PERSONAL ACCOUNTS

MR. GREEN: On behalf of the Commission on Safety and Abuse in America's Prisons, I would like to welcome everyone to the second day of our hearings in Newark, New Jersey. Before I introduce each of our witnesses, I would like to thank them for their willingness to discuss their very personal and moving experiences with us.

Joe Baumann is a state correctional officer in Southern California with 19 years of experience working in prisons. His work has included two years spent in a mental health unit for women where there was a single staff psychologist caring for 700 inmates. Mr. Baumann will testify to the wide-range of problems he has experienced firsthand as a correctional officer, problems ranging from extreme

overcrowding to virtually nonexistent mental healthcare.

Thomas Farrow is a former inmate who was incarcerated for over two decades in the New Jersey Department of Corrections. Diagnosed with bipolar disorder, Mr. Farrow will describe the poor mental healthcare which he received and the abuse of mentally ill prisoners that he witnessed while incarcerated during an era when the New Jersey prison system was engaged in efforts to improve its quality of care for the mentally ill.

Sister Antonia Maguire is a chaplain of Taconic Correctional Facility, a women's prison in West Chester County, New York. Sister Antonia has been working in prisons for over 30 years and is a member of the Franciscan Missonary Sisters of the Sacred Heart. She will testify about her experiences ministering to women prisoners and, particularly, the grave difficulties they face in obtaining adequate medical care.

Before we begin I would like to take the opportunity to thank each of you again for your willingness to come before this commission to discuss your experiences. We will begin with Joe Baumann.

MR. BAUMANN: Thank you. I would like

to thank the Commission for this opportunity. My name is Donald Joseph Baumann, I am a correctional officer with the State of California. I started with the state about 19 years ago. I realize the amount of time I have allotted is brief so I will keep my comments relatively short. I encourage any member of the Commission to ask any follow-up questions or stop me during the break, if they need to.

Since coming to the Department of Corrections I've been assigned to the California Institution For Men, California Institution for Women and I am currently assigned to the California Rehabilitation Center. While assigned to these three institutions I have had the opportunity to work medium security general population, administrative segregation, protective custody housing, reception centers and several mental health programs.

I'm also the current CRC Chapter President of the California Correctional Peace Officers Association, a position I've held since 1998. I point this out to you primarily because I've been threatened with discipline in the past for speaking out about conditions in the prison system. Particularly, if I identify myself as an employee of the department. The observations and opinions I

express here are mine, solely and not those of the department, nor the union.

In my capacity as a CCPOA activist, I've had the opportunity to travel to all 32 adult prisons and observe their operations and negotiate terms and conditions of employment for our members with various levels of departmental management. I have seen overcrowded prisons that lack sufficient space for proper medical and mental health facilities, prisons that cannot recruit or attain qualified medical healthcare professionals and a cadre of custody and medical staff that are stretched to the limits with the day-to-day grind to do a thankless job.

As a correctional officer, I've helped to disarm and restrain a suicidal inmate who was slashing his wrists with a box cutting razor blade, using nothing but a mattress because we lacked to put men in training to do it any other way. I have had to walk inmates who had a mouthful of their own fecal matter to a psychiatrist for an exam. I've seen inmates inappropriately housed for long periods of time because the lack of bed space, placing the other inmate staff and the general public at risk.

California is the largest correctional

system in the United States with over 160,000 inmates in its various institutions, camps and community correctional facilities and an additional 120,000 offenders on parole.

Most of its institutions currently house over 190 percent of their design capacity. Several exceed 220 percent, including my own.

Estimates vary on the number of inmates with mental health concerns in the CDC, ranging from 8 percent to as high as 30 percent.

During the 1980s and '90s the CDC and the state legislature commissioned several studies on conditions of the mental health delivery system within the department and consistently came to the conclusion that CDC was not meeting the constitutional level of mental healthcare for its inmates.

During the same time period, inmate advocacy groups embarked on litigation in an attempt to address the issues outlined in those reports. Primarily, Coleman versus Wilson. Coleman versus Wilson alleged that the department's mental healthcare was inadequate in several areas, including intake screening, access to care, treatment and records-keeping and constituted cruel and unusual punish. As a result, the Federal Court ordered the

department to develop a remedial plan to correct these deficiencies. The court also ordered a Special Master to oversee the implementation of the plan, which addresses several areas, including the processes for identifying and screening inmates in the intake reception process, access to mental healthcare for inmates in the general population, staffing standards for psychiatrists, psychologists and other mental healthcare professionals, monitoring and documenting the use of psychotrophic drugs and guidelines and drugs over the use of forced medication.

Unfortunately, CDC's remedial plan failed to formalize training for correctional officers and supervisors to help them differentiate between behavior that is attributed to mental health disorders and normal disciplinary issues. This is an extremely serious problem since unless a given correctional officer is familiar with the particular inmate involved, outbursts and unusual behavior are often misinterpreted and, therefore, reacted to in a way that may worsen a given situation. An officer generally assumes that an inmate doesn't make his bed or clean-up after himself because he is lazy, rather than realizing that the individual may be decompensating. Because we're not properly trained

and are often unfamiliar with the individual inmate, officers may also interpret outbursts of anger or other emotion as an inmate wanting attention when, in fact, an inmate is in serious distress and lacks the faculties to properly express that fact.

