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New York City Board of Correction
1 Centre Street
Room 2213
New York, NY 10007

May 10, 2019

Dear Members of the New York City Board of Correction:

Thank you for the opportunity to speak about our client J.G. at the April 23, 2019 Special Hearing on the Minimum Standards to Eliminate Sexual Abuse and Harassment ("Special Hearing"). We now write to address an overarching issue we saw in our representation of J.G. and in prior litigation handled pro bono by Cleary Gottlieb involving Rikers Island correction officers: the utter absence of any meaningful consequence to correction officers even when there is no genuine doubt about their having violated the civil rights of detainees.

The Department of Justice has established that sexual abuse at Rikers Island is a daily occurrence. Other urban jails, even those of similar size, protect inmates dramatically better. This striking disparity is both an embarrassment to New York City and, more significantly, evidence of a civil rights crisis in our main jail. At Rikers Island sexual abuse is largely underreported. When it is reported, investigations rarely substantiate the charges (at levels lower than half the national average), and even when substantiated, correction officers are almost never even disciplined, much less prosecuted, for having raped or sexually abused those they are charged with protecting. As a result, civil litigation—lawsuits seeking money damages—are left to be a primary vehicle through which abused inmates can seek some form of justice. For a multitude of reasons, that recourse does not deter the conduct it seeks to redress. Among other things, in our experience, the Corporation Counsel has a practice of making any such litigation as expensive as possible for the victims of that abuse, to the point where, however egregious the behavior of the correction officers, few lawyers can pursue claims on behalf of abused inmates in economically viable ways. Such tactics put tremendous pressure on victims and their counsel to settle them quickly and cheaply, irrespective of their merits. More significantly, the City itself largely underwrites the defense of these cases, with the Corporation Counsel (or the correction officers' union) paying the freight. As a result, rarely do the correction officers themselves pay anything meaningful, again irrespective of how egregious their behavior.

This unacceptable but long-standing system seldom leads to any consequence for abusive correction officers. One does not need to be a corrections expert to know that where there is no real consequence for misbehavior, policies—however detailed, comprehensive, or elegant—fundamentally fail to prevent the conduct they are purportedly designed to deter.

Immediately before representing J.G., Cleary Gottlieb lawyers (working with the Legal Aid Society) represented two women who alleged that, between 2008 and 2013, they were repeatedly raped by the same correction officer while detained in the Rose M. Singer Center ("RMSC"). *Jane Doe 1 and Jane Doe 2 v. City of New York and Benny Santiago*, 15 Civ. 3849 (AKH) (S.D.N.Y. 2015). In that action, Timothy P. Ryan conducted an investigation of RMSC and in November 2016 issued a 50 page report. Mr. Ryan is one of the nation's leading jail experts, with over 40 years of experience in the criminal justice field, including as a line officer, supervisor, manager, and administrator for four of the twenty largest jails in the United States. That service included managing the Miami-Dade jail system, which is similar in size and urban population to Rikers Island. Mr. Ryan concluded that DOC's practices showed a "callous disregard for legal requirements and correctional professionalism and demonstrate deliberate indifference by the City to the sexual safety and well-being of the female detainees for which it is responsible." Ryan Report ¶ 2. (appended hereto as Exhibit A). His conclusion was based on several interrelated factors, including that:

> [T]he City failed to conduct vigorous, effective, and properly managed sexual misconduct investigations. As a result, the City has failed to effectively enforce its "zero tolerance" policy on sexual misconduct. That failure feeds into the DOC culture where *the correctional staff know that there is a minimal probability that the City will discover sexual misconduct, and that if discovered, the misconduct would not be effectively investigated so that, at conclusion, punishment would be unlikely*. Given this, it is my further opinion that the departmental "code of ethics" was not enforced, and that *any professional prohibitions relative to sexual misconduct were not real and that violation of the same was a tolerated employee practice sheltered by the code of silence exhibited by the staff*.

Id. ¶ 185 (emphasis added).

Mr. Ryan's conclusions were based on substantial evidence. Among other things, he pointed to the abysmally few times City investigators substantiated reports by detainees of sexual abuse. For example, even though he was aware of "no reason why female inmates at RMSC would make false allegations at a rate higher than at other jails in America," "the City's average substantiation rate is between one half and one third the national average." *Id.* ¶¶ 187-88. Relying on records produced in the *Jane Doe* lawsuit, Mr. Ryan was shocked to find that "since 2011, only two employees have been disciplined for sexual abuse and those persons were not correctional officers, but civilian staff." *Id.* ¶ 194. He noted that "to have only two 'substantiated' cases involving punishment is just not credible." *Id.*

The *Jane Doe* case settled in 2017 on the eve of trial, with the City paying more than $1 million.[1] While we would be more than willing to provide the Board with the details of that case (which was the subject of many press articles, including a lengthy one entitled "Rape at Rosie's" in a June 2018 issue of *New York* magazine), the size of the payment the City agreed to make is enough to dispel any genuine doubt that the City in fact concluded that the correction officer at issue was guilty of raping these women. Indeed, prior to our bringing suit, the Department of Investigation itself had substantiated that, at minimum, the correction officer was in an "unduly familiar" relationship with one of the women. For a variety of unacceptable reasons, including the tampering with material evidence (washing DNA off of pants before being lab-tested), destruction of evidence (such as video tapes), and similar fundamental investigative failures, the DOI deemed "unsubstantiated" the reports of sexual abuse. Nevertheless, according to written DOC policy, a correction officer found to be in an unduly familiar relationship with an inmate is to be terminated. Yet the *Jane Doe* correction officer was never criminally prosecuted, was not terminated, was not even the subject of any administrative discipline, and was instead permitted to remain on full salary, accruing his pension. So far as we know, that officer remains gainfully employed by DOC even to this day.

Perhaps in recognition of the *Jane Doe* case, and knowing that Cleary Gottlieb also both represented J.G. in his case and would be present to address the Board at the April 23 Special Hearing, or simply because DOC wanted to convey to the Board that material progress had been made at Rikers Island since the *Jane Doe* case, at that hearing DOC stated that every perpetrator of substantiated cases of sexual abuse has either resigned or been terminated following a disciplinary proceeding, implying that the practices Mr. Ryan excoriated were no longer prevalent at Rikers Island. *See* Special Hr'g at 1:06:55-1:07:08 ("[W]e have a <u>zero tolerance policy</u> for sexual abuse cases that come to us substantiated from DOI. We don't negotiate. That person has to resign or we will take them to trial and seek termination."). Further, at the Special Hearing DOC specified that following an investigation, the DOI can either refer a correction officer to DOC for administrative action, can refer the officer to the Bronx District Attorney ("Bronx DA") for prosecution, or can refer the officer for both. These assertions, of course, cannot be squared with the absence of any consequence to Santiago for having raped Jane Doe 1 and Jane Doe 2 (as alleged in their lawsuit, there were also other victims as well).

Unfortunately, these assertions also cannot be squared with the facts at issue in J.G.'s case, notwithstanding the suggestion otherwise by DOC at the Special Hearing. It is true that, unlike for the *Jane Doe* plaintiffs, the DOI did in fact substantiate J.G.'s report of sexual abuse by correction officer Clay. Indeed, in an October 2016 closing memorandum the DOI found that the correction officer at issue there, Clay, "engaged in unlawful sexual contact" with J.G. and <u>three other inmates</u>, "recommended that th[e] matter be closed as **<u>SUBSTANTIATED</u>**, and referred to the Bronx District Attorney's Office for criminal prosecution" and "referred [to] DOC for administrative action." Closing Memorandum at 7 (appended hereto as Exhibit B). Notably, of the over 300 reports of sexual abuse at Rikers Island made in 2015 to the DOC, we understand that J.G.'s report was the *only one* that was substantiated. If so, this substantiation rate—less

[1] A portion of this payment was for legal fees and out-of-pocket costs. Cleary Gottlieb donated all of the legal fees it was entitled to receive to the Legal Aid Society. The Legal Aid Society, in turn, made a gift in that amount to the two women plaintiffs.

than ½ of 1% of all reported sexual abuse in 2015—would fall even below the abysmal substantiation rates discussed by Mr. Ryan in his report.

More importantly, having conducted an investigation and having reached the conclusion that in fact the correction officer at issue was a sexual predator, what was the consequence? When asked at the Special Hearing "how many staff have been terminated as a result of substantiated sexual abuse claims?" Special Hr'g at 1:06:55-1:07:08, DOC answered that "every single individual" against whom claims of sexual abuse were substantiated has been terminated.[2] But that response is simply untrue. Despite the DOI's substantiation of J.G.'s claims and referral of the officer to the Bronx DA and DOC, more than 900 days have passed, and no administrative action has been taken against the officer, nor has he been prosecuted. Instead, to our knowledge, just as with the sexual predator correction officer in the *Jane Doe* case, J.G.'s victimizer remains gainfully employed by DOC.

Based upon our firm's experience, we urge the Board to demand: (1) regular reports from the DOC and the DOI describing the reports of sexual abuse made by Rikers Island detainees, including how many are substantiated; (2) regular reports compiled from similar jails showing the number of sexual abuse reports they received, and substantiate; (3) copies of all closing memoranda (or similar writings) documenting the conclusions reached by DOI or DOC where at least some portion of the detainee's claims are substantiated; (4) regular reports from the DOI and/or DOC with respect to the progress of investigations by the relevant District Attorney's Office with respect to any sexual abuse claim substantiated by DOI or DOC; and (5) regular reports on the 12 month anniversary of any sexual abuse report stating what the DOC intends to do with respect to administrative sanctions against the subject City employee, including what it will do to prevent any relevant statute of limitations from expiring (the significance of this last point is discussed further below). For obvious reasons, DOC should already be preparing these, or substantially similar, reports, so demanding the reporting suggested should pose no undue burden on DOC. In the event DOC is not already preparing such reports, there is all the more reason for the Board to demand them. We also ask that the Board specifically investigate why the correction officer who abused Jane Doe 1 and Jane Doe 2 was never disciplined, and why and who allowed the statute of limitations for administrative discipline to run without taking any action.

There are two further issues that DOC raised in response to our client's case that warrant further discussion: (1) pending a criminal investigation, a correction officer cannot be forced to go forward in an administrative proceeding; and (2) as the expiration of the statute of limitations nears, DOC will charge the officer in order to preserve its ability to later take administrative action.

First, DOC's policy of delaying administrative actions pending a criminal investigation protects potential criminal defendants at the expense of victims. At the Special Hearing DOC justified this policy on the basis that "a defense attorney is not going to recommend that their

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[2] "So, every single individual, every single case, of sexual assault, that has been substantiated from DOI, the individual has either resigned . . . or they have been terminated after an oath trial or at times they will leave with charges pending . . . what happens there is we defer prosecution so that if they ever try to come back we reopen the case and will seek their termination." Special Hr'g at 1:07:28-1:08:19.

client either sign a [non-prosecution agreement] or not sign one and instead take the case to trial at oath at which point they will have to testify or present their defense, which would really make their criminal defense case suffer." Special H'rg at 3:15:30. This "justification" is an affront to any genuine effort to making Rikers Island safe and constitutionally compliant.

The law provides no basis for protecting employees against whom claims of sexual abuse have been substantiated. Indeed, the United States Court of Appeals for the Second Circuit has been explicitly clear that "the Fifth Amendment 'does not protect against hard choices.' It protects against coercion that deprives a defendant of the opportunity to make such choices for himself." *United States v. Roberts*, 660 F.3d 149, 157 (2d Cir. 2011) (quoting *United States v. Solomon*, 509 F.2d 863, 872 (2d Cir. 1975)). Thus, whether a potential criminal defendant's "interests in his liberty and his employment [are] best served by maintaining his innocence or negotiating a plea agreement, by remaining silent or cooperating," are not hard choices from which a government employee (or, more broadly, and person) is protected. *Id.* To the contrary, criminal defendants regularly do invoke the Fifth Amendment in order to avoid answering questions where truthful responses would tend to incriminate themselves, but frequently suffer collateral consequences (such as adverse findings in related civil litigations) when they do so. And that is the case even when they face criminal charges based upon an indictment (which requires only a very low burden of proof for prosecutors to meet); in contrast, when the DOI substantiates sexual abuse or other charges, that means the evidence found by investigators compels the conclusion that he violated the civil rights of an detainee under the far more stringent more probable than not" standard of proof. When the investigative agency of the City has determined that it is more probable than not that a correction officer has sexually abused a detainee, there must be some consequence to that officer, and elevating the rights of that correction officer over the rights of his victim to criminal and civil redress is not just bad policy, but utterly unacceptable.

Second, in cases where DOC is unable to bring administrative proceedings against the employee, DOC must, at an absolute minimum, protect its right to terminate the correction officer. In the *Jane Doe* case, the DOI took more than a year to investigate, it and DOC simply allowed the 18-month limitation to expire, and then DOC used the limitation period's expiration to terminate its own investigation of the correction officer and to justify failing even to bring administrative charges against him, much less to impose any discipline for his misconduct. Nevertheless, at the Special Hearing, DOC stated that if it "see[s] that our statute of limitations is coming close, which is 18 months, we will charge. . . . We will draft and charge the individual in order to preserve the statute of limitations so that if and when the criminal prosecution concludes . . . we wouldn't have lost the ability to do so." Special Hr'g at 3:18:13. But, based upon our experience in J.G.'s case, that assertion is either a gross overstatement, or highly misleading. Through discovery in J.G.'s civil case, we learned that, despite the substantiated claims of sexual abuse and DOI's recommendation in October 2016 that the "matter . . . be referred to DOC for administrative action," to date *no disciplinary proceedings have been initiated against the officer*. Instead, to our knowledge, the officer remains employed by DOC collecting a full salary. In this regard, we urge the Board specifically to ask DOC whether the correction officer at issue in the J.G. case has been disciplined, and if he has not, to determine why and who is responsible.

In order to combat the pervasive sexual abuse in New York City correctional institutions, the policies and practices we discuss above must change. And these policies and practices are just part of the problem; we strongly encourage the members of the Board to review Mr. Ryan's comprehensive report and to demand prompt and comprehensive changes to the investigation and enforcement of sexual abuse at Rikers Island. Thank you.

Sincerely,

Mitchell A. Lowenthal
Rahul Mukhi
Jessa DeGroote
Ariel M. Fox
Hannah Belitz (Law Clerk)
Morton Bast (Law Clerk)

Attorneys for J.G.

Enclosures:
Report of Timothy P. Ryan dated November 3, 2016
Closing Memorandum dated October 6, 2016

Exhibit A

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

JANE DOE 1 and JANE DOE 2, on behalf of themselves and all similarly situated women,

Plaintiffs,

-against-

THE CITY OF NEW YORK and BENNY SANTIAGO,

Defendants.

15 Civ. 3849 (AKH)

EXPERT REPORT OF TIMOTHY P. RYAN

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ACKNOWLEDGEMENT

Pursuant to Fed. R. Civ. P. 26(a)(2), I, Timothy P. Ryan, submit this report on the above referenced case. It contains a complete statement of expressed opinions and the basis and reasons therefore; the data and other information I considered in forming my opinions; my qualifications, including a list of publications authored within the preceding ten years; the compensation for the study and testimony; and a listing of other cases in which I have testified as an expert at trial or by deposition within the preceding four years.

I. Introduction

***Jane Doe 1 and Jane Doe 2, on behalf of themselves and all similarly situated women, Plaintiffs, -against- The City of New York and Benny Santiago, Defendants* (United States District Court, Southern District of New York, No. 15 Civ. 3849 (AKH)).**

I was retained on July 5, 2016, by counsel to the Plaintiffs, to serve as an expert witness in the above entitled federal civil rights case brought against the City of New York (the "City") and Correction Officer Bienvenido (Benny) Santiago.

Plaintiffs accuse the defendants of acts, inactions, and/or omissions that resulted in the repeated rape and sexual abuse of inmates confined to the all-women jail on Rikers Island known as the Rose M. Singer Center ("RMSC"), and the consequent denial of Jane Doe 1's and Jane Doe 2's civil rights.

I was retained to assess this matter from the perspective of a long-time correctional professional. I have endeavored to provide an accurate assessment of the materials provided to me on which I relied (set out below) and observations I made while conducting such an analysis.

The following is that written Report.

II. Summary of Opinions

1. Given my education, training, and experiences over 44 years of public service in the criminal justice field, including as a line officer, supervisor, manager, and administrator for four of the twenty largest jails in the United States (two in California and two in Florida) and based on the materials that I have reviewed (set forth below in Appendix C) and my observations while inspecting Rose M. Singer Center ("RMSC"), I have come to the following conclusions.

2. It is my opinion that the City's practices show a callous disregard for legal requirements and correctional professionalism and demonstrate deliberate indifference by the City to the sexual safety and well-being of the female detainees for which it is responsible.

3. The City fails to meet the expected national standards for the operation of RMSC as a sexually safe and secure housing facility for female detainees. This includes, but is not limited to, my opinion that the City of New York remains out of compliance with the Prison Rape Elimination Act of 2003 ("PREA"), which was enacted in 2003 and formally implemented in the summer of 2012 with the promulgation of PREA regulations by the U.S. Department of Justice ("PREA Standards"), and that the New York City Department of Corrections ("DOC") leadership has yet to embrace its requirements.

4. The City's hiring practices fail to adequately screen prospective correction officers ("COs") for problematic backgrounds, including histories of criminal activity, gang involvement, domestic violence, and other characteristics that are recognized to substantially increase the likelihood of criminal sexual assault in jail.

5. The City inadequately trains its correction officers, supervisors, medical personnel, and investigators to detect, report, and investigate sexual abuse, which has fostered a culture of impunity where correction officers can sexually abuse inmates without fear of punishment.

6. The City's practice of permitting male correction officers to guard female inmates without adequate supervision or assistance from female correction officers materially increases the risk of staff-on-inmate sexual abuse, and violates correctional best practices, the PREA Standards, and state law.

7. The City's reporting mechanisms for sexual abuse are non-functional and inadequate, making it nearly impossible for inmates and staff to report sexual abuse to the City's investigators. The culture at RMSC also fosters the notion of a "code of silence" among correction officers, which prevents correction officers who are not involved in but are aware of criminal sexual abuse from coming forward.

8. The City fails to protect inmates who do successfully report sexual abuse from retaliation, which further suppresses the ability of sexual abuse victims to come forward.

9. Once the City receives an allegation of sexual abuse, the City's practices do not support a rigorous investigative program that aggressively examines the sexual victimization of female inmates by its correctional staff. As a result, correction officers at RMSC can rape and sexually abuse inmates without likely consequence, despite the City's "zero tolerance" written policy.

10. Because of the City's inadequate practices, RMSC has a culture of impunity where female detainees are sexually abused and raped at significantly higher levels than at other jails in America, and where the staff sexual abusers can be nearly assured of a mismanaged investigation without realistic fear of any sort of punishment or discipline.

III. Summary of Facts

A. General Overview

11. The DOC is an agency of the City of New York. The DOC began as a department of the City in the late 1800's. It is overseen by the Commissioner of Correction, Joseph Ponte, as of April 2014, who reports to the Mayor and the Board of Correction. The agency is responsible for nearly 10,000 inmates in custody across 12 facilities.

12. The stated mission of the DOC is that "[a]s part of the criminal justice system, the New York City Department of Correction is dedicated to enhancing public safety by maintaining a safe and secure environment for our staff, while providing inmates with the tools and opportunities they need to successfully re-enter their communities."[1]

13. Regarding the values of the DOC staff, it states: "To be BOLD is to lead honorably and selflessly serve your community. As bold and faithful members of the New York City Department of Correction we pledge to: [i] Act with integrity [ii] Respect our fellow citizens [iii] Serve with compassion [iv] Inspire correctional change nationwide [v] Transform the lives of those in our care."[2]

14. In order to ensure that the mission and vision statements of the DOC are achieved, and that any inmates incarcerated by DOC are kept safe and secure and free from any form of sexual abuse (e.g., rape), the State of New York has legislated criminal statutes and sanctions prohibiting all sexual activity between incarcerated individuals and correctional staff (New York Penal Law Sections 130.05(3)(f), 130.25(1), and 130.40(1)). The DOC is required to ensure that these laws are not violated, and if they are, to seek swift, sure, and appropriate adjudication in favor of the victim inmate.

[1] *Our Mission*, DOC, http://www1.nyc.gov/site/doc/about/mission.page (last visited Oct. 31, 2016).

[2] *Id.*

B. Case Overview

15. Both of the Plaintiffs in this matter, Jane Doe 1 and Jane Doe 2, were incarcerated at RMSC during different, and partially concurrent, times between 2006 and 2014. RMSC is one of the nine jail facilities located on Rikers Island, operated under the authority of the City of New York via its Department of Correction. RMSC houses only female inmates and mostly those who are pre-sentenced and still attending court-related functions. The facility is designed for 1,700 inmates. However, that count fluctuates. For example, at the specific time when Jane Doe 2 reported being raped (May 2013), the inmate count was less than 700.

16. The facility is administered by the position of Warden who reports, via chain of command, to the Commissioner of the DOC. Additionally, in leadership, there is a Deputy Warden and Assistant Deputy Wardens, as well as shift personnel. The shift personnel includes both male and female correction officers, sometimes working alone in housing units, supervised by the position of Captain. The staff has general responsibility for the care, custody, and control of the women inmates.

17. Throughout the relevant periods, the subject officer, identified as Correction Officer Benny Santiago, was employed by the DOC and assigned to RMSC. His hiring personnel file was provided. Notably, that file contained no records of Santiago having received any training after January 1998, when he completed the standard CO Academy training.[3]

C. Jane Doe 1

18. Jane Doe 1 is a 31 year-old woman. She was detained at RMSC for several different periods beginning in 2006, and I understand that she was sexually assaulted and abused by Santiago during her detention at RMSC.

19. First, Jane Doe 1 alleges that in 2006, while she was housed in Dorm 8 of RMSC and guarded by Santiago,[4] Santiago instructed her to come to his desk and then unzipped his pants, exposed himself and masturbated in front of her.[5] He then warned her to keep quiet about the incident. Second, Jane Doe 1 alleges that Santiago raped her approximately eight or nine times while she was incarcerated in 2008 or 2009.[6] She testified that the rapes took place in the Dorm 8 dayroom during Santiago's night shift, after the Captain had completed his rounds.[7] She further alleges that on several of these occasions, after having sex with her, Santiago provided her with balloons filled

[3] *See* DOC, Personnel File of CO Santiago (DEF_0000705-1377) ("Santiago Personnel File").

[4] DOC, Inmate Lookup Service: Inmate Details for Jane Doe 1 (Aug. 3, 2015) (DEF_0000559-62); Santiago Personnel File, at DEF_0001127-28 (attendance record for 2006).

[5] Jane Doe 1 Dep. 137:1-140:13 ("JD1 Dep.").

[6] JD1 Dep. 31:17-20, 135:3-8.

[7] *Id.* 24:13-27:18, 43:2-44:7, 54:20-55:3.

with marijuana and tobacco.[8] Finally, Jane Doe 1 alleges that Santiago raped her six times during her incarceration beginning in September 2011.[9] She testified that these rapes took place in an area known as the "sprungs,"[10] which included a series of tents on Rikers Island, outside of the permanent RMSC structure, which is now demolished. Female detainees had previously been housed in facilities at the sprungs. Jane Doe 1 stated that Santiago took her to the tent facilities of the sprungs when escorting her back to her dorm from the medical clinic.[11] Jane Doe 1 alleges that Santiago was physically rough when raping her, frequently choking her and pulling her hair.[12] She alleges that on two occasions Santiago anally raped her because he was angry with her.[13]

20. I understand that Santiago denies ever knowing Jane Doe 1,[14] and, accordingly, denies raping or sexually abusing her. However, I also understand that Jane Doe 1 alleges that Santiago went to visit her mother,[15] and that her mother testified to having met Santiago and correctly identified Santiago's photograph.[16] I also note that Santiago was employed as a CO at RMSC for the entire period while Jane Doe 1 was confined there,[17] and that Jane Doe 1 knew specific, personal information about Santiago, including information about his ex-wife, children, car, and food preference.[18]

21. In an affidavit, Jane Doe 1 states that she was intimidated against reporting Santiago while he abused her.[19] She states that she was terrified of what Santiago would do to her if she reported him. She states that Santiago threatened her many times and told her not to tell anyone, and that he informed her that he had visited her mother, which

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[8] JD1 Dep. 24:13-25:7; 50:24-3; 53:13-54:4, 80:14-81:7, 116:25-117:15.

[9] *Id.* 136:11-25.

[10] *Id.* 56:23-57:1, 82:13-83:9.

[11] *Id.*

[12] *Id.* 25:22-26:2.

[13] *Id.* 83:14-22.

[14] Benny Santiago Dep. 243:25-245:14.

[15] JD1 Dep. 142:5-17.

[16] B.W. Dep. 29:5-30:4, 36:23-37:5, 37:21-38:24, 60:6-20.

[17] Santiago Personnel File, *supra* note 3, at DEF_0000826-27 (Jan. 18, 2007 awardance of post and June 1, 2007 squad change notice), DEF_0000876 (July 8, 2009 squad change notice), DEF_0000938-40 (Nov. 2006 to Jan. 2007 squad change notices), DEF_0001053 (Dec. 10, 2002 squad change notice), DEF_0001138-39 (attendance record for July 2011 to June 2012); Santiago Dep. 65:13-67:22.

[18] JD1 Dep. 63:21-64:11; 118:11-119:12.

[19] Decl. of Jane Doe 1 in Supp. of Mot. for Class Certification ¶¶ 7-11 (Oct. 9, 2015), ECF No. 29.

Jane Doe 1 took as an implicit threat against her family.[20] She further states that she did not think that anyone would believe her allegations because she was an inmate and Santiago was an authority figure.[21] On July 29, 2013, however, counsel filed on Jane Doe 1's behalf a Notice of Claim with NYC.[22] That Notice of Claim alleged that she was sexually abused and raped by Santiago and that DOC failed to protect her from those incidents.[23] Even though Jane Doe 1 was confined to RMSC when she filed the Notice of Claim (and remained there for almost two years), I am unaware of any investigation conducted by RMSC, whether by the New York City Department of Investigation ("DOI"), the DOC Investigation Division ("DOC ID"), or any other NYC agency, to examine the allegation Jane Doe 1 made about Santiago in the Notice of Claim.

D. Jane Doe 2

22. Jane Doe 2 is a 26 year-old woman. She was a pre-trial detainee at RMSC from December 1, 2012 through May 14, 2013, and for a brief period in March 2014.[24]

23. I understand that during her incarceration, in February 2013, Jane Doe 2 began working as a Suicide Prevention Aid ("SPA") in Building 9 at RMSC.[25] As an SPA, she was responsible for monitoring inmates on suicide watch and had to make rounds at night.[26] At the time, Jane Doe 2 was housed in Building 11, where Santiago was the steady officer assigned to the night shift (11 p.m. to 7 a.m.).[27] Jane Doe 2 and Santiago therefore came into contact nearly all of the nights Santiago was on duty because Jane Doe 2 would return to Building 11 during and at the end of her SPA shift in Building 9.

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[20] JD1 Dep. 72:4-22; 79:18-22.

[21] *Id.* 79:23-80:6.

[22] Jane Doe 1 Personal Injury Claim Form (July 29, 2013), at JANEDOES_00000029-30 (JANEDOES_00000029-32).

[23] *Id.*

[24] Inmate Movement History Log for Jane Doe 2 (Dec. 2, 2012 to May 14, 2013), at DEF_0002260 (DEF_0002260-64); Inmate Movement History Log for Jane Doe 2 (Mar. 27 to Apr. 3, 2014), at DEF_0002258.

[25] Jane Doe 2 Dep. 83:5-84:2; 87:3-16 ("JD2 Dep."). I understand that the records necessary to confirm Jane Doe 2's employment have been lost or destroyed by the City. Specifically, the City confirmed that Jane Doe 2's inmate folder, which would contain this information, for her 2012 to 2013 incarceration at RMSC, cannot be located.

[26] *Id.*

[27] Inmate Movement History Log for Jane Doe 2 (Dec. 2, 2012 to May 14, 2013), *supra* note 24, at DEF_0002262; Santiago Personnel File, *supra* note 3, at DEF_0000845 (Mar. 8, 2012 awardance of post).

