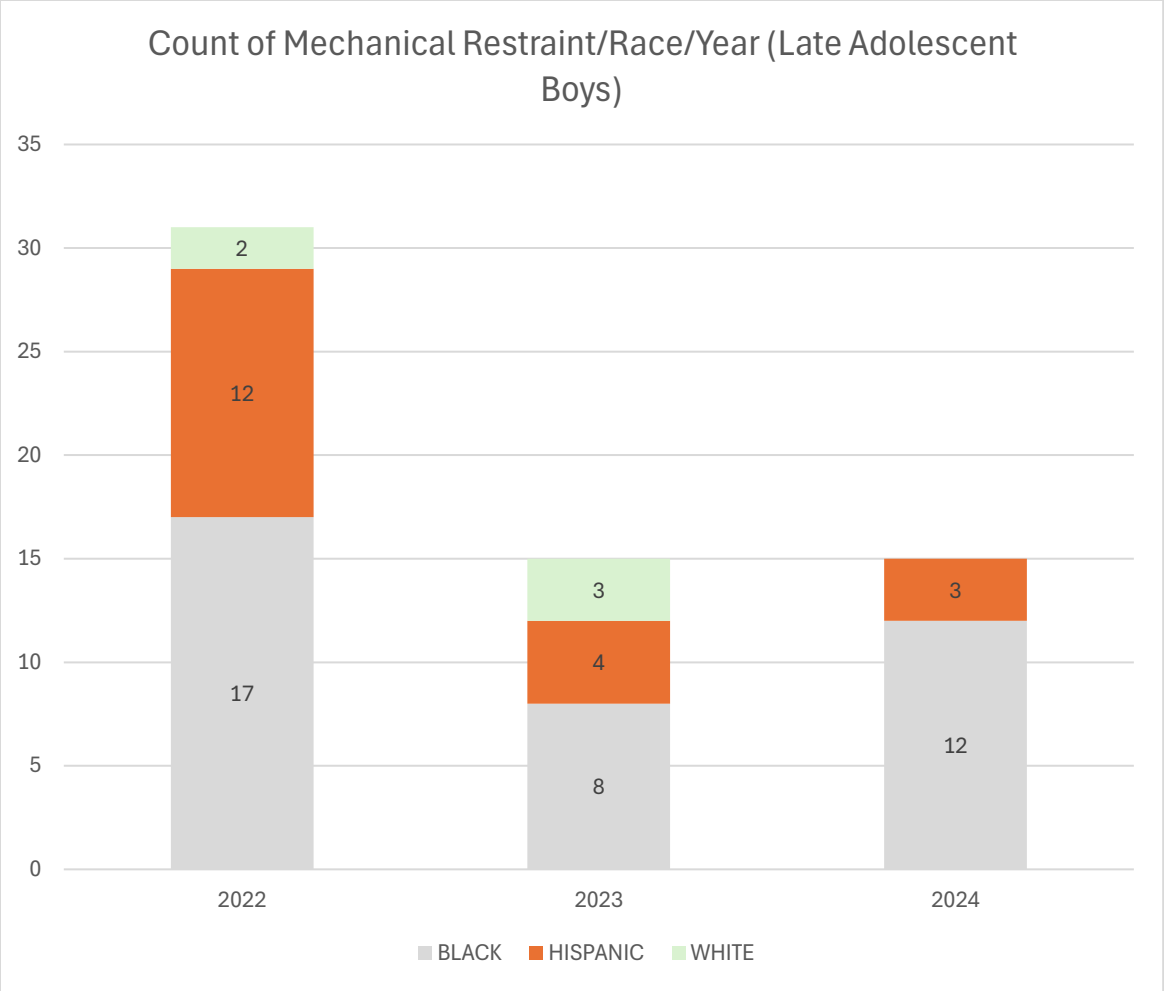
DOC Directives also define the term restraint as: "any mechanical device used to control the movement of an inmate's body and/or limbs, including but not limited to flex cuffs, soft restraints, hard metal handcuffs, a black box, Chubb cuffs, leg irons, belly chains, a security (tether) chain or a convex shield."[31]

Mechanical Restraint Data – Late Adolescent Boys

OCA receives monthly incident report data from the DOC documenting any use of in-cell, therapeutic or full stationary restraint for late adolescent boys aged 18-21. While each kind of restraint is defined differently, they are similar in that they occur within in a cell and late adolescents are typically placed in handcuffs and leg irons, which are connected by chains, and these are often attached to the bed. The length of restraints is documented, but not tracked.[32]

[31] DOC Administrative Directive 6.5.

[32] DOC employees are required to document the start and end time on paper forms, but this information is not entered into the data system, tracked or analyzed.



2022

For calendar year 2022, there were 31 instances of in-cell, therapeutic or full stationary restraint involving 16 late adolescent boys. Of the 31 instances, 55% (17) involved late adolescent boys who were Black, 39% (12) Hispanic, and 6% (2) White.

Of the 16 unique individuals, 50% (8) were Hispanic, 38% (6) were Black and 12% (2) were White.

2023

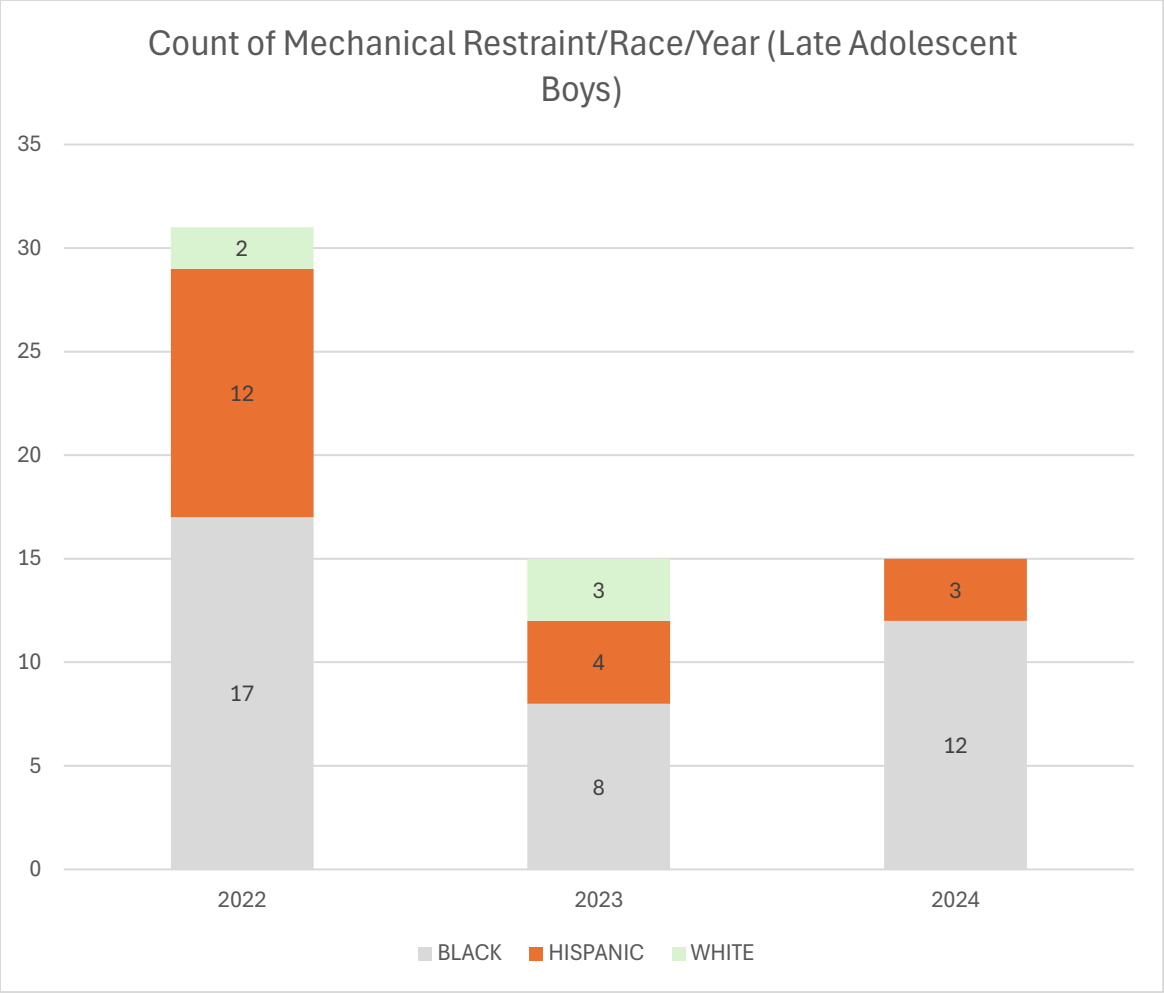
For calendar year 2023, there were 15 instances of in-cell, therapeutic or full stationary restraint involving 12 late adolescent boys. Of the 15 instances, 53% (8) involved late adolescent boys who were Black, 27% (4) Hispanic, and 20% (3) White.

Of the 12 unique individuals, 50% (6) were Black, 33% (4) were Hispanic, and 17% (2) were White.

2024

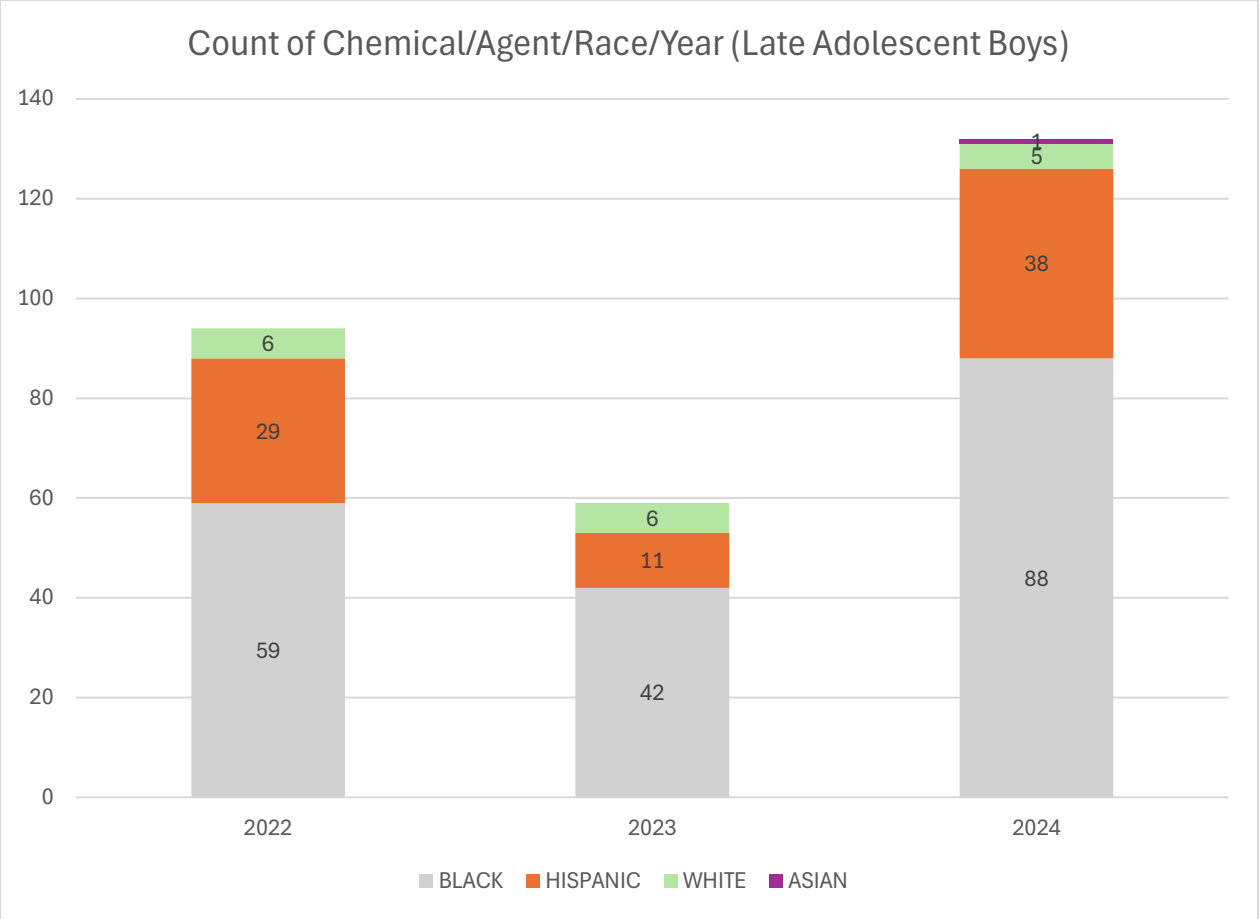
For calendar year 2024, there were 15 instances of in-cell, therapeutic, or full stationary restraint involving 12 late adolescent boys. Of the 15 instances, 80% (12) involved late adolescent boys who were Black and 20% (3) were Hispanic.

Of the 12 unique individuals, 75% (9) were Black and 25% (3) were Hispanic.



Chemical Agent Data – Late Adolescent Boys

OCA receives monthly Incident Report data from the DOC documenting the use of chemical agent on late adolescent boys aged 18 to 21.



2022

For calendar year 2022, there were 94 instances of chemical agent utilization involving 70 late adolescent boys. Of the 94 instances, 63% (59) involved late adolescent boys who were Black, 31% (29) Hispanic, and 6% (6) White.

Of the 70 unique individuals, 61% (43) were Black, 30% (21) were Hispanic and 9% (6) were White.

2023

For calendar year 2023, there were 59 Instances of chemical agent utilization involving 45 late adolescent boys. Of the 59 Instances, 71% (42) involved a late adolescent boy who was Black, 19 % (11) Hispanic 10 % (6) White.

Of the 45 unique individuals, 71% (32) were Black, 20% (9) were Hispanic, and 9% (4) were White.

2024

For calendar year 2024, there were 132 instances of chemical agent utilization involving 119 late adolescent boys. Of the 132 instances 66% (88) involved late adolescent boys who were Black, 29% (38) Hispanic, 4% (5) White, and less than 1% (1) Asian.

Of the 119 unique individuals, 66% (78) were Black, 30% (36) were Hispanic, 3% (4) were White and 1% (1) were Asian.

Physical Restraint and Chemical Agent Data – Late Adolescent Girls

OCA receives monthly Incident Report data from the DOC documenting any use of in-cell, therapeutic or full stationary restraint and any use of chemical agent for late adolescent girls aged 18-21.

2022

During calendar year 2022, there were 2 instances of in-cell restraint involving 1 late adolescent girl who was Black.

There were 3 instances of chemical agent utilization involving 3 late adolescent girls, (66%) 2 were Hispanic and 1 (33%) was White.

2023

Durning calendar year 2023, there were 4 instances of in-cell, therapeutic or full stationary restraints involving 4 late adolescent girls, all of whom were Black.

There were 5 instances of chemical agent utilization involving 3 late adolescent girls, all of whom were Black.

2024

During calendar year 2024, there were 3 instances of in-cell, therapeutic or full stationary restraint involving 2 late adolescent girls. Of the 3 instances, 2 (66%) involved a White late adolescent girl and 1 (33%) Hispanic.

There were 2 instances of chemical agent utilization involving 2 late adolescent girls, both White.

RESTRICTIVE HOUSING

Restrictive Housing Status means "any classification of an incarcerated person by the Department of Correction that requires closely regulated management and separation of such incarcerated person from other incarcerated persons, including, but not limited to, administrative segregation status, punitive segregation status, transfer detention status, administrative detention status, security risk group status, chronic discipline status, special needs status and protective custody status."[33]

Punitive Segregation (PS), Administrative Detention, Transfer Detention Defined (Short Term)

Punitive Segregation is "placement of an inmate in a restrictive housing unit who is found guilty of violating the Code of Penal Discipline."[34] PS is intended to be short term (3 to 15 days) depending on

[33] Conn. Gen. Stat. §18-96b(a)(10).
[34] DOC Administrative Directive 9.4.

the violation and is for the purpose of discipline. No programming is provided to 18- to 21-year-olds in PS and individuals can accumulate significant lengths of time in PS (sometimes consecutively and sometimes in aggregate). Out-of-cell time is limited to two hours per day.

Administrative Detention is "[r]emoval of an inmate from general population and placement in a restrictive housing unit that results in segregation of the inmate" pending completion of a disciplinary hearing, pending the outcome of an investigations, or to provide "temporary protection of an inmate pending a decision for an inmate placed on Protective custody status or an evaluation by health services."[35]

Transfer Detention is "[p]lacement in a restrictive housing unit of an inmate who has been reclassified to a security level higher than the facility at which the inmate is housed and is awaiting transfer, or who is awaiting transfer to another facility for the inmate's own protection or the protection of others."[36]

Administrative Segregation, Chronic Discipline, and Security Risk Group Defined (Long Term)

Administrative Segregation, Chronic Discipline, and Security Risk Groups are longer term restrictive housing statuses that, like Punitive Segregation, involve significant cell confinement, and, frequently, a lack of programming.

- Administrative Segregation (AS) is placement in a restrictive housing unit due to a determination that the individual's "behavior or management factors pose a threat to the security of the facility or a risk to the safety of staff, the inmate, or other inmates."[37] There are three phases of AS, each lasting 90 days. Progression from one phase to the next is contingent upon successful completion of each phase, including being free of class A and class B disciplinary reports for each 90-day period. The authorized length of confinement in AS is indefinite.

- Chronic Discipline (CD) is placement in a restrictive housing unit and is a "status that results in management of an inmate whose behavior, while incarcerated, poses a threat to the security and orderly operation of the facility, or a risk to the safety of staff or other inmates due to the inmate's repetitive disciplinary infractions."[38] Those placed in CD will remain in Interval I for a minimum of thirty (30) days and Interval II for a minimum of sixty (60) days. Those who display good behavior may progress early at the discretion of the Chronic Committee/Unit Administrator.