I have personally had cases where inmates have stopped taking their medication because they're feeling better at a given point in time and have decided they don't need it anymore. Several days later the inmate realizes they're decompensating decompensating and need to see the doctor. Other times I've seen radical changes in behavior and refer the inmate to the psychologist or psychiatrist.

But on more than one occasion I've had medical staff advise me to have the inmate sign for a sick call and they will be seen in two or three days. Left untreated for that length of time, the inmate becomes a ticking time bomb and a danger to themselves, staff and other inmates. Because of my working relationship with the doctors at my particular institution, I was usually able to get the inmates in to be seen as someone was available, but that's by no means the norm in these type of situations.

There are also occurrences when COs are reluctant to confront inmates who are act out in some

fashion for fear of being injured or maimed, or out of fear of being accused of overreacting. Staff are also often afraid that an escalation may be taken out of context by their superiors and will then lead to discipline within the department or criminal charges by either the state or federal government. This is always in the back of their minds. At the same time they also fear that if they don't intervene, they will be accused of underreacting. It's a catch-22 that no one has ever attempted to address, and the lack of training to interpret and address behavior, combined with chronic understaffing and the lack of effective supervision, only exacerbate the problem.

As I sit here and speak to you today, at least ten percent of all correctional sergeants' and lieutenants' positions in the State of California are being run unfilled so that the department can generate salary savings, right now as I speak.

Currently, correctional officers receive a 15 page training module entitled "Identification of Special Needs Inmates" and this is all the training we receive in the area. The training module is designed for the employee to read during the normal working hours, while conducting their normal duties. It contains information on the following

topics; diabetics, heat-related illness, epileptics, developmental disability training, ADA and suicide prevention.

Correctional officers are the employees with the highest level of interaction with the inmate population. They are the ones required to monitor the day-to-day behavior and activity of the inmates who are placed in the mental health delivery system, as well as those that haven't, yet we're not properly trained to do so.

When CDC implemented the first phase of the Coleman Remedial Plan at CRC back in July 1995, I requested that local management negotiate the impact of the implementation with the local chapter. I wanted an opportunity to formally review the department's operational procedures and policies and their training modules, in order to be able to address any potential impact the remedial plan would have on my membership, who worked in a prison that was already at that time 225 percent over capacity and it suffered several rounds of staffing reductions.

Local management refused, saying that the remedial plan would have no impact on the correctional officers and CRC. They said there was no additional training necessary in suicide

identification/prevention, forced medication procedures, et cetera, because there was no requirement to do so in the remedial plan.

In January 1996 an inmate utilized several combination locks in a mesh laundry bag, assaulted a correctional officer at my institution. After a violent struggle with several staff, the inmate was subdued and ultimately transferred to another institution. The victim of the assault medically retired because of the significance of the head injuries she received.

The follow-up investigation revealed that the inmate had a long history of schizophrenia and hadn't received his medication in the three weeks he had been housed in prison. No one at healthcare services had been monitoring the inmate's medication regimen. The confrontation between the officer and the inmate was triggered over the inmate's distress over his mother's failing to arrive for an expected visit. The woman had passed away five years previous.

When I approached management about my concerns related to staff and lack of training and a lack of written policies and procedures, the response I received was you're -- you've always had them here, treat them like you've always treated them. Since

that date, the number of inmates at CRC's mental health delivery system has climbed from less than 300 to more than 800. While we've received an increase in psychologists and psychiatrists, we've never received additional staff necessary to supervise and distribute medication within the allotted time frames, and the training received by C/Os is still lacking at best.

Again, I want to thank the Commission for the opportunity to participate in this forum. Many of the issues the plague the inmate population directly affect the working conditions and safety of the correctional officers of this country. I would hope through processes like this one that the stereotype of the violent, knuckle dragging prison guard can be put to rest once and for all. For too long it's been used to simply systemic problems that the vast majority of the public has no interest in, prisons. Thank you.

MR. GREEN: Mr. Farrow.

MR. FARROW: Good morning. I want to thank the commissioners for inviting me to speak and I especially want to thank them for holding these hearings because they opened the door for a lot of possibilities for qualitative change in New Jersey.

My name is Thomas Farrow and I would

like to share with you my experiences as someone who has struggled with mental illness while incarcerated in the New Jersey prison system. As we sit here I would like to remind the Commission that in this state alone there are perhaps thousands, several thousands of prisoners with serious mental health problems suffering from inadequate care and mistreatment in New Jersey's prisons today.

In some ways my story is one of relatively good fortune. I remained fairly stable throughout my incarceration, but faced some of my biggest personal challenges during my transition out of prison.

I am not here to tell you that there is no treatment on the inside and there's always greet treatment on the outside; rather, I would like to impress upon this Commission that much of the mistreatment and abusive of inmates with mental illness persists in our prisons despite improved conditions. And although it can be difficult to get treatment in the free world without any money or resources, the fact does not justify the serious abuse and degradation of mentally ill prisoners that I have witnessed during my time in prison.

A little bit about myself. I was first

incarcerated in 1970, when I was sentenced to death in New Jersey. In 1972 the United States Supreme Court declared the death penalty unconstitutional and my death sentence was commuted to life in prison. I remained in prison until 1984, when the governor commuted my life sentence and I was granted parole after I had demonstrated my rehabilitation through efforts I made to educate myself and gain a degree.