24. Jane Doe 2 alleges that once she became a SPA and came into frequent contact with Santiago, Santiago began making lewd sexual comments to her and eventually told her that he would pay her for oral sex.[28] Jane Doe 2 alleges that Santiago raped her several times between February to early May 2013. These incidents took place in an empty cell or in the janitor's closet in Building 11.[29] Jane Doe 2 alleges that throughout this period Santiago told her details about his personal life[30] and repeatedly provided her with various forms of contraband, including ecstasy.[31] Jane Doe 2 also testified that after the first incident of abuse, Santiago paid her $100 in twenty dollar bills.[32] After the last incident of abuse, Jane Doe 2 alleges that she spit Santiago's semen into her hand and wiped it on her jeans.[33]

25. On May 4, 2013, Jane Doe 2 was infracted for possession of contraband and moved out of Building 11.[34] Jane Doe 2 alleges that because she feared retaliation from Santiago she told investigators that someone other than Santiago had given her the contraband items.[35] She was subsequently moved back to Building 11.[36] Jane Doe 2 alleges that upon her return, she was subject to harassment and threats by inmates and correction officers who all appeared to believe that she had "snitched" on Santiago.[37] Jane Doe 2 alleges that Santiago refused to feed her – an occurrence that Santiago confirms but claims was punishment (that Santiago personally imposed) for fighting with other inmates, not retaliation for ostensibly having reported his crimes.[38]

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[28] JD2 Dep. 81:21-82:11.

[29] *Id.* 95:20-25, 104:18-21, 117:23-118:11, 119:7-22.

[30] *Id.* 98:22-99:12, 129:4-10, 138:1-13, 138:23-139:13; Bible and Diary Entries of Jane Doe 2, at DEF_0018263 (DEF_0018259-70) ("JD2 Bible and Diary").

[31] JD2 Dep. 111:2-112:8, 130:24-131:6, 157:1-4, 185:22-186:6.

[32] *Id.* 95:10-96:7.

[33] *Id.* 190:5-24, 191:14-23.

[34] DOC, File for Investigation of Infraction for Jane Doe 2, at DEF_0016140-41 (May 9, 2013) (DEF_0016136-51) (May 4, 2013 incident report form); DOC ID, Case File regarding Jane Doe 2's allegations against CO Santiago, at DEF_0002498 (DEF_0002479-525) ("JD2 DOC ID Case File") (history inquiry for May 4, 2013 infraction); Inmate Movement History Log for Jane Doe 2 (Dec. 2, 2012 to May 14, 2013), *supra* note 24, at DEF_0002264.

[35] JD2 Dep. 210:24-211:9.

[36] Inmate Movement History Log for Jane Doe 2 (Dec. 2, 2012 to May 14, 2013), *supra* note 24, at DEF_0002264.

[37] JD2 Dep. 153:7-21; 161:5-164:24; 178:15-17; JD2 Bible and Diary, *supra* note 30, at DEF_0018266-68.

[38] Santiago Dep. 90:3-97:9; JD2 Bible and Diary, *supra* note 30, at DEF_0018268.

26. Jane Doe 2 alleges that, on May 9, 2013, she could no longer stand the retaliation, and she reported her sexual abuse to a mental health clinician.[39] She alleges the mental health clinician told her there was nothing that could be done and was escorted back to Building 11,[40] where she was subject to more threats and bullying by inmates while correction officers turned a blind eye.[41] On May 10, Jane Doe 2 again reported her abuse to a member of the DOC medical staff.[42] This person then informed the DOI, which is a separate NYC agency not accountable to the DOC, which is tasked with investigating misconduct by City employees and agencies.[43] A summary of DOI's investigation of Jane Doe 2's claim is set forth *infra* ¶¶ 32-41.

27. On May 14, 2013, because of the ongoing DOI investigation, Jane Doe 2 was moved out of RMSC to Orange County Correctional Facility in Goshen, NY.[44] On March 27, 2014, Jane Doe 2 was transferred back to RMSC because she had a hearing in court in New York City.[45] Jane Doe 2 alleges that during this time she was subject to further retaliation and verbal attacks from RMSC correction officers.[46] Jane Doe 2's father and her legal counsel notified DOI that Jane Doe 2 was being retaliated against, but DOI did not open an investigation into the retaliation charges.[47]

E. Santiago

[39] JD2 Dep. 169:24-171:25; JD2 Bible and Diary, *supra* note 30, at DEF_0018268-69.

[40] JD2 Dep. 169:24-171:25.

[41] *Id.* 165:24-166:24.

[42] DOI, Case File regarding Jane Doe 2's allegations against CO Santiago, at DEF_0001515, DEF_0001945-46 (DEF_0001378-1962) ("JD2 DOI Case File") (May 10, 2013 e-mail from Jennifer Sculco to James Christo forwarding e-mail from DOC medical staff regarding sexual assault); JD2 Dep. 194:5-21.

[43] JD2 DOI Case File, *supra* note 42, at DEF_0001948 (May 10, 2013 e-mail from Jennifer Sculco to James Christo and Ferdinand Torres forwarding e-mail from DOC medical staff regarding sexual assault).

[44] James Christo Dep. 78:24-79:20, March 24, 2016.

[45] Inmate Movement History Log for Jane Doe 2 (Mar. 27 to Apr. 3, 2014), *supra* note 24, at DEF_0002258.

[46] JD2 Dep. 203:14-204:25.

[47] DOI, Referral to Florence Finkle, DOC Deputy Comm'r of Investigations (Apr. 11, 2014) (NYC_00001483-86); DOI, Referral to Florence Finkle, DOC Deputy Comm'r of Investigations (Apr. 11, 2014) (NYC_00001488); JD2 DOI Case File, *supra* note 42,at DEF_0001909 (Apr. 2, 2014 e-mail from James Christo to Rhonda Young forwarding e-mail from attorney William Gibney, The Legal Aid Society).

28. Santiago is a 45 year-old man. He has been a correction officer since October 1997.[48] Prior to that, he owned a store that rented and sold video tapes.[49] He testified that he became a correction officer because he wanted to comfortably retire.[50]

29. At the time that DOI investigated her allegations of sexual abuse in May 2013, Jane Doe 2 knew many personal facts about Santiago. Among other things, Jane Doe 2 knew Santiago's cell phone number and address.[51] She knew that he was a Virgo.[52] She knew information about his ex-wives, daughters, and grandson.[53] She knew what kind of car he drove.[54] She knew that his penis was uncircumcised.[55] Santiago confirmed the accuracy of each of these pieces of information.[56]

30. In addition to Jane Doe 1 and Jane Doe 2, several female inmates have made sexual abuse allegations against Santiago. None of the allegations were properly investigated. First, the City never investigated Jane Doe 1's allegations of abuse after receiving her notice of claim in July 2013. Second, when Jane Doe 2 first reported her abuse on May 9, 2013, she was effectively ignored, and her subsequent allegations of retaliation were never investigated, even though they were reported by Jane Doe 2, her legal counsel, and her father. Third, in 2012, a female detainee at RMSC alleged that Santiago was having sex with two inmates.[57] Her allegation was recorded during a disciplinary hearing for a charge the inmate alleged was falsely entered against her by Santiago as an implicit threat to prevent her from reporting his sexual abuse.[58] The DOC captain presiding over the disciplinary hearing promptly reported the allegation to DOI.[59] DOI never recorded or investigated the allegation. Fourth, in 2007, another female inmate reported to DOI that Santiago was supplying inmates with contraband,

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[48] Santiago Dep. 23:15-20.

[49] *Id.* 23:24-24:5.

[50] *See id.* 24:12-20.

[51] JD2 Dep. 98:22-12, 138:1-13, 138:23-139:5; JD2 Bible and Diary, *supra* note 30, at DEF_0018263.

[52] JD2 Dep. 129:4-10.

[53] JD2 DOI Case File, *supra* note 42, at DEF_0001474, DEF_0001498 (handwritten notes from Jane Doe 2 interview).

[54] *Id.* at DEF_0001474.

[55] *Id.* at DEF_0001498.

[56] Santiago Dep. 10:18-24, 11:7-8, 45:20-23, 168:8-12, 179:16-17; JD2 DOI Case File, *supra* note 42, at DEF_0001919-20 (memorandum of interview with Santiago conducted by James Christo and Rhonda Young).

[57] Diane Medina Dep. 114:24-4.

[58] Recording of Disciplinary Hr'g of J.F. (July 23, 2012) (NYCAUDIO_00000544).

[59] Diane Medina, Assistant Deputy Warden, DOC, Page from Hr'gs Journal (July 23, 2012) (DEF_0014497).

and her husband subsequently informed DOI that correction officers have oral sex with inmates.[60] There is no record of DOI following up on these claims. Finally, in June 2013 – at the same time he was investigating Jane Doe 2's allegations of sexual abuse against Santiago – DOI Investigator James Christo was informed by a detective that a confidential informant had learned that a female inmate was having sex with a CO Santiago and had become pregnant.[61] The informant also reported that another female inmate was recruiting a young female inmate to have sex with a CO Santiago in exchange for cigarettes.[62] Despite being provided with detailed information – including one of the inmates' Book & Case numbers – Investigator Christo did absolutely nothing with this information and did not even follow up to find out if the allegations referred to the same CO Santiago as the one he was then currently investigating.[63] When asked why he failed to investigate these serious allegations, Investigator Christo testified, "I just didn't."[64]

31. On May 13, 2013, after DOI opened its investigation into Jane Doe 2's allegations, Santiago was placed on modified duty.[65] He was returned to full status in May 2016.[66] Santiago testified that he expects to retire in 2017 and expects to receive a full pension.[67]

F. The DOI Investigation of Jane Doe 2's Allegations

32. On May 10, 2013, DOI was notified of Jane Doe 2's allegations of rape and sexual abuse against Santiago.[68] That afternoon/evening DOI investigators Ferdinand Torres, and Belarminia Ortiz, met with Jane Doe 2.[69] They took no notes of their conversation with Jane Doe 2,[70] but Torres went to Jane Doe 2's cell and retrieved a pair of jeans

[60] DOI, Intake form documenting notification of allegation by inmate M.F. that CO Santiago was supplying inmates with contraband, at DEF_0001931 (DEF_0001931-001934).

[61] E-mail from Belarminia Ortiz, Chief Investigator, DOI, to James Christo, Assistant Inspector Gen., DOI (June 3, 2013) (NYC_00007047).

[62] *Id.*

[63] Christo Dep. 339:21-341:19, July 27, 2016.

[64] *Id.* 340:13-17.

[65] Eliseo Perez Jr., Assistant Chief of Security, DOC, Teletype Order No. HQ -01070-0, Personnel Orders – Notification of Temporary Assignment to Modified Duty (May 13, 2013) (NYC_00003703-3704).

[66] Santiago Dep. 44:11-12.

[67] *Id.* 51:23-52:20.

[68] JD2 DOI Case File, *supra* note 42, at DEF_0001945-46 (May 10, 2013 e-mail from Jennifer Sculco to James Christo forwarding e-mail from DOC medical staff regarding alleged sexual assault); JD2 Dep. 194:5-21.

[69] JD2 Dep. 200:1-3.

[70] Ferdinand Torres Dep. 213:16-20; Belarminia Ortiz Dep. 87:18-25.

that Jane Doe 2 reported contained Santiago's semen.[71] Torres testified that, using gloves, he placed the jeans in a brown paper bag.[72] There is no documentary record regarding what Torres did with the jeans. His testimony is in conflict: at some point, he states that he gave the bag with the jeans to DOI Investigator Christo on May 10,[73] but Christo denies that.[74] Christo testifies that Torres gave the bag with the jeans to him on May 14,[75] but (if so) there is no accounting for what happened to the jeans between May 10 and May 14. Moreover, Torres admits that he placed no seal on the bag.[76] On May 14, Christo submitted the pants to the New York City Police Department ("NYPD") Property Clerk's Office,[77] and on May 16, the pants were sent to the Office of the Chief Medical Examiner for testing.[78]

33. On May 10, and a second time within the next few days, DOI Investigators Christo and Rhonda Young interviewed Jane Doe 2 in the counsel visit room at RMSC.[79] Jane Doe 2 provided the investigators with a detailed account of her abuse, including dates and locations of each incident of rape.[80] She also relayed identifying, personal information about Santiago, including information about his ex-wives, daughters, vacation, and car and a description of his penis – its length, both erect and flaccid, and that it was uncircumcised.[81] Young and Christo shared note taking responsibilities during the May 13 interview of Jane Doe 2 (no notes were produced from the May 10 interview).[82] Afterward, Young began drafting an interview memorandum, but neither

[71] JD2 DOI Case File, *supra* note 42, at DEF_0001825 (closing memorandum from James Christo dated June 25, 2014), DEF_0001948 (May 10, 2013 e-mail from Jennifer Sculco to James Christo and Ferdinand Torres forwarding e-mail from DOC medical staff regarding sexual assault).

[72] Torres Dep. 219:24-220:2, 220:23-25.

[73] *Id.* 223:12-14; 229:20-230:5.

[74] Christo Dep. 83:2-6, Mar. 24, 2016.

[75] *Id.* 142:3-5.

[76] Torres Dep. 222:22-223:2; Christo Dep. 142:12-143:6, Mar. 24, 2016.

[77] JD2 DOI Case File, *supra* note 42, at DEF_0001736 (July 18, 2013 letter from James Christo to the Office of the Chief Medical Examiner regarding submission of forensic evidence); Christo Dep. 141:9-11, 144:6.

[78] NYPD, Chain of Custody for Invoice for Jane Doe 2's pants (May 14, 2013) (DEF_0016121).

[79] JD2 Dep. 200:6-11; Christo Dep. 111:23-112:4, Mar. 24, 2016.

[80] JD2 DOI Case File, *supra* note 42, at DEF_0001423-69, DEF_0001470-500 (handwritten notes from investigative interviews); Young Dep. 193:22-194:3.

[81] JD2 DOI Case File, *supra* note 42, at DEF_0001474, DEF_0001498.

[82] Rhonda Young Tr. 168:15-169:7; Christo Dep. 175:6-176:10, Mar. 24, 2016.

she nor anyone else ever completed it.[83] The incomplete memo – which contains obvious inaccuracies and trails off in garbled text halfway through the chronology of events Jane Doe 2 reported – is included in the final case file.

34. The investigators also took possession of Jane Doe 2's bible and notebook (though there is no record of when or how those items were collected).[84] Jane Doe 2 alleges that Santiago gave her the notebook.[85] In it, she kept a diary and recorded, among other things, her encounters with Santiago and the incidents of sexual abuse. The notebook contains a list of contacts, including one labeled "Boo" with a home address, email address and two telephone numbers.[86] Jane Doe 2 testified that she referred to Santiago as "Boo" in her diary.[87] Santiago testified that the home address, email address and one of the phone numbers are his,[88] but he denies telling Jane Doe 2 this information.[89]

35. Also on May 10, Christo and Young briefly interviewed Santiago (for roughly five minutes) outside of RMSC when he was on his way into the facility to begin his shift.[90] The investigators took no notes during the interview,[91] which is contrary to standard practice, though they did later prepare a brief interview memorandum.[92] The investigators told Santiago the name of the alleged victim and the nature of her claim.[93] Santiago stated that he knew Jane Doe 2 because she was the SPA in Building 9 but denied having any kind of an inappropriate relationship with her.[94] When asked how Jane Doe 2 knew details about his personal life, Santiago stated that she must have overheard him talking to other correction officers.[95] He further stated that Jane Doe 2

[83] JD2 DOI Case File, *supra* note 42, at DEF_0001923-25 (draft memorandum from Rhonda Young of interview with Jane Doe 2).

[84] Torres Dep. 245:5-21.

[85] JD2 Dep. 130:24-131:6.

[86] JD2 Bible and Diary, *supra* note 30, at DEF_0018263.

[87] JD2 Dep. 32:18-24.

[88] Santiago Dep. 10:18-24; 45:20-23; 160:6-13; 168:8-12.

[89] *Id.* 160:21-163:8.

[90] Young Tr. 265:5-16.

[91] *Id.* 264:21-265:2.

[92] JD2 DOI Case File, *supra* note 42, at DEF_0001919-20 (memorandum of interview with Santiago conducted by James Christo and Rhonda Young).

[93] *Id.* at DEF_0001919.

[94] *Id.* at DEF_0001919-20.

[95] *Id.* at DEF_0001919.

had a 50% chance of guessing right when she said he was uncircumcised.[96] Santiago declined taking a DNA test.[97]

36. After completing these initial interviews, DOI's investigation was cursory and, in many ways, flawed. First, Christo requested audio recordings for Jane Doe 2's recorded-line phone calls;[98] Jane Doe 2 had told the investigators that she had called Santiago from RMSC via a three-way call.[99] Christo was notified that the calls were saved to a CD and ready for pick up, but he claimed he never retrieved or otherwise reviewed them.[100] I understand that the CD has been subsequently lost and the phone recordings are no longer preserved. Second, Christo suggested subpoenaing Santiago's and other relevant phone records – a routine step in investigations – but this was never done.[101] Third, Christo testified that he interviewed a few other inmates regarding Jane Doe 2's allegations, but he took no notes and did not otherwise memorialize these interviews.[102] Finally and crucially, Christo stated that he reviewed video footage from the cameras in Buildings 9 and 11.[103] Both Jane Doe 2 and Santiago testified that Jane Doe 2 used to walk back and forth between these buildings nearly every night while she was working as an SPA.[104] The camera footage should therefore have captured interactions between Santiago and Jane Doe 2. However, Christo did not preserve the footage he reviewed,[105] despite DOI's policy to preserve relevant video evidence.

37. There are several obvious investigative steps that DOI also failed to take: investigators did not interview other correction officers from the "bubble" or Buildings 9 or 11, tour supervisors from Buildings 9 or 11, or involved medical staff; they did not review the logbooks that should have logged Jane Doe 2's movements between Building 9 and Building 11; and they did not review Santiago's duty records. Christo testified that the

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[96] *Id.* at DEF_0001920.

[97] *Id.*

[98] E-mail from James Christo, Assistant Inspector Gen., DOI, to Susan O'Leary, DOC Legal Div. (May 14, 2013) (NYC_00007056).

[99] JD2 DOI Case File, *supra* note 42, at DEF_00001489 (handwritten notes from investigative interviews).

[100] Christo Dep. 320:10-17, July 27, 2016.

[101] E-mail from Kate Zdrojeski, Investigative Att'y, DOI, to James Christo, Assistant Inspector Gen., DOI, at NYC_00007061 (May 13, 2013) (NYC_00007060-61).

[102] Christo Dep. 351:11-16, 352:6-10, 352:22-353:2, July 27, 2016.

[103] *See* JD2 DOI Case File, *supra* note 42, at DEF_0001824-25 (closing memorandum from James Christo dated June 25, 2014).

[104] JD2 Dep. 95:14-104:6, 112:12-113:10; Santiago Dep. 190:22-192:17.

[105] Christo Dep. 248:3-5, Mar. 24, 2016.

investigators took so few investigative steps because they were waiting for the results of the semen tests on Jane Doe 2's jeans.[106]

38. On April 2, 2014, Christo and Young spoke with Jane Doe 2 again, in order to inform her that the results of the semen tests were negative.[107]

39. On June 25, 2014 – nearly 14 months after learning of Jane Doe 2's allegations – DOI closed its investigation.[108] The closing memorandum submitted by Christo states that the allegations of sexual contact were "inconclusive" because the semen test was negative and because Jane Doe 2 "could not remember dates or other specific details."[109]

40. The closing memorandum does state that Santiago was "unduly familiar" with Jane Doe 2 and that DOI would therefore refer the matter to DOC ID for disciplinary action against Santiago.[110] In support of the finding of undue familiarity, DOI's closing memorandum lists a series of factors, including that Jane Doe 2 knew Santiago's contact information, that Jane Doe 2 posted on Facebook on dates that were consistent with dates she told investigators that Santiago permitted her to use his iPhone, and that five inmates from Building 11 all confirmed that they saw Jane Doe 2 with contraband and that Santiago was infatuated with her.[111]

41. The closing memorandum contains several misrepresentations and material omissions. First, DOI's assertion that Jane Doe 2 "could not remember dates or other specific details" is contradicted by the specific dates and level of detail included in the investigators' contemporaneous, handwritten notes of their interviews with Jane Doe 2, and in Jane Doe 2's diary. Second, although the memorandum states that Jane Doe 2 informed investigators that Santiago's penis was uncircumcised, it did not include that she also described the length of his penis, both erect and flaccid. In his deposition, the DOC Deputy Commissioner referred to this additional, omitted detail as "important information" that clearly should have been included in the memorandum.[112] Third, the memorandum states that investigators reviewed video footage. During his depositions, Christo provided inconsistent testimony on this matter: at one point he said that this sentence was simply "boilerplate" and he did not review any video footage and at another point he said that he did review relevant video footage but did not preserve

[106] *Id.* 128:6-130:23.

[107] James Christo, Assistant Investigator Gen., DOI, Memorandum of Interview of Jane Doe 2 (Apr. 4, 2014) (NYC_00006601).

[108] JD2 DOI Case File, *supra* note 42, at DEF_0001824-27 (closing memorandum from James Christo dated June 25, 2014).

[109] *Id.* at DEF_0001827.

[110] *Id.* at DEF_0001826-27.

[111] *Id.*

[112] Gregory Kuczinski Dep. 100:9-18.

it.[113] DOI and DOC personnel, who had read Christo's closing memorandum, all testified that they read this memorandum to represent that Christo had reviewed the video footage.[114] Either way, it is clear that crucial evidence was mishandled. Finally, the memorandum does not include the fact that Jane Doe 2 alleged that Santiago had provided her with ecstasy. Moreover, although the memorandum states that other inmates reported that they saw Jane Doe 2 with candy, makeup and headphones that she claimed were given to her by Santiago, it does not state that one of the inmate witnesses also reported that Santiago provided Jane Doe 2 ecstasy,[115] thereby corroborating Jane Doe 2's own allegation. In fact, the investigators did not include the inmate's statement regarding ecstasy anywhere in the case file.

G. The DOC ID Investigation of Jane Doe 2's Allegations

42. Although DOI closed its investigation on June 25, 2014 and referred the case to DOC ID for action against Santiago on July 8, 2014,[116] DOC ID apparently lost track of the case file and was completely unaware of the investigation until at least November 2014.[117] Even then, there were further delays, and DOC ID did not assign an investigator to the case until February 2015.[118]

43. From February 2015 to May 2015, minimal investigative steps were taken.[119] The investigator assigned, Alexandra Wityak, testified that she did not interview Jane Doe 2 because Jane Doe 2 had since been released from prison and Wityak did not want to visit her at home in what she believed was a dangerous neighborhood[120] Wityak also did not interview Santiago or any potential witnesses.

44. On May 19, 2015, Plaintiffs filed this lawsuit in the Southern District of New York, alleging sexual abuse. Suddenly, over the next few weeks, senior DOC leadership became actively involved and DOC ID began paying attention to Jane Doe 2's

[113] Christo Dep. 164:9-165:25, 247:2-249:19, Mar. 24, 2016.

[114] Kuczinski Dep. 88:7-89:12; Alexandra Wityak Dep. 61:25-62:18; Michael Blake Dep. 65:6-67:13.

[115] E-mail from James Christo, Assistant Inspector Gen., DOI, to Jennifer Sculco, Senior Inspector Gen., DOI (Nov. 1, 2013) (NYC_00006878).

[116] E-mail from Jennifer Sculco, Senior Inspector Gen., DOI, to James Christo, Assistant Inspector Gen., DOI, at NYC_00009005 (May 22, 2015) (NYC_00009004-05).

[117] *Id.*

[118] DOC ID, Investigative Case Log regarding Jane Doe 2's allegations against CO Santiago, at DEF_0016125 (May 27, 2016) (DEF_0016125-26) ("JD2 DOC ID Case Log").

[119] *See id.*

[120] *See* Wityak Dep. 57:16-58:4.

allegations.[121] On May 20, Wityak scheduled a time to interview Santiago, but this was later cancelled and the interview never took place.[122]

45. Instead, on August 3, 2015, after several meetings of high-ranking DOC officials, DOC ID closed its investigation of Jane Doe 2's allegations on two grounds: DOI's failure to provide case information to DOC ID and an expired statute of limitations.[123] The decision to close the investigation on either of these grounds was not justified.

46. With respect to the first ground, beginning on May 19, DOC ID made repeated requests to DOI for evidence that DOI had collected during its investigation, including phone and video records and interview memoranda.[124] DOI ignored these requests, and failed to turn over any case information other than its closing memorandum and Jane Doe 2's bible and notebook.[125] Without this information, Wityak and others from DOC ID testified that they could not properly investigate Jane Doe 2's claims.[126] Christo testified that he did not provide the case materials despite repeated requests because it was DOI policy not to provide evidence to DOC ID.[127] Although it is

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[121] Central Operations Desk, DOC, 24 Hour Report (Initial), at NYC_00002507-11 (Oct. 3, 2015) (NYC_00002505-17); E-mail from Michael Blake, Confidential Investigator/Consultant and Former Deputy Comm'r of Investigations, DOC, to Joseph Ponte, Comm'r, DOC (May 20, 2015) (NYC_00000788-89); E-mail from James Christo, Assistant Inspector Gen., DOI, to Mark G. Peters, Comm'r, DOI, and Jennifer Sculco, Senior Inspector Gen., DOI (May 21, 2015) (NYC_00006328-29).

[122] JD2 DOC ID Case Log, *supra* note 118, at DEF_0016125; JD2 DOC ID Case File, *supra* note 34, at DEF_0002521-22 (May 21, 2015 e-mail from Steven Jones to Alexandra Wityak regarding closing of case number 13-05490).

[123] JD2 DOC ID Case Log, *supra* note 118, at DEF_0016126; JD2 DOC ID Case File, *supra* note 34, at DEF_0002480-82 (closing report from Alexandra Wityak to Sean Cussen, dated Aug. 3, 2015 ("DOC ID Closing Memorandum")).

[124] JD2 DOC ID Case File, *supra* note 34, at DEF_0002521, DEF_0002525 (May 22, 2015 e-mail from Steven Jones to Alexandra Wityak regarding request of phone and video records), DEF_0002523 (May 20, 2015 e-mail from James Christo to Alexandra Wityak regarding request of interview memoranda), DEF_0002513 (May 28, 2015 e-mail from Alexandra Wityak to Jennifer Sculco regarding request of phone and video records); DOC ID Closing Memorandum, *supra* note 123, at DEF_0002481; E-mail from Steven Jones, Dir. of Special Investigations, DOC, to Gregory Kuczinski, Deputy Comm'r of Investigations, DOC ID (June 25, 2015) (NYC_00004007-08).

[125] E-mail from Steven Jones, Dir. of Special Investigations, DOC, to Gregory Kuczinski, Deputy Comm'r of Investigations, DOC ID (June 2, 2015), at NYC_00004005 (NYC_00004005-06); JD2 DOC ID Case File, *supra* note 34, at DEF_0002523 (May 20, 2015 e-mail from James Christo to Alexandra Wityak regarding request of interview memoranda); DOC ID Closing Memorandum, *supra* note 123, at DEF_0002481.

[126] *See* Wityak Dep. 149:16-150:10; Kuczinski Dep. 49:23-51:20, 180:14-181:4.

[127] Christo Dep. 380:3-21, July 27, 2016.

difficult to believe that it is the policy of a NYC agency not to cooperate with another NYC agency, no other explanation was provided for DOI's failure to provide relevant information to DOC ID.

47. With respect to the statute of limitations, Civil Service Law Section 75.4 prohibits commencement of an administrative action to remove or discipline a City employee for acts of misconduct more than 18 months after those acts occur.[128] However, if the alleged act of misconduct would constitute a crime if proven in a court of competent jurisdiction, then the statute of limitations applicable to the criminal offense applies instead of the 18-month statute of limitations. Here, Jane Doe 2 accused Santiago of acts that, if proven in such a court, would have constituted rape – a felony offense with a statute of limitations of at least five years. Thus, DOC ID was incorrect to apply the 18-month statute of limitations as a justification for closing its investigation. Moreover, even if the 18-month statute of limitations did apply, it only ran due to the City's own inexplicable delay, and DOC ID should have continued to investigate Santiago in order to ensure the safety of its female inmate population.

48. Thus, DOC ID closed its investigation for two baseless reasons without determining whether Santiago raped or sexually abused Jane Doe 2, a result that Wityak described as "troubling" and "horrible."[129]

H. Other RMSC Victims

49. The record indicates that there are many other RMSC detainees who are victims of staff rape and sexual abuse, including:

- N.B. was incarcerated at RMSC from March 2008 to June 2011. She alleges that she was raped and sexually abused by two correction officers, one of whom impregnated her.[130]

- L.L. was incarcerated at RMSC from February 2012 to April 2014. She alleges that Santiago touched her in an inappropriate, sexual manner. She further alleges that in 2012, she woke up in her cell and saw a different RMSC correction officer masturbating inside her cell and watching her sleep.[131]

[128] N.Y. Civ. Serv. Law § 75.4 (McKinney 1995).

[129] Wityak Dep. 149:21-150:10.

[130] DOI, Case File regarding investigation into allegation that inmate N.B. was impregnated by a correction officer (DEF_0018272-302).

[131] Aff. of L.L. (Mar. 20, 2015) (JANEDOES_00000255-56).