- Security Risk Group (SRG) is "[a] group of inmates, designated by the Commissioner, possessing common characteristics, which serve to distinguish them from other inmates or groups of inmates and which as a discrete entity, jeopardizes the safety of the public, staff or

[35] DOC Administrative Directive 9.4.
[36] DOC Administrative Directive 9.4.
[37] DOC Administrative Directive 9.4. Policy Directive 9.4 was revised on April 21, 2023. The prior version of the policy defined administrative segregation as a "placement of an inmate on a restrictive housing status that results in segregation of the inmate whose behavior or management factors pose a threat to the security of the facility or a risk to the safety of staff or other inmates and that the inmate can no longer be safely managed in general population."
[38] Id.

other inmate(s) and/or the security and order of the facility."[39] In practice, those identified for SRG status are persons deemed to be gang affiliated. Designation as an SRG member must be reviewed at least every six months.

According to DOC Directives, individuals designated as SRG must participate in the SRG Member Phase Program, a program through which, "after successful completion of a structured 5 phase program, may be reintegrated into General Population."[40] Phase I is a minimum of four months, and the remaining phases are 2 months each, for a total of 12 months. Phase I and Phase II are highly restrictive. Individuals in Phase I are provided with no programming[41] and must remain discipline free for at least four months to move to Phase II. According to DOC policy, those who are designated to begin in Phase II or III must be discipline free for 90 days to be eligible to begin in-cell and/or group programming. If an individual receives a disciplinary report while in SRG, that may result in regression of one or more phases, thus extending the stay in SRG. Individuals may be considered for renunciation of gang affiliation and removal from SRG status after a minimum of nine consecutive months and successful completion of the required phases.

Punitive Segregation (PS) Shorter Term Isolation -Late Adolescent Boys

OCA receives monthly data from the DOC with all of the Disciplinary Reports that result in a late adolescent boy aged 18-21 being placed in a restrictive housing unit to serve time in Punitive Segregation.

In the vast majority of incidents resulting in PS in calendar years 2022 through 2024, confinement was for a period of 5 days. The range of days of confinement was one (1) day to fifteen (15) days consecutively, though individuals may accumulate multiple days over time.

2022

Calendar year 2022 data showed there were 724 Disciplinary Reports involving 351 late adolescent boys leading to Punitive Segregation. Of the 724 infractions, 56% (409) involved a late adolescent boy who was Black, 32% (233) Hispanic, 11% (98) White, and less than 1% (2) American Indian.
Of the 351 unique individuals, 56% (198) were Black, 31% (110) Hispanic, 12% (41) White and 1% (2) American Indian.

Sixty percent of the incidents leading to Punitive Segregation occurred at MYI. Most incidents involved fighting (54%), interfering with safety/security (10%), or refusing housing (10 %).

2023

[39] DOC Administrative Directive 6.14.
[40] Id.
[41] While the DOC policies indicate that those in SRG I receive "in-cell programming," OCA found no evidence to suggest any in-cell programming is provided.

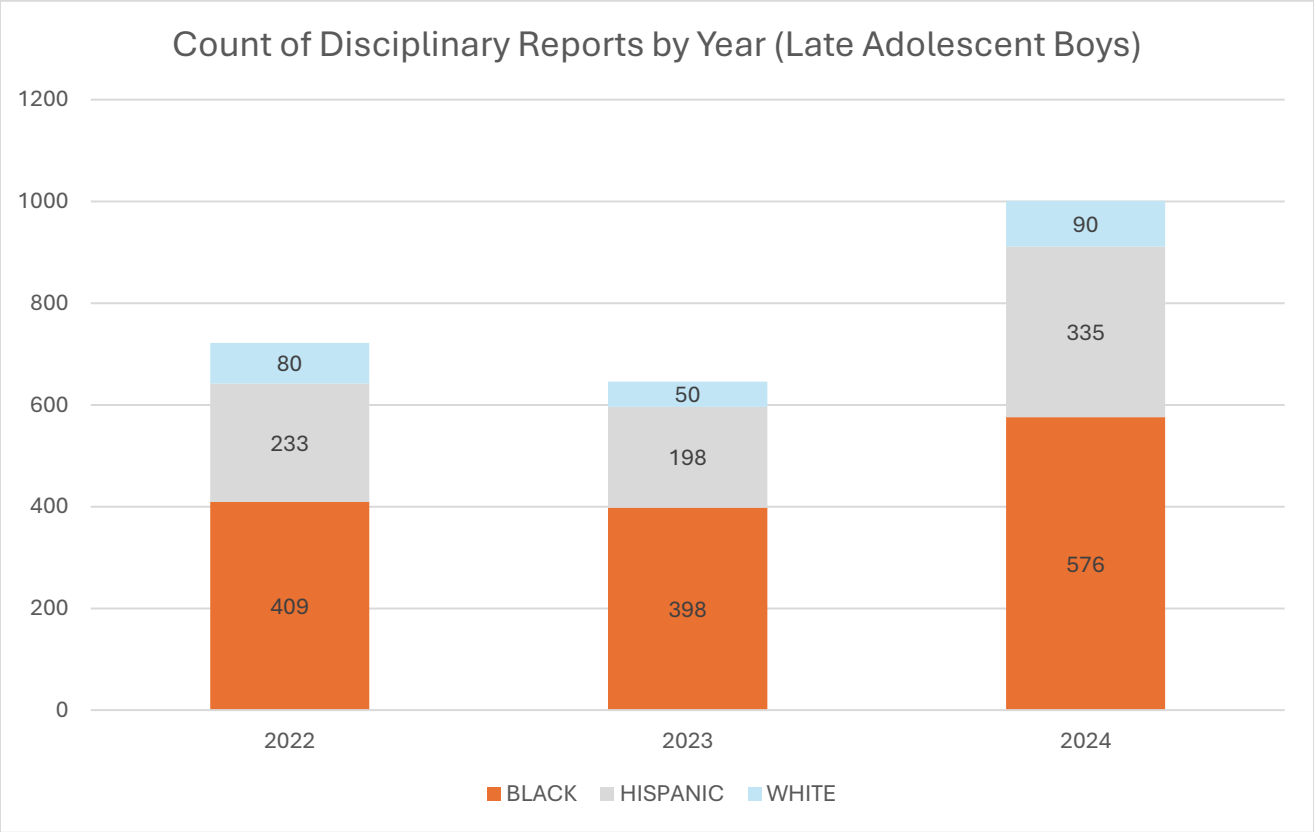
Calendar year 2023 data showed there were 646 Disciplinary Reports involving 329 late adolescent boys leading to Punitive Segregation. Of the 646 infractions, 62% (398) involved a late adolescent who was Black, 30% (198) Hispanic, and 8% (50) White.

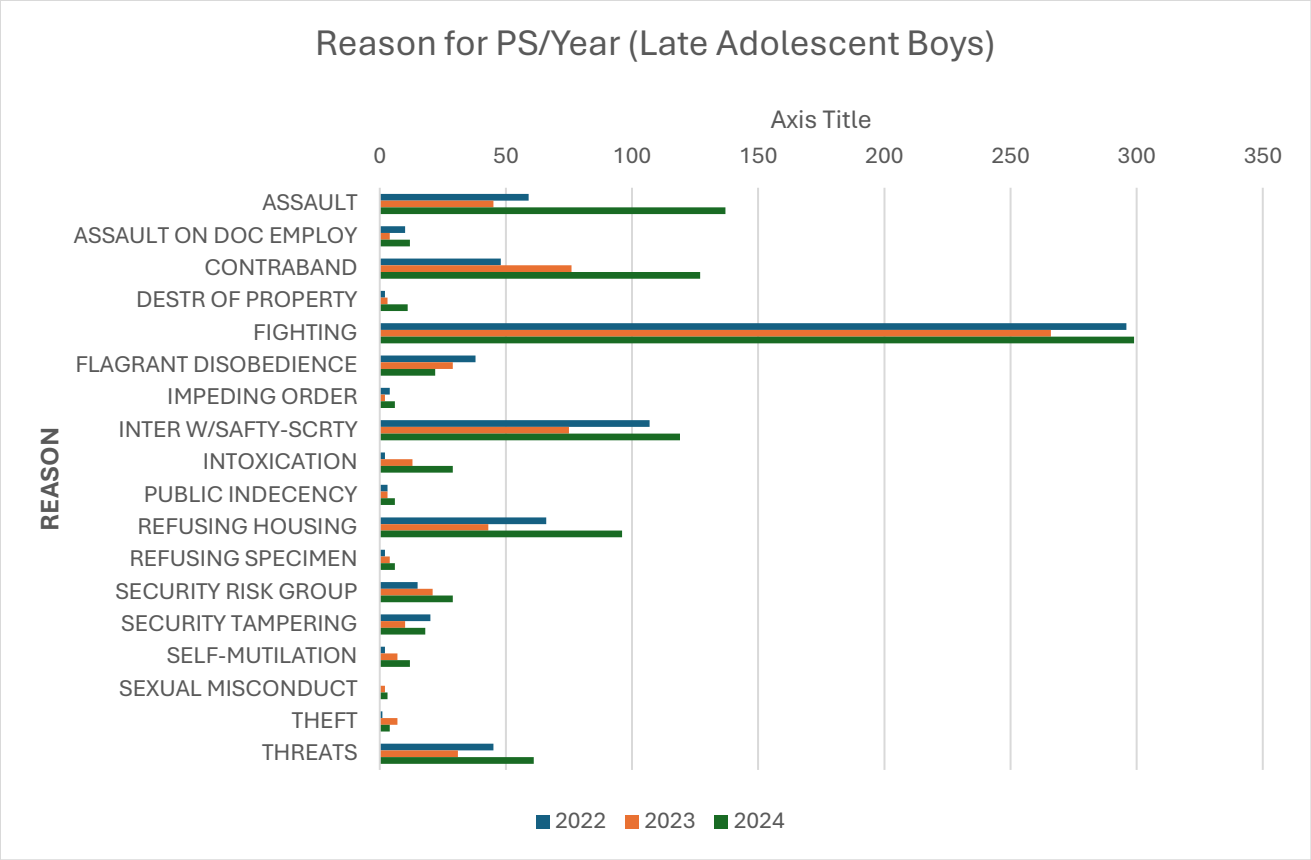
Of the 329 unique individuals, 60% (197) were Black, 30% (100) Hispanic, and 10 % (32) White. Fifty-nine percent of the incidents leading to Punitive Segregation occurred at MYI, most frequently due to fighting (57%), possession of contraband (12%), or interfering with safety and security (12%).

2024

Calendar year 2024 data showed there were 1002 Disciplinary Reports involving 400 late adolescent boys leading to Punitive Segregation. Of the 1002 infractions, 57% (576) involved a late adolescent boy who was Black, 33% (335) Hispanic, 9% (90) White, and (1) less than 1% Asian.

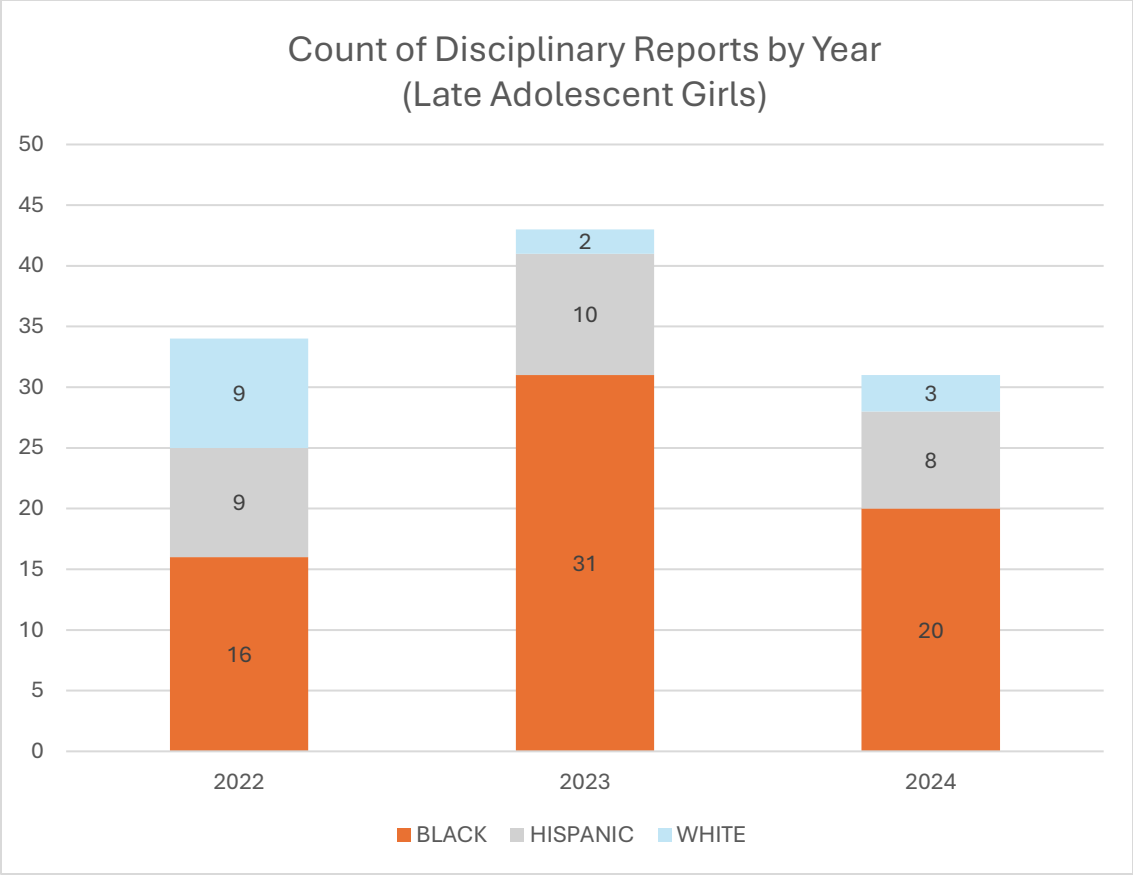
Of the 400 unique individuals, 57% (229) were Black, 32% (128) were Hispanic, 10% (42) were White and (1) less than 1% Asian.





Punitive Segregation (Short Term) – Late Adolescent Girls at York

OCA receives monthly data from the DOC with all of the Disciplinary Reports that led to a late adolescent girl aged 18-21 being placed in a restrictive housing unit to serve time in Punitive Segregation.



2022

For calendar year 2022, data showed there were 34 Disciplinary Reports involving 14 late adolescent girls leading to Punitive Segregation. Of the 34 infractions, 47% (16) involved a late adolescent who was Black, 26% (9) Hispanic, and 26% (9) White.

Of the 14 unique individuals, 43% (6) were Hispanic, 36% (5) Black, and 21% (3) White.

The majority of incidents were for Fighting/Assault (50%) and Flagrant Disobedience (18%).

One girl who was Black accounted for 30% of the incidents, and she spent over 45 days in Punitive Segregation over a 120-day period.

Another late adolescent girl spent 35 days in Punitive Segregation, in addition to being placed on Chronic Discipline for over 200 days.

2023

For calendar year 2023, data showed there were 43 Disciplinary Reports leading to Punitive Segregation, involving 19 late adolescent girls. Of the 43 infractions, 72% (31) involved late adolescent girls who were Black, 23% (10) Hispanic, and 5% (2) White.

Of the 19 unique individuals, 53% (10) were Black, 37% (7) Hispanic, and 10% (2) White.

The majority of incidents were for Fighting/Assault (31%), Flagrant Disobedience (19%), and Security Tampering (14%).

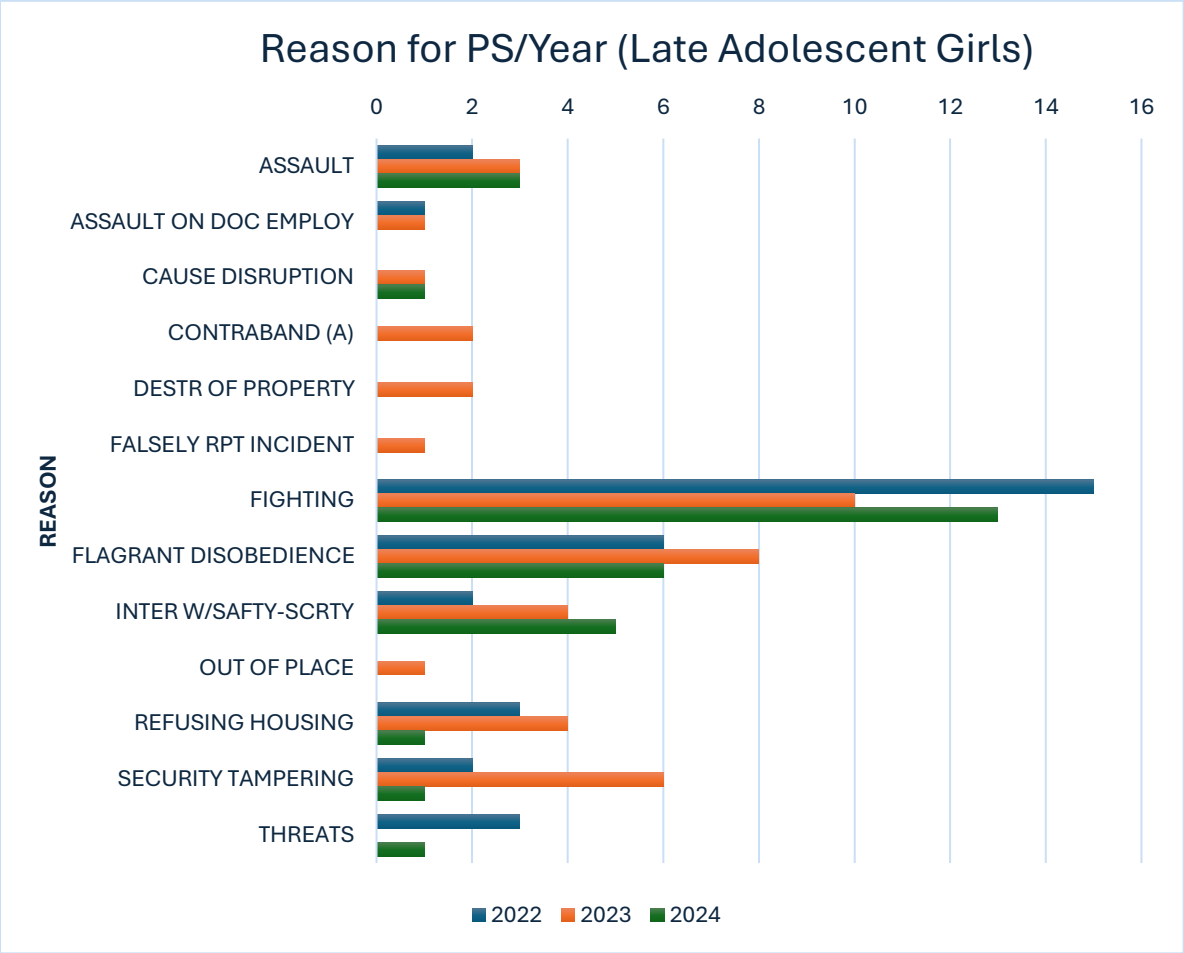
One late adolescent girl accounted for 35% of the disciplinary infractions, and she spent over 50 days in Punitive Segregation over a 200-day period. She also had two placements in Chronic Discipline, one lasting 97 consecutive days and one lasting 64 days.