I may have had a longer history of mental illness that went undiagnosed, but it was in 1995 that I was hospitalized for the first time, after I had a serious reaction to a medication for depression. I was diagnosed as bipolar disorder at that time.

Then in 1996, while I was an outpatient at Saint Mary's Hospital, I was returned to prison for a technical parole violation and was confined for eight years and five months prior to my release this past May 2nd.

At the time that I re-entered the prison system, the conditions and treatment of the mentally ill in New Jersey was deplorable. There were only five full-time psychiatrists in the entire Department of Corrections, serving at least 2,000 identified mentally ill prisoners. And when I say

identified, the overwhelming majority of the people with mental illness in the prison system of this state are not diagnosed, which means that there was no meaningful treatment for those patients whatsoever. There was little or no sensitivity among staff to the special needs of the mentally ill and prisoners with serious mental health problems were being physically abused by staff and other inmates and often landed in segregation as a result of disciplinary action when they needed some form of treatment.

A class action suit was filed that same year, in 1996, on behalf of all mentally ill prisoners in the state and in 1999 that case was settled in the United States District Court for this district. The settlement was to begin a new era in the treatment of mentally ill prisoners in New Jersey, however that did not happen. It changed disciplinary regulations so that prisoners with pending disciplinary charges were to be screened for mental health needs and referred to mental health treatment, if it was deemed appropriate. If means that it still depended on the attitude of the prison guards, which had a great deal to do with interfering with the operation of the program.

Prisoners confined in the segregation who were suffering deterioration in their mental

health status were to be referred by the mental health staff for review of their segregation in order to decide whether it was appropriate to end that confinement in light of their mental health status. All new prisoners were to receive a mental health assessment within 72 hours of their arrival. Officers and other staff were all to be given more training about mental health illness and how to deal with the mentally ill in prison. More psychiatrists and psychologists were to be hired and special mental health units were to be created at three different facilities so that prisoners who were vulnerable to the general population and needed care would be able to get it.

Over the course of my remaining years in prison I witnessed firsthand the efforts by the Department of Corrections to adhere, to a certain degree, to the Settlement Agreement and while I saw some improvements, many of the worst problems still continue and they persist. Even with the addition of psychiatric staff, it is nearly impossible to receive meaningful mental health counseling in prison.

First, counseling requires trust and an ongoing relationship with a psychologist. As a prisoner you may be transferred at any time, abruptly

ending the relationship you have with your provider, and there is tremendous turnover in the psychiatric staff so that even if a prisoner stays in one facility for an extended time and is assigned to a psychologist that he trusts, it is unlikely that that psychologist will remain long enough to provide meaningful care. It takes time to build a relationship with a mental health provider and you must eventually be able to share very personal details about your life for counseling to be effective.

Prison is a hostile environment that uses your illness against you so, naturally, it's difficult to trust the prison psychologist, who is to you only a stranger who works for the prison system.

Between 1996 and 2005 I was incarcerated at four different prison facilities and saw many different psychologists and counselors. For most of those years I was in I was lucky to see any single psychiatrist or psychologist more than three times. It was not until I was transferred to the psychiatric unit at Northern State Prison here in Newark that I saw the same psychologist for a year and a half. The psychiatrist who ran the mental health unit at Northern State Prison was making an effort to maintain a more stable environment for the prisoners

and staff so that there was a better chance of receiving meaningful treatment there, but, in general, I did not trust any of my counselors, and most prisoners do not trust them either.

Most of my encounters with mental health providers, like those of most prisoners, were extremely brief and only for about 15 minutes. We knew we could not expect to see them for long and they worked for the prison and we knew that even if we felt comfortable, confiding intimate things with a counselor, we could not be sure that what we shared would not some day be used against us.

There are other problems that commonly interfere with the prisoner's ability to get quality mental healthcare. Many of the people on the mental health staff in all of these prisons are from other countries and so they have difficulty communicating with prisoners, not only because of language barriers but largely because of the enormous cultural differences between them and the prisoners.

It is less difficult to get medications in prison, but this is both good and bad. While medication is widely dispensed to prisoners, it is not always appropriate and its effects are not monitored closely. Prisoners often feel that the prison

administration would like to keep them sedated rather than help them to be helped.

We all heard the story about the prisoner who was strapped naked into a restraining chair and forced to take his medication and while this may not happen that often, it is a fear we all share and this fear motivated many prisoners to avoid any contact with mental health providers.

Perhaps the single biggest problem that prisoners with mental illness face in prison is the insensitivity of correctional staff. In my experience the majority of corrections officers respond to outbreaks by mentally ill prisoners as a disciplinary matter, a response to which usually ends with the prisoner being placed in lockup where he would go without any form of treatment and into a process of deterioration.

I witnessed a lot of resistance by correction officers to the administration's efforts to empower mental health providers to intervene on behalf of mentally ill prisoners. This resistance took many forms. For example, at times when I would meet with a psychiatrist to discuss my medication, the officer who escorted me there would purposely and unnecessarily stand in the door and listen to what we had to talk

about, which made it impossible for me to confide in the doctor and signalled to me, also, that there was no respect for the doctor-patient relationship. Often correction officers would refuse to bring us to our appointments with mental health providers and it seemed they simply had no respect for mental health treatment.

