COUNCIL OF THE DISTRICT OF COLUMBIA
THE JOHN A. WILSON BUILDING
1350 PENNSYLVANIA AVENUE, NW
WASHINGTON, D.C. 20004

BRIANNE K. NADEAU
Councilmember, Ward 1

Chairperson
Public Works and Operations

Committee Member
Recreation, Libraries, and Youth Affairs
Facilities and Family Services
Health

October 17, 2023

Nyasha Smith, Secretary
Council of the District of Columbia
1350 Pennsylvania Avenue, N.W.
Washington, DC 20004

Dear Secretary Smith,

Today, I, along with Councilmembers Robert White, Janeese Lewis George, Anita Bonds, Charles Allen, Zachery Parker, and Kenyan McDuffie, am introducing the "Eliminating Restrictive and Segregated Enclosures ("ERASE") Solitary Confinement Act of 2023." Please find enclosed a signed copy of the legislation.

This legislation prohibits nearly all forms of segregated confinement for individuals incarcerated at penal institutions owned, operated, and controlled by the Department of Corrections. It also limits the use of safe cells, would mandate that all residents in a DOC facility receive at least eight hours of out-of-cell time a day, and charge DOC with providing residents mental health services any time they're placed in prolonged confinement, medical isolation, or suicide watch. An oversight provision of the bill would require DOC to collect and publish data on the ongoing use of solitary, allow residents to file special grievances, and potentially sue the agency if they've been subject to prolonged confinement.

In general, solitary confinement is a cruel, inhumane, and degrading mode of punishment that has been equated to torture.[1] Studies have consistently proven that solitary confinement can create or exacerbate both short- and long-term psychological and physical health issues for people placed in solitary confinement, including self-harm and suicide, anxiety and depression, and gastrointestinal and cardiovascular problems.[2] Solitary confinement does not properly

[1] *See* G.A. Res. 70/175, at 8, 15–17, The United Nations Standard Minimum Rules for the Treatment of Prisoners, the Nelson Mandela Rules (Dec. 17, 2015).
[2] *See* Sharon Shalev, A Sourcebook on Solitary Confinement 15–17 (2008).

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remedy the root problems that lead to a person's placement in solitary,[3] and the economic costs of solitary far exceed any perceived benefits.[4]

Similarly, the profound stress caused by spending time in solitary confinement can lead to permanent damage to a person's identity, including changes in the brain and personality of the people subjected to it. "Depriving humans—who are naturally social beings—of the ability to interact with others can cause social pain" which affects the brain in the same way as physical pain.[5] Additionally, the overwhelming amount of research proves that solitary confinement leads to greater recidivism and misconduct.[6] If we care about reducing crime, we should care about solitary for that reason, too.

The deplorable conditions at the District's jails and restrictive housing units— including flooding, lack of grievance procedures, lack of mattresses, and more[7]— only exacerbate the harmful effects of solitary confinement. The conditions of safe cells in the District's jails are

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[3] Kayla James & Elena Vanko, *The Impacts of Solitary Confinement*, Vera Institute of Justice 5 (Apr. 2021) ("In short, solitary confinement does not improve safety and may actually lead to an increase in violence and recidivism. This is not surprising, given that people in solitary are typically denied the opportunity to participate in education, mental health or drug treatment, and other rehabilitative programs or to otherwise prepare for reentering the community.").

[4] *Id.* at 5-6 ("The Federal Bureau of Prisons estimated in 2013 that it cost $216 per person, per day, to hold people in solitary in the Administrative Maximum Facility at the Federal Correctional Complex in Florence, Colorado. In comparison, the estimated cost of housing people in the complex's general population was $86 per person, per day.") (emphasis in original); see also Alison Shames et al., Solitary Confinement: Common Misconceptions and Emerging Safe Alternatives, Vera Institute of Justice 24 (May 2015) ("The significant fiscal costs associated with building and operating segregated housing units and facilities are due to the reliance on single-cell confinement, enhanced surveillance and security technology, and the need for more corrections staff (to handle escorts, increased searches, and individualized services).").

[5] Katie Rose Quandt & Alexi Jones, *Research Roundup: Incarceration can cause lasting damage to mental health, Prison Policy Initiative* (May 13, 2021), https://www.prisonpolicy.org/blog/2021/05/13/mentalhealthimpacts/.

[6] Andreea Matei, *Solitary Confinement in US Prisons*, Urban Institute (August 2022).