- L.G. was incarcerated at RMSC for two brief periods in March and May 2013.[132] She alleges that she had sex several times inside RMSC with a correction officer in exchange for him bailing her out and that the correction officer impregnated her.[133]

- N.M. was incarcerated at RMSC from April 2013 until at least August 2013.[134] She alleges that a RMSC Discharge Planner made a sexual comment about her lips and groped her breasts.[135]

- A.G. was incarcerated at RMSC in early 2013. She alleges that when she was in the health clinic, a Physician Assistant made sexual gestures and comments at her, exposed his penis in front of her, and groped her breast and buttocks.[136]

I. Inspection of RMSC

50. On October 20, 2016, I attended an inspection of RMSC, including the clinic, specialty clinic, Building 8, Building 9, Building 11, the area where the sprungs were previously located, and the counsel visit area.

51. I had requested to inspect RMSC during the 11 p.m. to 7 a.m. shift – when much of Jane Doe 1's and Jane Doe 2's rape and sexual abuse is alleged to have occurred – but the City refused this request. As a result, the inspection took place during the day shift, between the hours of 11 a.m. and 1:30 p.m.

Inspection of the Entrance to RMSC

52. While outside of the entrance to RMSC, I observed the Rikers Island transport bus, which loads and unloads personnel near the front entrance of RMSC. The bus stop is not enclosed and would not provide privacy.[137]

53. The outside of the RMSC parking lot and building entrance had many weeds, litter, and other issues demonstrating a lack of care for the facilities. We then entered the visitor lobby, which likewise showed a lack of care, including missing molding, taped signs, and a partly falling ceiling.

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[132] DOI, Case File regarding investigation of CO Alvarez, at DEF_0010629 (DEF_0010621-805).

[133] *Id.* at DEF_0010630.

[134] DOC ID, Case File regarding investigation of Discharge Planner Blackshear, at DEF_0004587 (DEF_0004584-629).

[135] *Id.* at DEF_0004587.

[136] DOC ID, Case File regarding investigation of Physician Assistant Rich, at DEF_0009855-56 (DEF_0009854-10272).

[137] JANESDOES_00004625 (Nov. 20, 2016) (photograph of front of RMSC); JANEDOES_00004626 (Nov. 20, 2016) (photograph of bus stop in front of RMSC).

54. When entering the facility, I noticed that the procedures and policies for signing in and signing out of the facility were seemingly not followed. For example, although some visitors signed the entrance logbook, others did not.

Inspection of Counsel Visit Room

55. Beyond the security desk, to the left of the entrance, are the counsel visit rooms. [138]

56. The rooms are very small, and it would have been uncomfortable to conduct a serious interview in them. The visitor rooms are separated into two sides by a wall containing a narrow window.[139]

57. The door to the inmate-side of the visit room has a window in it, exposing the inside of the counsel visit room to the staff. Therefore, it is difficult to maintain confidentiality on the inmate-side.[140]

Inspection of RMSC Clinic

58. The RMSC clinic is located past the main interior gate to the facility down a hallway to the left.

59. We first walked through a door into what appeared to be a waiting area for the clinic. A staff member was sitting at a desk to the left after entering the room, and inmates sat to the right, against the wall.

60. We then walked through a door to the treatment area of the clinic. At that time, I requested to walk from the clinic to the location where the sprungs were formerly located in order to better understand Jane Doe 1's allegations that defendant Santiago, while working as a recreation officer, would regularly escort her from the clinic to the sprungs. This request was denied by attorneys for the City.

61. We turned right down a hallway in the clinic that was surrounded on both sides by observation areas for inmates. At the end of the hallway, on the right side, is what I understand to be the waiting area for the specialty clinic.[141]

Inspection of Building 8

62. Building 8 was divided into two parts, Building 8A and Building 8B, connected by the "bubble."

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[138] JANEDOES_00004617 (Nov. 20, 2016) (photograph of counsel visit room area).

[139] JANEDOES_00004620 (Nov. 20, 2016) (photograph of inside of counsel visit room).

[140] *Id.*

[141] JANEDOES_00004499 (Nov. 20, 2016) (photograph of waiting area for specialty clinic); JANEDOES_00004501 (Nov. 20, 2016) (same).

63. We entered Building 8A first. Building 8A is rectangular in shape, and has two floors, with the second-level exposed to the first level. Stairs on each side of the room provide access to the second floor.

64. From the door where we entered the housing unit: the Building 8 bubble is to the right;[142] a set of stairs to the second floor of Building 8A is directly to the front;[143] against the wall, beyond the staircase, is a row of cells; to the left, generally, is the day room and a food preparation area.[144] There was a barrier in the center-left of the Building 8A day room.

65. We then inspected the "bubble." The bubble was accessible via a staircase in a small room connecting Buildings 8A and 8B. The bubble was fully enclosed and elevated off of the ground several feet.

66. The walls of the bubble were covered with windows beginning at approximately waist height.[145] Because the bubble was elevated several feet off of the ground, the glass began nearly 6 feet off of the ground when viewed from Building 8A.[146] The glass was transparent from both directions.

67. In front of the windows was an approximately 2 to 3 foot deep table containing certain controls, logbooks, and other materials.[147]

68. The purpose of a bubble, in my experience, is to observe inmate and staff conduct in the adjacent areas. That is typically done through visual observation, through communication with staff, and by listening for any noises coming from the housing unit.

69. While inspecting this bubble, I noted substantial visual blind spots. Given the height of the windows relative to Building 8A, it became more difficult to observe objects and people the closer that they got to the bubble. This would have been made worse if staff were sitting in the chair present in the bubble during our inspection. Two other areas were also largely obscured: (i) the area behind the day room barrier, mentioned *supra* ¶ 64, obscured the back portion of the day room, as viewed from the bubble, and (ii) the staircase in front of the housing unit door, mentioned *supra* ¶ 64, created a blind spot in the rear of the housing unit, near the shower.[148]

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[142] JANEDOES_00004531 (photograph of bubble relative to the door, right).

[143] *Id.*

[144] JANEDOES_00004514 (Nov. 20, 2016) (photograph of day room and food preparation area).

[145] JANEDOES_00004534 (Nov. 20, 2016) (photograph of inside of bubble).

[146] JANEDOES_00004531 (Nov. 20, 2016) (photograph of outside of bubble).

[147] JANEDOES_00004534, *supra* note 145.

[148] *Id.*

70. The floor of the bubble was very worn in one spot – under the chair that was placed in the middle of the bubble. This seems to suggest that the chair does not regularly move. As positioned, the chair faced the obscured view of the Building 8A shower and not the day room.

71. There did not appear to be any television or computer in the bubble for accessing or viewing camera footage.

72. I also noted that the ability to hear conversations and activities in Building 8A was severely limited. For example, although a TV was playing at substantial volume in Building 8A, I was unable to hear it while inside of the bubble.

73. We then inspected Building 8B. When we arrived, there were several female inmates who appeared to be cleaning. There was one male correction officer supervising the inmates.

Inspection of Building 9

74. We then walked down a hallway to inspect Building 9, which is the special observation unit where Jane Doe 2 worked as an SPA.

75. Building 9 smelled strongly of antiseptic, and freshly so in the entry vestibule. However, the bulletin boards and officer's tables were not neat, which indicates to me that the cleaning was just recently done and with not much care.

76. In Building 9, inmates were housed in cells across two floors connected by staircases closer to the entrance to the housing area. Relative to the entrance looking into the housing unit, cells lined the left, right, and farthest walls on both the first and second floors. The cells on the first floor looked out into the day room, which was an open rectangular area.

77. It is my understanding that during discovery, Plaintiffs requested to be given copies of the suicide prevention aide logbooks, which were supposed to log the activities of the Building 9 SPA (the position held by Jane Doe 2 when she alleges she was raped by CO Santiago) and inmates under special observation in Building 9, pursuant to Rule 7.05.160 of the DOC Employee Handbook. [149] It is my understanding that the City informed plaintiffs that the relevant logbooks were lost or destroyed.

78. On the correction officers table in Building 9, I found a copy of the latest SPA logbook. It was a document with multiple pages and small blocks on it seeming to indicate locations where the SPA was to make appropriate notations during each shift. However, this document only showed daily listings, with the latest being October 12, 2016 – over a week before the inspection. I requested to look at the SPA logbook in more detail, but counsel for the City said that I could only review the latest page.

[149] Employee Handbook, at DEF_0002190 -91 (DEF_0002049-255).

Therefore, I could not assess whether the lack of adequate logging was an anomaly or regular practice.

Inspection of Buildings 9 and 11 Pantry

79. The entrance to the pantry area connecting Buildings 9 and 11 was in the corner next to the bubble. The pantry was small and non-rectangular. The doors to Buildings 9 and 11 roughly faced each other. On the wall to the left after entering the pantry from Building 9 were two narrow windows in opposite corners that looked into the Buildings 9 and 11 bubble. The bottom of the windows were elevated 6 or 7 feet off of the ground.[150]

80. The pantry was poorly maintained (chipped paint and infested with flying insects).[151]

Inspection of Building 11

81. Building 11 appeared to be roughly a mirror image of Building 9. When we entered through the pantry, the bubble between Buildings 9 and 11 was to our left,[152] and the day room and inmate cells were roughly to our front and to the left.

82. Building 11, like Building 9, was also two floors high. The second floor was covered with a fence,[153] but was generally observable from the day room area of the first floor. The second floor was accessible from either of two staircases near the entrance to the housing area. The cells on the second floor were connected by a concrete walkway that hung over the entrances of the first floor cells by several feet.[154]

83. There was a small officer's table made of plastic on the left wall of the first floor of Building 11 when viewing the housing area from the entrance into the day room.

84. Behind the officer's table, there was an alcove. The alcove was approximately 10 to 15 feet in depth. At the rear of the alcove, in the corner, was the entrance to the janitor's closet described by Jane Doe 2 in her allegations of sexual abuse.[155]

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[150] JANEDOES_00004553 (Nov. 20, 2016) (photograph of window, right, relative to height of door into Building 9); JANEDOES_00004552 (Nov. 20, 2016) (photograph of window, left, relative to height of door into Building 11).

[151] JANEDOES_00004550 (Nov. 20, 2016) (photograph of pantry area).

[152] JANEDOES_00004561 (Nov. 20, 2016) (photograph of Building 11, including pantry door, left, bubble, center, and main entrance, right).

[153] JANEDOES_00004566 (Nov. 20, 2016) (photograph of second floor walkway, facing towards entrance to Building 11).

[154] *Id.*

[155] JANEDOES_00004576 (Nov. 20, 2016) (photograph of Building 11 officer's table, left, and janitor's closet, center).

85. The janitor's closet was large enough for several people to enter at the same time. It contained a sink, water heater, and a mop and two buckets.[156]

86. We observed cell number 32, which was Jane Doe 2's cell when she was housed in Building 11 in February and March 2013. The cell is located on the second floor of the facility.

87. On the second floor of Building 11, there were at least two cells being used as offices. The offices were fully open and accessible to inmates. In my experience, this appeared to be a clear security violation.

88. Although the inspection was conducted during the day shift, we requested that the lights be dimmed, as would be the case during the night shift. Building 11 had several sky lights in its ceiling that likely interfered with the creation of accurate nighttime lighting conditions. However, even with the additional light from the skylights, there was minimal visibility on the first floor beneath the second floor walkways.

89. I understand from the deposition testimony of Santiago that there were only two cameras in Building 11 during the time period Jane Doe 2 alleges she was abused there.[157] Those cameras faced each other on the ceiling over the day room. At no time did I observe a monitor feed of those cameras, and I understand that Plaintiffs' counsel requested to see the video observation room, and were told there was none. Nonetheless, after viewing the facility, it is likely that cameras in the locations described by Santiago would inadequately cover Building 11, including because the second floor concrete walkway would substantially obstruct the view of the correction officers' table. However, the cameras would have likely covered the staircase to the second floor, where Jane Doe 2's cell was located, and everyone entering and leaving Buildings 9 or 11 through the pantry.

Inspection of Buildings 9 and 11 Bubble

90. We then inspected the bubble connecting Buildings 9 and 11. The bubble was elevated several feet off of the ground and was accessed via a small set of steps.[158] The bubble itself was horseshoe shaped, with the left arm of the bubble looking out onto Building 11 and the right arm looking out onto Building 9. Between the two sides of the bubble was a bathroom that jutted out into the bubble and made it difficult, if not impossible, to observe Buildings 9 and 11 at the same time. On each side of the bathroom, in the corner, was one of the narrow windows looking into the pantry, discussed *supra* ¶ 79.[159]

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[156] JANEDOES_00004572 (Nov. 20, 2016) (photograph of Building 11 janitor's closet).

[157] Santiago Dep. 120:15-121:19.

[158] JANEDOES_00004561 (Nov. 20, 2016) (photograph of bubble from inside of Building 11)

[159] JANEDOES_00004590 (Nov. 20, 2016) (photograph of pantry window from bubble, Building 11 side); JANEDOES_00004597 (Nov. 20, 2016) (photograph of pantry window from

91. The windows into each of the housing areas and the pantry began at approximately waist height. The windows were transparent from both directions. Beneath the window, lining the walls, were several approximately three-foot deep control panels. As a result of the control panels, it was not feasible to get close to the windows overlooking the housing areas and the pantry.

92. The height of the bubble (and the windows) off of the ground created a substantial blind spot covering objects and people closer to the bubble. This was amplified by the inability to get closer to the windows than the depth of the control panels. From a seated position, the view into Buildings 9 and 11 were particularly poor.[160] It would have been impossible to monitor the pantry from a seated position. The view of the janitor's closet in Building 11 was likewise obscured.

93. There did not appear to be any television or computer in the bubble for accessing or viewing camera footage.

94. My ability to hear conversations and activities in Buildings 9 and 11 was severely limited while inside the bubble.

Inspection of the Sprungs

95. We then walked from Building 11 to the area where the annex and sprungs had formerly been located. It is my understanding that the sprungs were torn down a year or two prior to the date of the inspection.

96. To access the sprungs, we walked down a corridor to the loading dock for RMSC.[161] It is my understanding that the corridor had previously extended beyond the loading dock along the exterior wall of RMSC, and then continued past the permanent structure until reaching the annex and sprungs complex. The corridor, along with the annex and sprungs, had been torn down by the time of the inspection.

Inspection of Reporting Channels

97. During our inspection, I noted that there was a poster adjacent to the inmate phones that identified phone numbers for confidential contact with outside investigative

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bubble, Building 9 side); JANEDOES_00004556 (Nov. 20, 2016) (photograph of windows into bubble from pantry, Building 9, left, Building 11, right).

[160] JANEDOES_00004583 (Nov. 20, 2016) (photograph looking out into Building 11 from seated position); JANEDOES_00004584 (Nov. 20, 2016) (photograph looking out into Building 11 from standing position).

[161] JANEDOES_00004615 (Nov. 20, 2016) (photograph of loading dock, right, entrance to RMSC, center; hallway to sprungs and annex would have run down center of photograph, along left wall).

agencies of staff/inmate sexual abuse issues.[162] Those posters listed four phone numbers including 718-204-0378; 212-266-1900; 212-639-9675; and 212-227-3000.[163] However, those numbers were not accessible unless the inmate provided their identifying "pin and case number" (which would make the call non-confidential, contrary to PREA). This problem was identified in the Moss Group's June 2015 Sexual Safety Assessment Report as an issue to be resolved.[164] As the DOC PREA Coordinator Faye Yelardy, who is responsible for the implementation of PREA, attended our inspection of RMSC, I asked for permission to question her regarding this problem. I was told by the City's attorneys that she could not respond to the question at that time.

98. In the lobby of the facility, I noticed another phone number for reporting officer misconduct: 347-669-4075. I called the phone number after the inspection and nobody answered. After ringing for nearly a minute, it went to a voice mailbox. The recording for the voice mailbox simply repeated the phone number but did not indicate that it was a hotline for officer misconduct.

99. I also noted inmate grievance boxes in the hallway, but the boxes were located behind locked gates and not accessible to inmates. I did see some boxes inside the hallways that were similar in appearance, but they did not have "Grievance" painted on them and it was not clear whether they were actually grievance boxes.

IV. **Opinion**

A. Primary Opinion

100. As stated above in *supra* ¶¶ 1-10, the City's practices show a callous disregard for legal requirements and correctional professionalism and demonstrates "deliberate indifference" by the City to the sexual safety and well-being of the female detainees for which it is responsible.

B. Secondary Opinion #1: The City has been out of compliance with national correctional standards for years

101. It is my opinion that the City of New York knew, or should have known, of the necessity to implement immediate and specific proactive measures to address the issues of sexual abuse at RMSC on or before January 1, 2011, but failed to act. Further, given the extensive period of time over which the City must have known about

[162] JANEDOES_00004524 (Nov. 20, 2016) (photograph of reporting sign in Building 8A, in English and Spanish).

[163] *Id.*

[164] Moss Group, Inc., Sexual Safety Assessment Report, at DEF_0014425 (2015) (DEF_0014410-95) (report conducted for the N.Y.C. Dep't of Correction and funded by the U.S. Dep't of Justice, Bureau of Justice Assistance) ("Sexual Safety Assessment Report").

the rampant sexual abuse at RMSC, that failure to act implicates major systemic issues at the DOC.

102. In September 2003, then President Bush signed PREA. With that, all of the correctional facilities in America were put on notice that sexual abuse was an extremely important issue that needed prompt special attention in every U.S. jail, including jails in the City of New York.

103. The National Institute of Corrections' ("NIC") Large Jail Network, of which the DOC is a member, began discussing the implications of PREA soon after its passage, and those discussions continue to this day. To my knowledge, the City of New York is invited twice a year to attend these NIC meetings. Thus, the leadership of the DOC had the opportunity to understand this law and act accordingly very early in the process.

104. The American Jail Association, which holds annual conferences and invites jail managers from around the nation to attend, also began training classes soon after PREA was adopted in 2003. To my knowledge, the City of New York has had the opportunity to attend those meetings as well.

105. As early as 2010, the press had extensively reported on sexual misconduct at RMSC.[165]

106. A report conducted by the U.S. Department of Justice ("DOJ") Bureau of Justice Statistics over the period 2011 through 2012 shows that RMSC had one of the highest rates among jails of staff-on-inmate sexual misconduct. Specifically, the DOJ Inmate Victimization Report found that 5.9% of the inmates are subject to staff on inmate sexual misconduct. [166] Further, 2.3% stated that they were "physically forced" to engage in sexual activity with a correction officer, and 5.6% reported that they felt pressured into sexual activity.[167] These numbers are significantly higher than the nation-wide averages.

107. The City's own records document a substantial number of reported staff-on-inmate sexual abuse allegations[168]: in 2013, the City logged 17 allegations of reported staff-on-inmate sexual victimization (with the following dispositions, 2 substantiated, 10 unfounded, 5 unsubstantiated, 0 closed); in 2012, 18 allegations of reported staff-on-inmate sexual victimization (with the following dispositions, 1 substantiated, 1 closed

[165] *See, e.g.*, Elizabeth Dwoskin, *Inmate Gets Pregnant in Rikers, Sparking Investigation*, Village Voice (Apr. 29, 2010), http://www.villagevoice.com/news/inmate-gets-pregnant-in-rikers-sparking-investigation-6706471.

[166] Allen J. Beck et al., *Sexual Victimization at Prisons and Jails Reported by Inmates, 2011-2012*, at 13 & tbl. 4 (2013), https://www.bjs.gov/content/pub/pdf/svpjri1112.pdf ("DOJ PREA Report").

[167] *Id.* at 87 app. tb.7.

[168] *See* PREA Spreadsheet: Log of Sexual Abuse Investigations (Updated) (May 31, 2016) (DEF_0016124).

with charges, 10 unfounded, 6 unsubstantiated); and in 2011, 21 allegations of reported staff-on-inmate sexual victimization (with the following dispositions, 0 substantiated, 11 unfounded, 10 unsubstantiated, 0 closed).

108. The numbers of reported allegations are astoundingly high. To put them into context, RMSC had an average daily population of 815 in 2012 and 785 in 2013.[169] During the period 2012 to 2013, the Miami-Dade County Jail System in Florida (which I led) had a maximum capacity of 7,000 detainees but only 14 allegations of any type of staff-on-inmate sexual victimization, a number considered too high by the jail staff. On a comparison basis, the 18 allegations at RMSC would, given the much larger populations at Miami-Dade, translate to approximately 150 allegations at Miami-Dade.[170] During the period 2013 to 2014, the Miami-Dade County Jail System had 15 allegations of staff-on-inmate sexual victimization compared to RMSC's 17. Taking into consideration Miami-Dade's larger population, the 15 allegations would again translate to approximately 150 allegations, 10 times Miami-Dade's actual number.[171]

109. Furthermore, the City's own records may understate the problem, as a Civil Rights for Institutionalized Persons Act ("CRIPA") investigation conducted by the U.S. Attorney's Office for the Southern District of New York made clear.[172] That investigation found that there were widespread sexual misconduct issues at Rikers, and the CRIPA report expressed "concern that DOC may be under-reporting sexual assault allegations."[173]

110. Contrary to the City's directive on preventing inmate sexual abuse in effect until early 2016, the City failed to collect annual statistics regarding the numbers, types, and actions surrounding inmate sexual abuse. In my opinion, the City's failure to follow its own directive (and best practices) would have prevented it from closely monitoring sexual abuse and the locations where sexual abuse occurred, or assessing necessary actions to address any deficiencies.

111. Contrary to national correctional best practices, there is no evidence that the City ever conducted annual assessments of "staff found in violation of facility policies," "staff terminated for conduct violations," and "inmate grievances attributed to staff misconduct," as is required by national correctional best practice. The goal of such an action would be to determine the need to examine staff behaviors relative to the safe and secure operation of the facility.

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[169] Decl. of Letitia James, Public Advocate for N.Y.C., in Support of Pls.' Mot. for Class Certification ¶ 23 (Oct. 9, 2015), ECF No. 32.

[170] Email Correspondence with Miami Dade PREA Coordinator (Nov. 2, 2016).

[171] *Id.*

[172] Letter from Jeffery Powell, Assistant Att'y Gen., to Joseph Ponte, DOC Comm'r, re CRIPA Investigation of the DOC Jails on Rikers Island (Aug. 4, 2014) ("CRIPA Report").

[173] *Id.* at 10 n.14.

112. In June 2015, the Moss Group – outside consultants hired by the City to assess sexual safety on Rikers Island – found the need to make 93 recommendations for action to bring the City in compliance with inmate sexual safety practices.[174] The Sexual Safety Assessment Report also contained numerous recommendations specific to RMSC, including (i) updating policies and procedures, (ii) correcting insufficient training, (iii) correcting the staff's inability to articulate the proper steps for reporting allegations of sexual abuse, (iv) correcting confusion by medical and mental health staff on their responsibilities to report sexual abuse, (v) correcting failure of the phone reporting system to function, (vi) fixing the lack of trust in the grievance procedure, and (vii) educating staff in understanding the requirements of confidentiality in sexual abuse cases.[175]

113. It was not until 2016 that the DOC updated its sexual safety directive to purportedly implement PREA. And the Board of Correction, which has oversight authority over the DOC and is tasked with "establish[ing] minimum standards for the care, custody, correction, treatment, supervision, and discipline of inmates,"[176] has yet to enact regulations implementing PREA.

114. In light of the foregoing, including press reports, internal City records showing abnormally high rates of reported sexual abuse, the DOJ PREA Report, and the CRIPA Report, it is my opinion that the City knew or should have known about its failure to comply with national correctional sexual safety practices at least as early as 2010, and did not take appropriate, effective steps to address those issues.

C. Secondary Opinion #2: The City's hiring practices are inadequate

115. It is my opinion that the City of New York has extremely serious deficiencies in its recruitment and hiring practices, which contribute to its culture of sexual victimization.[177]

116. As recently as January 2015, over one-third of recently hired DOC correction officers had significant warning signs in their backgrounds – including criminal histories of domestic violence and improper preexisting relationships with incarcerated individuals. This number is unusually high. Even before 2012 when the DOJ promulgated the PREA Standards that required additional screening of correction officers, jails had already begun reforming their hiring practices to conduct additional screening of individuals with these kinds of warning signs. As the DOI itself found, there is a link between prior criminal history of correctional staff and their propensity for

[174] Sexual Safety Assessment Report, *supra* note 164, at DEF_0014410-95.

[175] *Id.* at DEF 0014454-62 (summary of recommendations).

[176] Directive, DOC, Classification 1100R-A Board of Correction Authority, at 2 (effective May 1, 2007), http://www.nyc.gov/html/doc/downloads/pdf/1100R-A.pdf.

[177] DOI, Press Release & Report on the Recruiting and Hiring Process NYC Correction Officers, at report 1 (Jan. 2015).

inappropriate contact with inmates, and therefore these candidates must be subject to heightened scrutiny.[178]

117. DOI Commissioner Mark Peters, as part of an investigation into DOC hiring practices, stated that "DOI's latest investigation on Rikers Island exposes a shockingly inadequate screening system, which has led to the hiring of many officers that are underqualified and unfit for duty . . . Positions as law enforcement officers demand better."[179] That same report stated that "[t]he results of DOI's investigation demonstrates, conclusively, that significant improvements must be made . . . . [including that] DOC must have a system in place to proactively monitor applicants who are hired but are considered vulnerable to corruption."[180]

118. Given the statements by Commissioner Peters and the report's conclusions, at the time of the victimization of both Jane Doe 1 and Jane Doe 2, the hiring process left the female inmates at RMSC vulnerable to sexual abuse and demonstrates yet another facet of the City's indifference to the sexual safety of RMSC inmates.

D. Secondary Opinion #3: The City's training is inadequate

119. It is my opinion that the City of New York has failed for years in its responsibility to adequately train its correction officers, medical staff, investigators, and supervisors to follow DOC directives and national correctional practices concerning staff-on-inmate sexual abuse.

120. Given the size of the City of New York, the professional expectation of such a large organization, and the potential ability to provide the highest levels of training for its staff, it would be reasonable to assume that the City of New York should have easily met national standards. However, that is clearly not the case.

Correction officers are inadequately trained

121. The City of New York knew, or should have known, that to safely place inmates, especially female inmates, under the care, custody, and control of correction officers requires a legally up-to-date, detailed, intense, and critical training package delivered both at the outset of the correction officers' careers, and subsequently on an annual basis.

122. Indeed, the City has responsibilities relative to the training of their custodial staff in their responsibilities relative to the sexual safety of every inmate in custody, both male and female. The responsibility to adequately train staff starts when an employee is hired and is required and necessary throughout the career of the custodial officer.

[178] *Id.* at report 19, 21.

[179] *Id.* at press release 1.

[180] *Id.* at press release 2.

123. Yet, the City inadequately trained its correctional staff to properly interact with female inmates through Interpersonal Communication Skills (IPC) training upon assignment to RMSC and, subsequently, annually, during in-service training. RMSC custodial staff interviewed by the Moss Group confirmed, nearly universally, that they had never received specialized training on working with female inmates.[181]

124. This initial, and annual subsequent training, is considered an industry standard and, by not providing it as prescribed, the City has been derelict in its responsibilities, thus jeopardizing the sexual safety and security of the female detainees at RMSC.

125. The correctional staff were also "insufficiently" trained in DOC's written practices on preventing inmate sexual abuse,[182] in carrying out staff duties under PREA, and in reporting knowledge and suspicions of staff-on-inmate sexual abuse,[183] and DOC correction officers also provided contradictory testimony regarding training on the topic of undue familiarity.[184] In December 2014, a "director" at DOC told the Moss Group that officers receive an hour and 45 minutes of pre-service training on preventing inmate sexual abuse and then only 30 minutes of training per year thereafter.[185] The same director reported that no PREA training was provided, as of December 2014, because "unionized uniformed staff . . . will often state, 'I will not do *XYZ* unless you show it to me in a policy'" and there was no policy.[186]

126. In 2016, when the DOC issued a new directive to replace the 2008 Sexual Abuse Directive,[187] the DOC yet again failed to provide adequate training. Such actions do

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[181] Moss Group, Inc., RMSC Staff Focus Group Notes, at TMGNYC10765 (Jan. 15-16, 2015) (TMGNYC10758-73) ("RMSC Staff Focus Group Notes") (staff noting that training was on the job).

[182] *See, e.g.*, DOC, Classification 5010R-A Preventing Inmate Sexual Abuse (effective Dec. 31, 2008) (DEF_0000001-15) (the "2008 Sexual Abuse Directive"); Memorandum, DOC, No. 01/08 Undue Familiarity and Prevention of Sexual Abuse of Inmates by Staff and Other Inmates (effective Feb. 7, 2008) (DEF_0000019-21) (the "2008 Undue Familiarity Memo").

[183] Sexual Safety Assessment Report, *supra* note 164, at DEF_0014428; DEF_0014433, DEF_0014465.