But these forms of resistance are minor compared with the brutality that persisted even after the Settlement Agreement from the District Court. During my time in prison and particularly in the mental health units I had many -- I heard many accounts of beatings of mentally ill inmates who were subsequently thrown into segregation.

While I was in the mental health unit at Northern State Prison, goon squads, which is a term we used to describe groups of officers who are known to ban together to beat inmates, would come into the unit at night and take inmates that they perceived to be a problem and put them in the barber shop, which was an isolated area, where they would beat them.

Officers knew that prisoners often shared their medications and rather than address this problem through administrative channels, they would raid the unit in the middle of the night, take away a

prisoner whom they believed to be causing problems and beat him in the barber shop where no one would be able to witness it. I saw these goon squads take prisoners away and we all understood what happened to them.

I personally witnessed two serious beatings of mental ill inmates. In one case an older man in his 60s was attacked by a correction officer while he was waiting in line to get his Insulin. He was also a diabetic, like myself, and he was in a mental health unit with me and although he had a gruff manner, he was quite harmless. This officer perhaps misperceived his manner as hostile or dangerous and attacked and beat him with no apparent provocation.

I wrote the incident up following the attack and the officer was eventually removed from the mental health unit, but that eventually caused me some problems with other officers.

In general, I think it is fair to say that correction officers in the mental health units do not evidence any special training or sensitivity toward the mentally ill. In fact, in these units it appears that most of the officers are placed there because they have administrative problems of their own in other parts of the system and so these units become a dumping ground for officers that are labeled as

problematic.

Our problems persist in the special mental health units because overcrowding in the system at large has pushed an overflow of the general population into these units. In other words, these units were originally established, by law, for people with mental illness, but because of the overcrowding in the prison system they put other people from the general population into these units and that brings with it a whole host of problems that are outside of the spectrum of mental health.

The result is that these units are not always the refuge they are meant to be for prisoners with problems and who are particularly vulnerable. Much of the violence and corruption that exists in the general prison population, including drug dealing and gambling, is also brought into these units when they absorb prisoners from the general prison population.

I also witnessed deplorable conditions in the administrative segregation unit, or isolation units and they're called. For a period of time, it was my job to feed the prisoners in these units. I saw many prisoners with extremely serious mental illness who seemed to be deteriorating in their cells. I witnessed some of these men sitting or lying on the

floor in their own urine and feces. I got the sense that they were receiving little or no positive attention and many of them seemed to be in distress.

Finally, I would like to say a little bit about what I experienced prior to and in the months immediately following my release. I've had a very difficult time putting services in place to be able to continue medication and care after my release. When I became eligible for a halfway house, I slowly began to withdraw from my medication because I was both afraid that I would be denied entry into a halfway house if I was known to be on medication and because I did not know what services would be available when I got out and I did not want to have problems if I had to go off my medication abruptly.

Once I was placed in the halfway house I went back on my medication. But when I was released on May 2nd of this year I had absolutely no way of getting any medication, any prescriptions, any follow-up care, any treatment, any counseling service and I was -- I only had $15.58. My parole officer did not have any resources, even though he made tremendous efforts to help me. He made phone calls on my behalf and although I followed up on those phone calls with pleas for assistance from numerous sources, I had no

luck for quite some time.

I was hospitalized recently and developed pneumonia and while at the hospital I learned that my Lithium levels had dropped dangerously low. It is only recently that I was finally given charity care at St. Mary's Hospital in Passaic and through that charity was able to get outpatient assistance at the Seton Center and a prescription for my medications. I am now at the YMCA.

As difficult as this transition has been for me, I still consider myself lucky because I see numerous men that was in prison with me who have mental illness, they're homeless, they're not getting any medication, they're not getting any counseling and the parole authorities are not being bothered with them because they don't want the burden and they're just out there, floating. You know, some of them don't even know what day it is. I see many men on the street homeless in dire straits, having come out of prison and had no luck of finding any kind of services.

My own illness has not been so debilitating that I am unable to work and I have an education and ability to advocate on my own behalf. So many of the men I met in prison have illnesses that

make it impossible for them to be their own advocates or to maneuver through a system that requires extreme sophistication and persistence. They suffer in prison and they suffer when they get out.

Although this Commission is focused on the abuse of prisoners and not on the resources available to them when they get out, you should understand that the lack of care and truly effective therapy on the inside means that those people will be sure to be released in no shape to fight for the health they need on the outside. Abuse and degradation of the mentally ill in the New Jersey prison systems persist despite efforts to reform the system and it is my hope that this Commission will do something to address the attitudes towards prisoners that make it so difficult to change the way they are treated. Thank you.

MR. GREEN: Thank you, Mr. Farrow. Sister Antonia.

SISTER MAGUIRE: When I was asked to speak today to this commission, my immediate response was no. I felt it would be just one more attempt to bring the plight of the prisoners to the public's attention that would be just another exercise in futility.

However, that afternoon I witnessed a young woman being subdued by 11 officers. I attempted to go to her aide and was ordered back into my office and I watched until the end. After a sleepless night my no turned to yes and I'm here today.