2024

For calendar year 2024, data showed there were 31 Disciplinary Reports involving 21 late adolescent girls at York. Of the 31 infractions, 64% (20) involved late adolescent girls who were Black, 26% (8) were Hispanic, and 10% (3) were White.

Of the 21 unique individuals, 53% (11) were Black, 33% (7) were Hispanic, and (3) 14% were White.

The majority of the incidents were for Fighting/Assault 52%, Flagrant Disobedience 19% and Interfering with Safety and Security 16%.

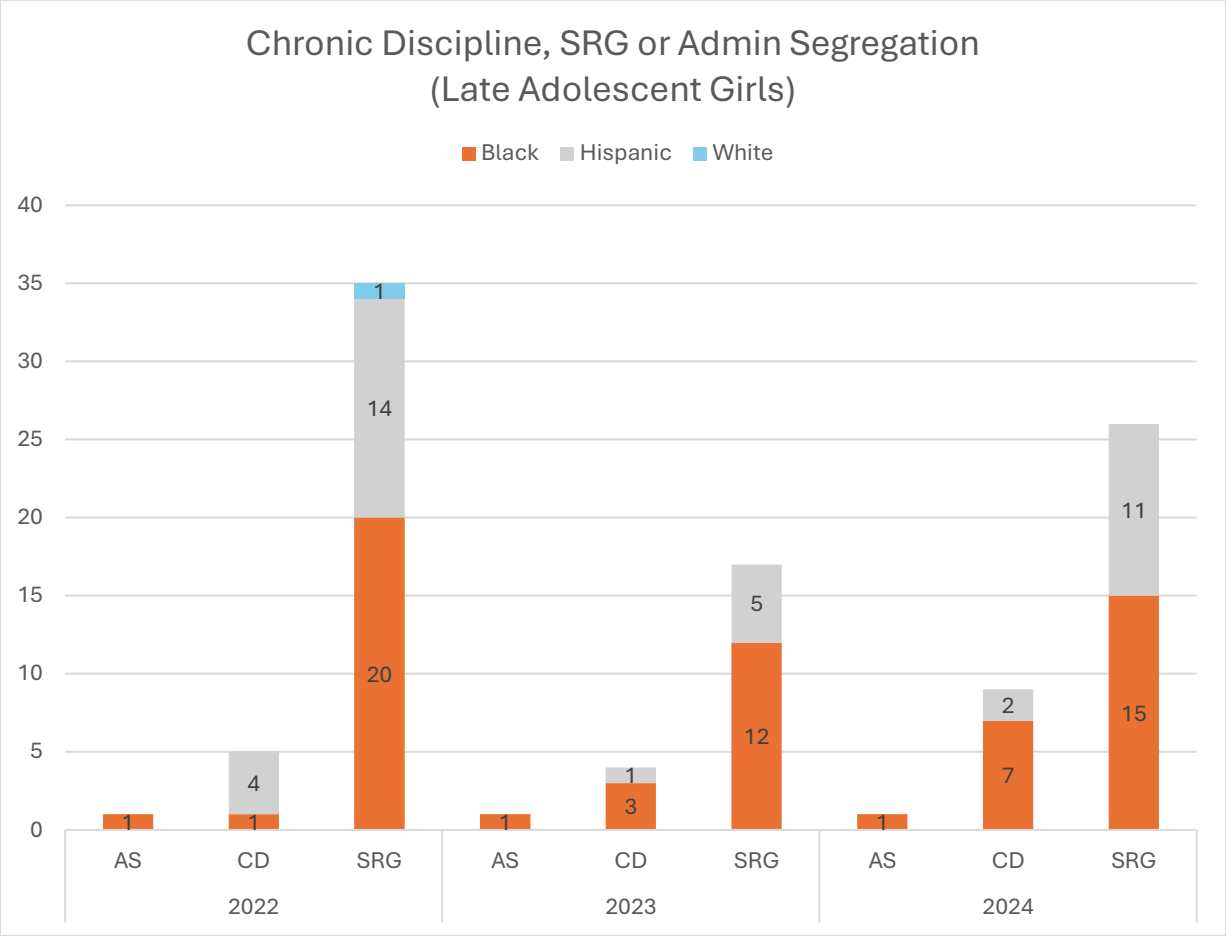


Chronic Discipline (CD), Administrative Segregation (AS), and Security Risk Group (SRG) – Late Adolescent Boys

For the calendar year 2022, there were 41 occasions in which a late adolescent boy aged 18 to 21 was confined in Chronic Discipline, SRG, or Administrative Segregation. Of these, 54% (22) of the late adolescent boys were Black, 44% (18) were Hispanic, and 2% (1) were White.

For the calendar year 2023, there were 22 occasions in which a late adolescent boy aged 18 to 21 was confined in Chronic Discipline, SRG, or Administrative Segregation. Of these, 73% (16) of the late adolescent boys were Black and 27% (6) were Hispanic.

For calendar year 2024, there were 36 occasions in which a late adolescent boy aged 18 to 21 was confined in Chronic Discipline, SRG or Administrative Segregation. Of these, 64% (23) of the late adolescent boys were Black and 36% (13) were Hispanic.



Chronic Discipline, Administrative Segregation, and Security Risk Group – Late Adolescent Girls

For calendar year 2022, there were two late adolescent girls placed in Chronic Discipline. One was White and one was Black.

For calendar year 2023, there was one late adolescent girl, who was Black, placed on Chronic Discipline status twice.

For calendar year 2024, there was one late adolescent girl, who was Black, placed on Chronic Discipline.

DISCUSSION

The increase in 2024 in disciplinary reports and the related increase in the use of chemical agent for late adolescent boys raises serious concerns. Both speak to the need for meaningful engagement and therapeutic interventions. In addition, responses to misconduct are harsh and may exacerbate mental health needs and increase the likelihood of future misconduct.

Site visits and interviews with late adolescents indicated that conditions in Punitive Segregation are highly restrictive. Late adolescent boys eat in their cells, are not allowed any personal belongings, and do not participate in programming or school. No phone calls and no visits are permitted. Individuals are brought out of their cells at most twice per day for 30 minutes to an hour, but do not engage in recreational or structured programming, group or otherwise. Showers may be permitted during this time. Otherwise, they spend the out-of-cell time in an indoor or outdoor cage.[42]

Late adolescents may accumulate numerous days in Punitive Segregation, and documentation is not always clear about the total duration of isolation. For example:

- One late adolescent boy had 38 documented days in Punitive Segregation over the course of one calendar year, but other DOC records indicated that the individual spent an additional 16 days in punitive segregation without specific documentation.
- Another late adolescent boy's records noted placement in Punitive Segregation for 5 days, but review of records indicated that he remained in Segregation for 16 days, with an intervening cell movement for less than 24 hours.

Records did not reflect whether late adolescents placed in Punitive Segregation, once or for multiple placements, were offered individualized services or interventions. In depth review of records associated with a cohort of individuals placed on restrictive housing status during our PUR, including Punitive Segregation, did not identify any individualized behavior plans, other than one requested by the OCA, including for youth who were placed multiple times in Punitive Segregation.

Discipline in Punitive Segregation often includes other consequences such as loss of recreation (out-of-cell time), loss of commissary, loss of visits, loss of social correspondence, and loss of tablets. These are generally of longer duration than the days in Punitive Segregation. For example:

[42] DOC did not agree that individuals get less than two hours per day. DOC stated that logging and auditing of out of cell time is underway.

- David, who has intellectual disability, was placed in Punitive Segregation for a total of 106 out of 466 days during our PUR. For the same period, he lost 248 days of recreation, 373 days of commissary, 300 days of social contact (visits, mail, phone).
- Jeremy was placed in Punitive Segregation for a total of 38 recorded days during our PUR. OCA's review of DOC records indicates Jeremy spent an additional 16 days in RHU/PS that were not documented as such, as he remained in the same location according to prison records. For disciplinary infractions occurring over a period of 91 days, Jeremy received 325 consecutive days of loss of recreation. In addition, for the same disciplinary events and time period, Jeremy lost visits for 285 consecutive days and social correspondence for 225 consecutive days. He also lost commissary for 145 days, with 130 of these days being consecutive. The majority of his disciplinary infractions were for "interfering with safety and security."

While recreation, commissary, visits, mail, and phone calls are not permitted during time in punitive segregation, the counting of days for loss of such privileges does not begin until after release from time in segregation.

IV. IN-DEPTH REVIEW OF CONDITIONS IN LONG-TERM RESTRICTIVE HOUSING IN DOC FACILITIES OTHER THAN MYI (CHRONIC DISCIPLINE, ADMINISTRATIVE SEGREGATION AND SECURITY RISK GROUP)

OCA's audit of conditions in these Restrictive Housing settings raised immediate concerns about prolonged isolation and deprivation for these late adolescents. As a result, OCA conducted an in-depth review of conditions for a cohort of the late adolescent boys (n=13). In addition to site visits and interviews with incarcerated individuals and facility staff and administrators, OCA reviewed DOC electronic health records (EHR), activity logs, and program completion data to assess the conditions of restrictive housing, the length of time in restrictive housing, and the educational services provided to those with identified special education needs.

Using census data for one day during our PUR, OCA determined that there were 142 late adolescent boys aged 18 to 21 who were held in non-MYI facilities.[43] Fifty-nine percent (59%) were Black, 28% were Hispanic, 12% were White and less than one percent were Asian. Of these, twenty-one (21) late adolescent boys were confined in longer-term Restrictive Housing settings: Chronic Discipline, Administrative Segregation, and SRG.

OCA's in depth focused on late adolescents in the following DOC facilities:

[43] The specific date of the census is not being released to protect the privacy of the individuals in our cohort.

- Corrigan-Radgowsky Correctional Institution is a level 3-4 facility that houses over 650 male incarcerated individuals. It has units to house individuals identified as SRG Phases II to V, as well as an Administrative Segregation/Chronic Discipline unit. Educational services are available for late adolescents housed at Corrigan, but only for the purpose of obtaining a GED.

- Garner Correctional Institution is a level 5 mental health facility that houses up to 693 male individuals. It has been identified by the DOC as a consolidated location for individuals with significant mental health needs and most individuals confined in this facility have a mental health score of 4 or 5.[44] There is a space for school. Educational services are available for late adolescents, though only for GED track services. There is also an Administrative Segregation unit in this facility.

- MacDougall-Walker Correctional Institution is a level 4-5 facility that houses up to 2218 male individuals. It consists of two buildings: MacDougall and Walker. MacDougall houses individuals designated as high-bond, Administrative Segregation, and Chronic Discipline. Walker houses individuals identified as SRG-1 and Administrative Segregation. There is space for a school in MacDougall. There is no school in the Walker building, though there is a space where class can take place.[45]

PROLONGED CELL TIME AND ACCOMPANYING RESTRICTIONS

In all restrictive housing settings reviewed by OCA (PS, AS, Chronic, SRG I), late adolescent boys spend almost all hours of the day in their cell, though some may have cell mates. Meals are provided in cell through a small slot in the door. Access to property is determined by the Unit Administrator in the facility. OCA staff observed multiple 18- to 21-year-olds who were not permitted to have pillows, pajamas, or sweatpants. They did not have access to a television, a radio, paper or writing instruments, or even a photo album. One late adolescent boy told OCA that he did not go to the outside cage for "out-of-cell time" because he did not have a sweater or jacket, and it was cold outside.

[44] There are individuals housed at Garner, called permanent party workers, who are not individuals with significant mental health needs. Rather, they are low risk individuals who provide maintenance services to the facility.

[45] Walker has been described to OCA by DOC administrators as not intended for long-term prison housing. The design and purpose at the Walker facility was to be temporary housing for inmate screening and designation within the prison system (reportedly a week at most). However, Walker is now used as a long-term housing unit for SRG. This SRG unit is one of the most restrictive in the DOC system. Its purported purpose is for individuals placed there to denounce gang affiliation.

Recreation areas in restrictive housing settings

With regard to recreation/out-of-cell time, OCA site visits and interviews with incarcerated individuals and facility staff during 2023 and early 2024 confirmed that individuals in these settings were not receiving four hours of out-of-cell time per day. To the extent that out-of-cell time is provided, it consists of movement, in mechanical restraints, from the individual's cell to a cage either inside the unit or outdoors. Restraints are removed once the individual is placed in the outdoor cage. The outdoor cage is constructed of chain link, with a chain link roof. At McDougal-Walker and Corrigan, where late adolescent boys on restrictive status are housed, the chain link cage is in an area enclosed by tall concrete walls such that only the sky is visible. Some late adolescent boys are placed alone in the cage, and some are placed in the same cage with other individuals. Inside the cage, in these locations, there are no seats and no tables. On the SRG I units, there is nothing to use for the purpose of recreation.[46] On multiple occasions, OCA staff observed individuals simply standing in the outdoor cage as that is the only thing they can do in that space.

[46] Individuals on SRG II and SRG III are housed in Corrigan, where recreation is provided in either an indoor or outdoor area. The outdoor area is surrounded by a cage and individuals are provided with some limited recreation. Whether indoor or outdoor, individuals are provided with some movement, social interaction, and recreational activities, like playing cards.

Late adolescent boys in restrictive settings are routinely strip-searched.[47] Every time a late adolescent boy leaves his cell, including for a clinical visit or school, he is strip-searched before exiting the cell and placed in restraints. For visits, late adolescent boys in these settings are strip-searched before and after visits. No data is collected as these strip-searches are considered routine in SRG I and Administrative Segregation 1, 2 and 3.

Visitation and phone calls are sharply curtailed or not permitted depending on the phase of Administrative Segregation, Chronic Discipline, or SRG.[48] Any late adolescent boy who receives disciplinary sanctions may lose visitation and/or access to the tablet for purposes of making phone calls. OCA observed numerous late adolescent boys who lost access to visitation and/or phone calls for extended periods of time while in restrictive housing.

> "They see us as animals because that's how they treat us. We are all human beings. We just had other circumstances and are just wearing different clothes."
>
> *Late adolescent in restrictive housing*

LACK OF REHABILITATIVE PROGRAMMING IN LONG TERM RESTRICTIVE HOUSING

While policies provide for access to some (in-cell) programming in Administrative Segregation, Chronic Discipline, and SRG-1, OCA interviews with DOC staff and with late adolescent boys revealed that boys are not provided with access to programming. Staff reported to OCA that late adolescent boys may be given "packets" to fill out on their own. However, DOC was unable to produce any completed packets for OCA to review. One late adolescent boy recounted to OCA the innumerable hours of empty time in his cell, listing activities he wished he could do, including: exercise, education, bible study, and small groups. He described deteriorating due to the endless isolation and lack of activity and said that individuals resort to shouting at each other through the vents and the walls just to be heard and responded to.

OCA's record review revealed that for the entire one-year period reviewed, 9 of the 13 late adolescent boys participated in no groups or programs, except for very limited hours of special education services for those who were eligible. For the remaining 4, program participation was minimal, consisting of only a few hours of programming over the course of the entire year.

18- TO 21-YEAR-OLDS SOMETIMES LANGUISHED IN RESTRICTIVE SETTINGS FOR YEARS

As outlined above, Security Risk Group (SRG) status frequently consists of long-term cell confinement. OCA reviewed SRG progression and regression forms, restrictive housing forms,

[47] While the DOC policy provides a list of situations where strip searches are permitted without reasonable suspicion, this does not include strip searches upon exiting one's cell while in restrictive settings. Nonetheless, wardens in more than one facility have confirmed that individuals in SRG I or AS are routinely strip searched before exiting their cells for any activity.

[48] Individuals in general population are permitted to have six phone calls per day and are provided with tablets for that purpose. They are also permitted at least two in-person visits per week.

activity logs, and program completion data for 9 late adolescent boys.[49] While DOC policy indicates that the five phases of SRG should take 12 months, review of records showed that these individuals remained in SRG longer than 12 months. Of the 9 late adolescent boys in the cohort reviewed by OCA, 4 spent the entire one-year period reviewed in SRG I/II, and records indicate they had been on SRG status for years.

Recreation Area for SRG Phase I

Indoor Individual Recreation Area SRG Phase I

Recreation Area for SRG Phases II to V

[49] These nine late adolescents are part of the cohort of thirteen late adolescents for whom programming was reviewed. All names used are pseudonyms to protect the identity of the individual.

