Audit Report on the New York City Department of Correction's Sexual Assault and Sexual Harassment (PREA) Closing Reports

The New York City Board of Correction

September 2018

EXECUTIVE SUMMARY

This is the report of an audit carried out by the New York City Board of Correction (or the Board) of the New York City Department of Correction's (DOC or the Department) investigations into allegations by people in custody of sexual abuse or harassment.[1]

From 2016 to 2017, the number of sexual abuse and sexual harassment complaints by people in custody increased by 40% from 823 to 1151. In 2017, the rate of allegations of sexual victimization per 1,000 incarcerated persons was 19.2.[2]

The Board's Minimum Standards on the elimination of sexual abuse and sexual harassment in correctional facilities[3] require DOC to meet PREA requirements and a number of additional expectations around timely and robust investigation methodology and accurate reporting. Similarly, under Standard 115.71 of the Prison Rape Elimination Act 2003 (PREA)[4], DOC's Investigation Division (ID) is required to conduct prompt, thorough and objective investigations into all allegations of sexual abuse or harassment. Timely, robust and comprehensive investigations are critical to ensuring justice for survivors of sexual violence and harassment, affording a reliable and accountable process for alleged perpetrators, and guaranteeing accountability that will deter sexual violence.

Board staff designed this audit to determine whether DOC's PREA investigations are meeting the requirements of the Board's Minimum Standards which closely follow federal PREA standards. Minimum Standard 5-30 (r) requires the Department produce a completed investigation form (also referred to as a Closing Report) at the conclusion of each investigation

[1] Routinely referred to as PREA allegations.
[2] N.Y.C. DEP'T OF CORR., *NYC Board of Correction Sexual Abuse and Sexual Harassment Minimum Standards 5-40 Assessment Report* (Mar. 2018), https://www1.nyc.gov/assets/boc/downloads/pdf/Reports/DOC-Reports/2018.03.15%20-%20Annual%20Sexual%20Abuse%20and%20Sexual%20Harassment%20Assessment%20Report%20(PREA).pdf.
[3] N.Y.C. RULES, Tit. 40, Ch. 5, http://library.amlegal.com/nxt/gateway.dll/New%20York/rules/title40boardofcorrection/chapter5eliminationofsexualabuseandsexua?f=templates$fn=default.htm$3.0$vid=amlegal:newyork_ny$anc=JD_T40C005
[4] Prison Rape Elimination Act Juvenile Faculty Standards, 28 C.F.R. Part 115 (2014).

of alleged sexual abuse or sexual harassment and provide a copy to the Board within five business days of completion.[5]

Board staff reviewed a sample of 42 investigation reports related to incidents occurring between January 2010 and December 2017. This report includes aggregate information about these investigations (such as the categories of allegation, the outcomes and the time taken to complete the investigation) and concludes with key thematic findings and eight recommendations for improvements to DOC's processes, both of which are summarized below. The Board has raised the Department's failure to comply with Minimum Standards on PREA investigations at multiple public meetings and the findings of this report emphasize again those failings. The Board's recommendations should be integrated into the Department's existing Corrective Action Plan (June 2018) on PREA investigations to ensure that their implementation is effectively monitored.[6]

Key Thematic Findings:

- There are significant gaps in the Department's investigations of sexual abuse and sexual harassment in the City's jails, including missing supervisory approval of investigations, key interviews not completed, and insufficient explanations as to why crime scenes were not established.

- The investigation reporting format, including the Department's June 2018 update to the form, is not sufficient to record, in detail, the precise investigative steps taken regarding interviews and available evidence.

- The PREA investigations audited were not completed in a timely manner. Significant delays in an investigation threaten the legitimacy and accuracy of its outcomes. However, DOC did complete initial interviews within 72 hours of allegation, as required.

[5] Since June 2018, the Department has been submitting Closing Reports to the Board on a weekly basis.
[6] N.Y.C DEP'T OF CORR., *NYC Department of Correction – June 2018 PREA Investigations Corrective Action Plan* (June 2018), https://www1.nyc.gov/assets/boc/downloads/pdf/Meetings/2018/June-12-2018/PREA%20Public%20Corrective%20Action%20Plan.pdf.

- Alleged victims were informed of the outcome of the investigation in a quarter of the cases audited. In cases where the victim was still in custody, the Department generally provided notice however, short stays and long investigatory time leads to many victims discharged prior to investigation conclusion.

Summary of Recommendations:

1. The Department should re-train investigative staff to record complete and comprehensive information in relation to every stage of their investigation, including the reasons why apparently key interviews do not take place and the steps taken to determine the need to secure a crime scene.