I speak not as a representative for the Department of Corrections, but I speak through my own experience. I have been a chaplain in correctional facilities for almost 32 years. I've worked in both male and female maximum and medium security prisons.

I was able to watch Taconic change from a medium male facility to a female facility. That was quite a change. Two days before the women arrived the superintendent gathered all the staff in the visiting room and tried to brief us on how women should be treated. Amazingly, most of the staff who were there saw there would be no difference at all in treating women any differently than men were treated. The one question that was posed to the superintendent was, well, when they get here are you going to test them to see if they're pregnant? And the superintendent said, why would I do that? And their immediate response was, well, when you find that they are pregnant, we'll know whether it was them or us responsible.

Prisons were never made for women.

When Taconic changed over and the women came in, bathrooms had urinals. The programs were all male oriented. The women were expected to do the same hard labor that the men did, including working on the detail in a cemetary and lowering the bodies into a grave. I saw so many times women being put into a position where the labor was so extreme and so hard that I worried about what it would do to their physical bodies and began to ask that, you know, they be relieved from those kind of duties. And I was told over and over again they commit the crime, they're going to do the time and nothing is going to be changed.

I just for a moment would like to talk a little about how we raise children. We in the United States, if we have a little girl, three years old girl who runs and falls and scrapes her knee and she comes crying to you, usually we hold them and kiss them and comfort them. When her three year old brother falls and scrapes his knee and comes running to us we say stop crying, be a man, and from that moment we set the norms of behavior almost that males and females respond to.

The little girl who was cuddled and held and comforted becomes a prisoner one day and is

supposed to respond as a prisoner responds, whatever that is. If they show any emotion or if they expect to experience any touch, they're penalized.

Men, when they're little boys growing up, are used to group sports, showering together, being exposed to each other. Women, for the most part, have had a more modest bringing up. Very, very painful for women to endure that first initial shower where they're being viewed by several officers while they're being showered. Very painful for them to go to the visiting room and be strip searched prior and after the visit. I know many women who refuse visits all together because they can't go through that.

Perhaps 90 percent of the women in our prison are the victims of incest or terrible brutality in their childhood and to be exposed to the view of other people at this time in their lives is very painful to them.

In New York state, as far as I know, the past 20 years the number of men in prison has doubled, while the number of women in prison has quintupled. I would think that that is a case before us that we need to examine very closely and see what can be done.

I would like to tell you just a few

stories, stories that I have seen with my own eyes, that have occurred in one small prison in New York, but stories which I'm sure can be multiplied throughout the state many, many times.

I would like to introduce you first of all to Kathy. Kathy was a young woman serving time for drug use. Small amount of time. She was a very hard-working woman. She became sick one day, she had a cold, she felt, and she went to clinic. And when she went in, because it was wintertime they gave her a cold pack; standard procedure for all women who had colds in the prison, without thinking of what the effects of that medication would have on anyone.

Kathy took her medication dutifully and no change came by. She went every day for over a week to the clinic, reporting how sick she felt and that there was no change at all. The civilian staff with whom she worked saw how sick she was and they let her sit in the back and gave her tea and helped her rest. The officer on the floor would not let her stay on the floor, even in rainy weather, because she wanted her to be out and in the population.

Kathy became so sick that she had to turn away her visit when they came and the next day she called her mother and begged her mother to call

the superintendent. She said I haven't seen a doctor, please, I'm so sick, I need help, please call the superintendent tomorrow. And tomorrow never came for Kathy. At 2:00 that morning she was so violently ill that she banged on the door and, fortunately, a caring officer was there. Very frequently the officers do not respond to an inmate banging on the door in the night. He went immediately to her room, saw how sick she was and helped her to get dressed. He then called the sergeant to come and see.

We do not have medical services or anyone on duty in our facility from 11:00 at night until 6:00 the following morning. This in a facility where we have newborn babies, pregnant mothers, women with heart problems, many women with AIDS, no medical care at all.

The sergeant saw Kathy, saw she was very sick so he called his superior, the watch commander, to come in, walked up three flights of stairs to her room, saw how terrible she was and he said we've got to get her out of here. They brought her down three flights of stairs, shackled her, put her in a van and drove her across the street to the facility that had a clinic open at night. When she got to the clinic her heart had already stopped but

they resuscitated her because you are not allowed to die in prison, put her in an ambulance and brought her out to the hospital where she was pronounced dead. Upon the autopsy findings she had congestive heart failure and died from congestive heart failure. During the entire time she sought help not once did she saw a doctor, not once did anyone put a stethoscope to her chest, not once was her blood pressure taken. Kathy was 32 years old.

We have a newborn nursery. Babies are allowed to stay with their mothers for a year for bonding. Just a year ago we had a young mother whose four month old baby looked very lethargic to her. She brought him down to the clinic and the nurse said there's nothing wrong with him, he's doing fine. This went on for days. She kept bringing him to the clinic, she kept being told he was fine.

Finally, the counselor intervened and said this baby looked sick. The counselor said to me I think the baby is dying. They brought the baby down this last day and the nurse finally called and had the baby brought out to a clinic, but not to a pediatrician. Since the baby didn't have a temperature, he was sent back to the facility. The following day he was so very lethargic that they

brought him out to the hospital, brought the mother with him and she stood in shackles while the doctor pronounced him dead. Xavier was four months old.