- Jeremy was designated SRG at age eighteen. Jeremy progressed and regressed through the SRG phases over several years. At the time of our review, he had been on SRG status for a total of 1355 days (over 3.5 years). For the one-year period reviewed, Jeremy participated in two hours of coping skills programming and one mental health session. He received no other programming that year. Records indicate that the only programming he received prior to that year occurred three years prior at MYI. At MYI, he received two visits. Early in his admission to DOC, the only diagnosis recorded was Conduct Disorder. He was classified as a Mental Health 2, and therefore not identified as needing mental health treatment. Documents reflect that Jeremy's mental health deteriorated over the course of his time in SRG, with staff recording that he reported pacing in his cell, punching the wall, being unable to sleep, and having racing thoughts and mood swings. He began to engage in suicidal and/or self-harming behaviors and was repeatedly placed on Behavioral Observation Status.[50] He was hospitalized on multiple occasions for suicidality and intentional self-harm. He later reported fixating on suicide and death. He expressed how difficult his incarceration had been and that "he didn't care anymore." When told by DOC staff he would be placed on Behavioral Observation Status again, he became angry and "inconsolable." He presented as "hopeless, exhausted, and having a tangential thought process." He was placed in the infirmary on BOS. Following advocacy by OCA, he was moved to a mental health unit. Diagnoses at that time, after over three years in SRG, included Bipolar 1 Disorder (manic), rule out for Borderline Personality Disorder, and Mood Disorder of Depressed Type. Jeremy was a special education student and exited from special education services when he turned 22. Upon review of a draft of this Report, USD 1 reported that Jeremy "earned his diploma after his 22nd birthday." DOC did not provide supporting documentation.[51]

- Charles was designated as SRG shortly before turning 18.[52] During the PUR, he was SRG II for the first six months of the year and then regressed to SRG I and remained in SRG I for the remainder of the year. At the time of our review, he had been on SRG status for 1654 days (4.5 years). OCA's review of records revealed no documentation of any programming being provided, and no evidence of participation in any groups.

- Keith was identified as SRG at the age of 19. He progressed as high as Phase IV, but never completed the five phases. With the exception of a brief period of release from incarceration, he spent the entire one-year period reviewed in SRG I. When he was discharged from his incarceration, he was in SRG I and had been on SRG status for 646 days. There is no activity log for Keith. There is no record of participation in any programs or groups. He received no visits.

- Timothy was identified as SRG at the age of 18. At the time of our review, he had been in SRG I for a total of 413 days. He completed no programs and there is no evidence that he participated in any programming or groups. He received no visits.

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[50] DOC Policy states: "For inmates who are using maladaptive behaviors, such as threatening self-harm without intent, or destroying property to avoid compliance with custody requirements such as housing or disciplinary actions, Behavioral Observation Status (BOS) shall be initiated." Administrative Directive 8.5.

[51] OCA had previously requested certain educational records pertaining to Jeremy and DOC did not provide them as Jeremy had turned 22 and DOC determined that OCA lacked authority to review records for an individual aged 22.

[52] Following OCA's 2019 conditions of confinement report identifying that minor youth were classified as SRG and placed on long term cell confinement, DOC ended that practice. Youth may not be designated SRG until they turn 18.

- Larry was initially placed on SRG status, starting at Phase II, at the age of 19. At the time of our review, he had been on SRG Phase II for approximately 10 weeks. Program data indicates that Larry completed SRG III during that time, however this is not supported by other records. Records revealed no programming, no visits, and participation in one coping skills group session.

- Nathan was identified as SRG at the age of 18. At the time of our review, he had been on SRG status for a total of 530 days of incarceration with all but 31 of those days in SRG I or II. Records show he received no programming, no visits, and no groups.

- Andre was designated as SRG at the age of 18. Program completion data was not consistent with SRG forms provided by the DOC, thus it is unclear which phases he actually completed. For the duration of his time in SRG reviewed by OCA, he received no programming, no visits, and no groups.

- Michael appeared to move through the phases at a pace similar to what is described in the policy. When he entered DOC custody, he was placed in SRG III, at the age of 18. He progressed to SRG IV, regressed to SRG II, and then progressed to SRG IV. At the time of our review, he was in SRG IV and had been on SRG status for 443 days. His activity log shows completion of SRG III two times over the course of two years. No other activities are recorded in the activity log. There is no evidence that Michael received any programming or groups. He received visits on a regular basis, either via video or in person.

The degree of isolation and inactivity for the 18- to 21-year-olds on these restrictive statuses is alarming. OCA is recommending an immediate end to the placement of late adolescents on SRG, Administrative Segregation, and Chronic Discipline as these statuses currently operate.

MINIMAL MENTAL HEALTH CARE FOR 18- TO 21-YEAR-OLDS IN LONG-TERM RESTRICTIVE HOUSING

Of the 13 late adolescent boys in restrictive housing settings whose records were reviewed by OCA, 2 were identified as Mental Health 4 or 5, and 8 were identified as Mental Health 3 for all or part of the time. For most of these late adolescent boys, regularly scheduled mental health sessions were not provided consistent with DOC policy requirements. While DOC mental health encounter data at times documented a scheduled session for an individual, the corresponding electronic health record often documented that the visit was not scheduled and was instead a brief contact in response to a staff or incarcerated individual's request. Some of the late adolescent boys had frequent crisis/custody calls and "inmate requests," for which they received brief cell side mental health contacts. Frequency of crisis calls did not appear to result in a change to the individual's mental health classification or result in an increased number of scheduled visits by mental health staff. For at least two of these late adolescent boys, review of the electronic health record revealed significant unaddressed mental health treatment needs.

OCA observed that indicators of mental distress were viewed by staff, including clinical staff, as maladaptive and manipulative in nature. Responses to requests for mental health treatment were slow, and individuals resorted to covering the cell window or flooding the cell to get a response, which was

then followed by discipline. When individuals did report feeling suicidal, they were put on Behavioral Observation Status (BOS), placed in a cell alone and often stripped and provided with a stiff covering (which individuals refer to as the "turtle suit"). There was little treatment provided and individuals were generally released from BOS status when they indicated that they no longer felt suicidal. When OCA inquired with clinical staff about the use of BOS, staff indicated this was only the response when DOC believed the statements of suicidality to be maladaptive.[53] OCA observations raised serious concerns that BOS is at times used despite indicators that individuals were expressing suicidal ideation and in obvious significant mental distress.

DOC Directives require that incarcerated individuals be assessed by a psychologist prior to placement in Restrictive Housing.[54] OCA's review of multiple individual records indicates that assessment is very limited, is frequently a screening, and is not conducted by a mental health professional.[55] Review of multiple videos by OCA showed that assessment frequently consisted of a cell side inquiry to the late adolescent that lasted less than a minute or two and was completed in the presence of non-clinical staff. Review of records indicated that such assessments have disregarded prior documentation of an individual's serious mental health concerns.

- Charles: Charles reported to DOC a prior serious mental health diagnosis. Charles expressed frequent medical symptoms (poor sleeping, difficulty breathing, chest pain). These symptoms were deemed to be related to anxiety and panic attacks. He repeatedly reported difficulty sleeping and ongoing intrusive nightmares about death and loved ones being hurt. On one occasion, he reported auditory hallucinations, and, on another occasion, he reported seeing violent images that were not actually there. DOC staff determined that these complaints were feigned. On one occasion, he ingested and excessive amount of over-the-counter medication, which he reported was an effort to treat his chest pain. On another occasion, he was transported to the Emergency Room due to chest pain. Providers determined that he did not have a physical health problem resulting in chest pain, and that the complaints were related to anxiety. Throughout, he was identified with a mental health score of 3 and generally seen one time per month for scheduled mental health visits.

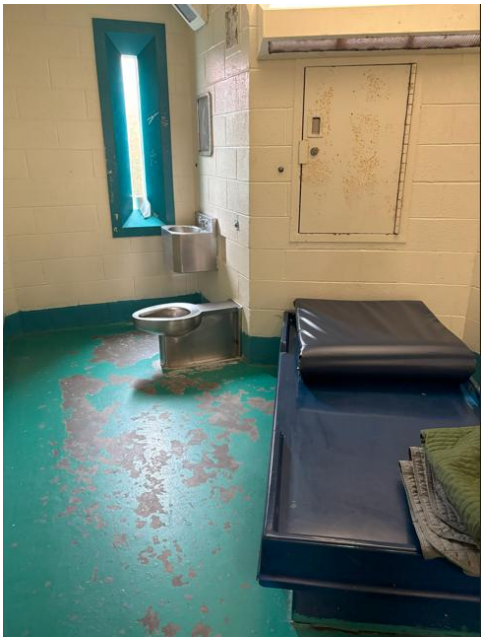
- Jeremy: Early in his incarceration at MYI, his only diagnosis was Conduct Disorder-Adolescent Onset. During his incarceration, he was placed in SRG I, where he experienced significant isolation. After 3 years in SRG, he began to engage in self-injurious behaviors and suicidal ideation. When he reported that he took pills that were not prescribed to him, flooded his cell, covered his window, and reported he was feeling suicidal, it was documented that he engaged in self-harm and that suicidality was present. He was transported to the hospital. When he returned, he was placed on BOS by custody staff and not seen by mental health staff before returning to his unit. Medical records indicated that he was in in-cell restraints, requiring medical check of his hands, wrists, and ankles. For this incident, he was placed in punitive segregation for 8 consecutive days, sanctioned with 45 days of loss of recreation, 30 days of

[53] DOC Policy states: "For inmates who are using maladaptive behaviors, such as threatening self-harm ***without intent***, or destroying property to avoid compliance with custody requirements such as housing or disciplinary actions, Behavioral Observation Status (BOS) shall be initiated. Behavioral Observation Status shall be utilized in areas other than an infirmary/hospital unit but shall be limited to housing areas in which custody staff routinely conduct 15 minute tours. Placement shall be completed by a qualified mental health professional." DOC Administrative Directive 8.5.
[54] DOC Administrative Directive 9.4.
[55] Records indicate that initial screens may be conducted by medical nursing staff rather than clinical staff.

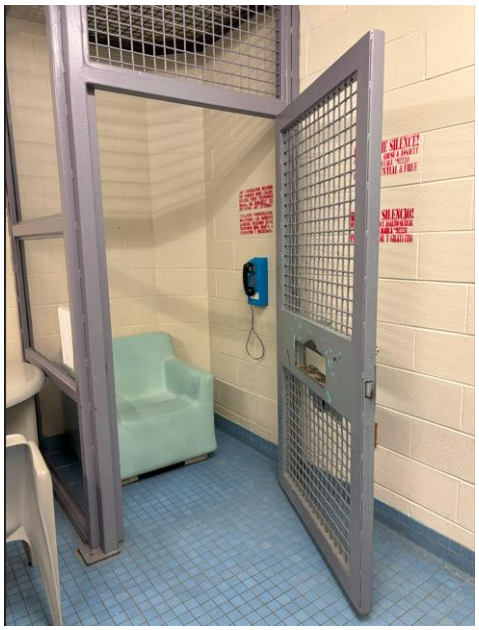
loss of visits, 30 days of loss of social correspondence. Similar incidents of distress, flooding the cell, and informing mental health staff of mental distress, including thoughts of self-harm, nightmares interfering with sleep, and incidents of self-harm persisted for the next four months. In response, DOC imposed sanctions. During the one-year period reviewed, Jeremy was placed in Punitive Segregation for a total of 38 days. OCA's review of the records includes an additional 16 days in Segregation that were not documented as such. At the time of our review, Jeremy had lost recreation for 430 consecutive days, lost visits for 270 consecutive days, and lost social correspondence for 234 consecutive days. He lost commissary for 130 consecutive days. These losses, combined with the restrictions of Phase I SRG, where all meals are delivered in-cell and no meaningful programming is provided, resulted in extended periods of isolated confinement. During our PUR, Jeremy's mental health had deteriorated to the point where he was identified as a mental health 5 and had to be transferred to the mental health unit.

- Dante: When Dante re-entered the correctional system, DOC medical records stated that he was "void of any major Depressive, Manic, or Hypomanic signs or symptoms" with "no signs, nor reports any symptoms consistent with emotional distress." Nonetheless, "due to his prior levels of care [from prior incarceration records] in CT DOC and his admission that he requires medication," he was placed in IPMU [In-Patient Mental Health Unit] MH 5 with privileges." His mental health level was reduced to MH4 one day after his admission. Despite well-documented mental health needs, and history of deterioration in punitive segregation, he was repeatedly placed in punitive segregation, resulting in deterioration. While he spent months in the infirmary, there is little evidence of mental health treatment during that time, other than medication, including involuntary medication at times. For the one-year period reviewed, he received the expected number of scheduled mental health visits (as outlined in policy) in only four of the twelve months.

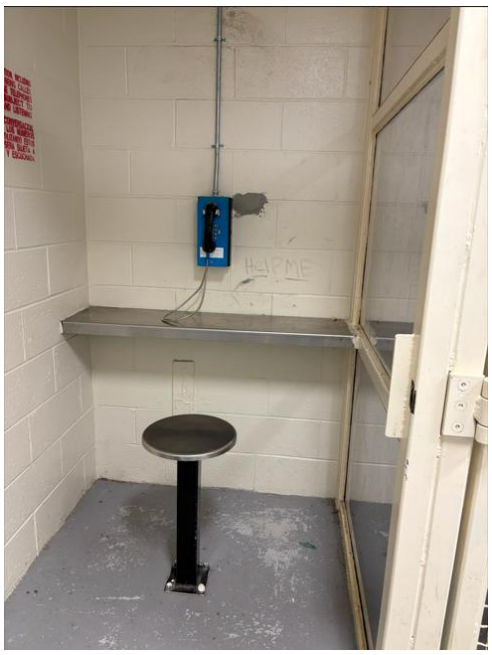
- Kevin: Kevin had a history of trauma and was diagnosed with Post Traumatic Stress Disorder (PTSD). Kevin was removed from his classroom at MYI due to disruptive behavior. He was sent to RHU/PS where he was restrained for a strip search. He was later transferred to Chronic Discipline, a restrictive housing unit, in a facility other than MYI, where he remained in RHU/PS. Shortly after his transfer from MYI, he was found non-responsive in the outdoor "recreation" cage. Naloxone was administered and he was transferred to the hospital. The hospital determine that he ingested fentanyl, and this was communicated to DOC. The next day, he returned to the facility. Upon return, he was seen by medical staff, given a nebulizer treatment for wheezing, and cleared for return to RHU/PS. Despite his apparent overdose, he was not seen by mental health upon return to the facility. According to the EHR, Kevin requested to see mental health and was told mental health staff would come and speak to him. DOC documents indicate that Kevin did not comply with directives to go with staff to his cell and continued to ask for mental health. Because he did not comply, he was taken to the ground and sprayed with a chemical agent.



Cell in the Infirmary



Infirmary - Individual Therapy Space



Infirmary – Space Used for School and Therapy

Infirmary - Recreation Area

LIMITED EDUCATIONAL SERVICES FOR 18- TO 21-YEAR-OLDS IN RESTRICTIVE HOUSING

The state "has ultimate responsibility for ensuring [a free appropriate public education] is made available to all eligible students with disabilities residing in State and local juvenile and adult correctional facilities."[56] Federal law requires that states ensure that a "free appropriate public education [FAPE] is available to all children with disabilities residing in the State between the ages of 3 and 21, inclusive . . . ."[57] This includes children under the age of 22 who are incarcerated in adult facilities.[58]

Unified School District #1 is responsible for the delivery of educational services within the Department of Correction. It is required to comply with the same federal and state laws applicable to all other districts in the state.[59] The State Department of Education (CSDE) is required to monitor and enforce compliance with federal special education laws.

The USDE has issued a Dear Colleague Letter on the Civil Rights of Students in Juvenile Justice Residential Facilities[60] and a Dear Colleague Letter on Individuals with Disabilities Education Act (IDEA) for Students with Disabilities in Correctional Facilities.[61] Together, these documents describe the legal rights of, the importance of high quality education for, and guidance on best practices for incarcerated students with disabilities. They make clear that "[a]bsent a specific exception, all IDEA protections apply to students with disabilities in correctional facilities and their parents."[62]

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[56] Dear Colleague. United States Department of Education, Office of Special Education and Rehabilitative Services. December 5, 2014. https://www2.ed.gov/policy/gen/guid/correctional-education/idea-letter.pdf, at 6.
[57] 20 USC 1412 (a)(1).
[58] See C.F.R. 300.102(a)(2)(i) and 300 C.F.R. 300.324 for limited exceptions and modifications.
[59] See 34 C.F.R. 300.28; Conn. Gen. Stat. §10-15d.
[60] Dear Colleague. United States Department of Justice and Department of Education. December 18, 2014. https://www2.ed.gov/policy/gen/guid/correctional-education/cr-letter.pdf
[61] Dear Colleague. United States Department of Education, Office of Special Education and Rehabilitative Services. December 5, 2014. https://www2.ed.gov/policy/gen/guid/correctional-education/idea-letter.pdf.
[62] Dear Colleague. United States Department of Education, Office of Special Education and Rehabilitative Services. December 5, 2014. https://www2.ed.gov/policy/gen/guid/correctional-education/idea-letter.pdf, citation omitted. The

The Dear Colleague Letter on the IDEA for students with disabilities in correctional facilities describes the legal rights of students and obligations of state and local educational agencies, most notably:

- "States and their public agencies must have child-find policies and procedures in place to identify, locate, and evaluate students who are in correctional facilities who may have a disability under the IDEA and are in need of special education and related services . . . . This responsibility includes students who have never been identified as having a disability prior to their incarceration."
- "The IDEA requirements related to least restrictive environment (LRE) apply to the education of students with disabilities in correctional facilities. IEP [Individual Education Plan][63] teams or placement teams must make individualized placement decisions and may not routinely place all incarcerated students with disabilities in classes that include only students with disabilities, even if this means creating placement options or using other arrangements," to the maximum extent appropriate to the student's needs.
- Public agencies must comply with all applicable IDEA secondary transition requirements to facilitate eligible students' movement from secondary education in the correctional facility to appropriate post-school activities.[64]
- A student with a disability in a correctional facility who violates a code of student conduct is entitled to the protections in the IDEA discipline procedures that must be afforded to all students with disabilities. These protections apply regardless of whether a student who violates a code of student conduct is subject to discipline in the facility or removed to restricted settings, such as confinement to the student's cell or "lock down" units. In any event, a removal from the current educational placement that results in a denial of educational services for more than 10 consecutive school days, or a series of removals that constitute a pattern that total more than 10 school days in a school year is a change in placement, which, in turn, requires a manifestation determination under the IDEA.
- In developing the IEP, "the IEP Team [must] consider the use of positive behavioral interventions and supports and other strategies to address behavior in the case of a student whose behavior impedes his or her learning or the learning of others (34 CFR §300.324(b)(2)). Appropriate implementation of these positive behavioral interventions and supports and other strategies to address behavior should ensure that the student is able to benefit from his or her educational program in the correctional facility and hasten the student's transition from the facility and re-entry into the community."

