Good evening members of the Corrections Advisory Committee,

My name is Josiah Schlee. I submit this written testimony to place into the official record a series of consistent, firsthand accounts from multiple incarcerated individuals currently or recently housed within Connecticut Department of Correction facilities, including Cheshire Correctional Institution.

The information presented below is derived from direct communications with incarcerated individuals, including my incarcerated friend and numerous individuals housed on the same cell block. These accounts are mutually corroborating, span extended periods of time, and describe systemic operational failures, not isolated or anecdotal incidents.

1. Inhumane Temperature Conditions and Failure of HVAC Systems

Multiple incarcerated individuals report prolonged exposure to unsafe and inhumane temperature conditions caused by outdated and failing HVAC systems.

Most urgently, I was informed that Southside Cheshire Correctional Institution, Units 1 through 6, experienced no functional heat for five consecutive days, affecting approximately 100 incarcerated individuals per housing block.

During this period:

- Staff reportedly brought personal heaters, fans, and air-conditioning units into staff-only work areas.
- Incarcerated individuals were provided no equivalent relief, despite extreme and fluctuating cold conditions.
- Temperature variance reportedly differed drastically by tier and housing area, compounding health risks.

These conditions raise serious concerns under:

- Connecticut General Statutes §18-81, which requires DOC facilities to be maintained in a manner consistent with health and safety.
- The Eighth Amendment to the United States Constitution, which prohibits cruel and unusual punishment, including prolonged exposure to extreme temperatures.
    - Wilson v. Seiter, 501 U.S. 294 (1991)
    - Farmer v. Brennan, 511 U.S. 825 (1994)
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Prolonged exposure to cold is not a mere inconvenience. It is a well-documented health risk and a fundamental conditions-of-confinement issue.

2. Routine Violations of the Connecticut PROTECT Act

Incarcerated individuals consistently report practices that appear to violate the Connecticut PROTECT Act (Public Act 22-19) and its implementing statutes.

Reported violations include:

- Placement in restrictive housing or segregation for non-violent disciplinary infractions, despite statutory limitations on such use.
    - See CGS §18-96b and §18-96c.
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- Restriction or suspension of inmate tablets as punishment, effectively depriving individuals of their statutory entitlement to electronic messaging.
- Frequent cancellation of gym access, outdoor recreation, and unit dayroom time without:
    - a declared emergency,
    - written notice,
    - or documented justification.
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Under CGS §18-81 and DOC administrative directives, recreation and communication are regulated components of humane confinement, not privileges subject to arbitrary withdrawal.

3. Arbitrary Cancellation of Visitation Without Notice

Incarcerated individuals report frequent and arbitrary cancellation of scheduled social visits without notice.

This practice commonly occurs through the reassignment or withdrawal of staff from visiting rooms, without:

- advance notice to inmates,
- announcements on the unit,
- or explanations provided afterward.

Families routinely travel long distances only to be turned away upon arrival.

This practice conflicts with:

- DOC Administrative Directive 10.6 (Inmate Visits),
- and broader due-process and family-integrity principles protected under the Fourteenth Amendment.

These harms are entirely preventable through basic staffing transparency and communication.

4. Serious Deficiencies in Mental-Health Care (Anonymous Account)

I now raise serious concerns regarding mental-health care, based on the firsthand account of my incarcerated friend at Cheshire Correctional Institution, whose identity I am keeping confidential.

Upon intake:

- My friend immediately notified DOC staff of the need for mental-health treatment.
- A mental-health evaluation was conducted.
- A recognized mental-health level designation was assigned.

Despite this:

- Therapy has been intermittent and infrequent.
- Continued care has been repeatedly delayed.
- For many months, requests for treatment of long-documented attention and anxiety disorders have gone unfulfilled.
- Multiple written requests and grievances were submitted.
- Multiple medical-release forms were signed.
- Prior medical records have still not been obtained.

Most concerning, after my friend's cellmate died unexpectedly, there was:

- no debriefing,
- no crisis evaluation,
- no trauma-informed mental-health intervention,

despite explicit requests.

This raises serious concerns under:

- CGS §18-81 (medical and mental-health obligations),
- DOC Administrative Directive 8.5 (Mental Health Services),
- the Eighth Amendment deliberate-indifference standard (Farmer v. Brennan).

The absence of care following a traumatic death has resulted in significant mental and physical deterioration.