A young woman was sent to my office because the teacher thought she was sick and could I help her. She was shaking, her eyes weren't focusing, she kept saying how very sick she felt, her stomach was very distended. I asked her if she saw the doctor and she said she had seen the doctor that day. And I said what did the doctor say? And she said, well, she took blood because she thinks maybe I'm pregnant. I said could you be? And she said no, I'm not, Sister. It was almost count time and I was afraid to send her back to her room because she looked so sick to me.

I called the clinic and I was screamed at, there's nothing wrong with her, she's been here she knows she's all right and I said she's not all right and I won't have it on my conscious by sending her back. So I said I'm writing it up in my report that I think she's sick. So eventually they sent her down to the clinic. She was Hispanic and I thought maybe because she didn't understand what they were saying -- we do not have interpreters -- and they said no, she understands.

They pulled her chart and they found

out that two weeks before she had had bloodwork done and her blood sugar level was 500. When she got down there they gave her ten units of Insulin and took her blood level sugar again, it was 595 and they gave her 10 more units of Insulin. And she didn't respond so they sent her out to the hospital, where she spent five days in intensive care and the doctor said to her I hope you are going to sue. She said I don't want to sue, I just want to live.

She came back to the facility, the following week. I had spent some time with her to tell her how to take care of her diabetes. I am a diabetic. I am in a wheelchair today partly because of the response of the diabetes to me, the destruction of the nerve cells. I don't want to see any woman have to go through what I've gone through. She came into my office looking sicker and when I said, you know, what's your blood sugar, she said it was 122 today. I said, that's perfect. I said, do you have any Insulin, she said yes, 30 units of Insulin, enough to have killed her.

I went to the deputy and I said If wonder if we have a protocol about diabetes because it doesn't seem that they know what they're doing down there. Women who have 180 to 200 blood level get two

and four units of Insulin, women with 130, 120 are getting 20 units of Insulin and just this past month a new diabetes protocol arrived at the prison beautifully bound, beautifully written, it's an excellent protocol, as are so many of the directives in corrections, excellent directives, they just are not followed.

Last person I would like to talk about is Esse. Esse had multiple problems. She had brain aneurysm, she has high blood pressure, she has AIDS, she had a bypass surgery just last year and she now this year was beginning to have -- experiencing the same problems she had prior to the bypass surgery. She went to the doctor and told him and he said everything that was wrong with your heart is fine now, they took care of it with the surgery, there's nothing wrong with you.

She used to tell me that she would wake up at night and she felt that her heart had stopped and she would sit up in bed and punch herself in the chest to jump start her heart again. She asked the doctor to check her heart because she was so frightened that she was going to die in prison and before she walked up the stairs her heart rate was 54. She climbed one short flight of stairs and her heart

rate was 120 and she used to say to me, I just pray to God I get out before I die and, fortunately, she did get out before she died.

Many people have said to me throughout the years why do you think the treatment of prisoners is so bad. Is it because of the lack of personnel? And, in part, yes, but, also, if you have ever talked to officers who have come through the training academy, they're taught that all inmates are con artists, don't trust them, they're out to get over on you.

And just as years and years ago slave traders were able to convince plantation owners that the black man was an animal with no soul and could be treated and worked as an animal, good people became slave owners. In our day the inmate is portrayed as an animal. I've heard it said over and over again, they're just animals, without souls, who deserve whatever they get, and sometimes good people buy into that.

And I sit before you today and I ask you to please, please, think very, very closely of what you have heard here and I just believe in my heart that if right-minded people can get together and make a decision to solve some of the problems and come

to the aides of our brothers and sisters who are incarcerated, then something could be done because each one of us, one day, will have to stand alone before our God and answer to the way -- for the way we treated his children and I know I, for one, cannot have that on my conscious.

MR. GREEN: Pat, did you want to start questioning, please.

MR. NOLAN: Thank you, each of you, for your compelling testimony. It's been said that the opposite of compassion is not hatred, it's indifference and thank you for not being indifferent and for trying to awaken compassion for people in some cases that have done bad things but are still worthy of dignity, in other cases are just sick, not bad, and each of your stories helps us understand the difficulties as staff member trying to obtain care for inmates and other staff to try to ensure the proper level of care.

Sister Antonia, you mentioned Kathy and in her death and you made a statement that prisoners are not allowed to die in prison. Can you explain that to us?

SISTER MAGUIRE: I wish I could. The only thing is there's a tremendous amount of paperwork

that happens when a person dies in prison and a lot of investigation when a person dies in prison. However, if they die in the hospital, that's taken out of the hands of the prison, so that they are brought out to the hospital to die.

MR. NOLAN: So they're officially declared dead on arrival?

SISTER MAGUIRE: Right.

MR. NOLAN: As opposed to --

SISTER MAGUIRE: Dying in the facility.

MR. NOLAN: Mr. Baumann, is that your experience and can you explain?

MR. BAUMANN: No, sir, we've had inmates pass away at the institution itself. Normally after about 3:00 in the afternoon till about 6:00 or 7:00 the next morning we have no one there who could legally pronounce the inmate dead so they will run them to the hospital and have the hospital actually do the pronouncement.