For this report, OCA focused its observations on education in Corrigan, Garner, and MacDougall-Walker. In these facilities, OCA observed that individuals had access only to GED programming and did not have access to the K-12 High School Diploma Program. While a GED program is said to be

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document notes that "[f]or the purposes of this letter, "correctional institution" or "correctional facility" refers to juvenile justice facilities, detention facilities, jails, and prisons where students with disabilities are, or may be, confined. In addition, this letter uses the term "students with disabilities" to refer to children with disabilities, as that term is defined in 34 CFR §300.8." Letter at 1, N.1.

[63] In Connecticut, these teams are referred to as Planning and Placement Teams (PPT). Individualized Education Plans (IEPs) are developed at PPT meetings.

[64] *But see* 34 C.F.R. 300.324 for exceptions related to transition services for students convicted as adults and incarcerated in adult facilities.

available, late adolescent boys reported persistent lack of access to education. OCA was provided with a school schedule from the DOC for Walker and Corrigan. The schedule calls for 2 hours daily educational services. However, observations and interviews indicate that late adolescent boys do not receive educational services consistent with the schedule. Many reported receiving no educational services for weeks at a time, without explanation.[65] Some reported receiving packets infrequently delivered to their cells. DOC reported to OCA that high school diploma programs do not exist at every DOC facility, in part due to lack of staffing and lack of programming space. DOC administrators stated that they examine how many credits students have when they are incarcerated, and where the student may be able to graduate, the administrators do what they can to get students back to MYI so that they can pursue their high school diploma.

Education in these facilities for students with special education needs is extremely limited. For those late adolescent boys identified with special education needs, the IEPs for all individuals who are transferred from MYI to other adult facilities provide for GED track education, with extremely limited hours of service.[66] Several of the late adolescents in OCA's cohort of 13 individuals had special education needs. OCA reviewed several IEPs in which students were provided special education instruction in the amount of 0.5 hours of academic instruction per week and 1 hour/month vocational of vocational services. Total educational hours, including the special education instruction, ranged from 10 to 11 hours per week. The apparently standard reduction in educational instruction and special education service hours raises concerns for violation of IDEA's requirements that IEPs be individualized and tailored to meet the needs of each individual student. Individuals on SRG status whose records were reviewed by OCA, including those identified as students with special education needs on pretrial status, routinely did not receive educational services. One reason for the lack of service delivery appears to be restrictions on movement for those on SRG status, including a requirement that those in SRG cannot be moved unless everyone else is secured. Nearly all late adolescents designated as SRG reported receiving no educational services while in SRG I, a status which lasts a minimum of four months. Records indicate that at least two late adolescents on SRG status received infrequent short visits from an educational staff person, but not in the frequency or duration listed in IEPs. With the exception of counseling, no late adolescent received related services such as physical therapy, occupational therapy, or speech services. OCA efforts to review educational records for completed work revealed that nothing was available. Attendance records were noted to be unreliable as late adolescents confined in settings that would restrict their attendance, such as punitive segregation or the infirmary, were incorrectly marked as present.

- Wilson entered DOC custody at the age of 17 and was held at MYI. He was pretrial for the entire time of OCA's review. He remained in MYI until his transfer to another DOC facility, shortly after turning 18. At the time of entrance into DOC custody, Wilson was designated as a student with special education needs. According to his attorney, his IEP at that time called for 18.75 hours of special education services in a self-contained classroom with counseling supports in addition to lunch and certain courses in the mainstream general education environment. When he entered MYI, his IEP was reduced to one hour per week of special

[65] After reviewing a draft of this report, USD 1 stated that "teachers contractually have vacation days built into their schedules."

[66] The CSDE provided a waiver to USDE #1 in 2016 to permit those enrolled in GED preparation courses, which would typically require withdrawal from high school and termination of eligibility for special education services, to continue to receive special education services. This should be distinguished from offering only GED services and it must be noted that the CSDE does not have the authority to waive federal IDEA requirements.

education services and 2.25 hours per trimester of transition services. According to Wilson's attorney, once Wilson was transferred out of MYI, educational staff made clear that the only option available was to pursue a GED, as this is the only track of education offered in facilities other than MYI. He was scheduled for two-hours per day of education. Despite aggressive advocacy by his attorney, with the support of an educational consultant, Wilson's educational hours remained the same, but approximately 30 minutes of his time daily was dedicated to special education services. His attorney reported that educational time was often limited to being provided with worksheets and/or homework for him to do independently, rather than verbal instruction in the content. He struggled to complete educational work and reported that he often got about half of the questions wrong because he did not understand the material. While his IEP stated he should have access to assistive technology, he was not provided with applications that would assist him with his education, such as text-to-speech and basic word processing.[67] He received virtually no transition programming or support. He had not received a transition assessment. In his four years in DOC custody, he obtained only three high school credits and passed none of the four pre-tests required to take and pass the GED. After Wilson's attorney filed a complaint with CSDE, the state found that USD 1 failed to comply with federal and state special education laws, both procedurally and substantively, and failed to provide education "reasonably calculated to meet the Student's unique needs resulting from his disability." Upon review of a draft of this Report, USD 1 challenged OCA's description of the District's educational service deficiencies. OCA references the following findings made by CSDE, in response to the administrative complaint submitted by Wilson's lawyer:

> When the Student was first placed with the District in [year], the amount and type of special education and related services were significantly reduced . . . During this time, the student was pursuing a high school diploma but only earned three academic credits [over 35 months]. Upon transferring [from MYI to another DOC facility], the Student was enrolled in the GED program. The academic goals and objectives in the student's IEP [from the date of transfer from MYI], have focused on preparing for the GED. However [after 16 months], the student has not yet passed any of the pretests for the GED. Despite this lack of progress, the PPT did not revise the student's IEP until [approximately three years after entry], primarily due to the request made by the claimant.
>
> The District failed to develop an appropriate IEP for the Student at the PPTs . . . . The social/emotional, post-secondary education/training, and employment, annual goals and objectives have remained the same for approximately three years. This fact, and the amount of services in the IEP (i.e. 15 minutes a week of transition services and 15 minutes a week of social/behavioral services) also calls into question the veracity of the progress reporting related to these goals and objectives . . . The progress reporting . . . show that the Student made limited progress on his goal and objectives related to reading and language arts. The Students scores on the Comprehensive Adult Student Assessment System (CASAS) and the Test of Adult Basic Education (TABE) show inconsistent progress in the areas of

[67] In response to a draft of this report, USD 1 stated that the Student's IEP showed that the IEP documented access to "low tech options including flash cards, graphic organizers, highlighters, read aloud, and skill based reference sheets" and "accommodations [including] breaks during assessments, and weekly review sessions."

> reading, math, and language. Even though the Student's teachers recognize that the Student benefits from talking through his learning, his classes include a high percentage of time dedicated to self-directed learning, instead of direct instruction. . . . The record does not contain any evidence that the District noted this or attempted to adjust the Student's program.
>
> The student's record demonstrates that he has a long history of social/emotional concerns such as attendance, hyper-activity, distractibility, and impulsive decision-making. The Student's IEPs have not contained any counseling services to address these concerns, until an hour a month of counseling was added to the student's IEP [approximately four years after entry]. Furthermore, there is no evidence that the District has utilized positive behavioral supports, conducted a functional behavioral assessment, or developed a behavioral intervention plan . . . .
>
> . . . .the Student's goals and objectives related to transition have remained the same for the past two annual review meetings. The student is over 14 years old when he transferred into the district and has only received nominal transition services (i.e., 15 minutes a week). The Student's IEP shows that he has an interest in vocational training and certificate opportunities but the District has not provided the student with access to such things. Furthermore, the District has not conducted age-appropriate transition assessments related to training, education, or employment.[68]

CSDE ordered corrective actions from USD 1 to include development of an IEP to meet the student's needs, extending the student's eligibility for special education services for an additional six months, 75 hours of compensatory education, and completion of a comprehensive transition assessment. A PPT was held in response. The student remained enrolled as a GED student. While goals and objectives were revised, the team recommended similar service hours to what was previously provided: 10 total hours of education per week, including 2 hours and 15 minutes per week of academic skills with a special education teacher, 15 minutes every other week of transition services, 15 minutes every 2 weeks with the school psychologist for transition services, 10 minutes per day with a special education teacher for behavior services, and one hour per month of individual counseling services. Shortly thereafter, the PPT added 15 minutes every other week of executive function instruction. Approximately one year after CSDE issued corrective actions, USD1 notified CSDE that the student passed his GED test. As a result, Wilson obtained his diploma. For the next five months, Wilson received 15.5 hours of the 75 hours of compensatory educational services, largely in the form of coursework in barbering.

In addition to the corrective actions regarding the student above, USD1 was to provide a training plan for all special education teachers, general education teachers, special education administrators, and related services provider at the facility regarding developing and implementing IEPs to provide FAPE, conducting appropriate annual review meetings, and conducting appropriate transition planning. DOC educational administrators reported to OCA that the DOC had been taking steps to improve transition assessments (a commitment

[68] Connecticut State Department of Education, Letter of Decision, Complaint No: 23-0373.

of three assessments per year per individual) and professional development for staff. USD1 provided a list of professional development hours provided between December 2022 and September 2024, totaling 158 hours.

- David entered DOC custody with an IEP. The Probate Court had previously appointed a plenary guardian for David, based on his intellectual disability. His educational disability classification was emotional disturbance. When he was in the community, David was placed in an out-of-district state approved private special education program. His IEP required a 30 hours per week transitional program, including 1 hour/week of academic support, 30 minutes per week of group therapy, and 30 minutes per week of individual counseling. His IEP, from his public school prior to entering custody, noted that he continued to have some struggles with emotional regulation but did "amazing" during 1:1 time. His IEP included goals/objectives related to identifying feelings and responding appropriately to social situations.

  At the time of his re-entry into DOC custody, at MYI, his IEP included 15 and one-half (15.5) total school hours, with two (2) hours per month of transition services and one (1) hour per month social work support. The exit criteria was listed as age twenty-two (22). While at MYI, David completed 9 vocational modules related to Graphic Arts and Barbering. Despite David's intellectual disability, documented need for significant educational services, and a well-established educational history of emotional/behavioral dysregulation, David was transferred to another DOC facility where access to educational services is limited to a GED program.[69]

  At that time of his transfer from MYI, he was unsentenced and eligible for special education services under IDEA.[70] Approximately one month after his transfer from MYI, a PPT was held, and he was exited from special education services. There is nothing in the file to indicate that David's plenary guardian was notified of the PPT. David was not present at the PPT. The IEP states that David was not able to attend the PPT due to "custodial constraints and quarantine lockdowns" but was interviewed and answered questions for completion of the Summary of Performance.[71] The PPT recommended that David "Exit Special Education due to graduation from High School with a regular High School Diploma." The DOC educational record includes a diploma and a high school transcript from the public school in which he was enrolled prior to entering custody, dated the same date as the PPT, noting a graduation date prior to his re-entry into DOC. His DOC education enrollment record indicates he completed the GED/ABE3 program, but also indicates he does not have a GED.

  Based on educational record review, it appears that David did not graduate from high school prior to his re-entry. Rather, he completed academic requirements but continued to be entitled to receive special education transition services. Because he was pre-sentenced, and his needs had not changed, he was entitled to receive special education transition services at least until his sentencing date. After his sentencing, it appears he continued to be eligible for transition

[69] He was initially placed in general population until he was designated as Chronic.
[70] David was not sentenced for approximately one year from the date of re-entry (four months after his transfer from MYI).
[71] In response to a draft of this report, USD1 noted that the IEP also notes that "[David] was willing to give consent for the meeting to proceed as long as he could provide input and be interviewed." This is accurate. Given that the court had previously appointed a plenary guardian, though, any such consents would have been required to be provided by the plenary guardian.

services as his release date was expected to end prior to his twenty-second birthday. OCA advocated for a PPT and facilitated an interview with the district to support appropriate receipt of special education transition services upon release.

- Nathan entered DOC custody at the age of 18 years and was discharged 3.5 months later. DOC educational records do not include any information for this time period. Nathan returned to DOC one month after his release. There is no record of a PPT being held at this time and no SEDAC[72] form to indicate what educational service hours were provided. DOC's SEDAC record indicates that Nathan had a total of 30 hours of educational services (noted as 19 hours of special education and 10 hours of regular education, without information on the additional hour). This was consistent with Nathan's IEP from prior to his incarceration. There is no record of the PPT at that time. The IEP from prior to his incarceration indicates that Nathan's instructional level for reading was in the 1st to 3rd grade level and instructional level for math was at the 3rd grade level. There was no information regarding Nathan's level of intellectual functioning. His primary educational disability was listed as Emotional Disturbance. Nathan was discharged and again returned to DOC custody three months later. A PPT was held approximately one month after his re-entry, at which time his IEP hours were reduced to 11.25 regular educational hours with special education services consisting of one hour per week of transition service/academic support and .25 hours/week for counseling. Nathan remained unsentenced at that time. The IEP documents that Nathan was in the GED program and school hours were amended to meet SRG constraints. Consents for evaluation were signed, to include individual social emotional and academic testing. DOC records include results for Woodcock Johnson Tests of Achievement in the areas of reading and math. The IEP did not include present levels of academic achievement and functional performance, goals and objectives, or modifications and accommodations. A PPT meeting was held four months later. At that time, Nathan was exited from special education services. The IEP indicates that the student refused school since his placement and the psychologist and special education teacher reported that Nathan requested to be exited from special education. Nathan did not participate in the PPT meeting and the team documented that he refused. The next month Nathan signed a form to withdraw from all educational services. In the same month, Nathan signed a form requesting to participate in the GED program. The form notes that this option will officially withdraw the individual from high school. In response to draft of this Report, USD 1 reported that Nathan passed the GED and was awarded a diploma approximately three years after his withdrawal.

OCA is concerned that educational services for late adolescents in restrictive housing settings are not adequate and violate state and/or federal laws. Data provided to OCA was not adequate to determine whether service hours in IEPs were actually provided. OCA is concerned that USD 1 may be in violation of the IDEA, including making changes to the IEP that are not based on the individual needs of the student, not providing necessary related services, failing to provide adequate behavioral supports to children in school, and failing to provide adequate transition planning and transitional services.[73]

[72] Special Education Data Application and Collection (SEDAC) was the state's system for collecting data regarding the provision of special education and related services. This has since been replaced with CT-SEDS.
[73] Upon review of a draft of this Report, USD 1 challenged this conclusion.

Upon review of a draft of this Report, USD 1 stated that they provide extensive professional development regarding special education. In addition, USD 1 queried whether OCA had documentation of students "who requested school that did not receive programming… [noting that] Priority students are offered educational programming via the intake interview."[74] None of the individuals OCA met with pursuant to this review expressed that they did not want educational services. Rather, in addition to educational service barriers outlined above, certain students avoid or decline educational hours due to their fears of movement in the facility, restrictions on movement including strip searches of all individuals exiting/returning to restrictive housing, and other barriers to leaving and entering the restrictive housing unit.

V. CONCLUSION AND RECOMMENDATIONS

OCA's review raises serious concerns about the well-being and rehabilitation of those aged 18 to 21 in the custody of the DOC. The increase in disciplinary reports and the related increase in the use of chemical agent for late adolescent boys in 2024 raises serious concerns. Both speak to the need for meaningful engagement and therapeutic interventions. In addition, responses to misconduct are harsh and may exacerbate mental health needs and increase likelihood of future misconduct.

With regard to late adolescents in restrictive housing settings, OCA's review revealed serious concerns about treatment, including prolonged use of isolated confinement, lack of programming, inadequate mental health treatment, and inadequate educational services.[75]

OCA acknowledges that, during the PUR, DOC made efforts to identify ways to reduce the use of restrictive housing and improve conditions. OCA met with DOC officials in November 2022 to discuss OCA's concerns regarding transfers of late adolescents to facilities other than MYI, lack of adequate mental health treatment, and the isolation of late adolescents in restrictive housing settings without access to programming or education. In October 2023, the DOC issued a Request for Proposals for Restrictive Housing Study, which was subsequently awarded to Falcon Inc. Falcon issued a report, entitled *Comprehensive Study, Program Validation, and Best Practice Recommendations* in November 2024. Falcon identified similar concerns to those identified by OCA and provided detailed recommendations.

Since the time of our cohort review, DOC has added an area where late adolescents can receive educational instruction at Walker, where individuals on SRG I are housed. Depending on their status, they may receive education alone or in groups. They remain in mechanical restraints in the classroom.

[74] Email from USD 1 to OCA, dated September 5, 2024.

[75] OCA acknowledges that this review of individuals in restrictive housing involves a small cohort of 18– to 21-year-olds and we cannot conclude that all individuals placed in SRG remain for years based on this data alone. Nonetheless, the findings are instructive as the current system design in Phase I requires no disciplinary infractions for four months in order for an individual to progress to Phase II and includes no meaningful activity or rehabilitative programming, no social interaction, and extensive loss of basic privileges.

School in SRG Phase I

In addition, in order to comply with Public Act 22-18, DOC revised all facility schedules to provide out-of-cell time consistent with legal requirements (four hours per day of out-of-cell time). DOC provided revised administrative directives showing that out-of-cell time requirements for certain restrictive housing settings (Administrative Segregation and Chronic) were revised in August 2024 to reflect four hours of out-of-cell time.