[7] *See* District of Columbia Corrections Information Council, DC Department of Corrections Inspection Report 6 (Sept. 30, 2021), https://cic.dc.gov/sites/default/files/dc/sites/cic/page_content/attachments/CIC%20Inspection%20Report%20DOC%20FY%202021%20site%20visit%20May%202021.pdf; Press Release, U.S. Marshals Service, Statement by the U.S. Marshals Service Re: Recent Inspection of DC Jail Facilities (Nov. 2, 2021), https://www.usmarshals.gov/news/chron/2021/110221b.htm.

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likewise troubling and, thus, similarly exacerbate the harms of solitary confinement for those on suicide watch.[8]

For these reasons, we must erase virtually all forms of segregated confinement for individuals incarcerated at penal institutions in the District. This legislation would produce a fairer and more humane criminal justice system in the District.

Should you have any questions, please contact my Legislative Aide Sabrin Qadi at sqadi@dccouncil.gov or (202) 834-8093.

Thank you,

Best,

Brianne K. Nadeau

Brianne K. Nadeau

[8] District of Columbia Corrections Information Council, District of Columbia Department of Corrections 2018 Inspection Report 17 (May 21, 2019), https://cic.dc.gov/sites/default/files/dc/sites/cic/page_content/attachments/DOC%20FY%202018%20Report%205.21.19%20FINAL.pdf; Mitch Ryals, *Attorneys Continue to Hear Reports of the Horrific Conditions in DC Jail's 'Safe Cells'* Washington Citypaper (May 13, 2021), https://washingtoncitypaper.com/article/516737/attorneys-continue-to-hear-reports-of-the-horrific-conditions-in-dc-jails-safe-cells/.

Councilmember Robert C. White, Jr.

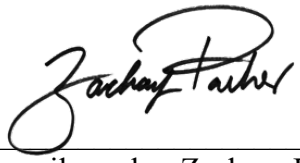
Councilmember Brianne K. Nadeau

Councilmember Charles Allen

Councilmember Anita Bonds

Councilmember Kenyan R. McDuffie

Councilmember Janeese Lewis George



Councilmember Zachary Parker

A BILL

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

To prohibit segregated confinement in jails; to strictly limit the use of safe cells and require that incarcerated people with mental health emergencies receive the care to which they are entitled; to require the Department of Corrections to create a plan to eliminate segregated confinement and report to the Council the impacts of doing so.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Eliminating Restrictive and Segregated Enclosures ("ERASE") Solitary Confinement Act of 2023".

Sec. 2. Definitions.

For purposes of this act, the term:

(a) “Appropriate healthcare” means the right to:

(1) Timely, responsive, respectful, and dignified attention to a resident’s healthcare needs by a qualified health professional;

(2) Assessment, consultation, and provision of health care consistent with the standard of care expected to be provided by a reasonably prudent qualified health professional in the professional’s specialty area, and not limited in any way because of status as a detained or incarcerated person;

(3) Have the qualified health professional respect a resident's privacy and confidentiality;

(4) Privacy and protection from inquiry by qualified health professionals regarding a resident’s charges, convictions, or duration of sentences unless expressly pertinent to the delivery of care;

(5) Freedom from physical restraints while receiving any form of healthcare, unless the treating qualified health professional requests physical restraints to address a specific safety concern;

(6) Obtain, at no cost, at the conclusion of a resident’s visit to a qualified health professional providing services outside of a penal institution, copies of all records of the resident’s own diagnoses, test results, treatment instructions, recommendations for further treatment and evaluation, and other documents that a person who is not detained or incarcerated would have a right to obtain from a qualified health professional;

(7) Obtain, at no cost, full or partial copies of a resident’s own medical records

that are created by or in the possession of either the Department or the entity providing health care on behalf of the Department, upon the request of a resident, former resident, or a resident or former resident's counsel without having to file a request under the District of Columbia Freedom of Information Act, D.C. Code § 2-531;

(8) A reasonable opportunity to discuss with a qualified health professional the benefits and risks of treatment alternatives, including the risks and benefits of forgoing treatment, and guidance about different courses of action;

(9) Ask questions about health status or recommended treatment and to have those questions answered by a qualified health professional;

(10) Make decisions about the care they receive and have those decisions respected;

(11) Be advised of any conflicts of interest a qualified health professional may have with respect to a resident's care;

(12) Obtain a second opinion from a qualified health professional providing services outside of the penal institution in the same or similar specialty within a reasonable amount of time in cases involving a serious risk of death or serious bodily injury;

(13) Coordination and integration of the care provided by a resident's qualified health professionals, including the timely provision of care by a suitable qualified health professional outside of the penal institution as necessary; and

(14) Visitation with a resident's "attorney in fact," as defined in D.C. Code § 21-2202.1, for the purpose of healthcare decision making, regardless of any Department policy to the contrary;

(15) All rights enumerated in the Consumers' Bill of Rights at D.C. Code § 7-

1231.04;

(16) Communication pursuant to the DC Language Access Act at D.C. Code § 2 1901 *et seq*; and

(17) Effective communication pursuant to Title II and Title III of the Americans with Disabilities Act at 42 U.S.C. §§ 12131-34 and 12181-89.