[184] Correction Officer Dominique Harris testified that he receives annual trainings on undue familiarity. Harris Dep. 168:6-21. However, Correction Officer Carlos Rodriguez testified that he has not received undue familiarity training since the academy. Rodriguez Dep. 170:11-17.

[185] Moss Group, Inc., Interview with DOC Director (Dec. 2, 2014), at TMGNYC13896 (TMGNYC13896-97) ("Director Interview"); *see also* E-mail from David Marcial to Laurel Wemhoff, Project Manager, Moss Group, Inc. (Jan. 27, 2015) (TMGNYC15647-48).

[186] Director Interview, *supra* note 185, at TMGNYC13896. The Moss Group noted that "division" between uniformed and non-uniformed staff was a "major cultural theme." *Id.*

[187] Directive, DOC, Classification 5011 Elimination of Sexual Abuse and Sexual Harassment (effective May 2, 2016) (DEF_0015078-143) (the "2016 Sexual Abuse Directive").

not indicate a new and updated approach, but rather, are indicative of a continuation of the failures of the past.

127. CO Santiago, for example, was hired and assigned to RMSC in 1998; yet, the only training he has apparently received occurred in 1997, when he attended the CO Academy.[188]

128. COs Harris and Rodriguez, who were directly responsible for guarding Jane Doe 2 when she worked as an SPA in Building 9 and who permitted Jane Doe 2 to move regularly to Building 11 – in the middle of the night – where she was repeatedly raped and sexually abused by CO Santiago, provided similar statements during their depositions: Both CO Harris and CO Rodriguez testified in June 2016 that the only training they had been given regarding PREA was in 2016; nothing previously.[189] Furthermore, that training was apparently ineffective – despite being deposed only months after the training, neither correction officer could remember what was said in those training sessions.[190]

129. COs Harris and Rodriguez likewise had minimal knowledge of Jane Doe 2's responsibilities as an SPA and apparently had never read the DOC policies on her position, despite their being her direct supervisor.

130. Industry training standards further call for correction officers to have a minimum of 40 hours of training initially, and then 40 additional hours each subsequent year. National correction standards call for specific curriculum at those trainings including, but not limited to, "sexual harassment/sexual misconduct awareness," "interpersonal relations", and "supervision of inmates." Additionally, new employee orientation is required to include the DOC "code of ethics," "personnel policies" (staff rules and regulations), and "employee right and responsibilities." There is no evidence that this training was ever administered at RMSC.

Medical staff are inadequately trained

131. It is my opinion that the medical staff at RMSC are inadequately trained in their responsibilities relative to the sexual safety of the inmates in custody.

132. As the City's own consultants state in the Sexual Safety Assessment Report, correctional industry standards require training on how to "detect and assess signs of sexual abuse and harassment, how to report in compliance with PREA Standards, how to respond effectively and professionally and how to accurately preserve medical forensic examination evidence."[191] However, the Moss Group found that the medical

[188] Form No. 22R Employees Performance Service Report for CO Santiago (June 3, 2015) (DEF_0000702-03) ("22-R Report").

[189] Harris Dep. 184:14-186:20; Rodriguez Dep. 158:2-160:12.

[190] Harris Dep. 184:21-186:2; Rodriguez Dep. 158:2-160:12.

[191] Sexual Safety Assessment Report, *supra* note 164, at DEF_0014424.

and mental health staff had received no training whatsoever on the PREA standards.[192] There was no documentation that the staff who might conduct the forensic examinations had received appropriate training and none of the staff had the proper certifications.[193]

133. When Jane Doe 2, for example, first reported her sexual abuse and rape to a medical clinician, the clinician told her that there was nothing that could be done for her. She failed to report Jane Doe 2's allegation to her supervisor or the DOC as mandated by the City's own Directive 5010-R.[194] Instead, Jane Doe 2 was sent back to Building 11 where she was subject to more threats and bullying by inmates while the correction officers did nothing.

DOC leadership is inadequately trained

134. It is my opinion that the leadership at RMSC are inadequately trained on their own duties and the duties of their subordinates to effectively supervise, and therefore contribute to RMSC's culture of impunity.

135. The industry standards for training call for facility management and supervisors to have 40 hours of initial training in their assignment, which is to be followed annually with 24 hours of training. There is no evidence that this was ever accomplished at RMSC.

136. The Sexual Safety Assessment Report found that the "lack of thorough training and mentorship for supervisors presents challenges to operational consistency and best practice implementation," including that captains "reported having little if any training to serve in their role and most reported a lack of support from [their] supervisors."[195]

137. Furthermore, the leadership at RMSC was found to have only limited knowledge of PREA, without any training having been conducted.[196] The Sexual Safety Assessment Report, whose auditors interviewed RMSC leadership, including Assistant Deputy Wardens in early 2015, found that the leadership had very limited knowledge of the law and needed training. This means that 11 years had passed since PREA's acceptance into law and still DOC leadership was in the dark.

138. Contrary to industry standards, the City did not require captains to conduct unannounced supervisory rounds until July 2015 when it promulgated a Chief's

[192] *Id.*; *see also* RMSC Staff Focus Group Notes, *supra* note 181, at TMGNYC10770-71.

[193] Sexual Safety Assessment Report, *supra* note 164, at DEF_0014424.

[194] 2008 Sexual Abuse Directive, *supra* note 182, at DEF_0000001.

[195] Sexual Safety Assessment Report, *supra* note 164, at DEF_0014447.

[196] *Id.* at DEF_0014445.

Order[197] (amended February 2016[198]). That order directed that staff were not to announce the shift tours inspections by captains prior to the captains' arrival at housing location.[199] The amended order specifically identifies storage areas and closets as places for captains to check due to their being high risk areas – precisely the areas where Jane Doe 2 was raped in 2013.[200]

139. Most concerning was the Moss Group's findings regarding the PREA Coordinator, Faye Yelardy.[201] In specific, the Moss Group stated that Yelardy, who is apparently in charge of implementing the PREA Standards, "had no direction in regards to her job responsibilities [and] no written job description." [202] The Moss Group indicated that Yelardy's stated plan to coordinate efforts among facilities to comply with the PREA Standards was limited to "going . . . into all facilities with a checklist" and that she had "no clear process for resolving a PREA-related issue."[203] An employee with the Department of Health and Mental Hygiene ("DOHMH") noted to the Moss Group that he had sent many emails to Yelardy but that "she is completely non-responsive and she is defensive when she does" respond.[204]

Investigators are inadequately trained

140. It is my opinion that investigators for both the DOI and DOC ID – the City's investigative units for sexual misconduct within RMSC (*see supra* ¶ 5) – are inadequately trained to seriously and vigorously investigate sexual misconduct.[205]

141. At the outset, there does not appear to be an appropriate selection process for the investigators, who are chosen from the compliment of DOC personnel. Best practices provide that the selection process should include a desire by the DOC staff to be so

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[197] Joseph Ponte, Comm'r, and Martin J. Murphy, Chief of Dep't, DOC, Teletype Order No. HQ -01670-0 PREA Unannounced Rounds (July 21, 2015) (DEF_0014006) ("2015 PREA Unannounced Rounds Order").

[198] Joseph Ponte, Comm'r, and Martin J. Murphy, Chief of Dep't, DOC, Teletype Order No. HQ -00343-0 PREA Unannounced Rounds (Updated) (Feb. 9, 2016) (DEF_0014004) ("2016 PREA Unannounced Rounds Order").

[199] 2015 PREA Unannounced Rounds Order, *supra* note 197, at DEF_0014006.

[200] 2016 PREA Unannounced Rounds Order, *supra* note 198, at DEF_0014004.

[201] Moss Group, Inc., Interview with PREA Coordinator, at TMGNYC13893-95 (Dec. 22, 2014) (TMGNYC13893-95) ("PREA Coordinator Interview").

[202] *Id.*

[203] *Id.*

[204] E-mail from Joyce Conley, Dir., Consultant Servs., Moss Group, Inc., to Wendy Leach, J.D., Senior Consultant, Moss Group, Inc. (Mar. 13, 2015) (TMGNYC15699).

[205] Sexual Safety Assessment Report, *supra* note 164, at DEF_0014423-24, DEF_0014435-36.

assigned, as well as a background in investigative skills. That, however, does not appear to be the case in NYC.

142. At the time that the Sexual Safety Assessment Report was conducted, specialized training records for investigators could not be reviewed, apparently because investigators personally (and not the City) maintain records of any specialized training.[206] This indicates that the City's records of its investigator trainings were so deficient that the City of New York could not identify what training their staff had even had. No documentation of investigative staff training has been produced in this litigation.

143. When the Moss Group asked DOC ID investigators to describe the specialized training that had been provided pursuant to the PREA Standards, they reported no knowledge of PREA training, but did indicate that they had received some training on other topics related to sexual abuse investigations. No documentation of that training has been provided in this litigation.

144. Deposed DOI and DOC ID investigators could not identify any specialized investigative training, other than "on the job training" during their first weeks on the job. One DOI investigator deposed, who provided such testimony, had been an investigator for over 30 years.[207] At least one investigator stated that she had only first received training in sexual abuse cases in early 2016.[208]

145. Any training that was conducted prior to 2015 was also seemingly ineffective, given that the Sexual Safety Assessment Report found that the investigators (i) lack training in contemporary investigative techniques and requirements, and especially, in the area of sexual abuse complaints; (ii) demonstrated an inability to understand the applicable burden of proof; (iii) fail to understand that investigations should be "prompt, thorough, and objective"; (iv) lack an understanding of proper requirements for evidence processing; and (v) demonstrate an inability to properly administer a *Garrity* warning.

146. One of the very basic skills of an investigator is having a thorough understanding of the concept of "burden of proof" (e.g., by preponderance of the evidence). Yet, this basic concept of investigations could not be articulated by investigators which taints the entire process of the investigations.[209] Adequately training investigators through appropriate curriculum, and to document the same, is a critical component of successful investigative units. The City of New York failed to meet that expectation showing a basic fallacy in the ability of these investigators to meet minimum standards.

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[206] *Id.* at DEF_0014423.

[207] Christo Dep. 21:9-11, 42:21-43:10; 46:3-9.

[208] Ortiz Dep. 63:8-13.

[209] Sexual Safety Assessment Report, *supra* note 164, at DEF_0014436.

147. The inability of the investigator's department administrators, managers, and supervisors to help them close the loop holes in their investigations and/or recognize that there are gaps indicates a lack of understanding on their parts as well.

148. Skepticism in the abilities of the City investigators was expressed by DOC staff, who, when asked, "did not believe investigators were well-qualified to conduct investigations of staff or inmates and did not have faith in the investigators and reported a general mistrust of them . . . ."[210]

149. Furthermore, the convoluted case investigation processes in the investigation into Jane Doe 2's allegations by DOI and DOC ID, discussed in greater detail in Secondary Opinion No. 8, *infra*, is further evidence that staff have not been trained in standard investigative techniques.

E. Secondary Opinion #4: The City's practice of permitting male correction officers to guard female inmates without supervision violates correctional best practices

150. It is my opinion that the City of New York failed to reasonably and appropriately supervise the male custodial staff at RMSC leaving the female inmates in jeopardy of sexual exploitation.

151. The DOC knew or should have known as early as January 1, 2011 – and likely earlier – that nationally accepted correctional practices did not permit female inmates to be supervised by male correctional officers, and instead required female staff to accompany male correction officers. This practice is designed to help ensure the sexual safety and security of those female inmates.

152. Indeed, the unacceptable practice of permitting men to supervise female inmates – without being accompanied by female COs – was known to jail management in New York since at least 2011 as a result of a lawsuit about this very issue. *See generally Cash v. County of Erie*, 654 F.3d 324 (2d Cir. 2011).

153. New York State law prohibits male correctional officers from guarding female inmates without supervision by a female correction officer (see N.Y. Comp. Codes R. & Regs. tit 9 §§ 7501.1, 7502.1). The DOC practice of allowing such male officer supervision is in violation of this legal mandate.

154. The PREA Standards,[211] which were promulgated in 2012, places limits on cross-gender viewing and searches (Section 115.15 (d)). "The facility shall implement policies and procedures that enable inmates to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts,

[210] *Id.* at DEF_0014423-24.

[211] National Standards to Prevent, Detect, and Respond to Prison Rape Under the Prison Rape Elimination Act (PREA), 28 C.F.R. § 115.15(d) (2012), https://www.prearesourcecenter.org/sites/default/files/content/prisonsandjailsfinalstandards_0.pdf.

buttocks, or genitalia, except in exigent circumstances or when viewing is incidental to routine cell checks." However, this is further clarified, under the "Prevention Planning" Section, PP-4, which states: "Except in the case of emergency or unforeseen circumstances, the facility restricts nonmedical staff from viewing inmates of the opposite gender who are nude or performing bodily functions and similarly restricts cross gender pat-down searches." Also, this standard expects that each time a male staff member enters a female housing unit, he must announce his presence. Therefore, the City of New York's practice of allowing male officers to conduct the care, custody, and control duties, alone, in a female housing unit is not an accepted practice generally, unless there is very close monitoring by a female partner or supervisor and/or there exists physical barriers that restrict observations and technological monitoring. Having three male officer working in female housing (Buildings 9 and 11) and the bubble would not be an accepted practice, especially given the sexual abuse allegations that had surfaced since 2010 and the lack of monitoring and/or barriers.

155. As a more general matter, one of the most important national correctional practices is that facilities must have staff members of the same gender immediately available in case of emergency. Clearly, this is not possible when the housing officers are all male. (Even if "bubble" officers are female, they are not immediately available to aid in emergencies.) Also, since officers are expected to look at inmates in their cells every half hour, staffing only male correction officers to the floors of female housing units means that they will need to observe female inmates in sensitive situations, like using the bathroom. At least, by the accompaniment of a female officer, this observation would be less troubling for female inmates and is just good professional practice.

156. The need for a new approach to female custody supervision would have been evident to the City had it followed American Correctional Association ("ACA") Standards requiring that an annual staffing analysis be conducted, which is a good "expected practice" for operations and budgetary purposes, properly implemented PREA, or conducted an assessment of the multitude of sexual abuse information. That these steps were not taken is evidence of a systemic failure of the DOC and demonstrative of a callous disregard of sexual abuse and rape by male staff exhibit by the City.

157. The City's inadequate and outdated staffing practices had a clear impact on Jane Doe 1 and Jane Doe 2. Jane Doe 1 and Jane Doe 2 testified that male officers brought in contraband (tobacco, marijuana, ecstasy, cosmetics) for female inmates in expectations of "favors."

F. Secondary Opinion #5: The City's reporting mechanisms are deficient

158. In my opinion, the City of New York allowed a culture of misbehavior at the DOC in which staff were not held accountable to ensure the integrity of the agency. This has been described as the culture of impunity, which fosters and allows staff to withhold information, intentionally, which, in this case, jeopardized the sexual safety of female inmates at RMSC.

Staff do not report due to a unwritten code of silence

159. Overall, the Sexual Safety Assessment Report described the DOC as having a "strong and culturally ingrained code of silence among staff and inmates."[212]

160. This is clear in the Moss Group's discussions with staff and inmates. In one focus group discussion with the Moss Group, custodial staff were split on whether they would report staff-on-inmate sexual abuse, stating that they "may try to 'talk to them first' or not want to be involved."[213] In another RMSC inmate focus group, a participating inmate recounted an incident where she personally reported inmate-on-inmate sexual harassment to a CO, but the officer "did nothing." That inmate then reported the CO to the officer in the bubble but was told by the bubble officer that he or she "wouldn't report another officer."[214] The conduct described is unprofessional and demonstrates a culture of impunity toward sexual abuse at RMSC.

161. Furthermore, staff regularly fails to adhere to the City's own directives on the maintenance of logbooks, which makes meaningful review of inmate activities by correction officers, supervisors, and investigators more difficult.

162. DOC Directive 4514R-A[215] specifically requires that the facility logbook be legible, in hand printing, and list certain routine information, as well as unique information identified in a particular unit or activity required in that unit. During review, many gaps in consistency were apparent. Depending upon the CO, the information varied from overly detailed accounts of the mundane or very sketchy. Depending on the supervisor inspecting the logbooks, the same was evident. The facility logbooks also did not consistently log the inmate Suicide Prevention Aide staffed to Building 9 on most nights.

163. Additionally, deponents provided conflicting testimony over whether a special observation logbook, which logs SPA activities, was maintained for Building 9 and none has been produced for the relevant period in the course of this litigation, despite the fact that the maintenance of such a logbook is required by DOC policy. During the inspection of RMSC, I observed the last page of an SPA logbook in Building 9 and noted that it had not been updated in over a week – again, contrary to DOC guidelines.

164. Santiago and Jane Doe 2 each testified that she was allowed to move between two RMSC buildings in the middle of the night. Per policy and procedure, such movements should have been logged – as a normal safety practice, and to ensure that supervisors were aware that this was happening. However, the movements were <u>not</u>

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[212] Sexual Safety Assessment Report, *supra* note 164, at DEF_0014448.

[213] RMSC Staff Focus Group Notes, *supra* note 181, at TMGNYC10762.

[214] Moss Group, Inc., RMSC Inmate Focus Group Notes, at TMGNYC13830 (Jan. 15-16, 2015) (TMGNYC13825-38) ("RMSC Inmate Focus Group Notes").

[215] Directive, DOC, Classification 4514R-A Housing Area Logbooks (effective Oct. 19, 2007), http://www1.nyc.gov/assets/doc/downloads/directives/4514R-A.pdf.

logged in any produced logbook, meaning that a half dozen correction officers flaunted policy, and certainly creates the suspicion that their omissions were done knowingly and for improper purposes.

165. CO Harris and CO Rodriquez, the officers on the midnight shift in Building 9 where Jane Doe 2 worked as an SPA, testified that they let her move back and forth to Building 11, where CO Santiago worked, on a regular basis, without logging her movement, in violation of the Inmate Observation Aide Program (also called Suicide Prevention Aide/SPA) directive.[216] Since it occurred night after night, and only when CO Santiago was on duty in Building 11, the implications are absolutely clear. To not have questioned this action, and/or reported it, is a violation of the 2008 Sexual Abuse Directive,[217] as well as the PREA Standards. It is unrealistic to assume that this was merely an oversight – the failure to act was and absolutely had to be intentional.

166. CO Harris's and CO Rodriguez's conduct was a clear violation of the rules of the DOC and this failure to act or report should have been investigated. However, the DOI never even questioned these officers, about anything, let alone their actions, suspicions, and/or actual knowledge. This failure can only be described as another investigative failure, and the failure to log Jane Doe 2's overnight movements, an intentional omission.

Reporting mechanisms for inmates are broken

167. The City fails to comply with PREA's requirements that there be operational avenues for inmates to report, in a confidential manner, sexual abuse by correctional staff.

168. The PREA Standards specifically require that telephone reporting systems be "functional," that inmates have access to responsible reporting agencies, and that reports be treated confidentially. However, the Sexual Safety Assessment Report found that the City's telephone system did not satisfy any of these three requirements.

169. Specifically, the Sexual Safety Assessment Report found that (i) phone numbers for reporting were not posted prominently or at all in inmate housing areas or near inmate phones contrary to industry minimum standard;[218] (ii) the hotlines did not work, relayed busy signals, rang a private citizen's number, rang directly to the Deputy Warden's office, went to answering machines without information about the number to

[216] Directive, DOC, Classification 4017R Inmate Observation Aide Program (effective Aug. 8, 1988); Harris Dep. 198:19-25; Rodriguez Dep. 85:17-86:3.

[217] 2008 Sexual Abuse Directive, *supra* note 182, at DEF_0000002 ("All staff are responsible for being alert to signs of potential situations in which sexual abuse might occur and signs of victimization. Any staff member who has either knowledge or reasonable belief or receives an allegation that an incident or threat of sexual abuse has occurred and fails to report such information will be subjected to disciplinary action.").

[218] Sexual Safety Assessment Report, *supra* note 164, at DEF_0014425-26.

be reached, or led to the DOI hanging up on the call or acting "very short"[219]; (iii) staff thought that 311 could be used, but IT stated that 311 could only be called from an outside line, meaning that it could be reached only with a three-way call[220]; (iv) calls could not be placed confidentially because they required the input of a particular pin[221]; (v) calls were also not free to reporting hotlines, disadvantaging indigent inmates.[222] Several inmates in discussions with the Moss Group also reported fear that the phone calls were recorded, and that others would know that they were "snitch" for providing information about sexual abuse.[223]

170. During my inspection of RMSC, I confirmed that many of the failures identified by the Moss Group have yet to be corrected, *supra* ¶¶ 97-99. The Moss Group report was released over one year ago.[224]

171. The City's failure to make functioning confidential phone lines available to inmates, as noted in, *supra* ¶ 169, left the female inmates with the only option of reporting sexual abuse via the grievance system,[225] which the Sexual Safety Assessment Report detailed as untrusted by the inmates[226]; via the correctional staff, whom the Sexual Safety Assessment Report reported that the inmates did not trust nor expect to keep the information confidential[227]; via the medical staff, whom the Sexual Safety Assessment Report indicated did not always report it[228]; or via the faith based staff, whom the Sexual Safety Assessment Report reported were not properly trained and were not always available.[229] In contrast, it has been the industry expectation for more than a

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[219] *Id.*

[220] *Id.*

[221] *Id.*

[222] *Id.*

[223] RMSC Inmate Focus Group Notes, *supra* note 214, at TMGNYC13826, TMGNYC13828.

[224] Email produced by the Moss Group confirm that the PREA Coordinator was personally made aware of the issues, in great detail, over a year and half ago. E-mail from Wendy Leach , Senior Consultant, Moss Group, Inc., to Faye Yelardy, PREA Coordinator (Mar. 18, 2015) (TMGNYC15651-53).

[225] Sexual abuse is not a grievable complaint under the City's policies. *See* Directive, DOC, Classification 3376 Inmate Grievance and Request Program (effective Sept. 10, 2012) (TMGNYC11620-66).

[226] Sexual Safety Assessment Report, *supra* note 164, at DEF_0014476; *see also* RMSC Inmate Focus Group Notes, *supra* note 214, at TMGNYC13826-28 (inmates noting that reporting an officer through the grievance system leads to retaliation, or reporting that the grievance system was ineffective).

[227] Sexual Safety Assessment Report, *supra* note 164, at DEF_0014427.

[228] *Id.* at DEF_0014469.

[229] *Id.* at DEF_0014471.

decade that each of these reporting mechanisms should have been properly in place, available for use by a victimized inmate, and appropriately functioning.

172. The failures of the reporting system are exemplified by J.F.'s experiences. In 2012, J.F. reported that CO Santiago was sexually abusing two women in RMSC to Captain Diane Medina, who was overseeing a disciplinary hearing brought against J.F. Captain Medina reported J.F.'s allegations to the City's investigative unit. Nevertheless, the allegation was never investigated or logged by the City's investigators. Had that investigation been properly initiated and conducted in 2012, Jane Doe 2's risk of being sexually abused by CO Santiago less than a year later would have been reduced.

173. In light of the deficiencies in the reporting system, it is no wonder that Jane Doe 2 had to make contact with the medical staff to begin the complaint process, as she had no other options. The City of New York was responsible to ensure that these processes were effectively in place no later than August 2012 when the PREA Standards were issued, but the Sexual Safety Assessment Report identified the City's reporting channels as non-functional and non-confidential even in 2015. The failure to have this system operationally in place, in a timely manner, jeopardized the sexual safety of all the female inmates and demonstrated indifference to their well-being.

G. Secondary Opinion #6: Inmates who report sexual abuse are retaliated against

174. In my opinion, the City of New York does not take appropriate measures to protect inmates from retaliation for reporting sexual misconduct, nor does the City take appropriate measures to investigate claims of retaliation. Given the number of inactions and omissions, the City's behavior goes beyond individual actors and are indicative of systemic failures.

175. The Sexual Safety Assessment Report found "a fear based environment as evidenced by reluctance to report staff or inmate misconduct, reluctance to raise issues or ask questions due to the belief that they won't be taken seriously or will be retaliated against."[230]

176. In a focus group, RMSC custodial staff told the Moss Group that they thought that there would be retaliation against both inmates and staff for reporting sexual abuse.[231] Civilian non-custodial staff likewise reported a concern retaliation could occur at RMSC. [232]

177. In other focus groups, inmates shared with the Moss Group their belief that "[t]here is a huge fear of retaliation."[233] On the grievance system, inmates stated that "once an inmate reports an officer, you are retaliated against." That same group indicated that

[230] *Id.* at DEF_0014448.

[231] RMSC Staff Focus Group Notes, *supra* note 181, at TMGNYC10769.

[232] *Id. at* TMGNYC10759.

[233] RMSC Inmate Focus Group Notes, *supra* note 214, at TMGNYC13829.

"if you talk and complain too much, you might get moved." [234] One inmate who reported knowledge of staff-on-inmate sexual abuse to the Moss Group in the focus group said that she was "afraid" to report the abuse because the phone lines were recorded and she did not want to be a "snitch."[235]

178. Any form of retaliation in the incarceration environment deters inmates from ever surfacing complaints against staff. This is especially true if these types of allegations are never investigated and no sort of corrective action is ever taken. If the system does not protect those that report, then reports will not be made and the inmate's sexual safety will continue to be compromised.

179. Victims of this failure of policy include Jane Doe 1, who testified that she was afraid that she would be retaliated against if she reported Santiago's abuse.[236] Jane Doe 1 only gained the courage to report years later, after learning that CO Santiago had been removed from RMSC (as a result of Jane Doe 2's report of her abuse).[237]

180. In 2012, the DOI was put on notice by Captain Diane Medina of an allegation that CO Santiago had used the disciplinary system as retaliation against J.F., with the purpose of having her moved because she threatened to expose his sexual abuse of two inmates. No investigation of that allegation of retaliation or sexual abuse ever occurred.

181. Jane Doe 2 (independently) accused CO Santiago of abusing the disciplinary system to further his sexual abuse of women when he threatened that he would give Jane Doe 2 "a fake ticket to get [her] put" in punitive segregation if she refused to have sex with him.[238] No investigation of that allegation of retaliation was ever conducted.

182. In May 2013 and again in 2014 (when Jane Doe 2 was returned to RMSC), Jane Doe 2 reported to DOI that she was being retaliated against by correction officers and inmates for reporting CO Santiago. Neither the DOI nor DOC ID conducted a formal investigation of those allegations. The failure to investigate and prosecute Jane Doe 2's retaliation once again shows tacit approval of behavior prohibited by relevant rules and directives.

183. Had the City investigated Jane Doe 2's allegations of retaliation – particularly her allegations in May 2013 that she was not being permitted to leave her cell to eat food for long periods of time – the City would have found support for her allegations.

184. Indeed, Santiago testified during his deposition that when Jane Doe 2 was transferred back to Building 11, Jane Doe 2 and eight other inmates got into a verbal argument

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[234] *Id.* at TMGNYC13828.

[235] *Id.* at TMGNYC13829.

[236] JD1 Dep. 79:18-80:6.

[237] Decl. of JD1 ¶ 11 (Oct. 9, 2015), ECF No. 29.

[238] JD2 Dep. 53:23-5:14.

toward the beginning of his shift, and therefore he refused to let Jane Doe 2 come out for breakfast many hours later.[239] Although Santiago claimed that he may have logged this incident, as is required under DOC Directives, the City claims to have lost the logbook (and myriad other pieces of evidence.) No other correction officer on duty in Building 11 or the Building 9/11 bubble logged this substantial inmate fight and there is no documentary record of any captain being informed of the purported fight, which raises questions about CO Santiago's explanation for what Jane Doe 2 perceived as retaliation, and makes the City's failure to take it seriously all the more problematic.

H. Secondary Opinion #7: The City's investigative units mismanage investigations and thereby encourage sexual abuse

185. It is my opinion that the City failed to conduct vigorous, effective, and properly managed sexual misconduct investigations. As a result, the City has failed to effectively enforce its "zero tolerance" policy on sexual misconduct. That failure feeds into the DOC culture where the correctional staff know that there is a minimal probability that the City will discover sexual misconduct, and that if discovered, the misconduct would not be effectively investigated so that, at conclusion, punishment would be unlikely. Given this, it is my further opinion that the departmental "code of ethics" was not enforced, and that any professional prohibitions relative to sexual misconduct were not real and that violation of the same was a tolerated employee practice sheltered by the code of silence exhibited by the staff.

186. A review of substantiation rates of allegations of staff-on-inmate misconduct by either of the City's investigative units produces a significantly lower level than found in other correctional facilities. The DOC records show that there were 19 reported allegations of staff-on-inmate sexual victimization in 2013, 17 in 2012, and 19 in 2011.

187. However, of the 56 reports of sexual abuse between 2011 and 2013, only 3 (5%) were substantiated, while 31 (55%) were determined to be unfounded, 21 (37.5%) were determined to be unsubstantiated and 1 (2%) was closed for unknown reasons. Of significance is that the City's average substantiation rate is between one half and one third the national average substantiation rate.[240]

[239] Santiago Dep. 90:16-92:23, 104:12-20, 106:17-107:5.