With regard to Security Risk Group, DOC's policy continues to provide for only one hour of out-of-cell time.[76] DOC administration indicated that, while the policy has not been updated, schedules for all facilities have been revised to allow four hours of out-of-cell time. As of summer 2025, the schedule for restrictive housing at Corrigan (where SRG Phases 2 to 5 are housed) reflected four hours of out-of-cell time. During facility visits to Corrigan and Garner during 2025, incarcerated individuals and staff both indicated an increase in out-of-cell time, with a schedule that requires four hours of out-of-cell time. DOC provided schedules for the SRG I unit at Walker showing four hours of out-of-cell time. During a facility visit in 2025, staff and incarcerated individuals confirmed that this schedule is in place, though both also confirmed that other factors (such as staff shortages) determine whether such out-of-cell time is actually received. This is consistent with observations by OCA during earlier visits, at which time schedules allowed for 1 hour and 15 minutes to 1.5 hours of out-of-cell time on SRG units but scheduled out-of-cell time did not consistently occur for a variety of reasons. OCA intends to revisit this issue in future investigations.

For other restrictive housing settings, including punitive segregation, administrative detention, and transfer detention, the current policy requires two hours of out-of-cell time. In those settings, individuals are, by definition, in isolated confinement. DOC Administration indicated that it collects data from facilities including:

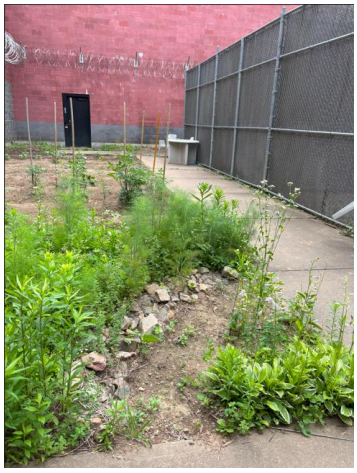
> 1) the number of persons in isolated confinement in this state's correctional facilities as recorded on the first day of each month for the twelve months preceding the report's submission; and
> 2) the total number of persons subjected to isolated confinement over that same twelve-month period.

[76] DOC Administrative Directive 9.4, Attachment F and Attachment G.

DOC Administration further indicated that the:

> Department's Data Unit has developed a dashboard that is tracking punitive segregation (PS) by measuring both consecutive days of PS time and the total days over any 60-day period. However, this dashboard currently accounts for punitive segregation time and excludes other statuses, such as administrative detention, transfer detention, and protective custody. The Department continues to look for better systems that more adequately collect such information.[77]

Lastly, OCA acknowledges that the DOC is in the process of making changes to the environment at Garner Correctional, where individuals with significant mental health needs are housed. These changes include physical plant changes, such as the creation of a vegetable/herb garden in the outdoor recreation area and a planned outdoor space for visitation. In addition, Garner has created a team of designated staff that respond to individuals who are having difficulty. The staff are not clinical staff. They are custody staff, designated to work in this position with the support of clinical staff, who can engage with individuals, identify positive supports that may be needed, and help individuals identify goals they wish to work toward. The goal of this effort is to provide individuals with a supportive relationship, give the individual an opportunity to talk, and prevent escalation into crisis. At the time of OCA's visit, this effort was in the early stages and there was not yet outcome data. Nonetheless, these changes are promising.



Garden in Recreation Area

OCA recognizes some areas of improvement since our cohort review. DOC's implementation of the requirements of Public Act 22-18 has resulted in more out-of-cell time. The addition of a classroom at Walker provides the potential for more continuity of education. Nonetheless, in the restrictive housing settings in which the individuals in our cohort were housed (PS, AS, Chronic, SRG I) many of the detrimental features of restrictive housing remain: lack of meaningful contact with others; lack of any meaningful programming; frequent strip searches; all movement requires mechanical restraints; phone calls and visits are curtailed; and disciplinary sanctions may include loss of visitation and/or

[77] Email from DOC, dated June 16, 2025. DOC also stated that their "review of the under-22 population revealed that no inmate was held for more than 15 consecutive days, nor did any exceed 30 days within a 60-day period."

phone calls. Mental health treatment is limited as described earlier in this report. Out-of-cell time means, except for showers, that the late adolescent is placed in mechanical restraints, often strip searched, and moved to an indoor cage or an outdoor cage where there are no seats and no activities in which to engage. In addition, 18–21-year-old late adolescents in these restrictive housing settings are housed with adults of all ages, many of whom have long histories of maladaptive behaviors.

Our cohort review revealed that some late adolescents remained in restrictive housing settings, SRG Phases 1 and 2 in particular, for years. When late adolescents remain in restrictive housing for years, they are experiencing significant deprivation during a critical period of development between childhood and adulthood. During adolescence, including late adolescence, the brain is malleable. This means that late adolescents are "not only adaptable to innovation and learning but also vulnerable to toxic experiences, such as resource deprivation, harsh, coercive or antisocial relationships, and exposure to drugs or violence."[78] Thus, we must recognize that prolonged restrictive housing for those aged 18 to 21 is particularly detrimental and contrary to what is developmentally appropriate.

Late adolescents are "more responsive to positive feedback (including both material rewards and social rewards such as praise and recognition) than to punishments."[79] The Center for Law, Brain & Behavior finds that "[f]or late adolescents who engage in criminal behavior, relying upon approaches that build on buttressing individual strengths and resiliencies, at a time when the brain's plasticity facilitates new learning from experience, can promote positive growth and prevent further penetration into the criminal justice system."[80] Policy makers should consider:

> evidence-based models . . . which improve recidivism outcomes by separating younger offenders from older adult offenders, placing them into their own units with developmentally aligned programming, and using developmentally-trained correctional, educational, pre-vocational, and behavioral health staff to utilize less punitive approaches and support positive community re-entry, thus increasing the likelihood of avoiding future criminal involvement.[81]

OCA recommends:

1. All individuals who are 18 to 21 should be housed in Manson Youth Institution. Programming should be developmentally appropriate and provide daily engagement. All staff should be trained in late adolescent development and de-escalation and intervention techniques. Evidence-based positive behavioral supports should be incorporated into the environment. One goal of improved programming should be the reduction in instances of interpersonal conflict and related use of chemical agent.

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[78] National Academies of Sciences, Engineering, and Medicine. (2019). The Promise of Adolescence: Realizing Opportunity for All Youth. Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/25388, at 58.
[79] Center for Law, Brain & Behavior at Massachusetts General Hospital (2022). White Paper on the Science of Late Adolescence: A Guide for Judges, Attorneys and Policy Makers (January 27th, 2022), 37. file:///C:/Users/ghioc/Downloads/CLBB-White-Paper-on-the-Science-of-Late-Adolescence-3.pdf,
[80] Id. at 41. (Citation omitted)(defining late adolescence as age 18-21).

[81] Id. at 24.

2. Transfer to other adult correctional facilities should be prohibited. Until such time as transfers to other adult facilities are prohibited, the following is recommended:
    a. The DOC should create a dashboard to identify any 18- to 21-year-old who is recommended for transfer for any reason and identify any individual aged 18 to 21 who has received two Class A Disciplinary Infractions within any 30-day period.
    b. The DOC should create a transfer review committee to review the circumstances of any recommended transfer and any individual with more than two Class A Disciplinary Infractions within any 30-day period. For each individual identified, the committee should review the reasons for the recommended transfer, disciplinary history, projected discharge date and the discharge transition plan, educational status, mental health needs, and visiting resources, and develop a positive behavioral support plan to maintain the individual at MYI. Transfer should occur only if necessary to ensure the safety of other late adolescents on the unit and should be in the least restrictive appropriate setting.
    c. If any transfer is recommended for the purpose of placement in Restrictive Housing, outside of short-term Punitive Segregation, additional review should be conducted by the Commissioner and three Administrators to ensure that less restrictive housing options have been exhausted, appropriate behavior intervention plans have been developed and properly implemented, and the proposed placement in restrictive housing has been reviewed by a qualified mental health professional. No individual who has intellectual disability or a serious mental health condition should be placed in restrictive housing.
    d. The DOC should create a mutli-disciplinary group, to include external experts in mental health and development of late adolescents, to review data and individualized information related to the circumstances of transfers to other adult facilities, including review of all information reviewed by the transfer committee in making the determination to transfer, review of the behavior leading to the transfer, review of the behavioral support plan and implementation of same prior to transfer. The multi-disciplinary group should make recommendations for improving developmentally appropriate programming and behavioral supports and reduce transfers to other adult facilities.

3. The information provided by DOC administration suggests that there are important gaps in counting days to ensure that incarcerated individuals are not subjected to isolated confinement for more than the maximum allowable time. In particular, time in administrative detention, transfer detention, and protective custody are not included. Currently, when an individual is going to be placed in punitive segregation, they may be placed in the restrictive housing unit while awaiting a decision regarding punitive segregation or while awaiting transfer back to their regular unit, called administrative detention or transfer detention. While the individual is housed on the restrictive housing unit, in administrative detention or transfer detention, out-of-cell time is limited to two hours per day, meaning they are in isolated confinement. Because they are not designated as being in punitive segregation, however, it appears that this time is not being counted toward the maximum length of 15 consecutive days or the maximum of 30 days within a 60-day time period. OCA found in its review of a small cohort several instances

of individuals who were held for several days longer than the documented time in punitive segregation. In addition, DOC indicated that current tracking "does not include the capacity to adequately track SRG program participants if in punitive segregation at this time."[82] This may be resulting in under-reporting of the use of isolated confinement. DOC policies should be revised, and statutory amendment may be required, to ensure that all time in settings with fewer than 4 hours of out-of-cell time is being counted toward the statutorily created maximum period for isolated confinement under Public Act 22-18.

4. The state should prohibit the use of restrictive housing for prolonged periods for individuals aged 18 to 21, except in rare circumstances, and the Department of Correction should develop alternatives to restrictive housing that ensure the safety of staff and incarcerated individuals while being developmentally appropriate. In keeping with the recommendations of the National Commission on Correctional Health Care, the use of restrictive housing should be used only as an exceptional measure when other, less restrictive options are not available and for the shortest duration. Where less restrictive means are not available, those in restrictive housing should have as much human contact as possible. This should include access to treatment and rehabilitative programming, visitation, phone calls, and education at the same level as those in general population as well as meaningful opportunities for exercise.

5. The legislature should create a working group that includes the Department of Correction, experts in mental health care, and experts in adolescent development to review methods for eliminating the use of long-term restrictive housing and make recommendations to the legislature. The working group may wish to consider as a model New York's Humane Alternatives to Long-Term Solitary Confinement Act, known as the HALT Act. The law, adopted in 2021, created limits the use of "segregated confinement" in important ways, including:
    a. limiting the use of restrictive housing to circumstances in which an individual has been found to have committed certain violent offenses;
    b. limiting the use of restrictive housing to no more than 60 days in a 12-month period;
    c. requiring discharge from restrictive housing if the person "has not engaged in behavior that presents a specific, significant, and imminent threat to the safety and security of themselves or other persons during the preceding 15 days;"
    d. requiring "access to congregate programming and amenities comparable to those housed outside of restrictive housing including access to at least seven hours per day of out-of-cell congregate programming or activities with groups of people in a group setting all in the same shared space without physical barriers separating such people that is conducive to meaningful and regular social interaction"; and
    e. evidence-based therapeutic interventions and restorative justice programs aimed at addressing the conduct resulting in their placement in restrictive housing.

[82] Email from DOC to OCA, dated June 18, 2025.

The working group may also find guidance for innovative practices to reduce the most harmful effects of restrictive housing in the Urban Institute's Justice Policy Center brief Solitary Confinement in US Prisons[83] including:

a. Prohibition on the use of solitary confinement for certain at-risk populations;
b. Conducting mental health assessments at the time of admission, prior to placement in solitary confinement, and throughout time in solitary confinement;
c. Requirement that those in restrictive housing be provided with group programming outside of their cells;
d. Creation of therapeutic communities that focus on rehabilitation and long-term behavioral change;
e. The use of "step down" units to support transition back to general population or the community; and
f. Training staff to identify signs that people are at risk of harming themselves or others and crisis intervention training.

6. Consistent with the recommendations of the National Commission on Correctional Health Care, the DOC should ensure that medical and mental health examinations are conducted without restraints and without the presence of custody staff, including for individuals in restrictive housing, unless there is an individualized high risk of violence. Even where custody staff must be present, such staff should be at sufficient distance to ensure auditory privacy.

7. The Department of Correction should develop a strategic plan to eliminate the use of in-cell restraints (including in-cell, therapeutic, and full-stationary restraints), consistent with the recommendations of the Falcon team in the Department of Correction Restrictive Housing System Study. The strategic plan should include methods for de-escalation, training on serious mental health needs, and transparent data sharing with stakeholders and the public.

8. The Department of Correction should obtain body scanners to be utilized as an alternative to strip searches. The Department's report to the legislature in response to Public Act 23-12 provides information on the capability of using body scanning machines to replace strip searches. While there is no data regarding strip searches, the Department estimated the number of strip searches in 2023 to be 235,050. The Department assessed that it would require 26 units to install body scanners in admitting and processing units, visiting rooms where contact visits take place, and restrictive housing units. The estimated cost for all 26 units is $4,001,400.

   The state recently approved funds for a pilot that promises to provide four body scanners in two facilities. Until such time as the Department can obtain body scanning machines in all facilities, it should re-assess policies and procedures to eliminate all unnecessary strip searches, collect data on all strip searches conducted, including those deemed to be routine (i.e. those conducted in

[83] https://www.urban.org/research/publication/solitary-confinement-us-prisons

restrictive housing settings), and prioritize placing scanners in York, MYI, and in the most restrictive settings where strip searches are routine.

9. Public Act 22-18 required DOC to report to the legislature, by January 1, 2024, regarding the measures taken by the Department to address, among other things, the presence of persons with serious mental illness or developmental and intellectual disabilities in isolated confinement or on restrictive housing status, efforts to increase out-of-cell time, the provision of therapeutic or other pro-social programming for persons on restrictive housing status, and the use of in-cell restraints.[84] This report was provided to the legislature and, upon request, to the OCA. While the report includes most of the data required under Connecticut General Statutes §18-96b(i), it did not include all of the data required under that section and does not include all of the information required under Connecticut General Statutes §18-96b(h). Specifically, it appears that DOC has not provided the following information:

> (1) The number of incarcerated persons who were in isolated confinement for more than fifteen cumulative days in the previous calendar year as categorized by the following periods of time:
>
> (A) Sixteen to thirty days;
>
> (B) Thirty-one to sixty days;
>
> (C) Sixty-one to ninety days; and
>
> (D) More than ninety days . . . .[85]
>
> (2) information on persons with developmental and intellectual disabilities in isolated confinement or on restrictive housing status;[86] or
>
> (3) the provision of therapeutic or other pro-social programming for persons on restrictive housing status.[87]

The legislature should require DOC to provide the remaining information as soon as possible.

[84] Public Act 22-18 was codified, in part, at Conn. Gen. Stat. § 18-96b(h).
[85] Conn. Gen. Stat. § 18-96b(i)(2).
[86] Conn. Gen. Stat. § 18-96b(h)(2).
[87] Conn. Gen. Stat. § 18-96b(h)(4).

VI. APPENDIX

The OCA includes below six individual case examples below to illustrate the concerns for 18- to 21-year-old late adolescent boys housed in facilities other than MYI, including prolonged isolation, inadequate mental health care, disability discrimination, inadequate special education services, and inadequate medical care. The information below is based on OCA's extensive review of DOC documentation including disciplinary reports, medical EHR, educational records, and policies. OCA met with each of the individuals discussed below. Some of these late adolescents were sentenced and some were unsentenced (awaiting trial) during our review. All experienced some form of restrictive housing. They are all Black or Hispanic. Five of the six had identified mental health diagnoses. Three of the six had a confirmed family history of child abuse and/or neglect. During various visits to the DOC facilities, OCA met with other incarcerated late adolescents who were similarly situated to these individuals highlighted below.

JEREMY

OCA Concerns: Prolonged Isolation; Inadequate Mental Health Treatment; Inadequate Special Education Services; Disability Discrimination

Jeremy was incarcerated at the age of 16 at MYI. Jeremy was identified as a student with special education needs based on a specific learning disability. Shortly after he turned 18, he was designated by the DOC for Security Risk Group (SRG) based on the belief that he was gang affiliated. He was transferred from MYI to another DOC facility shortly thereafter.

SRG I is purportedly the first phase of a structured five-phase program. Phase I is a minimum of four months, and the remaining phases are two months each, for a minimum total of 12 months. While Jeremy progressed as far as Phase IV of the program, he never completed all five phases. At the time of our review, Jeremy had been on SRG status for 1355 days (3.5 years).

Individuals in SRG I receive little to no programming. For the entire one-year period reviewed during our PUR, Jeremy spent 214 days in SRG I. During periods in Phase I, Jeremy, like all individuals in Phase I, was confined to his cell except for "recreation" and showers; received all meals in his cell; did not have access to television; did not have a pillow; and was routinely strip searched every time he left his cell. Per policy, he was placed in restraints for all out-of-cell movements. Any time he was transported to school, which was provided on a different unit from his cell, he would be required to undergo a strip search and was shackled for transport. "Recreation" was limited to transfer, in restraints, from his cell to the outdoor cage, where restraints were removed and he was left to stand on pavement in the outside cage. The actual amount of "recreation" time provided to any individual was not tracked. OCA reviewed records provided by the DOC for one-year period during our PUR to determine what, if any, programming Jeremy received. OCA could find no record related to participation in any programming related to gang affiliation (the purpose of SRG status). According to DOC records, for the entire one-year period reviewed, he participated in two sessions of a coping skills group and one session of a mental health group. He had no visits. We include the details of his

story because they are demonstrative of the deterioration that can occur following SRG designation, extended isolation, and a punitive response to mental health crises.