(b) "Chemical restraint" means a medication that is used in addition to or in place of the resident's regular, prescribed drug regimen to control extreme behavior during an emergency, but does not include medications that comprise the resident's regular, prescribed medical regimen and that are part of the resident's treatment, even if the intended purpose is to control ongoing behavior;

(c) "Department" means the Department of Corrections, as defined in D.C. Code § 24-211.01;

(d) "Disciplinary housing" means the separation of a resident from other individuals for the purpose of punishing the resident for a violation of the Department's or penal institution's rules;

(e) "Health care" means any type of care provided by a person licensed under or permitted to practice a health occupation in the District as defined in D.C. Code § 3-1201 et seq. Healthcare includes medical care, dental care, vision care, psychiatric care, psychological or other treatment for mental or behavioral health conditions, physical therapy, occupational therapy, chronic care, and the provision of medication or medical supplies;

(f) "Medical isolation" means the isolation of a resident consistent with a finding by a qualified health professional that the resident has a communicable disease for which the Centers for Disease Control and Prevention recommends or authorizes isolation or quarantine, and that

isolation is medically necessary for that resident's treatment or to protect other residents or staff from the communicable disease;

(g) "Minimum out-of-cell time" means at least 8 hours daily, between 8 a.m. and 8 p.m., during which a resident is not restricted to their cell and has the opportunity to move around a shared space, interact with other residents in a shared space without barriers or physical or chemical restraints, participate in programming, shower, or go to the commissary, gym, and recreation yard, or participate in other activities normally conducted outside of a resident's cell;

(h) "Penal institution" means any penitentiary, prison, jail, or correctional facility owned, operated, or controlled by the Department;

(i) "Physical restraint" means any mechanical device, material, or equipment attached or adjacent to the resident's body, or any manual method, that the resident cannot easily remove and which restricts their freedom of movement or normal access to their body;

(j) "Prolonged confinement" means the denial of minimum out-of-cell time, without a resident's informed written consent;

(k) "Punitive measures" means the loss of any privilege, including video and phone calls, recreation, reading materials, mail, or commissary, that is standardly provided to residents;

(l) "Qualified health professional" means a person licensed under or permitted to practice a health occupation in the District as defined by D.C. Code § 3-1201.08 who is providing services or treatment for which the individual is specifically licensed or is permitted to perform pursuant to D.C. Code § 3-1201 *et seq.*;

(m) "Resident" means any individual detained or incarcerated at a penal institution;

(n) "Safe cell" means a suicide-resistant housing cell designed to prevent a resident from inflicting serious bodily injury upon themselves or used by the Department as a place to hold and

continuously monitor residents placed on suicide watch;

(o) “Serious bodily injury” means a bodily injury or significant bodily injury that involves a substantial risk of death, protracted and obvious disfigurement, protracted loss or impairment of the function of a bodily member or organ, or protracted loss of consciousness;

(p) “Suicide precaution” means a measure used to observe a resident who is assessed by a qualified health professional and determined to not be actively suicidal, but expresses suicidal ideation or has a recent prior history of inflicting or attempting to inflict serious bodily injury upon themselves, or a resident who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior indicating the potential for inflicting death or serious bodily injury upon themselves; and

(q) “Suicide watch” means a measure used to observe a resident who is assessed by a qualified health professional and determined to be actively suicidal, by either threatening or engaging in inflicting serious bodily injury upon themselves.

Sec. 3. Scope.

This act shall apply to all residents detained or incarcerated at the Central Detention Facility, the Correctional Treatment Facility, the Central Cell Block, and any other penal institution owned, operated, or controlled by the Department.

Sec. 4. Limitations on the use of prolonged confinement.

(a) Department staff shall directly observe a resident on suicide precaution at staggered intervals not to exceed every 15 minutes and document those observations.

(b) Department staff shall directly observe a resident on suicide watch continuously and without interruption and document those observations every 15 minutes.