[240] *See* Allen J. Beck et al., DOJ, *Sexual Violence Reported by Correctional Authorities, 2006* 3 (2007), https://www.bjs.gov/content/pub/pdf/svrca06.pdf; Allen J. Beck et al., DOJ, *Sexual Victimization Reported by Adult Correctional Authorities, 2007-2008* 1 (2011), https://www.bjs.gov/content/pub/pdf/svraca0708.pdf; Allen J. Beck et al., DOJ, *Sexual Victimization Reported by Adult Correctional Authorities, 2009-11* 1 (2014), https://www.bjs.gov/content/pub/pdf/svraca0911.pdf. *See, e.g.*, Decl. of Letitia James, Public

188. I am aware of no reason why female inmates at RMSC would make false allegations at a rate higher than at other jails in America.

189. A more likely explanation than false allegations are the deficiencies in investigator training identified by the City's Sexual Safety Assessment Report (*see supra*, Secondary Opinion No. 3) and deficient investigator practices and policies.

190. An extremely important investigative concept is that investigations should be conducted from two perspectives. First, the allegations should be assessed assuming that they happened as described, and then, second, the allegations should be assessed from the point of view that the allegations did not or could not have happened as alleged. This procedure does not appear to be followed by the City and may explain why the City's investigators fail to investigate obvious leads and why its investigations contain substantial gaps.

191. The Sexual Safety Assessment Report found that investigations were not "thorough." And that for the majority of investigations reviewed the investigation did not contain interviews with all possible witnesses, including clinical staff, inmates in the area, nearby staff, the Legal Aid Society, clergy, or even the accused staff. Many staff members told the Moss Group that they would not cooperate with investigations, even though that is grounds for termination or discipline under DOC ID Directive #7000-R.[241] Due to those deficiencies, the City's own PREA consultants found that the City's investigations were "taint[ed]" from the outset.[242]

192. The written policies of the City investigators were also found to be out of date. The Sexual Safety Assessment Report recommended that the City investigators update their policies to comply with the PREA Standards and current acceptable correctional investigatory practices, ensure the new policy includes direction as to standards of proof, referral to prosecution, contents of investigative reports, types of evidence required to be reviewed, follow-up with inmates as to investigative results, how and where to keep documentation, timeframes, thoroughness, and objectivity. The Sexual Safety Assessment Report also recommended that the City of New York write a "Coordinated Response Institutional Plan" that includes the "roles and responsibilities of . . . investigators."[243] A well-drafted and implemented coordinated response institutional plan is integral to an effective investigative unit. That the City apparently had no such plan in 2015 is shocking.

Advocate for N.Y.C., in Support of Pls.' Mot. for Class Certification ¶ 39 (Oct. 9, 2015), ECF No. 32.

[241] Further, the City allowed its investigators to avoid seeking the truth even when they had absolute means to arrive at it (the immunity clause when confronted with recalcitrant staff). Such allowances perpetuated a culture of sexual abuse of inmates in violation of their own values and laws.

[242] Sexual Safety Assessment Report, *supra* note 164, at DEF_0014435 (emphasis added).

[243] *Id.* at DEF 0014457.

193. In another staff-on-inmate sexual abuse case involving CO Rene Alvarez (2013) – in which the inmate was possibly impregnated while in custody – the investigators focused on the date in which she could have had intercourse with the CO and determined she could not have been impregnated while in custody. However, the fact that she may have had sexual intercourse at any time while in custody (a criminal offense), nor the fact that the CO bailed her out of RMSC, were investigated. This investigative approach which focuses on only one element of the complaint shows a distinct lack of investigative skills and understanding.

194. The City's records indicate that since 2011, only two employees have been disciplined for sexual abuse and those persons were not correctional officers, but civilian staff. Given all the information the City of New York knew, or should have known relative to its correctional staff, especially relative to the behaviors of CO Santiago and other officers from 2007-2013, to have only two "substantiated" cases involving punishment is just not credible.

195. In my opinion, so many years have passed under the City's deficient investigative regime that ingrained and systemic staff sexual abuse behaviors are endemic to the operation of the DOC, and that those behaviors have become invisible to the complacent DOC leadership and accepted and tolerated by the custodial staff as a "normal" practice. Even after many years of sexual abuse complaints, media investigations and information, and federal reports of sexual misconduct and PREA violations, the City of New York has exhibited a striking indifference to the sexual abuse occurring at RMSC.

I. Secondary Opinion #8: Jane Doe 2's investigation was mismanaged

196. It is my opinion that the City of New York failed to act in accordance with its legal and professional responsibilities to conduct a thorough and objective investigation into the allegations of Jane Doe 2.

197. The PREA Standards took effect in the summer of 2012, but had been pending since signed into law in September of 2003. PREA absolutely called for inmate sexual abuse cases to be given a high priority and intense scrutiny. There should not have been any surprise for any correctional agency, especially a large agency like the DOC, of PREA's importance and immediate application. However, even after 10 years, the mismanaged investigation into the Jane Doe 2 case and the widespread misconduct exposed by the 2015 Sexual Safety Assessment Report show a callous disregard for this law.

198. The City's actions and omissions in investigating Jane Doe 2's allegations of sexual abuse indicate a dramatic disregard for standard investigative practices without due regard to the safety and security of Jane Doe 2, while significant delays and the absence of meaningful follow-up on leads nearly assured that CO Santiago would avoid any sort of criminal or administrative sanctions.

199. What is clear from the evidence provided is that the investigators only investigated a single element, semen on the pants, and little else. The failure to examine Jane Doe 2's complaint from the perspective of "did it or could it have happened" through careful review of video, phone records, and staff/inmate interviews left swaths of evidence forever lost. This lack of investigative action tainted this case and shows a failure to properly investigate overall for the investigative units.

200. Additionally, other allegations of prohibited behaviors by CO Santiago surfaced. Yet these allegations remain uninvestigated to this day, despite CO Santiago having been restored to full status as a correction officer.

201. For example, shortly after the DOI began investigating Jane Doe 2's claims, Jane Doe 1 filed a notice of claim (alleging that CO Santiago repeatedly raped her) with the Office of the Comptroller of the City of New York. At the time, Jane Doe 1 was still incarcerated at RMSC, yet it appears that no substantive follow-up was ever conducted and that DOI was never notified of another allegation against the same officer it was investigating for raping Jane Doe 2.

202. The DOI also failed to investigate an allegation that CO Santiago impregnated another inmate and was bringing contraband in for yet another. The lead investigator on Jane Doe 2's investigation, James Christo, received those allegations (in writing), yet when asked why he did not follow up on these, responded, "I just didn't."[244] Such a response from a senior investigator is incredible, but also indicative of a systemic failure of the investigative services at the City of New York.

203. During the course of this litigation, Plaintiffs uncovered J.F.'s 2012 allegation that CO Santiago was raping two women in RMSC in 2012. Given the seriousness of this allegation, it is inexplicable why the City would not investigate it – particularly given that the statute of limitation has not yet run. Furthermore, since the allegation was unknown to investigators at the time that they closed Jane Doe 2's investigation, there is good cause to reconsider Jane Doe 2's allegations – but the City has not done so.

The DOI investigation was mismanaged

204. It is my opinion that the DOI did not act responsibly in investigating CO Santiago's criminal sexual misconduct (rape perpetrated by CO Santiago of Jane Doe 2). The seriousness of such allegations should certainly have been evident to the DOI, and with that, a high priority placed on its investigation. Yet, the investigation was poorly done and ineffective, the results were untimely, and the propriety of the inquiry was tainted from the beginning.

205. As discussed in the "Summary of Facts" section above, the investigators focused in on a single element – semen on the pants – and essentially nothing else. The failure to examine Jane Doe 2's allegations objectively through careful review of video, phone records, and staff/inmate interviews left whole areas forever lost. This lack of

[244] Christo Dep. 340:13-17, July 27, 2016; E-mail from Belarminia Ortiz,, *supra* note 61.

investigative action tainted this case and shows a failure to properly investigate overall for the investigative units.

206. At the outset, the investigators failed to interview Jane Doe 2 in a proper setting. The interview was not done in a secluded room off site, but rather behind glass at RMSC; no audio tape was used, which is not an appropriate standard practice; evidence was collected out of the sight of the victim and in the presence of an uninvolved officer, which is not standard practice; upon being allowed to look into the bag which contained the evidence, it was done behind glass and Jane Doe 2 was not directed to point out the semen stained area, which is poor practice; some handwritten notes were taken for some (but not all) of the interviews, yet given the significance of the allegations, such a practice is not supported by standard correctional practices; no interview memorandum was ever completed for any of DOI's discussions with Jane Doe 2; and no chronology of Jane Doe 2's alleged abuse was ever put together, contrary to standard correctional practices.

207. Soon after completing the initial interview of Jane Doe 2, the DOI investigators, on the same day, just hours later, before a thorough investigation could be completed, confronted the subject perpetrator, CO Santiago, advising him of the allegations and specifically telling him the name of the victim.

208. The investigators spoke with CO Santiago on the evening (10:45 p.m. to 11:00 p.m.) of Friday, May 10, 2013. The interview lasted about 5 minutes. It took place in an open area outside of the RMSC building, where there would be no confidentiality: all other officers would see what was happening and the "rumor" mill would start, especially when Santiago was moved that night to another location. This was an absolutely absurd place to conduct such a serious interview.

209. The collected evidence was transferred to the NYPD laboratory for testing, but several questions were raised as to the propriety of the chain of custody. Chain of custody is a longstanding standard of evidence collection. But, evidence collection in this case shows that the investigators failed to properly meet appropriate investigatory standards and jeopardized the integrity of the entire investigation. At one point, NYPD discussed the "vouchering" process of evidence collection with the investigators, indicating that it was not properly done.[245]

210. After vouchering the DNA evidence, DOI Investigator Christo testified that he stood down from taking additional investigative steps pending the results of the test. This demonstrates a fundamental misunderstanding of proper investigative technique on the collection of evidence, which requires prompt and thorough action to avoid spoliation.

211. Around the same time, Jane Doe 2's inmate phone recordings were requested by Investigator Christo. They were collected and made available to Christo. Yet,

[245] Further, proper evidence collection is a National Standard, under the ACA's *Performance-Based Standards for Adult Local Detention Facilities*. *See* App. D, at "Disposition of Evidence," 4-ALDF-2C-06.

incredibly and inexplicably, they were never picked up by anyone at DOI, and no investigator reviewed them. Since Jane Doe 2 told the DOI investigators that she had called a friend on the recorded line and told him about CO Santiago's abuse and separately called CO Santiago on a three-way call with that same friend, the lost recordings potentially contain powerful incriminating evidence.

212. Other evidence was apparently gathered and reviewed, such as RMSC monitoring videos, but, in deposition, Investigator Christo testified that it was not preserved and that the substance of any review was not documented. If video was in fact reviewed, the uncontested testimony of Jane Doe 2, CO Santiago, and COs Harris and Rodriquez suggests that the video would have shown, at a minimum, Jane Doe 2 routinely and improperly travelling back and forth between Buildings 9 and 11 without it being appropriately documented and without an escort. This would have been an unmistakable sign of misconduct.

213. Furthermore, the investigators failed to interview other inmates and/or staff that might have had important information.

214. For example, there is no record that DOI ever spoke to CO Harris or CO Rodriguez, who were assigned to supervise Jane Doe 2 while she worked as an SPA, and who permitted her to leave Buildings 9 and 11. Given the information provided to the investigators by Jane Doe 2, the failure of investigators to interview officers in the adjacent building to simply check the credibility of the basic statements of Jane Doe 2 is a shocking failure. Such purposeful inactions, once again, show the failure of the City to even address its own rules of holding its staff accountable.

215. There is no record that DOI ever spoke with involved medical staff or tour supervisors (i.e., captains).

216. There is a notation in the final closing memorandum for Jane Doe 2's investigation that DOI spoke with some subset inmates that corroborated Jane Doe 2's allegations. However, there is no documentation of how those inmates were selected, or where and when those interviews took place, and there are no notes, memoranda, or recordings memorializing those interviews. The City's failure to document its interviews violates best correctional practices.

217. Following DOI's receipt of the semen test results in July 2013, the DOI took nearly another year to finally close its investigation. In the interim, the only documented investigative step is a short and apparently unscheduled interview with Jane Doe 2 in March 2014, when the DOI informed Jane Doe 2 of the results of the semen analysis without further questioning her on her sexual abuse allegations.

218. On June 30, 2014, nearly 14 months after the investigation began, a memorandum closing the investigation into Jane Doe 2's allegations was issued by the DOI. It indicated that the allegation of sexual abuse was "inconclusive," which is not one of the official dispositions for investigations conducted by the DOI (the three proper designations are "substantiated," unsubstantiated" and "unfounded"). Neither the

memorandum, nor the investigation more generally, focuses on or mentions the criminal statutes that Santiago may have violated – a list presumably including at least New York Penal Law Sections 130.00 (Sex offenses; definitions of terms), 130.05 (Sex offenses; lack of consent), or 130.25 (Rape in the third degree).

219. The DOI Closing Memorandum also concluded that CO Santiago should be subjected to administrative review for discipline up to and including, termination, for a violation of the DOC policy against undue familiarity with inmates by staff.

220. The DOI then sent a referral letter containing the substance of the DOI Closing Memorandum to the DOC ID for further proceedings. Given the delay in processing the investigation, it would have been best practice to send the memorandum with a special notice of priority. That was not done in this case.

221. The DOC/ID received that memorandum on or about July 7, 2014, *but they took no action*. Email exchanged between DOC Commissioner Joseph Ponte and DOI Commissioner Mark Peters indicates that memorandum sent to DOC ID was either lost or removed on or about the end of August of 2014, when files were removed from the office where this memo was supposed to have been located, without notice, by the DOI. No inventory of the removed materials was ever provided, so the DOC ID indicated that it had no specific knowledge of the contents of the DOI Closing Memorandum nor a copy thereof, meaning the administrative investigation then did not occur.

222. Under standard correctional practices, DOI should have had an auditing system in place to check on the status of its referral to DOC ID. However, DOI apparently did not, and no investigative activity occurred at the DOC ID until December 2014 – over 5 months after the initial referral.

223. Even letters exchanged between Plaintiffs' counsel and the DOI counsel concerning Plaintiffs' FOIL Request for investigative case records between September and October 2014 did not trigger a status review to determine if any administrative investigation was occurring.[246]

224. It was not until December 2014, after further FOIL requests from Plaintiffs' counsel, that the DOI Closing Memorandum was once again sent to DOC ID (19 plus months after the complaint was initiated). At that time, emails between DOI and DOC ID appear to show unprofessional behavior.[247]

225. The failings identified above, including the failure to follow appropriate interview procedures, interview all relevant witnesses, preserve and memorialize evidence, or

[246] JD2 DOI Case File, *supra* note 42, at DEF_0001854-1869 (letters to and from Sarah E. Edwards, Cleary Gottlieb Steen & Hamilton LLP, to DOI from Sept. 9 to Oct. 29, 2014 regarding FOIL request).

[247] Email from James Christo, Assistant Inspector Gen., DOI, to Ruben Benitez, Deputy Dir. of Investigations, DOC, at NYC_00006552-53 (Jan. 9, 2015) (NYC_00006551-55).

follow-up on obvious leads raises serious questions about the integrity of the investigation itself, and due consideration should have been given to requiring DOI conduct its own additional internal administrative inquiry into its procedures.

The DOC ID Investigation was mismanaged

226. On December 17, 2014, the DOI Closing Memorandum for the CO Santiago sexual abuse allegation and undue familiarity case was received by DOC ID, some 19 months after the formal complaint was taken from Jane Doe 2 on May 10, 2013. This delayed action immediately called into question the 18-month administrative statute of limitations imposed under New York Civil Service Law Section 75. Furthermore, the memorandum transmitted by DOC ID did not include any supporting evidence.

227. No actual investigator from the DOC ID was assigned to the case until late February 2015. The City has provided no explanation for this delay in investigative assignment. Further, the investigator assigned took little action due to vacation, training assignments, and other duties – until May 2015 after the filing of this lawsuit.[248]

228. Given that the allegations in the Jane Doe 2 case, whether rape or undue familiarity, involved sexual safety issues for the involved inmate – and for inmates generally – the failure to give it a high priority over other investigations and proceed in an expeditious manner is untenable and unsupported by correctional practices.

229. Between May 20 and June 3, 2015, several meetings among investigators and administrators of the DOC ID were held. Evidence was requested from the DOI but not provided (or the requests acknowledged). The DOC ID investigator, and senior staff, requested that DOI provide them with critical evidence DOI claimed to have obtained. Yet DOI failed to do so. Indeed, Christo testified that, at the time, it was DOI policy to not provide any of the supporting materials to DOC ID. Investigator Christo's statement of DOI policy is astonishing and would irreparably impede investigations into criminal activity at a disciplinary level.

230. On June 3, 2015, Alexandra Wityak, the DOC ID investigator assigned, drafted a closing memorandum recommending that the CO Santiago case be closed due to the administrative "statute of limitation" having been passed, and also "due to necessary evidence not being provided" by DOI.

231. DOC ID closed the case because of the running of the 18-month statute of limitations, pursuant to Civil Service Law Section 75; however, Subsection 4 of that law states that "*such limitations shall not apply* where the . . . misconduct complained of and described in the charges would, if proved in a court of appropriate jurisdiction, constitute a crime" (which inmate rape certainly would).

232. However, DOC ID's understanding of the statute of limitations is convoluted and/or apparently incorrect. When criminal conduct is alleged, the 18-month statute of

[248] JD2 DOC ID Case Log, *supra* note 118, at DEF_0016125.

limitations relied on by the City is superseded by the criminal statute of limitation for the alleged offense. The criminal statute of limitation for rape in the third degree is, at a minimum, 5 years – which would mean that the statute of limitations will not expire until early 2018. Some of Jane Doe 2's allegations include forcible rape in the first degree, which under New York does not have a statute of limitations.

233. Furthermore, Jane Doe 2 and her family made allegations in March 2014 that correction officers at RMSC were retaliating against her. This was seemingly not investigated by DOI or DOC ID, but would be relevant to the statute of limitation inquiry, if for no other reason than the statute of limitation period for the retaliation claim had not yet expired, even under the administrative 18-month statute of limitation.

234. The DOC ID Closing Memorandum was formally signed in August 2015, over two years (27 months) after the date of Jane Doe 2's report of her sexual abuse.

235. The closure of this matter without a collaborative meeting between the DOI and the DOC ID, inclusive of a review of Section 75 constraints by legal staff, allows the continuance of the culture of impunity that seems to have been instilled in the DOC staff, and therefore, accepted by the City of New York. Since this meeting did not actually occur, it would be only speculative to consider the implications of such a meeting. However, given the nature of the allegations – sexual misconduct with inmates and rape – as well as the email comment from DOI Investigator Christo that ID "should put [Santiago's] ass back to work in a male facility,"[249] the failure of these two entities to not sit together and develop a plan around the behavior of CO Santiago shows how little attention the City of New York was giving to these dangerous actions by correctional staff.

236. The Jane Doe 2 investigation was not treated in an expedited or serious manner, and through delays and mismanagement, the City allowed the perpetrator, who was clearly identified by the DOI as a staff person who should have, at least, been administratively prosecuted for undue familiarity, to avoid prosecution. As such, the City of New York failed to meet its PREA legal requirements which, again, indicates systemic failures.

[249] E-mail from Jennifer Sculco, Senior Inspector Gen., DOI, to James Christo, Assistant Inspector Gen., DOI, at NYC_00005890 (Aug. 18, 2015) (NYC_00005890-92).

Conclusion

238. Given my 44 years of public service in the corrections profession and jail management, I have had the opportunity to lead the operations of four of the largest jails in the United States, the last being the Miami-Dade County Corrections Department in Florida (eighth largest system in America). It had been my perception that the City of New York's Department of Correction was one of the most professional and well run operations in the business. However, upon inquiry into this matter, that perception has been shattered. Throughout this examination, I have found huge gaps in the standards of expectation for such an operation. There were identified actions, inactions, and omissions by the City of New York that have caused me to conclude that there were longstanding systemic failures throughout RMSC's operations, which could only be the result of deliberate indifference.

239. These systemic failures have jeopardized the sexual safety and security of those incarcerated while creating a "culture of impunity" for the staff who violate professional and safety requirements. The myriad of issues, problems, and concerns I have found support the findings in the DOJ PREA Report, as well as the Sexual Safety Assessment Report determinations and recommendations. The detachment of administration and management from line staff has created an environment of complacency to serious internal issues, like sexual abuse and the rape of inmates. The failure to properly investigate, substantiate the allegations, and then discipline the perpetrators is a monumental crisis of integrity and credibility, and serves to reinforce and perpetrate the culture of impunity.

240. The City of New York must immediately restructure RMSC. There has been a failure to create meaningful policy and procedure; a failure to properly train staff, supervisors, managers, and administrators; a failure to properly supervise and manage; a failure to hold personnel accountable; and a failure to create a culture of professional expectations.

241. The victims in this matter deserve much better, and so do the citizens of the City of New York.

Timothy P. Ryan

Timothy P. Ryan

Date: November 3, 2016

APPENDICES

Appendix A: Curriculum Vitae

Timothy P. Ryan
Ryan Correctional Consulting Services, P.L.L.C.
3333 Rice Street #203
Miami, FL 33133-5299

PRESENT POSITION: **Consultant,** serving as a correctional trainer, assessor/auditor, and expert witness since 3/12/2014;

SUMMARY: Over forty-four years in correctional and law enforcement services with experience covering administration, command, supervision, coordination, and duty in county jail and community corrections (probation) activities, including personnel and budget, internal affairs, patrol, criminal investigation, court security, recruit academy training, planning and research, records control and automated systems operations; and additional experience in legislative analysis, program development, technology application, criminal justice research, professional training, and local and national jail operational audits and assessments.

Serving over the last three plus years as a jail's operational consultant for National Institute of Corrections regarding 14 jails in America, a Trainer for NIC and American Jail Association, as well as an expert witness.

PREVIOUS POSITION: **Retired - Director (1/17/2014), Miami-Dade Corrections and Rehabilitation Department (MDCR).** Appointed to the position of Director of MDCR on December 4, 2006. With nearly 5,000 inmates in custody and 3,000 in community-based programs, the Miami-Dade C&R Department is the largest jail system in Florida and the 8th largest in the nation. The department employs over 2,200 sworn and 600 civilian staff, with a budget of $300 million, while serving 37 law enforcement agencies. It processed nearly 90,000 arrestees in 2013, all within 5 jails, including a Boot Camp. It includes court services and inmate transportation, as well as pre-trial services and juveniles, who are processed as adults. The Department developed a Master Plan in 2008 and is pursuing a Mental Health Diversion Facility and a new 2,000-4,000 jail facility, plus infra-structure.

EDUCATION:

California State University – East Bay, Hayward, CA, **Masters**, 1976: **Public Administration.**

University of California, Berkeley, CA, **BS**, 1970: **Business Administration.**

Harvard University, John F. Kennedy School of Government, Boston, MA, **Graduate**, 2001: Senior Executives in State and Local Government Program.

FBI National Academy (175th Session), Quantico, VA, **Graduate**, 1993: Executive Leadership, Legal Issues, Media Relations, Terrorism Assessment, Forensics, Major Case Management, and Fitness;

Florida State Sheriff's Association – Jail Managers Workshops, Trainer/Speaker/Moderator/Sponsor/Attendee (2002 – 2013);

Valencia College, Orlando, FL, **Graduate**, 2003: Corrections Officer Recruit Academy - Modified Program.

California Standards and Training for Corrections (STC) Programs, Graduate/Attendee Certificates (1987 – 1998): Jail/Correctional Management, Medical Issues in Jails, Inmate Management, and Others.

California Peace Officer Standards and Training (POST) Programs, Graduate/Attendee Certificates (1971-1998): Executive Development, Long Range/Strategic Planning, Advance Management, Leadership, Jail/Police/Administrative Services/Personnel/Records/Civil/ Emergency Management, and Supervisory/Intermediate/Basic Training.

Alameda County Sheriff's Academy (Recruit Training), Pleasanton, CA, **Graduate**, 1971: Valedictorian.

Chabot College, Hayward, CA, Law Enforcement Program and Teacher Education Certification, **Supplemental Course Graduate**, 1976-1984.

ELECTED OFFICIAL:

Retired – Trustee, Livermore Valley Joint Unified School District, Board of Education, Elected 12/1983 – 11/2001, Livermore, CA, overseeing 14,000 students, 1,500 employees, 5 unions, and 70,000 constituents. **Board President:** 1985/86, 1989/90, 1994/95, and 1999/00.

PAST EXPERIENCE:

Chief of Corrections, Resigned to accept MDCR Director Position, March, 2002 – December, 2006, Orange County Corrections Department, 3723 Vision Blvd., PO Box 4970, Orlando, FL 32802-4970.

Chief of Correction, Retired (3/20/2002), February, 1998 – March, 2002, Santa Clara County Department of Correction, 180 West Hedding Street, San Jose, CA 95110-1772.

Commander, Detention and Corrections Division, Retired (2/28/1998): September, 1989 – January, 1998, Alameda County Sheriff's Office, 1401 Lakeside Drive, 12th Floor, Oakland, CA, 94612. Previous ranks:

Captain: 1986 - 1989;
Lieutenant: 1979 - 1986;
Sergeant: 1974 - 1979;
Deputy: 1970 - 1974.

CREDENTIALS:

American Jail Association (AJA), Past President (2002 – 2003), **Member** (AJA Board of Directors 1996 – 2004), and **Certified Jail Manager** (1997 – Present);

American Correctional Association (ACA), Commissioner (Commission on Accreditation for Corrections (2005 – 2008)), **Delegate** (ACA Delegate Assembly (1998 – 2004)), **Member** (Adult Local Detention Committee (2000 – Present)), **Member** (Task Force on Correctional Affiliations (2002 – 2003)), and **Member** (ACA Standards Committee (2004 – 2008));

National Institute of Corrections Programs (NIC), Graduate/Attendee (1987 – 2013): Large Jail Network (1993-2013), Correctional Leadership, Public and Media Relations, HONI/PONI Schools, and Direct Supervision.

Federal Emergency Management Agency (FEMA), **Certified Emergency Manager** (2006);

Florida Corrections Accreditation Commission (FCAC), Commissioner (2010 – 2013);

Florida Department of Law Enforcement (FDLE), **Certified Correctional and Law Enforcement Officer** (Dual Certification Standards 2003/05 – Present);

Florida Criminal Justice Executive Institute (FCJEI), Board of Directors, Gubernatorial Appointee (2004 – 2013);

State of California, Community College Life-Time Teaching Credential (1980): Police Science.

UNIQUE CORRECTIONAL EXPERIENCE:

AJA Representative/Member, Integrated Justice Information Systems Institute (IJIS), Grantee from DOJ, Washington, D.C. (2014): Selected as one of the jail professionals to be involved in the PREA Work Group;

Director, Miami-Dade County Corrections and Rehabilitation Department, Miami, FL (2007 -2008): Administrator overseeing the research, preparation, review, and presentation of the County's Correction's Master Plan;

Juror, American Institute of Architects, Annual Justice Review Committee (2012): One of Seven Nationally Recognized Criminal justice Expert Selectees;

Selected Advisor, Federal Bureau of Justice Assistance (BJA) (2007 - 2008), Orlando, FL and Las Vegas, NV: Jail Leaders "Speak on Current and Future Challenges in Jail Administration and Operations";

AJA Selected Representative, Federal Commission on the Prison Rape Elimination Act of 2003, Miami, FL (2006): Presentation of the "National Position" of American Jails Association regarding the act's implementation;

Selectee/Member, National Prisoner Re-Entry Roundtable Task Force, Council of State Governments, Washington, D.C. (2006);

Commissioner, Commission on Safety and Abuse in America's Prison (and Jails), Vera Institute, Washington, D.C. (2005): Selected as national jail representative;

Selectee/Member, Prisoner Re-Entry Institute Advisory Committee, John Jay College, New York City, NY (2005 -2008);

AJA Selected Representative, Federal Bureau of Justice Statistics (BJS), Washington, D.C. (2003) and New Orleans, LA (2004): Prison Rape Elimination Act of 2003 Implementation Workshop;
Selectee/Member, **American Probation and Parole Association**, Dallas, TX and Washington, D.C. (2003): Council on Re-Entry Policy;

Selectee, National Center for Disease Control (CDC), San Antonio, TX (2003): Participant in the Workshop on the "Management of Hepatitis C in Prisons (and Jails)";

Selectee/Member, **National Institute of Corrections (NIC)**, Washington, D.C. (2002): Participant on the Assessment Committee for "Staff Sexual Misconduct with Inmates";

Attendee as President of AJA, National Highway Traffic Safety Administration, Washington, D.C. (2002): DUI Processing Review;

Selectee/Member, California State Board of Corrections, Sacramento, CA (1999): Executive Steering Committee to conduct the 2000 Biennial Review of the Minimum Jail Standards for Local Detention Facilities;

Selectee/Participant, California State Board of Corrections, Sacramento, CA (1997): Executive Committee to assess the "Impact of the Three Strikes on Local Jails";

Gubernatorial Appointee, Representative for the California State Sheriff's Association, Sacramento, CA (1987 – 1988): Senate Bill 550 – Advisory Committee on Pharmacy Standards in Corrections;

Transition Leader, Captain/Alameda County Sheriff's Office, Dublin, CA (1986 – 1989): Coordinated the construction, personnel plan, and policy/procedural development for the $172 million, 3600 bed Santa Rita Rehabilitation Center which opened September 1, 1989;

Transition Team Manager, Lieutenant/Alameda County Sheriff's Office, Oakland, CA (1983 – 1984): Developed operational plan components for the opening of the new North County Pre-Detention Facility (Jail);

Sheriff's Training Officer, Alameda County Sheriff's Office, Training Academy, Dublin, CA (1974 – 1991): Recruit Training Officer, and Intermittent Supervisors and Management Presenter and Trainer;

Law Enforcement Liaison Officer, Sergeant/Alameda County Sheriff's Office, Oakland, CA (1974 -1977): Served as the Sheriff's Representative to the CORPUS Integrated Criminal Justice Information System coordinating the 17 Alameda County Law Enforcement Agencies in the development of the Consolidated Arrest Report and overall technology program implementation;

Research Sergeant, Alameda County Sheriff's Office, Oakland, CA (1974 - 1976): Grantsmanship (Helicopter, Navigable Waters, and Inmate Education Programs); Analyst (Legislative Issues: Privacy/Security, Criminal Records Release, and Misdemeanor Release Policy); and Federal Jail Planning and Research Assessments.