5. Inconsistent Policy Enforcement and Staff Training Failures

Incarcerated individuals report widespread policy inconsistency caused by inadequate staff training, resulting in confusion, unjust discipline, and arbitrary enforcement.

Examples include:

- Unclear rules regarding use of second-floor areas during recreation.
    - No prohibition appears in the inmate handbook or administrative directives.
    - Enforcement varies by officer.
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- Conflicting enforcement of cell-door policies during recreation:
    - Some staff close doors during routine tours.
    - Others refuse to open doors during recreation, denying access to toilets and water, instructing inmates to “leave your door open.”
    - Theft occurs during these periods.
    - When theft is reported, staff frequently take no action despite camera coverage.
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Policies that materially affect liberty and discipline must be published, consistent, and uniformly enforced.

6. Property Loss, Confiscation, and Abuse During SHU Placement

If an inmate is sent to segregation (SHU / RHU / “the box”), which reportedly occurs easily due to staff inconsistency:

- Staff sometimes allow cellmates to pack the inmate’s property.
- Trustees are sometimes allowed access to packed property.
- Property theft during this process is reportedly common.
- Little to no investigation or accountability follows.

Additionally:

- Essential items (shoes, headphones, hot pots, televisions, fans, cords) take five weeks or more to obtain due to an antiquated paper-approval system.
- This delay forces informal borrowing or sharing.
- If an inspection occurs while an inmate possesses a borrowed item not listed on their property matrix:
    - the item is confiscated,
    - not returned to its rightful owner,
    - even when ownership is clearly marked.
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This has caused serious conflict, threats, extortion, and at least one individual being placed in protective custody after being blamed for losses.

Actual theft routinely goes unaddressed, while rightfully owned property is confiscated.

7. Unsafe Cell Assignments and Denial of Cell Moves

In cases of irreconcilable cellmate conflict involving theft or credible fear of violence:

- Requests for cell reassignment are routinely denied.
- Staff reportedly respond with statements such as:
  "We don't do convenience moves — fight or f***."

Cell reassignment is treated as a privilege rather than a safety measure.

Other facilities recognize cell reassignment as a basic safety right. Cheshire reportedly does not.

8. Communication, Legal Access, and Administrative Failures

Additional systemic issues include:

- Electronic messages being reviewed up to 14 days, undermining timely communication.
- Scheduled legal calls limited to 10 minutes, insufficient for meaningful legal work.
- Many attorneys are located hours away, making in-person access impractical.
- Mental-health medications remain unobtainable for many individuals despite documented diagnoses and months-long requests.
- Paper request systems lack accountability:
  - No receipt.
  - No tracking.
  - No escalation path beyond grievances.
- Cheshire reportedly lacked an assigned counselor for over two months, leaving essential duties unfulfilled.
- Breakdown in chain of command:
  - Disciplinary sanctions overturned by committee are not removed due to staff disagreement or inaction.
- Frequent cancellation of:
  - library,
  - gym,
  - outdoor recreation,
  - religious services,
  - group programming,

  without emergencies.
- Mixing of pretrial, unsentenced individuals with Level 4 sentenced inmates, exposing non-violent detainees to heightened danger.
- Inadequate nutrition, with multivitamins insufficient to offset poor diet.

- Planned lockdowns known to staff in advance but not communicated to inmates.

Conclusion

The issues raised in this testimony do not require new legislation.

They require:

- Enforcement of existing Connecticut statutes,
- Compliance with the PROTECT Act,
- Adherence to DOC administrative directives,
- Transparent communication,
- Accountability for repeated operational failures.

I respectfully urge this Committee to:

- Request documentation from the Department of Correction,
- Investigate these consistent reports,
- Require corrective action,
- Ensure Connecticut's correctional system meets its legal obligations and basic standards of human dignity.

Thank you for your time and consideration.

Respectfully submitted,
Josiah Schlee

Citation Reference List

- CGS §18-81 — Health, safety, medical & mental-health care obligations
- CGS §18-96b / §18-96c — Limits on restrictive housing
- Public Act 22-19 — PROTECT Act
- DOC Administrative Directive 10.6 — Inmate Visits
- DOC Administrative Directive 8.5 — Mental Health Services
- Eighth Amendment — Cruel and unusual punishment
- Farmer v. Brennan, 511 U.S. 825 (1994)
- Wilson v. Seiter, 501 U.S. 294 (1991)