(g) Supervision aids, like cameras, can be utilized as a supplement to, but never as a

substitute for, direct observation by Department staff of a resident on suicide precaution or suicide watch.

(c) A resident on suicide precaution shall never be placed in a safe cell and shall not be subject to prolonged confinement or punitive measures.

(d) All residents on suicide precaution or suicide watch shall be entitled to attend all court or parole hearings unless a qualified health practitioner makes a finding that non-attendance is immediately necessary to prevent a risk of death or serious bodily injury to the resident or another person.

(e) A resident on suicide watch shall reside in the least restrictive setting necessary to reasonably assure the safety of the resident and others, as determined by a qualified health professional, including housing in the general population, mental health unit, or medical infirmary.

(f) A resident on suicide watch may be placed in a safe cell only if it is immediately necessary to prevent death or serious bodily injury.

(h) A qualified health professional shall directly observe any resident in a safe cell a minimum of every 4 hours and shall formally reassess the resident at least every 24 hours.

(i) Removal of a resident's clothing shall be prohibited absent an individualized determination by a qualified health professional that such removal is necessary to prevent death or serious bodily injury. If the individualized determination to remove a resident's clothing is made, the resident shall immediately be provided with alternative safe clothing and blanket, and a qualified health professional shall reassess the determination at least every 24 hours. A resident shall never be without the clothing and blankets necessary to provide reasonable privacy and warmth.

(j) The Department shall transfer a resident from a safe cell to a local hospital or another appropriate healthcare facility as soon as practicable:

(1) Upon a determination by a qualified health care professional that the Department cannot provide the resident with appropriate healthcare;

(2) If the resident has been held in a safe cell continuously for 48 hours; or

(3) Upon request of the resident.

(k) The Department shall examine any incident involving a completed suicide and any incident involving a suicide attempt requiring hospitalization through a morbidity and mortality review process, which shall be completed within 30 days of the resident's death or suicide attempt.

(l) The review, separate and apart from other formal investigations that may be required to determine the cause of death, shall include:

(1) Review of the circumstances surrounding the incident;

(2) Review of procedures relevant to the incident;

(3) Review of all relevant training received by involved staff;

(4) Review of pertinent healthcare services reports involving the resident;

(5) Review of any possible precipitating factors that may have caused the resident to commit suicide or suffer a serious suicide attempt;

(6) Recommendations, if any, for changes in policy, training, physical plant, healthcare services, and operational procedures; and

(7) A written report detailing the Department's findings, including whether each recommendation was accepted or rejected and a corrective action plan specifying responsible parties and timetables for completion.

(m) Within 5 days of the conclusion of the review process, the Department shall transmit the report to the Mayor, the D.C. Council, and the Corrections Information Council.

(n) The Department shall publish on its website written updates on the status of the corrective action plan in 30-day intervals until the plan has been fully implemented.

(o) All staff involved in the incident should be offered critical incident stress debriefing.

Sec. 5. Plan and report on the elimination of prolonged confinement

(a) Within 90 days after the effective date of this act, the Department shall transmit to the Mayor, the Council, and the Corrections Information Council, and publish on its website a written report of its plans to effectuate this act.

(b) The report published under subsection (a) of this section shall include:

(1) The number of residents who have not received minimum out-of-cell time over the prior 12 months; and

(2) The number of residents who have been placed in disciplinary housing, medical isolation, or a safe cell over the prior 12 months.

(c) The report published under subsection (a) of this section shall include the following deidentified information about each resident:

(1) The cumulative number of days each resident has not received minimum out-of-cell time over the prior 12 months;

(2) The highest consecutive number of days each resident has not received minimum out-of-cell time over the prior 12 months;

(3) The cumulative number of days each resident has been placed in disciplinary housing, medical isolation, or a safe cell over the prior 12 months;

(4) The highest consecutive number of days each resident has been placed in

disciplinary housing, medical isolation, or a safe cell over the prior 12 months;

(5) The basis for denying the resident minimum out-out-of-cell time;

(6) The basis for placing the resident in disciplinary housing, medical isolation, or a safe cell, including:

(A) The communicable disease that is the basis for medical isolation; and

(B) The number of documented assessments made by a qualified health professional;

(7) The notice and procedures followed before denying the resident minimum out-of-cell time;

(8) The notice and procedures followed before placing the resident in disciplinary housing, medical isolation, or a safe cell;

(9) The timing and plan for restoring the resident's out-of-cell time and any known barriers to that transition; and

(10) The timing and plan for removing the resident from disciplinary housing, medical isolation, or a safe cell, and any known barriers to that transition.