OTHER UNIQUE RECOGNITION/ EXPERIENCE:

Role Model Honoree for the "5000 Role Models of Excellence", 19th Annual Dr. Martin Luther King, Jr. Unity Scholarship Breakfast, January 16, 2012, for "guiding minority boys along a carefully chartered path to manhood and sending them to college";

Manager of the Year, Alameda County, CA (1994): Selected among 2,000 Alameda County managers for the first annual presentation;

Coordinator, Commander/Alameda County Sheriff's Office, Hayward, CA (1997): Bay Area Mutual Aid Response to the "Rodney King Verdict";

Coordinator, Commander/Alameda County Sheriff's Office, Hayward, CA (1991): Bay Area Mutual Aid Response to the "Oakland Fire Storm";

President, Alameda County Management Employees Association (ACMEA), Oakland, CA (1991 – 1992): First President of the Association leading it in its inaugural year as the representation organization for managers in the county.

Recognized, Alameda County Board of Supervisors, Oakland, CA (1989): Relative to actions subsequent to the "Loma Prieta Earthquake";

Reserve Police Officer and Deputy Sheriff, Miami-Dade Police Department, Miami, FL (2007 – 2014) and **Orange County Sheriff's Office**, Orlando, FL (2002 -2006);

Graduate, Orlando Florida Chamber of Commerce, Orlando, FL (2004): Leadership Orlando Class #62;

Regional Director, California School Boards Association (CSBA), Sacramento, CA (1997 – 2001): Representing the Board Members of the School Districts of Alameda County, CA;
Elected Member, California School Boards Association (CSBA), Sacramento, CA (1989 – 2001): State Delegate Assembly;

Graduate, California School Boards Association (CSBA), Boardsmanship Academy (1991 - 1992): Leadership, Forecasting, Spokesperson, and Other Training;

Attendee, American Telephone and Telegraph (AT&T), Corporate Education and Training (1992): Communication about Performance and Development;

Member, Joint Powers Board of Directors, Special Education Local Plan Agency, Alameda County, CA (1984 – 1999): President (1991);

Member, Joint Powers Board of Directors, Amador Valley Regional Occupational Programs, Alameda County, CA (1986 -1990): President 1986/87 and 1989/90);

Field Platoon Leader, Lieutenant/Alameda County Sheriff's Office, Livermore, CA (1982): Response Team Supervisor to the civil demonstrations during the "Livermore National Laboratory Blockade";

President, Country Children Count Association (CCC), Livermore, CA (1979 -1983): 300 Community-based Educational Watch Dog Organization;

Personal General Contractor, Construction of Home, Livermore, CA (1979 -1980): Twenty-five acre ranch north of city;

Negotiations Chairman, Alameda County Deputy Sheriff's Association (DSA), Oakland, CA (1974 -1976): Lead the Association in its first response to employee representation discussions with the county under the newly approved California State Law "Meyers/Millias/Brown Act".

SPECIAL AUDITS/ INVESTIGATIONS/ ACTIONS:

Expert Witness Case Review, Consultation, and Testimony (2014-2016), involving:

1. Inmate homicide;
2. Inmate suicide;
3. Staff/Inmate Use of Excessive Force;
4. Sexual abuse

Volusia County, FL, Vulnerability Assessor (Jail Expert), selected October, 2014: Relative to breach of security concerning the exposure of

the Branch Jail Renovation Project's architectural and masonry plans on the Internet and *risk* to present and future jail operations;

Miami-Dade County Jail, Miami, FL, Director of the County Response Team, Selected by Office of the Mayor (2008-2014): Addressing the County Responses to the Department of Justice (DOJ) Investigation under the Civil Rights for Institutionalized Persons Act (CRIPA)**;**

Fulton County Jail, Atlanta, GA, Investigative Team Member (Jail Expert), Selected by NIC, June, 2010: One of three nationally identified jail professionals to audit/assess physical plant, jail operations, and adequacy of policies/procedures subsequent to a jail/court escape event;

Prince George County, MD, Investigative Team Member (Jail Expert), Selected by ACA, July, 2008: One of four nationally identified jail professionals selected to conduct an administrative inquiry into the internal operations of the jail necessitated by the mysterious death of an inmate.

Technical Resource Provider (TRP), Auditor/Assessor for NIC, relative to the following fourteen (15) County Jails:

- Multnomah County (UOF), Portland, Oregon (Pending - 9/23/16);
- Osceola County (Physical Plant), Florida (8/10/2016);
- Lawrence County, Deadwood, SD (4/8/2016);
- Baltimore City Jail (Staffing), MD (3/31/2016);
- Bernalillo County (UOF), Albuquerque, NM (11/2015);
- Franklin County Jail, Pasco, WA (9/2015);
- Philadelphia Prison System (UOF), MD (9/2015);
- Pueblo County, CO (2014);
- Jasper County, IO (2014);
- Baltimore County, MD (2014);
- Snohomish County, WA (2013);
- Baltimore City Jail, MD (2013);
- Westmoreland County, PA (2012);
- Siskiyou County, CA (2012);
- Shelby County, GA (2012).

Judicial Order Administrator, Captain/Alameda County Sheriff's Office, Santa Rita Rehabilitation Center, Dublin, CA (1986): Assessment and implementation of the Judicial Jail Capacity Release Order to reduce jail over-crowding.

Master's Thesis, California State University, Hayward, CA (1976): The applicability and results of the State Probation Subsidy Act on Alameda County probationers and county costs;

SPECIAL PRESENTATIONS:

Speaker/Presenter, American Jail Association (AJA), Jail Expo and Training Conferences, Numerous National Locations (1995 -2014): Presentations/Workshops including, but not limited to, PREA, Direct Supervision, Budget Management, RFP Development, Vendor Understanding, Personnel Scheduling, and Others;

Speaker/Presenter, American Correctional Association (ACA), Annual Conferences, Numerous National Locations (2002 – 2014): Presentations/Workshops including, but not limited to, PREA, Vendor Understanding, RFP Development, Direct Supervision, and Others;

Speaker/Presenter, Florida Sheriff's Association (FSA), Annual Jail Administrators Conferences, Several Florida Locations (2003 -2013): Speaker on "Jail Deaths and Investigations", plus presentations on "Hot Topics in Jail Operations" and "Legal Issues";

Speaker/Presenter, Numerous Civic Groups including Rotary, Lions, Kiwanis, Chambers of Commerce, and Others, California and Florida (1983 -2014);

Plenary Speaker, American Association for Treatment of Opioid Dependency (AATOD), Atlanta, GA (2006);

Special Speaker, American Correctional Association (ACA), Dallas, TX (1995): A response to "Overcrowding and Innovative Alternatives to Incarceration";

Presenter, Livermore Chamber of Commerce, Livermore, CA (1991 – 1992): "Leadership in Education";

Commencement Speaker, Livermore Valley Joint Unified School District, Livermore, CA (1984 – 1999): High Schools (1984, 85, 86, 91, 92, 93, 95, 98 and 99) and Middle Schools (1985, 87, 88, 89, 90, 96, 97);

Speaker/Presenter, California Work Furlough Conference, Concord, CA (1988): The "Role of Work Furlough in the Reduction of Jail Over-Crowding".

PUBLICATIONS:

"The Sensitive John Wayne" (Section: Your Haas Network), Berkeley Haas Magazine, Page 17, Fall (2014);

"My Excellent Opportunity: A Personal Reflection" (Retirement Speech), American Jails Magazine, Page 39**,** July/August (2014);

"Incarceration Therapy: Local Approaches", Corrections Today Magazine, February (2006);

"Confronting Confinement", Report of the Commission on the Safety and Abuse in America's Prisons (and Jails), Vera Institute, Washington, D.C. (2006): Contributing Commissioner;

"President's Commentary", American Jails Magazine (May/2002 – April/2003);

"Changes in Sentencing Patterns: Impact to Jails, Prisons, and Boards", **Proceedings from the 1995 ACA Annual Conference**, Washington, D.C. (1996);

"Alameda County moves Inmates to New Jail", California State Sheriff's Association Official Publication, Volume 5, Number 3, Fall (1989);

"Working with Illegal Aliens", American Jail Association Bulletin, Volume VI, #12 (1995).

PRESENT PROFESSIONAL ASSOCIATIONS:

American Jail Association (1991 – Present);

American Correctional Associations (1998 – Present);

Florida State Sheriff's Association (2003 – Present);

FBI National Academy Associates, Florida (2002 – Present).

PRESENT COMMUNITY ORGANIZATIONS:

Rotary Club of Miami (2007 – Present): President 2015-16; Board of Directors;

Plymouth Congregational Church, Coconut Grove, FL (2006 – Present).

PAST PROFESSIONAL/ COMMUNITY ASSOCIATIONS:

NIC Large Jail Network (1991 – 2014);

FBI National Academy Associates, California (1994 – 2002);

Rotary Clubs of Orlando, FL and San Jose and Livermore, CA;

United Way of Miami-Dade and Orange Counties, FL: Board of Directors;

Mothers Against Drunk Driving, Miami (2007 – 2016): Board of Directors;

Boy Scouts of Central Florida;

California State Sheriff's Association;

California Peace Officers Association (Life member);

Police Management Association;

Alameda County 4-H Association;

University of California Alumni Association (Life Member);

American Cancer Society, Tri-Valley Unit, CA;

Pleasanton-Blairgowrie Sister City Association (Scottish Games).

Appendix B: List of Acronyms Used

ACA:	American Correctional Association
ADA:	Assistant District Attorney
ADW:	Assistant Deputy Warden
AIG:	Assistant Inspector General
BJS:	Bureau of Justice Statistics
CMS:	Case Management System
CO:	Correction Officer
COD:	Central Operations Desk (control center at Riker's Island)
DOC:	New York City Department of Correction
DOC ID:	New York City Department of Correction, Investigation Division
DOI:	New York City Department of Investigation
ELS:	Employee Look-up System
GIU:	Gang Intelligence Unit
ICO:	Integrity Control Officer
ILS:	Inmate Look-up System
IRS:	Inmate Recording System
MOC:	Memorandum of Complaint
NYC:	New York City
OATH:	Office of Administrative Trials and Hearings
OJT:	On-the-job training
PREA:	Prison Rape Elimination Act of 2003
RMSC:	Rose M. Singer Center (NYC's all-women jail on Rikers Island)
SRG:	Security Risk Group (a/k/a "gang")

Appendix C: Documents Received/Reviewed

Since being retained in this matter, I have been provided with and/or reviewed the following:

A. **Case Filings and Discovery Responses:**

- Compl. (May 19, 2015), ECF No. 1;
- Decl. of JD1 (Oct. 9, 2015), ECF No. 29;
- Protective Order Concerning Confidential Information (July 30, 2015), ECF No. 24;
- Decl. of Letitia James, Public Advocate for the City of New York, in Supp. of Pls.' Mot. for Class Certification (Oct. 9, 2015), ECF No. 32;
- Joint Letter Mot. to modify scheduling order and regarding RMSC inspection (Oct. 13, 2016), ECF No. 220;
- Order granting in part and denying in part [220] Letter Motion for Discovery (Oct. 16, 2016), ECF No. 221;
- Pls.' Suppl. Resp. to Def. City of N.Y.'s Interrog. No. 14 (May 27, 2016);

B. **Statutes:**

- N.Y. Civ. Serv. Law § 75 Removal and other disciplinary action (McKinney 1995);
- N.Y. Comp. Codes R. & Regs. tit. 9, § 7003.3 Supervision of prisoners in facility housing areas (1998);
- N.Y. Comp. Codes R. & Regs. tit. 9, § 7501.1 Definitions (1993);
- N.Y. Comp. Codes R. & Regs. tit. 9, § 7502.1 Admission procedures (1976);
- N.Y. Crim. Proc. Law § 1.20 Definitions of terms of general use in this chapter (McKinney 2012);
- N.Y. Crim. Proc. Law § 2.10 Persons designated as peace officers (McKinney 2014);
- N.Y. Exec. Law § 296 Unlawful discriminatory practices (McKinney 2015);
- N.Y. Penal Law § 130.00 Sex offenses; definitions of terms (McKinney 2010);
- N.Y. Penal Law § 130.05 Sex offenses; lack of consent (McKinney 2012);
- N.Y. Penal Law § 130.25 Rape in the third degree (McKinney 2000);
- N.Y. Penal Law § 130.40 Criminal sexual act in the third degree (McKinney 2003);

C. **Transcripts and Exhibits from the Following Depositions:**

- Alexandra Wityak, Civilian Investigator, DOC ID;
- B.W. (Mother of Jane Doe 1);
- Belarminia Ortiz, Chief Investigator, DOI;
- Bienvenido Santiago, CO, DOC;
- Carlos Rodriquez, CO (Building 9 "B"), DOC;

- Diane Medina, Assistant Deputy Warden, DOC;
- Dominique Harris, Correction Officer (Building 9 "B"), DOC;
- Ferdinand Torres, Captain of Investigation (Squad 1), "On-Loan" from DOC to DOI;
- Gregory Kuczinski, Deputy Comm'r of Investigations, DOC ID;
- James Christo, Assistant Inspector Gen., DOI, Mar. 24, 2016;
- James Christo, July 27, 2016;
- Jane Doe 1;
- Jane Doe 2;
- Jennifer Sculco, Senior Inspector Gen., DOI, Dec. 21, 2015;
- Jennifer Sculco, July 27, 2016;
- Michael Blake, Confidential Investigator/Consultant and Former Deputy Comm'r of Investigations, DOC;
- Rhonda Young, Correctional Officer Investigator, "On-Loan" from DOC to DOI;
- Sean Cussen, Deputy Dir. of Investigations, DOC ID;
- Steven Jones, Dir. of Special Investigations, DOC;

D. **Directives and Internal Documents of the DOC**

- Central Operations Desk, 24 Hour Report (Initial) (Oct. 3, 2015) (NYC_00002505-17);
- Correction Academy Materials for Course "Preventing Inmate Sexual Abuse" (Aug. 12, 2014) (DEF_0014498-550);
- Diane Medina, Assistant Deputy Warden, DOC, Page from Hr'gs Journal (July 23, 2012) (DEF_0014497);
- Directive, Classification 1100R-A Board of Correction Authority (effective May 1, 2007), http://www.nyc.gov/html/doc/downloads/pdf/1100R-A.pdf;
- Directive, Classification 3376 Inmate Grievance and Request Program (effective Sept. 10, 2012) (TMGNYC11620-66);
- Directive, Classification 4017R Inmate Observation Aide Program (effective Aug. 8, 1988);
- Directive, Classification 4514R-A Housing Area Logbooks (effective Oct. 19, 2007), http://www1.nyc.gov/assets/doc/downloads/directives/4514R-A.pdf;
- Directive, Classification 5000R-A Reporting Unusual Incidents (effective Nov. 19, 2004) (TMGNYC11678-715);
- Directive, Classification 5010R-A Preventing Inmate Sexual Abuse (effective Dec. 31, 2008) (DEF_0000001-15);
- Directive, Classification 5011 Elimination of Sexual Abuse and Sexual Harassment (effective May 2, 2016) (DEF_0015078-143);

- Directive, Classification 7000R Office of Inspector General Investigative Procedures (effective Aug. 5, 1991), http://www.nyc.gov/html/doc/downloads/pdf/7000R.pdf;
- Directive, Classification 7001R Investigation Division (effective Sept. 28, 1992) (TMG 0532-35);
- DOC ID, *Chapter 8.0: Crime Scene Best Practices*, Investigation Manual (DEF_0002303-10);
- Eliseo Perez Jr., Assistant Chief of Security, Teletype Order No. HQ -01070-0, Personnel Orders – Notification of Temporary Assignment to Modified Duty (May 13, 2013) (NYC_00003703-3704);
- E-mail from James Christo, Assistant Inspector Gen., DOI, to Susan O'Leary, DOC Legal Div. (May 14, 2013) (NYC_00007056);
- E-mail from Michael Blake, Confidential Investigator/Consultant and Former Deputy Comm'r of Investigations, DOC, to Joseph Ponte, Comm'r, DOC (May 20, 2015) (NYC_00000788-89);
- E-mail from Steven Jones, Dir. of Special Investigations, DOC, to Gregory Kuczinski, Deputy Comm'r of Investigations, DOC ID (June 2, 2015) (NYC_00004005-06);
- E-mail from Steven Jones, Dir. of Special Investigations, DOC, to Gregory Kuczinski, Deputy Comm'r of Investigations, DOC ID (June 25, 2015) (NYC_00004007-08);
- Employee Handbook (DEF_0002049-255);
- Evelyn A. Mirabel, Chief of Dep't, Teletype Order No. HQ -00019-0, Evidence Handling and Integrity (Jan. 3, 2013) (TMGNYC13792-94);
- Form No. 22R Employees Performance Service Report for CO Santiago (June 3, 2015) (DEF_0000702-03);
- Inmate Handbook (Dec. 2007) (DEF_0001964-2009);
- Inmate Lookup Service: Inmate Details for Jane Doe 1 (Aug. 3, 2015) (DEF_0000559-62);
- Inmate Rule Book (Oct. 12, 2007) (DEF_0002011-47);
- Joseph Ponte, Comm'r, and Martin J. Murphy, Chief of Dep't, Teletype Order No. HQ -00343-0 PREA Unannounced Rounds (Updated) (Feb. 9, 2016) (DEF_0014004);
- Joseph Ponte, Comm'r, and Martin J. Murphy, Chief of Dep't, Teletype Order No. HQ -01575-0, Prison Rape Elimination Act (PREA) (July 9, 2015) (TMGNYC13795-96);
- Joseph Ponte, Comm'r, and Martin J. Murphy, Chief of Dep't, DOC, Teletype Order No. HQ -01670-0 PREA Unannounced Rounds (July 21, 2015) (DEF_0014006-07);
- Memorandum, No. 01/08 Undue Familiarity and Prevention of Sexual Abuse of Inmates by Staff and Other Inmates (effective Feb. 7, 2008) (DEF_0000019-21);

- Personnel File of CO Santiago (DEF_0000705-1377);
- Recording of Disciplinary Hr'g of J.F. (July 23, 2012) (NYCAUDIO_00000544);

E. **Internal Documents of the DOI**

- Chain of Command Organization Chart (Oct. 2015) (DEF_0014008);
- E-mail from Belarminia Ortiz, Chief Investigator, DOI, to James Christo, Assistant Inspector Gen., DOI (June 3, 2013) (NYC_00007047);
- E-mail from James Christo, Assistant Inspector Gen., DOI, to Jennifer Sculco, Senior Inspector Gen., DOI (Nov. 1, 2013) (NYC_00006878);
- E-mail from James Christo, Assistant Inspector Gen., DOI, to Mark G. Peters, Comm'r, DOI, and Jennifer Sculco, Senior Inspector Gen., DOI (May 21, 2015) (NYC_00006328-29);
- Email from James Christo, Assistant Inspector Gen., DOI, to Ruben Benitez, Deputy Dir. of Investigations, DOC (Jan. 9, 2015) (NYC_00006551-55);
- E-mail from Jennifer Sculco, Senior Inspector Gen., DOI, to James Christo, Assistant Inspector Gen., DOI (May 22, 2015) (NYC_00009004-05);
- E-mail from Jennifer Sculco, Senior Inspector Gen., DOI, to James Christo, Assistant Inspector Gen., DOI (Aug. 18, 2015) (NYC_00005890-92);
- E-mail from Kate Zdrojeski, Investigative Att'y, DOI, to James Christo, Assistant Inspector Gen., DOI (May 13, 2013) (NYC_00007060-61);
- Press Release & Report on the Recruiting and Hiring Process for New York City Correction Officers, and press release (Jan. 15, 2015), https://www1.nyc.gov/html/doi/downloads/pdf/2015/jan15/pr01rikers_aiu_011515.pdf;

F. **Other PREA-Related Documents**

- Allen J. Beck et al., DOJ, *Sexual Violence Reported by Correctional Authorities, 2006* (2007), https://www.bjs.gov/content/pub/pdf/svrca06.pdf;
- Allen J. Beck et al., DOJ, *Sexual Victimization Reported by Adult Correctional Authorities, 2007-2008* (2011), https://www.bjs.gov/content/pub/pdf/svraca0708.pdf;
- Allen J. Beck et al., DOJ, *Sexual Victimization Reported by Adult Correctional Authorities, 2009-11* (2014), https://www.bjs.gov/content/pub/pdf/svraca0911.pdf;
- Allen J. Beck et al., DOJ, *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-12* (2013), https://www.bjs.gov/content/pub/pdf/svpjri1112.pdf;
- Letter from Jeffery Powell, Assistant Att'y Gen., to Joseph Ponte, DOC Comm'r, re CRIPA Investigation of the DOC Jails on Rikers Island (Aug. 4, 2014) (TMG 0552-630);

- Moss Group, Inc., *Sexual Safety Assessment Report* (2015) (DEF_0014410-95);
- Nat'l Prison Rape Elimination Comm'n, *Standards for the Prevention, Detection, Response, and Monitoring of Sexual Abuse in Adult Prisons and Jails* (2009), https://www.ncjrs.gov/pdffiles1/226682.pdf;
- National Standards to Prevent, Detect, and Respond to Prison Rape Under the Prison Rape Elimination Act (PREA), 28 C.F.R. pt. 115 (2012), https://www.prearesourcecenter.org/sites/default/files/content/prisonsandjailsfinalstandards_0.pdf;
- N.Y.C. Bd. of Corr., Notice of Public Hearing and Proposed Rules related to Inmate Sexual Abuse (June 20, 2016);
- PREA Spreadsheet: Log of Sexual Abuse Investigations (Nov. 20, 2015) (DEF_0008570);
- PREA Spreadsheet: Log of Sexual Abuse Investigations (Updated) (May 31, 2016) (DEF_0016124);

G. **Investigative Files**

- DOC, File for Investigation of Infraction for Jane Doe 2 (May 9, 2013) (DEF_0016136-51);
- DOC ID, Case File regarding investigation of CO Williams (DEF_0002756-953);
- DOC ID, Case File regarding investigation of Discharge Planner Blackshear (DEF_0004584-629);
- DOC ID, Case File regarding investigation of Physician Assistant Rich (DEF_0009854-10272);
- DOC ID, Case File regarding Jane Doe 2's allegations against CO Santiago (DEF_0002479-525), including but not limited to the following:
    a. Interdepartmental Memorandum from Alexandra Wityak, Civilian Investigator, to Sean Cussen, Deputy Dir. of Investigations, Closing Report (Aug. 3, 2015) (DEF_002480-82);
- DOC ID, Investigative Case Log regarding Jane Doe 2's allegations against CO Santiago (May 27, 2016) (DEF_0016125-26);
- DOI, Case File regarding Jane Doe 2's allegations against CO Santiago (DEF_0001378-1962), including but not limited to the following:
    a. Letters between Plaintiffs' counsel and the City regarding Freedom of Information Law ("FOIL") request for information related to the investigation of Jane Doe 2's allegation and for Jane Doe 2's pants, bible and notebook;
    b. Handwritten notes from investigative interviews;
    c. Typed memoranda regarding investigative interviews;
    d. Semen test results information;
    e. Closing Memorandum (Case #13-05490) from James Christo, Assistant Inspector Gen. (June 25, 2014);

f. Closing Memorandum/Referral Letter from Jennifer Sculco, Senior Inspector General, DOI, to Florence Finkle, Deputy Comm'r of Investigations, DOC, CO Bienvenido Santiago (15713)/DOI #13-05490 (June 30, 2014);

- DOI, Case File regarding investigation of CO Alvarez (DEF_0010621-805);
- DOI, Case File regarding investigation of Discharge Planner Blackshear (DEF_0009489-853);
- DOI, Case File regarding investigation into allegation that inmate N.B. was impregnated by a correction officer (DEF_0018272-302);
- DOI, Intake form documenting notification of allegation by inmate M.F. that CO Santiago was supplying inmates with contraband (allegation dated July 30, 2007) (DEF_0001931-34);
- DOI, Referral to Florence Finkle, DOC Deputy Comm'r of Investigations (Apr. 11, 2014) (NYC_00001483-86);
- DOI, Referral to Florence Finkle, DOC Deputy Comm'r of Investigations (Apr. 11, 2014) (NYC_00001488);
- James Christo, Assistant Investigator Gen., DOI, Memorandum of Interview of Jane Doe 2 (Apr. 4, 2014) (NYC_00006601);

H. **News Articles Related to Rikers Island:**

- David Shortell, *Suit: City allowed Rikers officers to rape and sexually abuse inmates*, CNN, May 22, 2015, http://www.cnn.com/2015/05/21/us/rikers-island-lawsuit/;
- Elizabeth Dwoskin, *Inmate Gets Pregnant in Rikers, Sparking Investigation*, Village Voice, Apr. 29, 2010, http://www.villagevoice.com/news/inmate-gets-pregnant-in-rikers-sparking-investigation-6706471;
- Emma Whitford, *Federal Lawsuit Says Eight Rikers Guards Raped and Abused Female Inmates*, Gothamist, May 20, 2015, http://gothamist.com/2015/05/20/rikers_rape_retaliation.php;
- Florence Finkle, *How to Really Fix Rikers*, N.Y. Times, June 19, 2015, http://www.nytimes.com/2015/06/20/opinion/how-to-really-fix-rikers.html?_r=0;
- Michael Schwirtz and Michael Winerip, *At Rikers Island, Union Chief's Clout is a Roadblock to Reform*, N.Y. Times, Dec. 14, 2014, http://www.nytimes.com/2014/12/15/nyregion/at-rikers-a-roadblock-to-reform.html;

I. **Pages from RMSC Logbooks**

- Building 9 Lower:
  a. Jan. 11, 2013 to Feb. 23, 2013 (DEF_021948-53; DEF_0021937-43);
  b. Feb. 23, 2013 to Apr. 8, 2013 (DEF_021834-68; DEF_0021873-936);
  c. Apr. 8, 2013 to May 22, 2013 (DEF_022015-68; DEF_0022187-258);
- Building 9 Upper:

a. Jan. 22, 2013 to Mar. 10, 2013 (DEF_021967-2014; DEF_0022125-186);
b. Mar. 10, 2013 to Apr. 26, 2013 (DEF_021691-774);
c. Apr. 26, 2013 to June 8, 2013 (DEF_021954-66; DEF_0022091);

- Building 9-11 Bubble (a/k/a Control Room):
  a. Jan. 4, 2013 to Mar. 21, 2013 (DEF_021822; DEF_0021860);
  b. Mar. 21, 2013 to Apr. 30, 2013 (DEF_021869; DEF_0021944-2124);
  c. May 1, 2013 to July 22, 2013 (DEF_0021797-859);
- Building 11:
  a. Jan. 15, 2013 to Mar. 15, 2013 (DEF_021775-821; DEF_0022259-359);
- Cover letter to production of logbook pages from Anthony M. DiSenso, City of N.Y. Law Dep't, to Cleary Gottlieb Steen & Hamilton LLP and Koehler & Isaacs LLP (Sept. 30, 2016);
- Decl. of CO Chad Ellis regarding missing logbooks (Sept. 20, 2016);

J. **Case Filings from the *Nunez* Lawsuit**

- Consent Judgment, *Nunez v. City of New York*, 11 Civ. 5845 (LTS)(JCF) (S.D.N.Y. Oct. 21, 2015), ECF No. 249;
- First Report of the *Nunez* Independent Monitor, *Nunez v. City of New York*, 11 Civ. 5845 (LTS)(JCF) (S.D.N.Y. May 31, 2016), ECF No. 269;

K. **Documents Related to the Moss Group 2015 Sexual Safety Assessment Report**

- Moss Group, Inc., New York City Department of Correction Investigation Division: Overview of the Investigative Process (May 2014) (TMGNYC08004);
- Moss Group, Inc., NYC DOC Investigations Mapping Debrief (TMGNYC13908-09);
- Moss Group, Inc., Interview with DOC Director (Dec. 2, 2014) (TMGNYC13896-97);
- Moss Group, Inc., Interview with PREA Coordinator (Dec. 22, 2014) (TMGNYC13893-95);
- Moss Group, Inc., Potential Changes to Both Analyses of PREA Standards for RNDC and RMSC Utilizing Directive 5010R-A, Preventing Inmate Sexual Abuse (TMGNYC03288);
- Moss Group, Inc., RMSC Inmate Focus Group Notes (Jan. 15-16, 2015) (TMGNYC13825-38);
- Moss Group, Inc., RMSC Organizational Chart (TMGNYC14907);
- Moss Group, Inc., RMSC Staff Focus Group Notes (Jan. 15-16, 2015) (TMGNYC10758-73);
- Moss Group, Inc., Summaries of reviews of PREA investigations (TMGNYC11837-48);

- Moss Group, Inc., Summary of interview with NYC Department of Health and Mental Hygiene (DOHMH) employee (Mar. 13, 2015) (TMGNYC08126-29);

L. **Other**

- Aff. of L.L. (Mar. 20, 2015) (JANEDOES_00000255-56);
- ACA, *Performance-Based Standards for Adult Local Detention Facilities* (4th ed. 2004);
- Bible and Diary Entries of Jane Doe 2 (DEF_0018259-70);
- City of N.Y. Police Dep't, Chain of Custody for Invoice for Jane Doe 2's pants (May 14, 2013) (DEF_0016121);
- E-mail from Arthur G. Larkin, Senior Counsel, City of N.Y. Law Dep't, to Mitchell A. Lowenthal, Cleary Gottlieb Steen & Hamilton LLP (Oct. 13, 2016);
- Inmate Movement History Log for Jane Doe 2 (Dec. 2, 2012 to May 14, 2013) (DEF_0002260-64);
- Jane Doe 1 Personal Injury Claim Form (July 29, 2013) (JANEDOES_00000029-32);
- Legal Dep't, Civ. Serv. Emps. Ass'n, *Civil Service Law Section 75: A Basic Primer* (Jan. 2013);
- Photographs taken during inspection of Rose M. Singer Center (Nov. 20, 2016) (JANEDOES_00004496-627);
- Standards Committee, ACA, Meeting Minutes (Jan. 2002 to Aug. 2016).