JUDGE SESSIONS: Mr. Baumann --

MR. BAUMANN: Yes, sir.

JUDGE SESSIONS: -- you referred to the fact that there was fear of charges being filed in connection with your service as an officer or other services of other officers. Tell us a little bit

about that.

MR. BAUMANN: You have a lot of times where you have incidents that are taken out of context or you are put in a catch-22 and you're constantly afraid of Internal Affairs coming in and trying to use an incident because of outside political pressures, internal political pressures within the department and that that incident will be taken out of context and then having Internal Affairs or Department of Management going out and shopping district attorneys if they take any sort of outside political heat for it.

And there are times where we've had physical altercations where we've had -- most recently, a shooting incident at Wasco State Prison. Long and short of it, the officer who had fired a nonlethal baton round from a 40-millimeter weapon had gotten familiarity training per departmental policy, but none of us had ever shot the weapon before. We were never properly trained to use it. It arrived, he was handed the weapon. An individual ended up dying as a result of the use of the weapon. You have got the family beating on the media, beating on everyone, wanting the officer prosecuted for it, yet he was caught in the middle of the situation.

Since that incident, the department has come back and now it's mandatory any institution that uses that weapon, annually, everyone has to fire three rounds, but that doesn't take and solve the issue at Wasco and the death of that inmate.

JUDGE SESSIONS: So it's your fear for both administrative charges and criminal charges?

MR. BAUMANN: Yes, sir.

JUDGE SESSIONS: Second thing in connection with the intake procedures, as you observed --

MR. BAUMANN: Yes, sir.

JUDGE SESSIONS: -- tell us about testing or things like HIV, hepatitis, tuberculosis, do you know whether in the intake --

MR. BAUMANN: The department has a standard mandatory test for tuberculosis on entry, not on exit. There's no medical testing on exit. They do voluntary testing for HIV.

JUDGE SESSIONS: Voluntary, by the party, if they are willing to be interested?

MR. BAUMANN: Correct, yes, sir. And we ran a blind study with UCC San Francisco, I want to say six or seven years ago, they just took a cross-section of the inmate population on hepatitis C.

We lobbied, the association lobbied for that. The department lobbied against it because the department's concern at the time was once they identify, they have an obligation to treat and they didn't want to have ten or 15,000 inmates running around with hepatitis C that they had an obligation to treat.

JUDGE SESSIONS: So what is the service as it stands now, is hepatitis C routinely tested or not?

MR. BAUMANN: No, it is not.

JUDGE SESSIONS: Is TB?

MR. BAUMANN: Not that I'm aware, it is not.

JUDGE SESSIONS: HIV is or not?

MR. BAUMANN: It's a voluntary test.

JUDGE SESSIONS: It's voluntary?

MR. BAUMANN: Yes, sir.

JUDGE SESSIONS: Are there any other testing on communicable diseases that you know of?

MR. BAUMANN: Not that I'm aware of, no, sir.

JUDGE SESSIONS: Thank you, sir.

MR. BAUMANN: Thank you, sir.

MR. NOLAN: Can I ask a follow-up?

MR. BAUMANN: Yes, sir.

MR. NOLAN: What about a mental evaluation on intake?

MR. BAUMANN: They have a set protocol on -- I believe there are four levels of screening on intake. The unfortunate part is that part of Coleman was it was supposed to be a confidential screening and then all follow-up care was supposed to be done one-on-one and individually.

One of the things that they cited in the suit was that you have 200 inmates in a holding tank, they push 199 of them into a corner and call an individual over into the opposite corner to screen, well, nobody is going to admit that there's a mental health issue there in front 199 other people. That still goes on less often than it did at the time of Coleman, but it still happens sporadically.

I'm not as well prepared for this as I would like to have been because last week I was at one of our institutions helping a local union negotiate the implementation of an enhanced mental health program where, because the lack of program space, management is putting cubicles on the day room floors for the psychiatrists and psychologists to work in and try to do mental health screening in an open cubicle.

They have the money from the

legislature to retrofit some existing space, two offices, but when the institution did that on another yard two years ago, they don't allow inmates into the program space; it's everybody's private offices and they still have the cubicles on the floors and they're still doing business as usual.

So I mean, you know, the legislature has been wonderful with most of that stuff, it's the department misusing the resources and no one outside stepping in and saying, you know, that's not right.

MR. NOLAN: That's great to see you speak out.

MR. BAUMANN: I appreciate your time.

MR. GREEN: Senator Romero.

SENATOR ROMERO: Thank you. Let me ask especially Mr. Baumann -- and I appreciate you being here and I know that I have certainly relied on you and some of the other correctional officers to assist me in moving forward on some of the reforms that I'm interested in, but how do we address this situation; for example, what is the role of the correctional officer in particular in bringing to our attention many of these and sometimes they're atrocities?

You may recall in California the case of an inmate who starved to death.

MR. BAUMANN: Yes, ma'am.

SENATOR ROMERO: I don't understand how an inmate starves to death in a state prison when there are medical practitioners, when there are wardens, administrators and correctional officers.

There was another case not too long afterwards, it became known as the Super Bowl Sunday, when an inmate bled to death and, again, there are still investigations on this, I don't know all the details, but how does an inmate bleed to death without the care being provided?