(d) Within 180 days after the effective date of this act, the Department shall promulgate regulations and issue policy statements to amend the Department's processes for and use of prolonged confinement, medical isolation, and safe cells in accordance with this act;

(e) Within one year after the effective date of this act, and quarterly thereafter, the Department shall submit to the Mayor, the Council, and the Corrections Information Council, and make available on the Department's website a written report of its use of prolonged confinement, medical isolation, and safe cells.

(f) The reports published under subsection (e) of this section shall include deidentified

data on each resident placed in prolonged confinement, broken down by confinement that is the result of medical isolation, a safe cell, or any other reason, for any amount of time during the reporting period.

(g) The reports published under subsection (e) of this section shall include:

(1) Each resident's age, sex, gender identity, sexual orientation or other LGBTQ status, race, religion, and ethnicity;

(2) Whether or not each resident is diagnosed with a serious mental illness, as that term is defined in the current edition of The Diagnostic and Statistical Manual of Mental Disorders;

(3) Whether or not each resident is diagnosed with a physical disability, an intellectual or developmental disability, a traumatic brain injury, or any other disability, as defined in 42 U.S.C. § 12102;

(4) The location of the prolonged confinement, broken down by unit or type of unit;

(5) The highest consecutive number of days that each resident was in prolonged confinement;

(6) The cumulative number of days each resident was in prolonged confinement;

(7) The reasons each resident was subjected to prolonged confinement;

(8) Whether each resident was subject to any type of physical or chemical restraint while in prolonged confinement; and

(9) Whether each resident remains in prolonged confinement as of the time the report is finalized.

(h) The reports published under subsection (e) of this section shall include data on the

filing of grievances by people held in prolonged confinement, medical isolation, or a safe cell, including:

(1) The total number of grievances filed, reported by type of grievance;

(2) The number of grievances closed during the reporting period, including the reason for closure, and the number of grievances that remain open; and

(3) The average number of days from the filing of a grievance to final resolution, broken down by Informal Grievance, Formal Grievance, Level 1 Appeal, Level 2 Appeal and Prolonged Confinement Grievance.

(i) The reports published under subsection (e) of this section shall include data on assault and self-harm, including:

(1) The total number of residents in medical isolation who committed self-harm, attempted or completed suicide, were assaulted by another resident, were subjected to a use of force by a Department employee, or received an incident report or disciplinary infraction, and the type of that infraction; and

(2) The total number of residents in a safe cell who committed self-harm, attempted or completed suicide, were assaulted by another resident, were subjected to a use of force by a Department employee, or received an incident report or disciplinary infraction, and the type of that infraction.

Sec. 6. Private right of action.

(a) A resident or former resident may bring a civil action in the Superior Court of the District of Columbia against the District or any agent or employee thereof for violation of this act or of any regulation promulgated or policy statement issued there under. Relief may include:

(1) Injunctive relief;

(2) Declaratory relief;

(3) Liquidated damages of $1000 per each day a resident is unlawfully held in prolonged confinement;

(4) Compensatory damages; and

(5) Punitive damages.

(b) A resident or former resident who prevails in an action under this section shall be entitled to fees and costs, including reasonable attorneys' fees and reasonable expert fees.

(c) Notwithstanding any D.C. law, regulation, or policy to the contrary:

(1) The requirements of D.C. Code § 12-309 shall not apply to an action brought under this act;

(2) The only administrative remedy available to raise questions of compliance with or treatment under this act shall be filing a Prolonged Confinement Grievance at any time directly with the Director of the Department, which has 5 calendar days to respond;

(3) The grievance shall be considered exhausted at the time the Director responds or at the conclusion of 5 calendar days regardless of whether the Director provides a response.

(d) The Department shall provide the resident with a grievance form, writing utensils, and access to the Inmate Grievance Procedure mailbox.

(e) Failure to provide a resident with a grievance form, writing utensils or access to the grievance mailbox shall effectively render the grievance process unavailable to the resident.

(f) In an action under this section, a resident or former resident's sworn statement including facts that, if true, would be sufficient to show the resident or former resident had either completed the grievance process or that the grievance process was unavailable to that resident, shall create a rebuttable presumption that the grievance process was either completed or

unavailable that can only be overcome by clear and convincing evidence.

Sec. 7. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 4a of the General Legislative Procedures Act of 1975, approved October 16, 2006 (120 Stat. 2038; D.C. Official Code § 1-301.47a).

Sec. 8. Effective date.

This act shall take effect after approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), a 30-day period of congressional review as provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of Columbia Register.