Appendix D: Performance-Based Standards For Adult Local Detention Facilities – June, 2004

These standards were created by the American Correctional Association for the purpose of jails becoming nationally accredited. They include "mandatory and non-mandatory standards" which are designed to identify the "Expected Practices" of a professional correctional facility. They are conditions to be achieved, and then, maintained.

As an Expert Witness, I believe in these "Expected Practices" and support their achievement and maintenance. The DOC knew of these expectations, and as a professional organization in the business, should have been constantly striving to develop, achieve, train, and maintain the same.

Mission of the Standards

The American Correctional Association provides a professional organization for all individuals and groups, both public and private, that share a common goal of improving the justice system.

Standards

There are over 440 standards that are applicable to the DOC. Relative to these standards, I have identified the enclosed as those with the most applicability to the case at point.

Specifically, relevant portions of the following are excerpted below:

Glossary;

Safety;

Security; and

Justice;

The identified standards are listed in the body of the Report as may be appropriate to my opinions, as well as defined in detail below:

Glossary

Adult detention facility or Jail - A local confinement facility with temporary custodial authority. Adults can be confined pending adjudication for forty-eight hours or more and usually for sentence of up to two years.

Correctional facility - A facility used for the incarceration of individuals accused of or convicted of criminal activity. A correctional facility is managed by a single chief executive officer with broad authority for the operation of the facility. This authorization typically includes the final authority for decisions concerning (1) the employment or termination of staff members, and (2) the facility operation and programming within guidelines established by the parent agency or governing body.

Code of ethics - A set of rules describing acceptable standards of conduct for all employees.

Detainee - Any person confined in a local detention facility not serving a sentence for a criminal offense.

Emergency care - Care of an acute illness or unexpected health care need that cannot be deferred until the next scheduled sick call. Emergency care shall be provided to the resident population by the medical director, physician, or other staff, local ambulance service, and/or outside hospital emergency rooms. This care shall be expedited by following specific written procedures for medical emergencies described in the standards.

Personnel policies manual - A manual that is available to each employee and contains the following: an affirmative action program; an equal employment opportunity program; a policy for selection, retention, and promotion of all personnel on the basis of merit, and specified qualifications; a code of ethics; rules for probationary employment; a compensation and benefit plan; provisions of the Americans with Disabilities Act (ADA); sexual harassment/sexual misconduct policy; grievance and appeal procedures; infection control plan; and employee disciplinary procedures.

Training - An organized, planned, and evaluated activity designed to achieve specific learning objectives and enhance the job performance of personnel. Training may occur on site, at an academy or training center, an institution of higher learning, during professional meetings, or through contract service or closely supervised on-the-job training. It includes a formal agenda and instruction by a teacher, manager, or official; physical training; or other instruction programs that include a trainer/trainee relationship. Training programs usually requirements for completion, attendance recording, and a system for recognition of completion. Meetings of professional associations are considered training where there is clear evidence of this.

Safety

Goal: Provide a safe work environment for industries staff, volunteers, contractors, and inmates.

Performance Standard: Protection from injury and illness…

(5) Number of physical injuries or emotional traumas requiring treatment as a result of the physical environment of the facility in the past 12 months divided by the number of admissions in the past 12 months.

Security

Goal: Protect the community, staff, contractors, volunteers, and inmates from harm.

Performance Standard: Protection from Harm

2A. The community, staff, contractors, volunteers and inmates are protected from harm. Events that pose risk of harm are prevented. The number and severity of events are prevented. The number and severity of the events are minimized.

Outcome Measures:

(4) Number of physical injuries or emotional traumas requiring treatment as a result of the incidents in the past 12 months divided by the number of admissions in the past 12 months.

(5) Number of unauthorized inmate absences from the facility in the past 12 months divided by the average daily population in the past 12 months.

Standards:

4-ALDF-2A-04 (Ref. 3-ALDF-3A-05). There are current written orders for every correctional officer post. Officers assigned to those posts acknowledge in writing that they have read and understand the orders and record the date. The facility administrator or designee reviews post orders annually and updates them as needed.

4-ADLF-2A-08 (Ref. 3-ALDF-3A-08). When both males and females are housed in a facility, at least one male staff member and one female staff member are on duty at all times.

4-ALDF-2A-09 (Ref. 3-ALDF-3A-09). No inmate or group of inmates is given control, or allowed to exert authority, over other inmates.

4-ALDF-2A-10 (Ref. 3-ALDF-3A-15). All inmate movement from one area to another is controlled by staff.

4-ALDF-2A-11 (Ref. 3-ALDF-3A-10). Correctional staff maintain a permanent log and prepare shift reports that record routine information, emergency situations, and unusual incidents.

4-ALDF-2A-12 (Ref. 3-ALDF-3A-11). Supervisory staff conducts a daily patrol, including holidays and weekends, of all areas occupied by inmates. Unoccupied areas are to be inspected at least weekly. Patrols and inspections are documented.

4-ALDF-2A-14 (Ref. 3-ALDF-1C-03). A comprehensive staffing analysis is conducted annually. The staffing analysis is used to determine staffing needs and plans. Relief factors are calculated for each classification of staff that is assigned to relieved posts or positions. Essential posts and positions, as determined in the staffing plan, are consistently filled with qualified personnel.

4-ALDF-2A-15 (Ref. 3-ALDF-1C-05). The facility uses a staffing analysis to determine the essential positions needed to perform the health services mission and provide the defined scope reviewed annually for adequacy by the health authority.

Orientation:

4-ALDF-2A-27 (Ref. 3-ALDF-4A-01, 4A-02). Prior to being placed in the general population, each inmate is provided with an orientation to the facility, which includes at a minimum:…

- Explanation of grievance procedures
- This information is contained in a written handbook that is given to each inmate
- The handbook is translated into those languages spoken by significant numbers of inmates.

4-ALDF-2A-29 (Ref. New). The information is communicated **orally** and **in writing,** in a language clearly understood by the inmate, upon arrival at the facility.

4-ALDF-2A-52 (Ref. 3-ALDF-3D-08). All special management inmates are personally observed by a correctional officer at least every 30 minutes on an irregular schedule. Inmates who are violent or mentally disordered or who demonstrate unusual or bizarre behavior receive more frequent observation; suicidal inmates are under continuous observation until seen by a mental health professional. Subsequent supervision routines are in accordance with that ordered by

Disposition of Evidence:

4-ALDF-2C-06 (Ref. 3-ALDF-3A-33). Procedures govern the preservation, control and disposition of all physical evidence obtained in connection with a violation of law and/or institutional regulation. At a minimum, the procedures address the following:

- Chain of custody
- Evidence handling
- Location and storage requirements
- Manner of disposition.

4-ALDF-4C-32 (Ref. 3-ALDF-4E-34). (Mandatory) A suicide-prevention program is approved by the health authority and reviewed by the facility or program administrator. It includes specific procedures for handling intake, screening, identifying, and supervising of a suicide-prone inmate and is signed and reviewed annually. The program includes staff and inmate critical incident debriefing that covers the management of suicidal incidents, suicide witch, and death security, and health services. All staff with responsibility for inmate supervision are trained on an annual basis in the implementation of the program. Training includes but not limited to:

- Identifying the warning signs and symptoms of impending suicidal behavior.
- Understanding the demographic and cultural parameters of suicidal precipitating factors.
- Responding to suicidal and depressed inmates.
- Communicating between correctional and health care personnel.
- Using referral procedures.
- Housing observation and suicide-watch level procedures.
- Follow-up monitoring of inmates who make a suicide attempt.

Mental Illness and Developmental Disability:

4-ALDF-4C-34 (Ref. New). Inmates with severe mental illness or who are severely developmentally disabled receive a mental health evaluation. Where appropriate, these inmates are referred for placement in non-correctional facilities or in units specifically designated for handling this type of individual. These individuals may be a danger to themselves or others or be incapable of attending to their basic physiological needs.

Special Needs Inmates:

4-ALDF-4C-40 (Ref. 3-ALDF-4E-38). The facility and program administrator, or a designee, and the responsible clinician, or designee, consult prior to taking action regarding chronically ill, physically disabled, geriatric, seriously mentally ill, or developmentally disabled inmates in the following areas:

- housing assignments
- program assignments
- disciplinary measures
- transfers to other facilities.

When immediate action is required, consultation to review the appropriateness of the action occurs as soon as possible, but no later than 72 hours.

Emergency Response:

4-ALDF-4D-08 (Ref. 3-ALDF-4E-24). (Mandatory) Correctional and health care personnel are trained to respond to health-related situations within a four-minute response time. The training program is conducted on an annual basis and is established by the responsible health authority in cooperation with the facility or program administrator and includes instruction on the following:

- Suicide intervention.

Inmate Assistants:

4-ALDF-4D-11 (Ref. 3-ALDF-4E-16). Unless prohibited by state law, inmates, under staff supervision, may perform familial duties commensurate with their level of training. These duties may include the following:

- Serving as a suicide companion if qualified and trained through a formal program that is part of a suicide prevention plan.

Sexual Assault:

4-ALDF-4D-22 (Ref. New). The facility will ensure that information is provided to offenders about sexual abuse/assault including:

- Prevention/intervention
- Self-protection
- Reporting sexual abuse/assault
- Treatment and counseling

The information is communicated orally and in writing, in a language clearly understood by the offender, upon arrival at the facility.

4-ALDF-4D-22-2 (Ref. New). An investigation is conducted and documented whenever a sexual assault or threat is reported.

4-ALDF-4D-22-4 (Ref. New). Detainees identified as at risk for sexual victimization are assessed by a mental health or other qualified professional. Detainees at risk for sexual victimization are identified, monitored, and counseled.

4-ALDF-4D-22-5 (Ref. New). Sexual conduct between staff and detainees, volunteers or contract personnel and detainees, regardless of consensual status, is prohibited and subject to administrative and criminal disciplinary sanctions.

4-ALDF-4D-22-6 (Ref. New). (Mandatory) Victims of sexual assault are referred under appropriate security provisions to a community facility for treatment and gathering of evidence. If these procedures are performed in-house, the following guidelines are used:

- A history is taken by health care professionals who conduct an examination to document the extent of physical injury and to determine if referral to another medical facility is indicated. With the victims consent, the examination includes collections of evidence from the victim, using a kit approved by the appropriate authority.
- Provision is made for testing for sexually transmitted diseases (for example, HIV, gonorrhea, hepatitis, and other diseases) and counseling as appropriate.
- Prophylactic treatment and follow-up for sexually transmitted diseases are offered

242. to all victims, as appropriate.

- Following the physical examination, there is availability of an evaluation by a mental health professional to assess the need for crisis intervention counseling and long-term follow-up.

- A report is made to the facility or program administrator or designee to assure separation of the victim from his or her assailant.

4-ALDF-4D-22-7 (Ref. New). Detainees who are victims of sexual abuse have the option to report the incident to a designated staff member other than an immediate point of contact line officer.

4-ALDF-4D-22-8 (Ref. New). All case records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling are retained in accordance with an established schedule.

Peer Review

4-ALDF-4D-25 (Ref. New). (Mandatory) An external peer review program for physicians, mental health professionals, and dentists is implemented. The review is conducted no less than every two years.

Justice

Goal: Treat inmates fairly and respect their legal rights. Provide services that hold inmates accountable for their action, and encourage them to make restitution to their victims and the community.

Performance Standard: Inmate Rights

6A. Inmates' rights are not violated.

Outcome Measures:

(1) Total number of inmate grievances in the past 12 months, regarding: (a) access to court; (b) mail or correspondence; (c) sexual harassment; (d) discipline; (e) discrimination (f) protection from harm divided by the average daily population in the past 12 months.

Standards:

4-ALDF-6A-02 (Ref. 3-ALDF-3E-02). Inmate access to counsel is ensured. Inmates are assisted in making confidential contact with attorneys and their authorized representatives. Such contact includes, but is not limited to, telephone communications, uncensored correspondence, and visits.

Protection from Abuse:

4-ADLF-6A-07 (Ref. 3-ADLF-3E-08). (Mandatory) Inmates are not subjected to personal abuse, corporal punishment, personal injury, property damage, or harassment. Inmate property is protected.

Performance Standards: Fair Treatment of Inmates

6B. Inmates are treated fairly.

Outcome Measures:

(1) Number of inmate grievances regarding discrimination in the past 12 months divided by the average daily population in the past 12 months.

(2) Number of inmate grievances regarding discrimination resolved in favor of inmates in the past 12 months divided by the total number grievances filed regarding discrimination in the past 12 months'

(3) Number of grievances resolved in favor of inmates in the past 12 months divided by the average daily population in the past 12 months.

(4) Number of grievances resolved in favor of inmates in the past 12 months divided by the total number of grievances filed in the past 12 months.

(5) Number of court malpractice or tort liability cases found in favor of the inmate in the past 12 months divided by the number of court malpractice or tort cases in the past 12 months.

243. Expected Practices: Grievance Procedure

4-ALDF-6B-01 (Ref. 3-ALDF-3E-11). An inmate grievance procedure is made available to all inmates and includes at least one level of appeal.

Training and Staff Development:

4-ALDF-7B-05 (Ref. New). Each new employee is provided with an orientation prior to assuming duties. At a minimum, the orientation includes:

- Working conditions
- Code of ethics
- Personnel policy manual
- Employees' rights and responsibilities
- Overview of the criminal justice system
- Tour of the facility
- Facility organization
- Staff rules and regulations
- Personnel policies
- Program overview

4-ALDF-7B-11 (Ref. 3-ALDF-1D-13). Facility management and supervisory staff receive at least 40 hours of management and supervision training during their first yea and at least 24 hours of management training each year thereafter.

4-ALDF-7B-08 (Ref. 3-ALDF-1D-12, 1D-14). All new professional and support employees, including contractors, who have regular or daily inmate contact receive training their first year of employment. Forty hours are completed prior to being independently assigned to a particular job. An additional 40 hours of training is provided each subsequent year of employment. At a minimum, this training covers the following areas:…

- Rights and responsibilities of inmates
- Interpersonal relations
- Sexual harassment/sexual misconduct awareness.

Performance standard: Staff Ethics

7C. Staff, contractors, and volunteers are professional, ethical, and accountable.

Outcome Measures:

(1) Number of incidents in which staff found to have acted in violation of facility policy in the past 12 months divided by the number of full-time equivalent staff positions in the past 12 months.

(2) Number of staff terminated for conduct violations in the past 12 months divided by the number of full-time equivalent staff positions in the past 12 months.

(3) Number of inmate grievances attributed to improper staff conduct which were upheld in the past 12 months divided by the number of inmate grievances alleging improper staff conduct filed in the last 12 months.

(4) Number of inmate grievances attributed to improper staff conduct which was upheld in the past 12 months divided by the average daily population for the past 12 months.

Code of Ethics:

4-ALDF-7C-02 (Ref. 3-ALDF-1C-23). The facility has a written code of ethics that it provides to all employees. At a minimum, the code:

- Prohibits staff, contractors, and volunteers from using their official position to secure privileges for themselves or others

- Prohibits staff, contractors, and volunteers from engaging in activities that constitute a conflict of interest

- Prohibits staff, contractors, and volunteers from accepting any gift or gratuity from, or engaging in personal business transactions with an inmate or an inmate's immediate family

- Defines acceptable behavior in the areas of campaigning, lobbying, or political activities

All staff, contractors, and volunteers are held accountable for compliance with the code of ethics.

4-ALDF-7C-03 (Ref. New). New staff acknowledges in writing that they have reviewed facility work rules, ethics, regulations, conditions of employment, and related documents. A copy of the signed acknowledgement is placed in each staff member's personnel file.

Expected practices: Personnel Policies

4-ALDF-7E-01 (Ref. 3-ALDF-1C-01). There is a personnel policy manual that is available to each employee and is explained at employee orientation. The manual is reviewed annually and revised, as needed. This manual includes, at a minimum:…

- A code of ethics
- Sexual harassment/sexual misconduct policy
- Employee disciplinary procedures.

The above are an assortment of the most significant standards applicable to this case, but there are certainly other that are applicable. This is not meant to be exhaustive.

Appendix E: Listing of Previous Cases (Expert Witness Past Involvement)

Although I have given testimony during my previous employments, I have only been involved as an Expert Witness since March 12, 2014. Pursuant to that, I have participated as follows:

1. Confidential Consultant in two (2) cases (Non-Disclosure Agreements);
2. Expert Witness in three (3) cases:
    a. *Crisante v. Israel*, Case No. 12-018433 (Fla. 17th Cir. Ct. 2012);
    b. Pending in two (2):
        - *Williams v. Israel*, Case No. 14-023944 (Fla. 17th Cir. Ct. filed 2014);
        - *Militello v. Israel*, Case No. 14- 60173 (S.D. Fla. filed Jan. 24, 2014).
3. I have not been required to provide testimony in court.

Appendix F: Fee Schedule for Expert Witness Services

Pursuant to the Retention Agreement, the following is applied:

Expert Witness Service Fees
(6/1/2016)

The following are the routine, normal, and expected fees for Expert Witness Services:

1. All document review, any reports written, and any necessary site examination and/or other assessments will be charged at a rate of two-hundred dollars ($200) per hour;
2. Any necessary attorney and/or other meetings, phone contacts of an extended nature, and/or written communications required which are of an in-depth response (i.e., emails) will be charged at the same rate;
3. Any court or deposition testimony will be charged at the rate of two-hundred and fifty dollars ($250) per hour with a minimum of $500;
4. All actual travel time will be charged at a rate of one-hundred and twenty five dollars ($125) per hour to a maximum of 8 hours per day. Flights will be arranged and expensed at the business rate, if available; otherwise, arranged and expensed at the economy rate. Pre-check periods, up to two hours, will be expensed at seventy-five dollars ($75) per hour, unless work related actions are required during the period, which will be charged at the document review rate;
5. All travel expenses shall be expensed at the actual documented costs (i.e., flights, rental cars, taxis, etc.). (Note: The consultant will first attempt to use the Federal GSA Per Diem Rates for the City/County/State of lodging, unless this is not available (i.e., government lodging rates, plus taxes; three quarter meal rates on travel days; etc.). Further, as the consultant is not familiar with NYC locations for lodging that are best suited for CGSH and/or Legal Aid, appropriate guidance for such lodging would be appreciated.)
6. Any unusual expenses shall be discussed before occurrence, absent exigent circumstances, and are subject to approval;
7. All expenses are subject to appropriate supporting documentation and necessary approvals.

All expenses will be invoiced on a monthly basis, unless agreed otherwise.

Exhibit B

CITY OF NEW YORK
DEPARTMENT OF INVESTIGATION
SQUAD 1

TO: File
FROM: Richard Askin
Assistant Inspector General

DATE: October 6, 2016
DOI CASE #: 16-00019

CLOSING MEMORANDUM

The following is a summary only of information pertaining to this investigation and may not contain each and every fact learned during the course of this investigation.

INTRODUCTION:

On December 29, 2015, DOI was notified that inmate Joseph Garner had made a sexual abuse allegation against CO Raimeir Clay, and then retracted the allegation in writing after possibly being threatened with the denial of a transfer request for specialty housing. DOI interviewed Garner and through his statement identified several additional witnesses who in turn provided the names of more witnesses. Over the course of the investigation DOI interviewed 22 inmate witnesses, many of whom were able to corroborate Garner's initial allegation. Additionally, three of the witnesses provided statements which indicated that they were in fact victims of sexual abuse by CO Clay. Below is a breakdown of the four victims' statements followed by a summary of the witness statements. Lastly, there are several independent events, such as infractions or inmate fights, that tend to corroborate the victims' accounts. Those corroborating events are also detailed below.

PROFILE OF SUBJECT RAIMEIR CLAY:

Raimeir Clay is originally from the area of Memphis, TN. For approximately 12 years he worked as a Correction Officer for the Shelby County Sherriff's Office in Memphis. Personnel records obtained from Shelby County do not indicate any history of disciplinary issues or otherwise unusual behavior. In 2012, Clay abruptly resigned from employment with Shelby County citing "better career opportunities." Clay then moved to the New York City area and on September 26, 2013, was hired as a probationary Correction Officer with the NYC Dept. of Correction. Since his appointment to duty, Clay has been assigned to AMKC and has no disciplinary history.

Based on DOC records, Clay is married to a woman named [redacted] They were married in Queens County in 2003, however Accurint records indicate that [redacted]

STATEMENTS FROM VICTIMS:

- **Joseph Garner:**

On December 29, 2015, Joseph Garner submitted an application to be housed in a transgender housing area. In the comments section of the form, Garner alleged that had been sexually abused by an unnamed correction officer while in AMKC. On the same day Garner submitted a written statement on an "Inmate Voluntary Statement Form," which is normally used for uses of force or serious injuries, wherein he retracted his allegation against staff and vehemently denied that any DOC staff member had ever abused him.

Regardless of his retraction, pursuant to DOC policy Garner's initial allegation triggered a mandatory response by the Department. At approximately 5:00pm on that same day, investigators from DOC's Investigation Division responded to AMKC and interviewed Garner. During that interview Garner stated in sum and substance that shortly after he arrived in AMKC 4 Upper, he met CO Clay. Almost immediately upon arriving in the housing area, Clay began to make sexually inappropriate comments to Garner referencing Garner's genitalia and making it clear that Clay found Garner very attractive. Clay worked the steady midnight shift and during his first few nights in 4 Upper Clay would come to Garner's cell door and watch him in bed. Garner stated that over the next few weeks the level of sexual communication escalated between him and Clay to the point where Clay would come to Garner's cell at night, open the cell door, and then stand in the doorway of the cell and fondle Garner just inside his cell. Clay would stand in threshold of the door and constantly look up and down the tier to make sure no one was coming. Garner stated that on three occasions Clay fondled Garner's penis to the extent that he ejaculated. Garner was unable to provide specific dates that these encounters occurred, however he did provide a timeline from mid-October 2015 through early November. On January 9, 2016, Garner wrote a letter to various law enforcement agencies including DOC, BOC, NY State AG, and the Legal Aid Society's Prisoner's Rights Project wherein he named Clay personally and essentially reiterated the allegation previously made to ID.

On January 21, 2016, DOI interviewed Garner regarding this allegation. Garner essentially recounted the allegation about Clay that he had previously made. He added some details about how Clay had provided him things like extra food, perfumes, lotions, "do-rags," and a t-shirt in exchange for allowing Clay to touch him. Garner described that he felt at first like he and Clay were involved in some type of relationship. Garner had never been involved with a correction officer and at first was confused about what was happening. Garner stated that he began to realize that he was not actually involved in a relationship and that Clay was only using him for his own pleasure. Garner began to distance himself after that and acted less willing to allow Clay to touch him.

Garner believes that Clay began to sense his growing unwillingness to participate in the sexual contact. It seemed to Garner that Clay was shifting his interests towards other inmates. Then one day Garner was in the dayroom when Clay came in and told Garner that he wanted to watch Garner masturbate. Clay told him to go back to his cell, get naked, and start masturbating and that Clay would come down in a minute or two and watch. Garner did so and began masturbating but instead of Clay coming to watch him another inmate came over and began to laugh and make fun of Garner. Garner put his pants on and ran out of the cell but when he did there were five or six inmates waiting for him and jumped him. Garner said that an inmate named "[redacted] beat him with a bar of

soap stuffed in a sock. Garner stated that Clay wrote an infraction which falsely identified Garner as that perpetrator of the fight. Clay then used that infraction to get Garner kicked out of the house.[1]

[redacted]

During the course of the investigation, at least four of the inmate witnesses stated that Clay had shown a particularly strong interest in one inmate named [redacted] DOI conducted two interviews with [redacted] over the course of a week in January 2016. Below is a summary of [redacted] statement to DOI, in sum and substance.

[redacted] stated that when he first arrived in 4 Upper in August of 2015, CO Clay took an immediate interest in him. [redacted] said that when he first arrived he was uncomfortable because a large population of the house was transgendered and he was not accustomed to being around that type of population. CO Clay encouraged [redacted] to stay in the house, telling him that 4 Upper was a good house and to give it a little time. [redacted] agreed to stay but then about a month later in September he was transferred out of the house. [redacted] did not specify why he was transferred, but he believed that Clay worked out a way to get him back into the house. [redacted] said Clay apparently undertook many measures to ensure that he stayed in 4 Upper, including failing to serve [redacted] timely infraction paperwork which caused any infractions incurred by [redacted] to be dismissed[2].

[redacted] stated that in October 2015 he found himself back in 4 Upper with CO Clay. Clay began spending large amounts of time with [redacted] and told [redacted] that he was bi-sexual. Clay would come to [redacted] cell door at night and watch him through the window for extended periods of time. Clay would talk to [redacted] about sexual topics such as the size of Clay's penis and that Clay enjoys performing oral sex on men. Clay then began to bring in various items for [redacted] such as new clothes, a hairbrush, cash, and food from the outside. [redacted] stated, "Clay would look out for people. He would give you things, like clothes, dew rags, etc... If you accept it, you accept what comes." When asked to clarify this statement, [redacted] stated that he would allow Clay to touch him on the shoulders and watch him in the shower in exchange for receiving these items. According to [redacted] after Clay would give him things, he would say, "What are you going to do for me, I got needs too." Clay told [redacted] that his wife did not satisfy him enough.

[redacted] stated that Clay would allow him to use his cell phone sometimes to go online and check his facebook account. Clay also showed [redacted] photos of his wife on his phone. [redacted] described Clay's wife as being older, black, medium complexion, with glasses and dyed blonde hair.[3] [redacted] stated on one occasion Clay allowed him to use his cellphone to call his girlfriend late at night after lock-in, at approximately 2:00am or 3:00am. [redacted] girlfriend is a woman named [redacted] DOI contacted Ms. [redacted] who confirmed that back in November of 2015 she received a late-night call from a number she did not recognize and that it was [redacted] on the line. She asked how he was able to call her after lock-in and [redacted] told her that he was using a CO's cell phone.