OCA reviewed three years of disciplinary incidents following Jeremy's transfer out of MYI. During the first year, Jeremy had one disciplinary incident. For the second year, Jeremy had 2 disciplinary incidents. During the first half of the third year, Jeremy had 2 disciplinary incidents. After that, Jeremy's mental health declined and, as a result, his discipline tickets increased significantly. The deterioration in Jeremy's mental status is evidenced by repeated engagement in self-injurious behaviors and suicidal ideation. Jeremy would frequently place something over the small window on the door to his cell, which triggered punitive responses from DOC staff, including deploying chemical agent, four-point restraints, full custody restraints, and in-cell restraints. During the third year, there were 12 documented instances of in-cell restraint, two documented incidents of placement on BOS, and four documented incidents of use of a chemical agent.

After three years in SRG, Jeremy reported to a medical provider: "I need something to calm me down. I feel like nothing is helping me. I tried to talk, I tried to listen to music, I tried to reset. My thoughts just keep spinning and I feel like I don't know what to do anymore." He was noted to have tangential thought processes and depression. The medical provider encouraged Jeremy to continue to comply with the medication regimen. His mental health score at that time was a 3. He reported to mental health staff that he was struggling, that he was having issues with sleep and ruminating thoughts. He was encouraged to speak to his primary mental health worker about medication. A treatment plan included one objective: "Engage with [Mental Health Unit] as scheduled and PRN: MH3 follow up sessions; comply with MH med regimen; participate in psych med review(s)."

Later that month, mental health staff met with Jeremy for monthly psychotherapy. He reported that he was continuing to experience difficulties with emotion regulation. He reported pacing his cell, punching the wall, and staying awake for hours in the night. He reported racing thoughts, mood swings, and irritability. He reported concern about a loved one who was ill. He reported previous traumatic experiences. The clinician documented that he agreed to meet on weekly basis to work on grief and loss. His mental health score continued to be a 3.

Several days later, he was seen by an APRN and again reported excessive thinking, anger, and inability to calm himself. He reported his thoughts spinning out of control and inability to sleep. He was noted to recently need PRN medication to calm his anxiety. The clinician referred him for medication review. Nine days later, he again reported difficulty sleeping and pacing in his cell.

Incident 1: The records are unclear, but it appears that six days after that, he had a disagreement with his cell mate and there was an altercation. He was assessed and cleared for use of chemical agent and placement in RHU/PS for 5 days. He was placed on BOS [Behavior Observation Status]. His clothing was removed and replaced with a heavy gown where arms and legs are exposed.

Incident 2: About one week later, Jeremy reported that he took pills that were not prescribed to him. He flooded his cell, covered the window, and reported that he was suicidal. He reported being upset about loss of phone calls, stating he had been patient all week and wants phone calls back (though records do not show a disciplinary action resulting in loss of tablet for this time period). Records show that a planned use of force was approved in relation to use of chemical agents. Records for the same date, seven minutes later, state that Jeremy was unresponsive for approximately 10 minutes. He was straightening out his legs and his eyes were rolling. He was transported to the hospital. It was

documented in the EHR that it was determined that he engaged in intentional self-harm and that suicidality was present. When he returned to DOC, he was returned to his unit and was placed on BOS by custody staff. Mental health providers were not notified that he returned, and he was not seen by medical or mental health staff before returning to the unit. Medical records note that two days later, his hands, wrists, and ankles were checked as he was in in-cell restraints. For this incident (covering his window, flooding his cell, and taking pills while feeling suicidal), he was given four tickets and received a total of 8 consecutive days in RHU/PS, 45 days of loss of recreation, 30 days of loss of visits, 30 days of loss of social correspondence. For offenses dated the next date, Jeremy received an additional three tickets and lost recreation for an additional 45 days, loss of visits for an additional 30 days, and loss of social correspondence for an additional 30 days.

Following the incident described above, a mental health disciplinary review form was completed. The reviewer documented the following:

> 1. Does a mental disorder appear to have contributed to the inmate's behavior(s) resulting in the disciplinary violation? No
> 2. Does it appear participation in the disciplinary process will exacerbate any symptoms of an identified mental illness (including all steps of the process i.e. RHU placement, participating in the hearing, etc.)? No

He was placed in RHU/PS. A BOS assessment was completed and he was noted to report negative thoughts and inability to sleep. He reported sleeping less than 1 hour per day and then crashing physically and emotionally for a day. He was cleared of BOS to return to housing unit. His mental health score remained a 3.

Approximately two weeks later, his diagnoses were modified to include Mood Disorder of Depressed Type and a rule out for Borderline Personality Disorder.[88]

Incident 3: Approximately one month after incident 1, mental health staff were called to the unit to provide verbal intervention after Jeremy flooded his cell and covered his window. He reported to mental health that he had been asking for mental health all day. His voice was muffled but rapid. He was sprayed with chemical agent and then began head banging and reporting plans of self-harm. He was noted to be laughing and smiling while reporting plans of self-harm. He was placed on BOS. He remained a mental health 3. The next day, he remained on BOS and in-cell restraints were downgraded (removed). For these offenses (flooding cell; covering window), he was placed in RHU/PS for 5 days, lost recreation for 30 days, lost visits for 45 days, lost social correspondence for 30 days, and lost his tablet (phone calls) for 19 days.

Two days later, he was escorted to punitive segregation. He stated that he would bang his head and was placed on four-point restraints. On that date, he was reported to have "expressed statements around self-harm." He reported that he was experiencing recurring nightmares that interfered with sleep. He said "I want help, and I am willing to do the work." He remained a mental health 3. He was downgraded the same day from four-point restraints to in-cell restraints. On the same date, he received four days of RHU/PS, he lost recreation for 40 additional days, lost visits for an additional 30 days,

[88] DOC's EHR early after entry into DOC custody indicated that Jeremy was previously diagnosed only with Conduct Disorder.

and lost commissary for an additional 40 days. Records do not indicate when he was removed from BOS, though a post-BOS follow up is documented three days after the escort to RHU/PS.

Incident 4: About two weeks later, Jeremy was seen for mental health 3 follow up. He reported feeling angry, stating "I'm trying to figure out why and I don't know what to do." He was noted to report that meditation was helpful and he was listening to a meditation podcast. On the same date, he received a disciplinary ticket for fighting and was placed in RHU/PS for five days, lost an additional 15 days of recreation, lost an additional 30 days of social correspondence, and lost an additional 15 days of commissary. The EHR documents a review by an LPN, who indicated no known contraindications to the use of force and cleared Jeremy for placement in RHU/PS.

Two days later, Jeremy engaged in self-injurious behavior and was transported to the emergency room. He required surgery. He was returned to the DOC. There is no indication in the record that he was seen by a mental health clinician upon return.

Two days after that, the last documented day of his 5 days in RHU/PS for Incident 4, a medical incident report notes that a belly chain was added to his in-cell restraints. On the same day, medical records indicate Jeremy was seen in RHU/PS by mental health and complained that he had been informed that he would be housed in punitive segregation until further notice. While there are disciplinary tickets dated on the fifth day of RHU/PS, none resulted in placement in punitive segregation.

Incident 5: The next day, Jeremy covered the cell window, was sprayed with a chemical agent, and was placed in four-point restraints. Records noted that Jeremy was in RHU/PS. For this incident (covering the window), Jeremy received an additional 30 days of lost recreation, 30 days of visits, and 30 days of loss of commissary. On the same date, he requested a behavior plan, reported that his medication was not effective, and he needed medication to help him with impulses and anger. Although he remained in RHU/PS, no days of punitive segregation are recorded as part of the discipline for the incident. Two days later, mental health staff were called down to RHU/PS to see Jeremy. When mental health arrived, Jeremy was reported to solely request a notebook as he had not received his property back. A notebook was provided to him.

Incident 6: Four days after Incident 5, Jeremy was seen by mental health, again in RHU/PS. He again asked for a behavior plan and more consistency seeing mental health. Two days later, mental health was again called to RHU/PS due to Jeremy covering his window. He was again sprayed with a chemical agent and placed in four-point restraints. For this incident, he lost an additional 30 days of recreation, 30 days loss of social correspondence, and 30 days loss of commissary. Although he was in RHU/PS, no days of punitive segregation are reported as part of the discipline for the incident. The EHR record indicates that Jeremy is "currently housed in RHU/PS bc of lack of control of behavior and impulses and operations is testing whether he can have been [sic] control in a smaller and contained environment." Jeremy again asked for a behavior plan. The record notes that he has been observed laughing inappropriately during security and safety interventions such as four-point restraints. He remained a mental health 3. Nine days later, Jeremy was seen in RHU/PS and reported that he was told he needed to stay in RHU/PS for another week. Jeremy was noted to still be in RHU/PS ten days after the incident. He again asked for a behavior plan. He was informed that a behavioral health plan could not be created as that is done by the mental health unit.

The record does not indicate when Jeremy left RHU/PS but what is documented makes clear that Jeremy was placed in RHU/PS for 5 days and remained there for at least 21 consecutive days without documentation of the additional days. Isolation for more than 15 consecutive days, and more than 30 days in a sixty-day period, is expressly prohibited under Connecticut law.[89]

Five days after release from RHU, Jeremy was seen by mental health and reported being very upset because a loved one was ill. He expressed feeling angry and wanting to fight. A decision was made to send Jeremy to RHU/PS "for a couple of hours to get off the unit." The record indicates that Jeremy agreed to this. Jeremy was later seen in the RHU/PS and was asking when he was going back to his cell. He reported that he was going through a crisis earlier in the day and was placed in RHU/PS for some time away and to decompress. When mental health contacted the unit, they indicated that he would go back the next day. This time was not documented as time in RHU/PS.

The next day, mental health was again called to the unit because Jeremy covered his window. When mental health arrived, he removed the window covering and asked for a behavior management plan. When asked what such a plan might look like, Jeremy described having options help him regain a state of calm. He asked for items to be able to draw and write to family.

Five days later, Jeremy was assessed in RHU/PS due to threatening to cut himself. He began "threatening to hit his head against [sic] if placed on BOS and was placed on stationary full custody restraints in the infirmary." BOS placement was approved. While on BOS, he was seen by mental health and described loss of phone calls as a precipitating factor. He stated his medication was not working, noting that he went three or four days without sleeping. He showed the psychologist marks on his wrist, which were documented as superficial. His general appearance was noted as "disheveled." He remained a mental health 3. Records do not make clear how long he was on BOS status.

Incident 7: The next day, records document approval of the use of chemical agent in relation to an incident in which Jeremy covered his window and did not remove the covering in response to a request by supervisors and medical staff. In relation to this incident, he was placed in RHU/PS for three days, lost an additional 15 days of recreation, 15 days of visits, and 30 days of social correspondence. Records again indicate he was on BOS status, and it appears he remained so for four days.

During this time, Jeremy was seen by mental health staff in response to a crisis request because he covered his cell window. When reviewed for BOS, he was observed to be "quite withdrawn and subdued, not his usual presentation." He described feeling scared and said that he was upset about being placed in RHU/PS and began to feel depressed and ruminate. He reported thoughts of suicide and fashioning a noose out of a sheet, braiding the sheet and tying it to the top bunk. He was assessed as being depressed and withdrawn and noted to be having passing thoughts of self-harm and reporting that he does not feel in control of his impulses. It was recommended that his mental health classification remain a 3. He was to remain on BOS in the infirmary, in Ferguson gown and Ferguson

[89] Connecticut General Statutes §18-96b(a)(7) defines isolated confinement as "any form of confinement of an incarcerated person within a cell, except during facility-wide emergency, lockdown or for the purpose of providing medical or mental health treatment, with less than . . . four hours per day" of out of cell time on or after July 1, 2022, and less than five hours per day, on or after April 1, 2023. Individuals in isolated confinement must receive at least two-hours out of cell, including at least one hour for recreational purposes. Further, section 18-96b(e)(2) states that "[n]o person may be placed in isolated confinement for longer than necessary and no more than fifteen consecutive days or thirty days total within any sixty-day period, after which period, such person shall be released from isolated confinement."

blanket[90] for his own safety, to be reviewed the next day. For this incident, he lost an additional 15 days of recreation, 15 days loss of social correspondence, and 15 days of commissary. When he was seen the next day, he reported he was doing "great" and ready to come off BOS. He was assessed to present with "a semi inappropriate [sic] amount of happiness and an inappropriate affect." A decision was made to keep him on BOS. When assessed again on the next day, he was noted to be almost hypomanic but able to focus. He was described as joking and using appropriate humor. The plan was to discharge him from BOS. His mental health score remained a three.

Three days later, his mental health score was changed to five after he was seen in response to a custody request. He reported having thoughts of suicide, thinking about death, and thinking about "darkness, blackness, and no longer feeling pain." When asked about his family, which usually evoked a response related to wanting to stay alive and do well for his family, he responded that he was "a burden to his family." He expressed how difficult his incarceration had been and that "he didn't care anymore." When told he would be placed on BOS, he became angry. He was restrained and unable to de-escalate. He was "inconsolable." He presented as "hopeless, exhausted, and having a tangential thought process." He was placed in the infirmary on BOS.

Two days later, he was transferred to the mental health unit and diagnosed with Bi-Polar Disorder, manic. He remained on BOS status for at least two days. When seen by mental health, he expressed feeling like he was being punished being on mental health five status. He complained about being cold and wanting clothes and his tablet so he could call his family. Several days later, he reported that a new medication was helping him sleep and expressed surprise that he was able to sleep at night. His mental health status was returned to a three.

For an entire one-year period during our PUR, while in SRG I, Jeremy was placed in Punitive Segregation for a total of 38 days. In addition, OCA's review of the records includes an additional 16 days in RHU/PS that were not documented as such. At the time of our review, Jeremy had lost recreation for 430 consecutive days. Jeremy lost visits for 270 consecutive days, social correspondence for 234 consecutive days, and commissary for 130 consecutive days. These losses, combined with the restrictions of Phase I SRG, where all meals are delivered in cell and no meaningful programming is provided, have in extended periods of isolated confinement.

Jeremy was a special education student, classified as a student with a specific learning disability. His IEP provided for only 0.5 hours per week of academic support, 0.5 hours per week of counseling, and .5 hours per week of transition services. At a PPT, it was noted that he was working toward his GED. An educational advocate wrote to the Warden seeking assistance with ensuring that Jeremy could take the remaining GED tests. At that time, the building in which he was housed did not include a school. To attend school, Jeremy would have had to be strip searched before leaving his cell, shackled, and transported to another building. While this appears to have occurred on some occasions, the frequency and duration of any educational services is unknown, as attendance records are not reliable. Jeremy is marked present on days when other records make clear that he was not in school.

OCA's review raised concerns that Jeremy's behaviors were related to his mental health but were consistently viewed as maladaptive. After meetings with Jeremy and reviewing his records, OCA advocated with DOC administrators for mental health intervention and support. Jeremy was

[90] A Ferguson gown is an anti-suicide smock, sometimes referred to as a turtle suit, made of a single piece of tear-resistant material. A Ferguson blanket is similarly a tear-resistant blanket.

transferred to a mental health unit. He met with OCA representatives and reported improved conditions. In response to a draft of this report, USD 1 reported that Jeremy received his diploma several months after his transfer to the mental health unit.

DANTE

OCA Concern: Inadequate Mental Health Treatment; Disability Discrimination; Inadequate Special Education Services

Dante re-entered the correctional system at age 20. At that time, DOC records documented that he was "void of any major Depressive, Manic, or Hypomanic signs or symptoms" with "no signs, nor reports any symptoms consistent with emotional distress." Nonetheless, "due to his prior levels of care in CT DOC and his admission that he requires medication," he was placed in IPMU [In-Patient Mental Health Unit] MH 5 with privileges." His mental health level was reduced to MH4 one day after his admission.

Two weeks later, Dante was observed to be adjusting well, using coping skills and alert and oriented to time, place, and person. The next month, he was evaluated related to a planned use of force and transfer to the RHU/PS. DOC documented that there were no contraindications to RHU and Dante was approved for transfer to RHU/PS. At the end the month, Dante was transferred to MYI, still in RHU/PS. One day later, he was observed to be decompensated (mood labile, physically tense and agitated mood, making nonsensical persecutory statements). For the next several days, Dante was observed to be decompensated (naked, smearing feces, responding to internal stimuli, paranoid). He was then transferred to the infirmary. During this period in the infirmary, Dante's mental health presentation stabilized, and he was observed to be calm and compliant with medication. A mental health treatment plan was not created until twenty days after his transfer to the infirmary. The objective of the plan was that Dante would "take medication as prescribed and participate in individual mental health sessions while in IPM." Shortly thereafter, Dante was transferred to RHU/PS, following a refusal of housing. Despite prior decompensation and clearly identified mental health needs, the LCSW who cleared Dante for RHU documented that "[t]here does not appear to be a mental disorder that contributed to the inmate's behavior resulting in the disciplinary violation. It does not appear that participating in the disciplinary process or residing in RHU will exacerbate any symptoms of an identified mental illness. There are no mental health factors prohibiting participation in the disciplinary process."

Just days after being placed in the RHU/PS, Dante was admitted to the infirmary due to psychotic decompensation. Dante reportedly was unable to follow simple directions such as taking his meal trays and was refusing prescribed medication. He was described as follows: "naked in his cell, food, liquid smeared all over in his cell, moved to different cell for cleaning his cell multiple times and remains unchanged in his behaviors and functioning. He is highly unpredictable, impulsive, paranoid, disorganized, banging, mumbling to self, singing, would not engage in conversation."

Dante remained in the infirmary for the next three months and was then discharged to a mental health unit. OCA's review of records during the three months that Dante spent in the infirmary raised significant concerns about the lack of active mental health treatment, lack of educational supports, and lack of meaningful engagement. Dante was approved for involuntary medication approximately 6 weeks after placement in the infirmary. Within two weeks, he was observed to be compliant with

medication and taking medications "without issue." Throughout his time in the infirmary, Dante's mental health treatment consisted of three SOAP reviews for assessment and medication review, involuntary medication, and brief cell-side encounters. He received no scheduled individual psychotherapy and no group psychotherapy. He ate alone in his cell. Although he had an IEP, he did not go to school and was not provided with educational programming in cell. He received no programming of any kind and was not engaged in any meaningful recreation time. Out-of-cell time was limited to time in an outdoor cage.