Now, certainly, in the aftermath of that there were, of course -- and I understand it -- the concerns from correctional officers to not be implicated in this, but, by the same token, what do we do to encourage officers, practitioners, administrators to speak up and to say this is how we will have an institution in which an inmate starves or bleeds to death, that silence is not tolerated?

Recently, a warden in California was fired from her position because of threatening others, essentially, to not speak out on abuses in the healthcare delivery system.

So what do we do at all levels to say when somebody dies -- and people die in our prisons

every day -- but how do we -- what do you, as a correctional officer, advise with respect to how do we get people to simply sometimes do the right thing and speak up?

MR. BAUMANN: I think a lot of the problem on the removal of the warden in San Quentin was kind of a mixed signal to -- at least to myself, I can't speak for all officers -- but there have been case after case after case of administrative misconduct where the warden hasn't been held accountable or the middle management hasn't been accountable.

We've had people step forward to report things and had the legislature or had the office of the inspector general or the governor's office turn their back on the employee and leave the employee hanging in the breeze. And it's a tough world to work in whenever you know that if you step forward and no one cares, that you are going to be left out there hanging on your own, and that means a lot.

There was an article, I believe it was in yesterday's paper, about the Kikendell(ph.) sexual harassment cases at VSPW. That had gone on for years and employees had come forward and come forward and nothing happened. And how do you instill a sense of

morality to a group of people of middle management and upper management?

You know, we've advocated for fair and impartial investigations for years and that's all we've asked, is if the allegations there, no matter what level of government, that the same protocols and procedures be put in place. And whenever someone steps up and says, you know what, this is going on, that somebody doesn't run to the papers, get their 15 minutes of fame and then turn around and go back and lock their office door. There's nothing more shameful.

And I have had officer after officer retaliated against for coming forward and they come back and sit down and say, why would I step forward? I'm going to ruin my life, I'm going to ruin my livelihood.

I've been threatened to be terminated over speaking out about it and the department's attitude is come back in eight months, we know you'll go to state personnel for it and win, but we'll put you through the bankruptcy and we'll put you through the changes.

MR. GREEN: Mr. Maynard, I know you have a question. Can I ask one first, though, please.

Mr. Farrow, what do you believe to be the most significant barriers to implementing the class -- the mandated class action settlement that you alluded to in your statement?

MR. FARROW: Well, first is the politics of the union for the correction officers. They wield a lot of power and they really don't want any kind of a program dealing with nonuniformed personnel implemented without their input.

Secondly, you have a hierarchy that has a wonderful philosophy in terms of the direction that they want to take the system and the kind of programs that they want to implement, but they're not in touch with the people on the ground.

Thirdly, you have elements in New Jersey that have been entrenched in the correctional system for the past 50 years. You have second and third, fourth generations working in the system, holding key positions in terms of operations and policy.

I think a case that you should try to get your hand on is Edward O. Lone versus the Department of Corrections, it's about a former warden. That case illustrates that New Jersey is perhaps one of the most racist, sexist departments in the state

and that has a lot to do with how programs are implemented and how resources are spent.

For example, you take a prison like Northern State, a prison like East Jersey in Rahway. These institutions are predominantly black and Hispanic and other than money spent for security reasons, there's very few programs in these prisons. But then you go to South Jersey to South Woods, which is a relatively new 278 million-dollar prison, if you are fortunate to get transferred there, all kinds of programs and opportunities are available to you, but it's predominantly a white prison, both in terms of staff and the inmate population.

There is really a north and south struggle going on in the Department of Corrections. The northern prisons versus the southern prisons in terms of resources, personnel. So there are a lot of problems.

I mean, the present commissioner, Mr. Brown, has a lot of good intentions, but what he fails to understand is that everything that has taken place in New Jersey has been the result of either court action or crisis. Very few changes have come about voluntarily in New Jersey.

MR. GREEN: Gary Maynard. And Gary is

going to be the last question because we have to move on to our next panel, so, Gary.

MR. MAYNARD: I just have a question for Mr. Baumann and I heard from Sister Antonia's testimony and Mr. Farrow's a description of correctional staff that were basically uncaring and treated offenders as animals.

Is that your experience with the correctional staff?

MR. BAUMANN: To some degree, yes, sir.

MR. MAYNARD: What percentage do you think of the total line staff would have compassion for the offenders?

MR. BAUMANN: I honestly couldn't tell you. I have worked three different institutions and it varies. A lot of it depends on the custody level of the institution and the programs going on at the institution; the lower custody, higher programming ones, it tends to be a lot higher than it is at the reception centers where you've just got bodies en masse going through.

And most of the time -- I know when I worked the reception center at CIM, you just had such massive quantities of inmates, I mean you are talking about 3,000 inmates a month rolling through the place

and everybody is just a number. You just try to -- it's a production line, you just try to keep the bodies, try to keep everything going because if you don't, you end up in the situation where you're having to lay bunks out in the dining halls and everything else so your only goal is to get them in, get whatever protocol you need done and get them back out the other end.

MR. GREEN: Again, on behalf of the Commission we want to express our appreciation for your coming in and sharing your personal experiences and the important information you shared with us today. Thank you so much.