[1] DOC records indicate that Garner was infracted for fighting on October 10, 2015. He was transferred out of 4 Lower on October 11, 2015.
[2] DOC records indicate that [redacted] did not receive any infractions during his time in AMKC, even though he has been infracted 12 times in other facilities where he was housed.
[3] Based on a review of Clay's facebook page and the website for St. Michael's Church, [redacted] description of Clay's wife is consistent with how she looks in those photos.

[redacted] stated that he was aware that he was leading Clay on in some sense because he was accepting gifts and money from Clay but he was not really allowing Clay to do the things that Clay wanted to do with him sexually. [redacted] stated that everything with Clay culminated in an incident that took place in the middle of the night in [redacted] cell. [redacted] stated that one night in mid-November he was asleep inside his cell and was awoken when his cell door was opened. Before he realized what was happening he felt someone pull his shorts down from his waist. He immediately recognized the person in this cell to be CO Clay. [redacted] stated that he felt Clay put his mouth on [redacted] penis. [redacted] screamed at Clay, yelling things such as, "What the fuck? What are you doing? Etc..." [redacted] resisted Clay and tried to pull away. As soon as [redacted] started screaming Clay jumped up and ran out of his cell. Within a few seconds the on-duty suicide prevention aid ("SPA")[4] came over to [redacted] cell to see if everything was ok. [redacted] stated that Clay tried to play it off as if Clay had also come over to see if he was ok, asking [redacted] what was wrong and why he was screaming. [redacted] didn't say anything to the SPA and just tried to go back to sleep, but he stated that he knew right then that he had to get out of Clay's housing area.

[redacted] stated that a day or two after the assault from Clay he went to the law library in AMKC and looked up the phone numbers for the U.S. Attorney's Office. [redacted] state that he tried calling the U.S. Attorney's Office to report that he had been sexually assaulted by a Correction Officer but in his words it, "didn't seem like they could help me."[5] [redacted] stated that he tried to get transferred out of Clay's house but that his requests for a transfer were never processed and that any infractions he attempted to commit were either dismissed or were not filed. [redacted] believes that Clay was manipulating things in order to keep [redacted] in his house. Finally [redacted] took it upon himself to do something incontrovertible that he knew would get him kicked out of the house. In late December 2015, while another CO was conducting a tour [redacted] threw water out his cell striking the officer in the torso area. [redacted] was infracted and transferred out of the area to punitive segregation.[6]

- [redacted]

According to the statement made by Joseph Garner, he was set up by Clay to be the victim of a beating which led to him being kicked out of the house. According to DOC records, Garner was involved in an inmate fight in 4 Upper on October 10, 2015. Some of the other inmates reportedly involved in the fight were [redacted] and [redacted] On March 30, 2016, DOI interviewed [redacted] stated that he didn't know what the fight with Garner was about but that it was not set up by Clay. [redacted] was friends with Garner and saw that Garner was involved in a fight so he came over to help but was struck in the face by an unknown inmate and went down. He never learned what the fight was about.

When asked about CO Clay, [redacted] described him as a creep. [redacted] stated that when he first came into 4 Upper, Clay approached him and started saying sexual things to him like, "Pull out your stuff, let me see what you're working with." [redacted] stated that on Clay's next tour of duty after that, he came to [redacted] cell door, which was open at that time. [redacted] stated that Clay instructed him to come close to the door so that he was standing just inside the cell near the door. Clay stood just outside the door so that he could still see down the tier. Clay then put his hands

[4] SPAs are inmate workers assigned to make regular rounds of housing areas at night in an effort to watch out for anyone who may be self-injurious or suicidal.
[5] According to inmate phone records, [redacted] made four phone calls on November 19, 2015. Two of those calls were made to the main number for the U.S. Attorney's Office Eastern District, 718-254-7000, and the other two calls were made to the main number for the Queens District Attorney's Office, 718-286-6000.
[6] According to DOC records, [redacted] was charged with splashing CO Brian Saryian on December 27, 2015.

inside [redacted] pants and fondled his penis while saying things like, "You're so big." [redacted] stated that he felt extremely uncomfortable during this occurrence, but described that he, "ejaculated a little" during the incident. After that, Clay promised that he would bring [redacted] things like new clothing and commissary, but that Clay never followed up on that. [redacted] said that this incident with Clay only happened once and that Clay seemed to lose interest in him. A short time after that [redacted] was involved in the fight with Garner and was transferred out of the house.

- [redacted]

On April 1, 2016, DOI interviewed inmate [redacted] Regarding the fight with Garner, [redacted] simply stated that he did not know what the fight was about. All he knew was that two transgender guys were fighting with each other inside a nearby cell and that he just jumped in, but he had no stake in the fight.

[redacted] was asked about CO Clay. [redacted] began his answer by volunteering that he himself is an openly gay man and that he has frequent sexual encounters with transgender men. [redacted] stated that when he first arrived in 4 Upper CO Clay came over to his cell and made various sexual comments such as, "You a handsome young brother." Even though it was the middle of the night, Clay asked [redacted] if he wanted to come out of his cell to hang out. [redacted] said ok, but told Clay he just needed to use the toilet first and to give him a minute. Clay said ok, but he did not leave the area and instead stood outside [redacted] cell and watched him pee. After he was done, Clay opened the cell door and entered the cell. [redacted] was turned away from the door at that time and initially felt Clay put his hands on [redacted] buttocks. At first [redacted] did not resist Clay's advancement, but when he felt Clay's hand slide around [redacted] waist and toward his penis, he told Clay to stop and that he didn't want to do that sort of thing with him. Clay complied with [redacted] refusal and left the cell.

From that point on Clay continued to offer to bring things in for [redacted] such as food and clothing. [redacted] stated that the only thing he asked from Clay was for books to read so he could pass the time. Clay would say things to [redacted] such as, "Why don't you want to get with me, I could make your time in here easy or I could make it hard." [redacted] stated that he accepted the books from Clay but that he didn't want to take anything else from him because he didn't want it to seem like he owed Clay anything. A short time later [redacted] was involved in the fight with Garner and was transferred out of 4 Upper.

STATEMENTS FROM RELEVANT WITNESSES:

- [redacted] (AKA [redacted]

[redacted] was the SPA who was on duty the night that Clay entered [redacted] cell and assaulted him. On June 6, 2016, DOI interviewed [redacted] about this incident.[7] [redacted] stated that he worked as an overnight SPA in Clay's housing area during the time that [redacted] was there. [redacted] said that Clay and [redacted] had some sort of relationship going on, and that Clay was always hanging around [redacted] cell at night, and that during the day the two were always touching each other affectionately like a couple would. Clay would bring [redacted] new clothes and would frequently lock

[redacted]

[redacted] out of his cell at night to come and hang out in the dayroom. [redacted] said that Clay was trying to get him removed as the SPA so that he could get [redacted] assigned as an SPA. If [redacted] was made an SPA he would have a legitimate reason for being locked out at night, but Clay was ultimately unable to do it.

[redacted] recalled that on one particular night in November 2015, he was working as the SPA and as such he was locked out of his cell and his cell door remained open. At some point in the middle of the night he returned to his cell in order to use the toilet. While sitting on the toilet he heard who he recognized to be [redacted] screaming in his cell, yelling things like, "What the fuck" and "[redacted] understood this to mean that [redacted] was yelling for him to come over to his cell because "[redacted] is [redacted] nickname. [redacted] stated that it was not uncommon for inmates in the house to call for him to come over to their cells at night because they are locked in and they know that the SPAs are locked out, and if they need something like toilet paper they frequently ask him to bring it to them. However, [redacted] stated that he could tell by the tone of [redacted] voice that this was urgent.

[redacted] got off the toilet and walked the few steps down to [redacted] cell. When he arrived in the area he saw Clay standing just outside [redacted] door, and noticed that the cell door was open. [redacted] looked inside the cell door and observed [redacted] sitting on his bed. He said that [redacted] looked "scared and pissed." [redacted] asked [redacted] what happened, but [redacted] didn't say anything. Clay closed the cell door and [redacted] went back to his duties. [redacted] stated that over the next few days he tried to ask [redacted] again about that had happened that night, but [redacted] never told him a thing about what had occurred.

- [redacted]

[redacted] was reportedly involved in the fight with Garner. On March 30, 2016, DOI interviewed [redacted] about that incident. [redacted] contradicted Garner's account of the fight, stating that it was not Clay who set up the fight against Garner, but instead it was Garner who attacked [redacted] inside his own cell. [redacted] stated that Garner had been extorting [redacted] for phone calls and food and that when [redacted] told him no more, Garner came in his cell and punched him. [redacted] fought back but then a bunch of other inmates jumped in and it became a brawl.

When asked about Clay, [redacted] stated that Clay was homosexual. [redacted] also described Clay as a scumbag. [redacted] stated that there may have been something sexual going on between Garner and Clay because [redacted] observed Clay stand outside of Garner's cell on at least three occasions for half an hour or more. When asked if there were any other inmates that Clay seemed close with, [redacted] stated it was common knowledge that [redacted] was Clay's boy. [redacted] stated that Clay would lock [redacted] out of his cell at night and take him down to the dayroom. On at least two occasions [redacted] saw [redacted] and Clay exit the shower area together at around 3:00am. Clay would give [redacted] new clothes and food from the outside.

ADDITIONAL WITNESS STATEMENTS:

- **Harassment Allegations:**

Inmates [redacted] and [redacted] all independently alleged to DOC that they had been sexually harassed by CO Clay. DOI interviewed each of these inmates over the course of this investigation to determine the extent of the harassment. All three inmates denied

actually being touched by Clay, but all allege in sum and substance that Clay came onto them when they first arrived in the house and that if they had wanted to allow Clay to touch them he would have brought them things in exchange.

- **General Witnesses:**

Inmate [redacted] was interview by DOI on February 18, 2016. He stated that Clay had an unusually close relationship with [redacted] Clay would frequently let [redacted] out of his cell at night and would bring him food and clothes. Clay would also make sexually explicit comments to [redacted] and offered to bring him things if he allowed Clay to perform oral sex on him. [redacted] said he declined.

Inmates [redacted] and [redacted] also provided statements to DOI that, in sum and substance, CO Clay would make inappropriate sexual comments to the inmates in 4 Upper and that they would occasionally see Clay lingering in front of inmates' cells at night or go into the shower area alone with an inmate and that neither felt comfortable in that house and wanted to leave.

CONCLUSION AND RECOMMENDATION:

Based on the foregoing facts and statements, the conclusion of this investigation is that CO Clay engaged in unlawful sexual contact with Joseph Garner, [redacted] and [redacted] CO Clay is currently on modified duty with no inmate contact. It is recommended that this matter be closed as **SUBSTANTIATED**, and referred to the Bronx District Attorney's Office for criminal prosecution of Raimeir Clay for the applicable violations of the Penal Law. This matter should also be referred DOC for administrative action against CO Clay.

Submitted by: _____ Date: 10/6/16
Richard Askin
Assistant Inspector General

Approved by: _____ Date: 10/6/16
Chin Hb Cheng
First Deputy Inspector General

Approved by: _____ Date: 10/6/16
Jennifer Sculco
Inspector General

The City of New York
Department of Investigation

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COMMISSIONER

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Wanda Perez-Maldonado
Chief, Public Integrity Bureau
Bronx District Attorney's Office
198 East 161st Street
Bronx, NY 10451

October 6, 2016

Dear Chief Perez-Maldonado:

On June 22, 2016, the following matter was presented to your office during a meeting between DOI and [redacted] Sex Crimes Unit. I understand that this matter has now been assigned to the Public Integrity Bureau. Please accept this letter as the formal referral of this matter to the Bronx District Attorney's Office for review.

On December 29, 2015, the Office of the Inspector General (OIG) for the Department of Correction (DOC) was notified that inmate Joseph Garner had made a sexual abuse allegation against CO Raimeir Clay, and then retracted the allegation in writing after possibly being threatened with the denial of a transfer request for specialty housing. DOI interviewed Garner and through his statement identified several additional witnesses who in turn provided the names of more witnesses. Over the course of the investigation DOI interviewed 22 inmate witnesses, many of whom were able to corroborate Garner's initial allegation. Additionally, three of the witnesses provided statements which indicated that they were in fact victims of sexual abuse by CO Clay. Below is a breakdown of the four victims' statements followed by a summary of the witness statements. Lastly, there are several independent events, such as infractions or inmate fights, that tend to corroborate the victims' accounts. Those corroborating events are also detailed below.

Profile of Correction Officer Raimeir Clay:

Raimeir Clay is originally from the area of Memphis, TN. For approximately 12 years he worked as a Correction Officer for the Shelby County Sherriff's Office in Memphis. Personnel records obtained from Shelby County do not indicate any history of disciplinary issues or otherwise unusual behavior. In 2012, Clay abruptly resigned from employment with Shelby County citing "better career opportunities." Clay then moved to the New York City area and on September 26, 2013, was hired as a probationary

Correction Officer with the NYC Dept. of Correction. Since his appointment to duty, Clay has been assigned to AMKC and has no disciplinary history.

Based on DOC records, Clay is married to a woman named [redacted] They were married in Queens County in 2003, however Accurint records indicate that the couple did not reside together until 2012. [redacted]

Statements from Victims:

1. **Joseph Garner:**

On December 29, 2015, Joseph Garner submitted an application to be housed in a transgender housing area. In the comments section of the form, Garner alleged that had been sexually abused by an unnamed correction officer while in AMKC. On the same day Garner submitted a written statement on an "Inmate Voluntary Statement Form," which is normally used for uses of force or serious injuries, wherein he retracted his allegation against staff and vehemently denied that any DOC staff member had ever abused him.

Regardless of his retraction, pursuant to DOC policy Garner's initial allegation triggered a mandatory response by the Department. At approximately 5:00pm on that same day, investigators from DOC's Investigation Division responded to AMKC and interviewed Garner. During that interview Garner stated in sum and substance that shortly after he arrived in AMKC 4 Upper, he met CO Clay. Almost immediately upon arriving in the housing area, Clay began to make sexually inappropriate comments to Garner referencing Garner's genitalia and making it clear that Clay found Garner very attractive. Clay worked the steady midnight shift and during his first few nights in 4 Upper Clay would come to Garner's cell door and watch him in bed. Garner stated that over the next few weeks the level of sexual communication escalated between him and Clay to the point where Clay would come to Garner's cell at night, open the cell door, and then stand in the doorway of the cell and fondle Garner just inside his cell. Clay would stand in threshold of the door and constantly look up and down the tier to make sure no one was coming. Garner stated that on three occasions Clay fondled Garner's penis to the extent that he ejaculated. Garner was unable to provide specific dates that these encounters occurred, however he did provide a timeline from mid-October 2015 through early November. On January 9, 2016, Garner wrote a letter to various law enforcement agencies including DOC, BOC, NY State AG, and the Legal Aid Society's Prisoner's Rights Project wherein he named Clay personally and essentially reiterated the allegation previously made to ID.

On January 21, 2016, DOI interviewed Garner regarding this allegation. Garner essentially recounted the allegation about Clay that he had previously made. He added some details about how Clay had provided him things like extra food, perfumes, lotions, "do-rags," and a t-shirt in exchange for allowing Clay to touch him. Garner described that he felt at first like he and Clay were involved in some type of relationship. Garner had never been involved with a correction officer and at first was confused about what was happening. Garner stated that he began to realize that he was not actually involved in a relationship and that Clay was only using him for his own pleasure. Garner began to distance himself after that and acted less willing to allow Clay to touch him.

Garner believes that Clay began to sense his growing unwillingness to participate in the sexual contact. It seemed to Garner that Clay was shifting his interests towards other inmates. Then one day Garner was in the dayroom when Clay came in and told Garner that he wanted to watch Garner masturbate. Clay told him to go back to his cell, get naked, and start masturbating and that Clay would come down in a minute or two and watch. Garner did so and began masturbating but instead of Clay

coming to watch him another inmate came over and began to laugh and make fun of Garner. Garner put his pants on and ran out of the cell but when he did there were five or six inmates waiting for him and jumped him. Garner said that an inmate named [redacted] beat him with a bar of soap stuffed in a sock. Garner stated that Clay wrote an infraction which falsely identified Garner as that perpetrator of the fight. Clay then used that infraction to get Garner kicked out of the house[1].

2. [redacted]

During the course of the investigation, at least four of the inmate witnesses stated that Clay had shown a particularly strong interest in one inmate named [redacted] DOI conducted two interviews with [redacted] over the course of a week in January 2016. Below is a summary of [redacted] statement to DOI, in sum and substance.

[redacted] stated that when he first arrived in 4 Upper in August of 2015, CO Clay took an immediate interest in him. [redacted] said that when he first arrived he was uncomfortable because a large population of the house was transgendered and he was not accustomed to being around that type of population. CO Clay encouraged [redacted] to stay in the house, telling him that 4 Upper was a good house and to give it a little time. [redacted] agreed to stay but then about a month later in September he was transferred out of the house. [redacted] did not specify why he was transferred, but he believed that Clay worked out a way to get him back into the house. [redacted] said Clay apparently undertook many measures to ensure that he stayed in 4 Upper, including failing to serve [redacted] timely infraction paperwork which caused any infractions incurred by [redacted] to be dismissed[2].

[redacted] stated that in October 2015 he found himself back in 4 Upper with CO Clay. Clay began spending large amounts of time with [redacted] and told [redacted] that he was bi-sexual. Clay would come to [redacted] cell door at night and watch him through the window for extended periods of time. Clay would talk to [redacted] about sexual topics such as the size of Clay's penis and that Clay enjoys performing oral sex on men. Clay then began to bring in various items for [redacted] such as new clothes, a hairbrush, cash, and food from the outside. [redacted] stated, "Clay would look out for people. He would give you things, like clothes, dew rags, etc… If you accept it, you accept what comes." When asked to clarify this statement, [redacted] stated that he would allow Clay to touch him sexually and watch him in the shower in exchange for receiving these items. According to [redacted] after Clay would give him things, he would say, "What are you going to do for me, I got needs too." Clay told [redacted] that his wife did not satisfy him enough.

[redacted] stated that Clay would allow him to use his cell phone sometimes to go online and check his facebook account. Clay also showed [redacted] photos of his wife on his phone. [redacted] described her as being older, black, medium complexion, wears glasses, has dyed blonde hair.[3] [redacted] stated on one occasion Clay allowed him to use his cellphone to call his girlfriend late at night after lock-in, at approximately 2:00am or 3:00am. [redacted] girlfriend is a woman named [redacted] DOI contacted Ms. [redacted] who confirmed that back in November of 2015 she received a late-night call from a number she did not recognize and that it was [redacted] on the line. She asked how he was able to call her after lock-in and [redacted] told her that he was using a CO's cell phone.

[redacted] stated that he was aware that he was leading Clay on in some sense because he was accepting gifts and money from Clay but he was not really allowing Clay to do the things that Clay wanted to do

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[1] DOC records indicate that Garner was infracted for fighting on October 10, 2015. He was transferred out of 4 Lower on October 11, 2015.

[2] Due to 4 Upper being a protective custody house "PC", infractions issued to inmates housed there would be grounds for removal from PC. DOC records indicate that [redacted] did not receive any infractions during his time in AMKC, even though he has been infracted 12 times in other facilities where he was housed.

[3] Based on a review of Clay's facebook page and the website for St. Michael's Church, [redacted] description of Clay's wife is consistent with how she looks in those photos.

with him sexually. [redacted] stated that everything with Clay culminated in an incident that took place in the middle of the night in [redacted] cell. [redacted] stated that one night in mid-November he was asleep inside his cell and was awoken when his cell door was opened. Before he realized what was happening he felt someone pull his shorts down from his waist. He immediately recognized the person in this cell to be CO Clay. [redacted] stated that he felt Clay put his mouth on [redacted] penis. [redacted] screamed at Clay, yelling things such as, "What the fuck? What are you doing? Etc..." [redacted] resisted Clay and tried to pull away. As soon as [redacted] started screaming Clay jumped up and ran out of his cell. Within a few seconds the on-duty suicide prevention aid ("SPA")[4] came over to [redacted] cell to see if everything was ok. [redacted] stated that Clay tried to play it off as if Clay had also come over to see if he was ok, asking [redacted] what was wrong and why he was screaming. [redacted] didn't say anything to the SPA and just tried to go back to sleep, but he stated that he knew right then that he had to get out of Clay's housing area.

[redacted] stated that a day or two after the assault from Clay he went to the law library in AMKC and looked up the phone numbers for the U.S. Attorney's Office. [redacted] state that he tried calling the U.S. Attorney's Office to report that he had been sexually assaulted by a Correction Officer but in his words it, "didn't seem like they could help me."[5] [redacted] stated that he tried to get transferred out of Clay's house but that his requests for a transfer were never processed and that any infractions he attempted to commit were either dismissed or were not filed. [redacted] believes that Clay was manipulating things in order to keep [redacted] in his house. Finally [redacted] took it upon himself to do something incontrovertible that he knew would get him kicked out of the house. In late December 2015, while another CO was conducting a tour [redacted] threw water out his cell striking the officer in the torso area. [redacted] was infracted and transferred out of the area to punitive segregation.[6]

3. [redacted]

According to the statement made by Joseph Garner, he was set up by Clay to be the victim of a beating which led to him being kicked out of the house. According to DOC records, Garner was involved in an inmate fight in 4 Upper on October 10, 2015. Some of the other inmates reportedly involved in the fight were [redacted] and [redacted] On March 30, 2016, DOI interviewed [redacted] stated that he didn't know what the fight with Garner was about but that it was not set up by Clay. [redacted] was friends with Garner and saw that Garner was involved in a fight so he came over to help but was struck in the face by an unknown inmate and went down. He never learned what the fight was about.

When asked about CO Clay, [redacted] described him as a creep. [redacted] stated that when he first came into 4 Upper, Clay approached him and started saying sexual things to him like, "Pull out your stuff, let me see what you're working with." [redacted] stated that on Clay's next tour of duty after that, he came to [redacted] cell door, which was open at that time. [redacted] stated that Clay instructed him to come close to the door so that he was standing just inside the cell near the door. Clay stood just outside the door so that he could still see down the tier. Clay then put his hands inside [redacted] pants and fondled his penis while saying things like, "You're so big." [redacted] stated that he felt extremely uncomfortable during this occurrence, but described that he, "ejaculated a little" during the incident. After that, Clay promised that he would bring [redacted] things like new clothing and commissary, but that Clay never followed up on that. [redacted] said that this incident with Clay only happened once and that Clay

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[4] SPAs are inmate workers assigned to make regular rounds of housing areas at night in an effort to watch out for anyone who may be self-injurious or suicidal.

[5] According to inmate phone records, [redacted] made four phone calls on November 19, 2015. Two of those calls were made to the main number for the U.S. Attorney's Office Eastern District, 718-254-7000, and the other two calls were made to the main number for the Queens District Attorney's Office, 718-286-6000.

[6] According to DOC records, [redacted] was charged with splashing CO Brian Saryian on December 27, 2015.

seemed to lose interest in him. A short time after that [redacted] was involved in the fight with Garner and was transferred out of the house.

4. [redacted]

On April 1, 2016, DOI interviewed inmate [redacted] Regarding the fight with Garner, [redacted] simply stated that he did not know what the fight was about. All he knew was that two transgender guys were fighting with each other inside a nearby cell and that he just jumped in, but he had no stake in the fight.

[redacted] was asked about CO Clay. [redacted] began his answer by volunteering that he himself is an openly gay man and that he has frequent sexual encounters with transgender men. [redacted] stated that when he first arrived in 4 Upper CO Clay came over to his cell and made various sexual comments such as, "You a handsome young brother." Even though it was the middle of the night, Clay asked [redacted] if he wanted to come out of his cell to hang out. [redacted] said ok, but told Clay he just needed to use the toilet first and to give him a minute. Clay said ok, but he did not leave the area and instead stood outside [redacted] cell and watched him pee. After he was done, Clay opened the cell door and entered the cell. [redacted] was turned away from the door at that time and initially felt Clay put his hands on [redacted] buttocks. At first [redacted] did not resist Clay's advancement, but when he felt Clay's hand slide around [redacted] waist and toward his penis, he told Clay to stop and that he didn't want to do that sort of thing with him. Clay complied with [redacted] refusal and left the cell.

From that point on Clay continued to offer to bring things in for [redacted] such as food and clothing. [redacted] stated that the only thing he asked from Clay was for books to read so he could pass the time. Clay would say things to [redacted] such as, "Why don't you want to get with me, I could make your time in here easy or I could make it hard." [redacted] stated that he accepted the books from Clay but that he didn't want to take anything else from him because he didn't want it to seem like he owed Clay anything. A short time later [redacted] was involved in the fight with Garner and was transferred out of 4 Upper.

Statements from Relevant Witnesses:

[redacted] (AKA [redacted])

[redacted] was the SPA who was on duty the night that Clay entered [redacted] cell and assaulted him. On June 6, 2016, DOI interviewed [redacted] about this incident.[7] [redacted] stated that he worked as an overnight SPA in Clay's housing area during the time that [redacted] was there. [redacted] said that Clay and [redacted] had some sort of relationship going on, and that Clay was always hanging around [redacted] cell at night, and that during the day the two were always touching each other affectionately like a couple would. Clay would bring [redacted] new clothes and would frequently lock [redacted] out of his cell at night to come and hang out in the dayroom. [redacted] said that Clay was trying to get him removed as the SPA so that he could get [redacted] assigned as an SPA. If [redacted] was made an SPA he would have a legitimate reason for being locked out at night, but Clay was ultimately unable to do it.

[redacted] recalled that on one particular night in November 2015, he was working as the SPA and as such he was locked out of his cell and his cell door remained open. At some point in the middle of the

[7] [redacted]

night he returned to his cell in order to use the toilet. While sitting on the toilet he heard who he recognized to be [redacted] screaming in his cell, yelling things like, "What the fuck" and "[redacted] understood this to mean that [redacted] was yelling for him to come over to his cell because "[redacted] is [redacted] nickname. [redacted] stated that it was not uncommon for inmates in the house to call for him to come over to their cells at night because they are locked in and they know that the SPAs are locked out, and if they need something like toilet paper they frequently ask him to bring it to them. However, [redacted] stated that he could tell by the tone of [redacted] voice that this was urgent.

[redacted] got off the toilet and walked the few steps down to [redacted] cell. When he arrived in the area he saw Clay standing just outside [redacted] door, and noticed that the cell door was open. [redacted] looked inside the cell door and observed [redacted] sitting on his bed. He said that [redacted] looked "scared and pissed." [redacted] asked [redacted] what happened, but [redacted] didn't say anything. Clay closed the cell door and [redacted] went back to his duties. [redacted] stated that over the next few days he tried to ask [redacted] again about that had happened that night, but [redacted] never told him a thing about what had occurred.

[redacted]

[redacted] was reportedly involved in the fight with Garner. On March 30, 2016, DOI interviewed [redacted] about that incident. [redacted] contradicted Garner's account of the fight, stating that it was not Clay who set up the fight against Garner, but instead it was Garner who attacked [redacted] inside his own cell. [redacted] stated that Garner had been extorting [redacted] for phone calls and food and that when [redacted] told him no more, Garner came in his cell and punched him. [redacted] fought back but then a bunch of other inmates jumped in and it became a brawl.

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Additional Witness Statements:

Harassment Allegations:

Inmates [redacted], [redacted], and [redacted], all independently alleged to DOC that they had been sexually harassed by CO Clay. DOI interviewed each of these inmates over the course of this investigation to determine the extent of the harassment. All three inmates denied actually being touched by Clay, but all allege in sum and substance that Clay came onto them when they first arrived in the house and that if they had wanted to allow Clay to touch them he would have brought them things in exchange.

General Witnesses:

Inmate [redacted] was interview by DOI on February 18, 2016. He stated that Clay had an unusually close relationship with [redacted] Clay would frequently let [redacted] out of his cell at night and would bring him food and clothes. Clay would also make sexually explicit comments to [redacted] and offered to bring him things if he allowed Clay to perform oral sex on him. [redacted] said he declined.

Inmates [redacted] and [redacted] also provided statements to DOI that in sum and substance CO Clay would make inappropriately sexual comments to the inmates in 4 Upper and that they

would occasionally see Clay lingering in front of inmates' cells at night or go into the shower area alone with an inmate and that neither felt comfortable in that house and wanted to leave.

Conclusion:

Based on the foregoing facts and statements, the conclusion of this investigation is that CO Clay engaged in unlawful sexual contact with Joseph Garner, [redacted] and [redacted] CO Clay is currently on modified duty with no inmate contact. This matter is being referred to your office for consideration of criminal charges against CO Raimeir Clay. Please advise if any additional information is needed regarding this matter. Thank you.

Very Truly Yours,

Mark G. Peters

BY:

Jennifer Soulco
Senior Inspector General

cc: Omer Wiczyk