Despite his history of decompensation when in RHU/PS, Dante was again placed in RHU/PS three times over the course of the next six weeks. For the third incident, after 5 days in RHU/PS, Dante was placed on BOS status. He was again assessed for placement in the RHU/PS, and it was determined that he would remain in RHU/PS on BOS status. DOC initially documented that "RHU will not exacerbate any symptoms" and "this offender is at significant risk for maladaptive behaviors." DOC records indicate a second review took place and determined that RHU/PS would exacerbate symptoms and he was instead transferred to the infirmary. The next day, following a brief cell side encounter to review BOS status, the clinician documented signs of psychiatric decompensation. The clinician recommended Dante return to the infirmary and a referral for involuntary medication was made. Two days later, he was evaluated for placement in restrictive housing. DOC documented Dante's diagnosis with a serious psychiatric disorder, a history of decompensation and:

> The record indicates that RHU in particular seems to be a trigger for him and that being there has led to decompensations on several occasions. Writer is concerned that if IM participates in the AS program, that he may decompensate while in RHU and it will be very difficult to stabilize him again.

Twelve days later, an involuntary medication hearing was held and involuntary medication was approved. He remained in the infirmary for two weeks and was then transferred to a mental health unit with a designation as a mental health 4.

Within weeks, despite the well-documented decompensation when placed in RHU/PS, Dante was again transferred to RHU/PS. Records indicate he was placed in RHU/PS for 5 days. OCA's review of records, however, indicates that he remained in RHU/PS until transfer to another restrictive housing setting, a total of 16 days.[91] He was again placed in RHU/PS one month later, then returned to another restrictive housing setting. Three months later, he was again placed in RHU/PS on BOS status. Records do not indicate when BOS status ended.

Shortly thereafter, Dante was released to the community. Despite Dante's very serious mental health needs, there is no documentation in the EHR that any discharge planning was completed to connect Dante to mental health services. While policy states that "[i]nmates with a mental health score of 3 or greater shall be provided with a copy of Attachment A, Inter-Agency Patient Referral Report (W-10) upon discharge," there is no W-10 in the EHR. OCA confirmed with DOC that we received the entire EHR and confirmed that Court Support Services Division (CSSD) did not receive such documentation from DOC.

OCA is concerned about the lack of meaningful mental health treatment during incarceration. A treatment plan was created shortly after his re-entry into DOC custody and again approximately seven

[91] Records indicate one cell movement for less than 24 hours during this time period.

months later. The treatment plan included 1:1 therapy and the second also included group therapy at least twice per week. For the one-year period during our PUR, until his discharge at the end of the year, he received the expected number of scheduled mental health appointments in only 4 of the 12 months. While he did have contacts identified as "brief encounters" and "cell side," these are short encounters with most of these contacts occurring at the cell (the clinician standing outside of the cell communicating through the crack between the door and the cell). DOC policy requires group therapy for those identified with a mental health score of 4 and two treatment plans included group therapy at least two times per week. Records do not indicate that he received group therapy. One entry, indicates that Dante participated in group therapy on one date. There is another entry the next day that states that records were reviewed and Dante attended group therapy. There are no other entries for participation in group therapy.

OCA is concerned about the significant extent of isolation for this individual. For the one-year period during our PUR, Dante spent 165 days in restrictive housing and 32 days in punitive segregation. In addition, he spent six consecutive months in the infirmary (with the exception of 16 days in punitive segregation during that time period). Thus, for the entire one-year period, Dante was in some type of restrictive setting, with little appreciable difference between punitive segregation, the infirmary, or other restrictive settings. To participate in "recreation," Dante would be moved, fully shackled, from his cell to a cage outside, in which he would stand. No recreational programming was provided, and he would not have had access to recreational objects, like playing cards or a ball. For an entire one-year period during our PUR, Dante received no visits and participated in no groups or programs.

Dante was identified as special education student and was pretrial for the entire time of his incarceration. Despite his diagnosis with a serious psychiatric condition, his primary educational disability is identified as Other Health Impairment-ADD/ADHD. Despite his well-documented significant mental health needs, the PPT determined that no evaluations were needed for re-evaluation to determine ongoing eligibility and continued eligibility under the classification of Other Health Impairment-ADD/ADHD. The team did not propose evaluations or consider any other eligibility categories (such as Emotional Disturbance). Program enrollment information indicates he was enrolled in academic program at the 5th to 8th grade level. Dante's IEP from required 10 total hours of school per week, including 0.50 hour per week for academic/social behavioral support, .5 hours per month counseling and 1.0 hour per month for transition services. During his time in the infirmary, Dante did not receive any educational services. When he was in restrictive housing, reports indicate that a special education teacher did see him, but the actual frequency and duration of any educational services is unknown as attendance data is unreliable. There are times when Dante is reported as present or participating remotely on days when other records suggest that he did not attend school.

ANDRE

OCA Concern: Inadequate Medical Care

Andre was admitted to a DOC facility at age 19. Andre was diagnosed with a medical condition for which he was receiving treatment prior to his incarceration. From the time of his admission, despite information from community providers, Andre's attorney, and Andre's own request to continue treatment, he did not receive this treatment until ten months after admission, shortly after the OCA conducted a site visit and learned of the delay in care. Below is information from Andre's record regarding his medical treatment needs.

Day 1	Andre entered DOC
Day 13	Andre wrote a medical request inquiring as to when he will receive treatment, as he was in pain
Day 19	Andre signed a release of information for his community treatment provider, for current treatment and continuity of care.
Day 22	DOC faxed request for records to the community treatment provider.
Day 25	The community treatment provider faxed back records to DOC.
Day 29	Nurse Patient Encounter and call from Outside Attorney inquiring about medical treatment. Andre seen for "sick call," requesting treatment. Asked to sign another ROI for community provider.
Day 29	Return call to Attorney needing a ROI.
Day 29	ROI signed for community provider,
Day 31	ROI sent to community provider.
Day 38	Andre seen cell-side, experiencing symptoms. Medical prescriber said waiting for community provider to fax chart/meds/plan.
Day 44	Andre seen cell-side signed ROI for Attorney and mother to discuss medical concerns. Advised still waiting chart from treating providers.
Day 45	Andre seen by medical; minimally symptomatic at this time, experiencing pain at certain times. Records indicate he would be given a medication to treat symptoms, with a plan to see a specialist and provide treatment per their recommendations.
Day 56	Blood Tests Obtained
Day 58	Tele-visit with specialist.
Day 147	Order entered for treatment.
Day 249	Community Provider test results sent to DOC as previously requested.
Day 267	Clinic Visit – Experiencing pain due to medical condition. Symptoms getting worse.
Day 296	OCA staff met with youth and he reported he had not received treatment for his medical condition since his incarceration.
Day 297	Doctor reported that Andre received his first treatment.
Day 308	Discharged from DOC Custody.

Despite signing an authorization for the release of information within days of admission to DOC, Andre was denied a medically necessary intervention to treat his medical condition for nine months.

DAVID

OCA Concern: Prolonged Isolation; Inadequate Special Education Services

David originally re-entered DOC custody over the age of 18 and was transferred to MYI. Prior to his incarceration, the Probate Court appointed a plenary guardian based on a determination that David is a person with intellectual disability who is "unable to meet essential requirements for his physical health or safety" and unable to meet his own needs for medical care, nutrition, clothing, shelter, hygiene, and safety. The guardianship is documented in his educational file and referenced in the EHR.

David received special education services for most of his life prior to his incarceration. According to David's IEP, he has a full-scale IQ in the extremely low range, meaning that he has intellectual disability. When he was in the community, he was placed in an out-of-district private approved

therapeutic special education program. His IEP required a 30 hours per week transitional program, including 1 hour/week of academic support, 30 minutes per week of group therapy, and 30 minutes per week of individual counseling. His IEP from his public school in the community, noted that he continued to have some struggles with emotional regulation but did "amazing" during 1:1 time. His IEP included goals/objectives related to identifying feelings and responding appropriately to social situations.

While at MYI, his IEP included 15 and one-half (15.5) total school hours, with two (2) hours per month of transition services and one (1) hour per month social work support. The exit criteria was listed as age twenty-two (22). Despite his documented intellectual disability, the need for significant educational services, and a well-established educational history of emotional/behavioral dysregulation, David was transferred from MYI to another DOC facility.[92]

At that time of his transfer from MYI, he was unsentenced and eligible for special education services under IDEA. Shortly after this transfer, a PPT was held and he was exited from special education services based on alleged receipt of a diploma prior to entering DOC custody. DOC education staff were aware of the guardianship as David's guardian attended PPTs held while he was incarcerated within DOC. Nonetheless, there is no documentation to indicate that David's guardian was notified of this meeting and the guardian was not present. His education enrollment record indicates he completed the GED/ABE3 program, but also indicates he does not have a GED.

Based on educational record review, it appears that David did not graduate while in the community. Rather, he completed academic requirements but continued to be entitled to receive, and did receive from his local education agency, transition only services. Because he was pre-sentence, and his needs had not changed, he was entitled to receive transition services at least until his sentencing date. After sentencing, it appears he continued to be eligible for transition services as his release date was expected to end prior to his twenty-second birthday.

David's program activity log at the DOC shows that he participated in no programs, other than "orientation." Review of records for a one-year period during our PUR indicated that David participated in one group activity, and no other groups, programs, or activities. Review of records for the period of 466 days, David spent 106 days in punitive segregation. In addition, he lost the following "privileges": 248 days of recreation, 373 days of commissary, 300 days of social contact (visits, mail, phone). While recreation, commissary, visits, mail, and phone calls are not permitted during time in punitive segregation, the counting of days for loss of such privileges does not begin until after release from time in punitive segregation, thus extending the amount of time those "privileges" were lost. There are times when David reported that he was hungry and, with loss of commissary for nearly the full year, he had no opportunity to purchase his own snacks and food. It should be noted that David was placed in RHU/Chronic 14 months after his entry into DOC.

After meeting with David and reviewing his circumstances, OCA met with administration at the facility advocating for David to receive a behavior plan that would assist him with engagement and treatment. The facility created a plan and began having a psychologist and a counselor on the unit work more closely with David. OCA helped coordinate an educational planning meeting for David, and engaged with DOC and Judicial Branch Court Support Services Division to address discharge planning.

[92] He was initially placed in general population until he was designated as chronic.

CHARLES

OCA Concerns: Prolonged Isolation; Inadequate Mental Health Treatment

Charles was identified as SRG when he was 16 years old. Over the years, he progressed as high as Phase III but never completed the five phases of SRG. At the time of our review, he had been on SRG status for 1654 days (4.5 years). For the one-year period during our PUR, he was in SRG II for the first six months of the year and then regressed to SRG I and remained in SRG I for the remainder of the year. His program activity log shows an SRG "orientation" approximately 2.5 years after entering SRG and an entry indicating that a domestic violence program and "5/7-day job were added to his OAP [Offender Accountability Program]." The program activity log also notes one progression from SRG I to SRG II. OCA's review of records revealed no documentation of any programming being provided, and no evidence of participation in any groups. OCA attempted to determine what programming was provided in relation to gang disaffiliation, the purported purpose of SRG. OCA could find no evidence that Charles received any kind of programming related to gang disaffiliation. Rather, the SRG "program" appears to consist of isolation combined with a requirement that the individual not receive disciplinary infractions. As stated above, Charles, like everyone in SRG I experienced prolonged periods in his cell, with very limited access to out-of-cell time, eating meals in his cell, receiving no programming, participating in no groups, and with limited access to visits, phone calls, mail and commissary.

Charles reported to DOC a prior serious mental health diagnosis. Charles expressed frequent medical symptoms (poor sleeping, difficulty breathing, chest pain). These symptoms were repeatedly deemed to be related to anxiety and panic attacks. During our PUR, he repeatedly reported difficulty sleeping and ongoing intrusive nightmares about death and loved ones being hurt. On one occasion, he reported auditory hallucinations and on another occasion, he reported seeing violent things that weren't actually there. Providers determined that these complaints were feigned. On one occasion, he ingested an excessive amount of over-the-counter medication, which he reported was an effort to treat his chest pain. On another occasion, he was transported to the Emergency Room due to chest pain. Providers repeatedly determined that he did not have a physical health problem resulting in chest pain, and that the complaints were related to anxiety. Throughout, he was identified with a mental health score of 3 and generally seen one time per month for scheduled mental health visits.

KEVIN

OCA Concerns: Inadequate Mental Health Treatment; Special Education

Kevin most recently entered DOC custody at the age of 19. Kevin has a history of exposure to trauma and is diagnosed with PTSD. For more than one year, Kevin was housed at MYI. He received several disciplinary reports, many resulting in punitive segregation. Over the course of one year, Kevin was placed in punitive segregation for 53 days, lost 110 days of recreation, lost commissary for 285 days and lost his tablet (phone calls) for 60 days.

At one point, Kevin was removed from class at MYI due to disruptive behavior. He was cuffed and escorted to RHU/PS. His transfer was recorded on video. Review of the video showed the following:

> A correctional officer can be heard commenting that Kevin has been not feeling well, that is why this happened, and that is how the whole thing started. Kevin is silent, calm and cooperative. He is transferred to the RHU cell and informed that he will be strip searched. A correctional officer asks Kevin if he will comply and he does not respond. He is asked again and told it would happen either way. He remained calm, looked at the ceiling, but again did not respond. He is then taken down to the bed by several correctional officers. Kevin then says "take the cuffs off and see what happens." Kevin is held down (though he does not appear to be actively physically resisting), and a mesh bag is placed over his head while he is strip searched by the correctional officers. Kevin then remained in RHU at MYI.

Two weeks later, Kevin spat at a correctional officer. As a result, he was identified for designation for Chronic Discipline and transferred out of MYI. Pending his hearing, he was placed in restrictive housing and had no contact with other inmates. He was later transferred from MYI to another DOC facility, where he was placed in the RHU/PS, in a cell alone and with no access to other inmates. His medical records documented a history of asthma. The next day, Kevin was found unresponsive in the outdoor "recreation" cage in the RHU/PS, into which he had been placed alone. Naloxone was administered. Kevin was transferred to medical, where he remained unresponsive, despite efforts of medical personnel to elicit a response. A second dose of Naloxone was administered, and he was transferred to the hospital. The hospital determined that he had ingested Fentanyl, and this information was communicated to DOC. The next day, he returned to the facility. Upon return, he was seen by medical staff, given a nebulizer treatment for wheezing, and cleared for return to RHU/PS. According to the health record, Kevin requested to see mental health and was told mental health staff would come and speak to him. Kevin did not comply with directives to go with staff to his cell and continued to ask for mental health. Because he did not comply, he was taken to the ground and sprayed with a chemical agent. Shortly thereafter, DOC began recording the encounter. Review of the video shows the following:

> Kevin is on the ground and Correctional Officers are securing shackles. Correctional Officers state that Kevin became combative and was resisting. Kevin is heard to say "I wasn't resisting." A Correctional Officer can be heard saying "[h]e just came back from a trip. Give me his info. Somebody give me his info. Find out who he is and where he's from. He just came back from a trip." He is then walked to the hall outside of his cell while gasping. He yells to other inmates that he was punched in the face. He continues to gasp and scream, and Correctional Officers take him to the ground. Kevin complains that he is being choked, that he can't breathe, and that Correctional Officers are hurting his neck. Correctional Officers move the hand cuffs from in front of his body to the back and pull him into an upright position. He is then stripped in the hall and brought to a cell where his face is washed off. He is escorted back to the hallway, where he is dressed while he is held against the wall and continues to gasp and moan and say he can't breathe. Once he is dressed, Correctional Officers begin to escort him to a cell. He is having trouble standing fully upright. A Correctional Officer pokes him in the back, prodding him to stand up. When he does, the Correctional Officer notes for the recording that he is standing erect with no issues. He is then escorted to RHU, placed in a cell with in-cell restraints. He remained in in-cell restraints for four hours and 46 minutes.

Approximately two weeks later, Kevin was again found unresponsive, this time in his cell, in RHU. Naloxone was administered and he continued to be unresponsive. He was transported by ambulance, and, following numerous Naloxone administrations, regained consciousness.

OCA is concerned about how Kevin, who had been maintained in punitive segregation, with no contact with other inmates, procured and ingested Fentanyl. When OCA inquired about an investigation, DOC provided limited documents. The records provided document what occurred but there is no evidence of any investigation into how a 19-year-old individual placed in punitive segregation and without access to other inmates acquired Fentanyl. In response to OCA's inquiries, DOC officials indicated that Kevin admitted to faking being unresponsive in the first incident, when he was found unresponsive in the outdoor "recreation" cage. OCA obtained medical records for that date, which confirmed the presence of Fentanyl in Kevin's system.

OCA is also concerned that Kevin was not seen by mental health upon return from the hospital due to overdose. The Correctional Officers who interacted with him appeared to be unaware that he had just returned from the hospital following incapacitation due to Fentanyl exposure.

Kevin was identified as a student with special education needs. When he entered DOC custody, he was identified as a student with emotional disturbance, most recently been placed in a therapeutic educational program, and his IEP required a total of twenty-five (25) school hours per week, including forty (40) minutes of academic support and 30 minutes of counseling. During the PUR, Kevin was exited from special education and his IEP documented that this was per his request. Kevin was later sentenced and requested to return to educational services approximately two weeks later. His IEP indicates that he is enrolled in adult education, with total school hours of 16.25, requiring one-half (.5) hour of academic support per week, one-half (.5) hour of social/behavioral support, and counseling for two hours per month. Six months later, Kevin requested to participate in the GED program and then withdrew from education a few weeks later.