2. The Department must ensure that supervisory investigative staff are adequately trained and resourced to appropriately oversee PREA investigations. This should include working with investigators to address omissions in Closing Reports before they are finalized.

3. The Department should amend the Closing Report template to ensure that investigators can clearly follow the requirements and record the comprehensive information required by the Board's Minimum Standards and the PREA Standards. The form should include sections and guidance for fully explaining the different sources of evidence the investigation has considered or decided not to consider. In addition, the report template should be electronic and require that all elements are populated before the report can be completed.

4. The Department must take steps to address the extended delays in completing PREA investigations as a matter of urgency, including conducting an internal audit of the reason for delays in investigations being concluded. The Department should identify if (and how

many) additional staff numbers (both investigative and supervisory) and training are required to complete all investigations thoroughly and within 90 days of allegation. The City should make available additional resources as necessary. In addition, the Department should use the internal audit to identify where revisions to the investigative process can improve the timeliness and quality of the investigations.

5. The Board should conduct an annual audit of the Department's PREA Closing Reports to monitor their quality and timeliness.

6. The Department must ensure that investigative and supervisor staff are aware of, and comply with, the requirements of the Board's Minimum Standard 5-30 (q), including only conducting interviews of people in custody outside of the housing area and in a private and confidential setting. All Closing Reports should include information about the location of interviews conducted as part of the investigation.

7. The Department must ensure that PREA Closing Reports contain comprehensive information about the evidence analysis carried out as part of the investigation. Specifically, reports need to refer to: who is selected for interviews and why; how the investigator established the credibility of their information; and whether there was relevant historical information available about the alleged perpetrator.

8. Investigative staff should attempt to notify victims of the outcome of investigations, regardless of whether they are still in the Department's custody.

TABLE OF CONTENTS

METHODOLOGY

Board staff designed this audit to determine whether DOC's Investigation Division (ID)'s PREA investigations are meeting the requirements of the Board's Minimum Standards, which closely follow federal PREA standards. The Board's Minimum Standards require ID complete a report summarizing each investigation into sexual abuse or harassment.[7] These are referred to as PREA Closing Reports and were audited by the Board.

In order to assess investigations consistently, an audit 'Pro Forma' was developed to record information on a sample of cases (attached as Appendix 1). The categories within the Pro Forma are based upon the requirements of the Board's Minimum Standards and the requirements of Standards 115.71, 115.72 and 115.73 of the Prison Rape Elimination Act. The Pro Forma was used to record basic information about the allegations themselves, investigation outcomes and investigative methods used by DOC.

At the time of selecting the sample of cases to audit (May 2018), a total of 104 PREA Closing Reports had been received by the Board.[8] A sample size of 40% of the reports was selected as a reliable proportion for the purposes of this audit. Closing Reports for inclusion in the sample were selected at random, but care was taken to ensure that all categories of allegations[9] were captured in representative proportions.[10]

During the analysis phase of the audit, the Department provided additional PREA Closing Reports. In order to fairly represent more recently completed cases, the sample was amended to ensure that 50% (n=21) was comprised of these more recently closed investigations. The sample remained representative of the proportions of different categories of allegation.

[7] Minimum Standard 5-30 (m) requires that DOC must complete all investigations of sexual abuse and sexual harassment allegations no later than 90 days from the referral date, absent extenuating circumstances out of the Department's control (which must be documented). In addition, PREA Standard 115.71 (a) requires that all allegations of sexual abuse and sexual harassment be investigated promptly, thoroughly and objectively.

[8] This included twelve duplicate reports which were removed from consideration in the sample.

[9] The four PREA allegation categories recorded by DOC are: Staff on Inmate Sexual Abuse/Assault; Inmate on Inmate Sexual Abuse/ Assault; Staff on Inmate Sexual Harassment; and Inmate on Inmate Sexual Harassment.

[10] Analysis of the 104 Closing Reports demonstrated that the majority of allegations were of Staff on Inmate Sexual Abuse/ Assault (37%), followed by Staff on Inmate Sexual Harassment (26%), Inmate on Inmate Sexual Abuse/Assault (23%), and Inmate on Inmate Sexual Harassment (14%).

Of the 42 reports reviewed, 35 (83%) followed the same standard template. The remaining seven adhered to one of three additional report templates meaning that a total of four different report template models were included in the sample. As part of the audit, the newly developed DOC 'PREA Allegation Short Form' was provided to the Board in June 2018. Comments on the new form are included in the final section of this report. The reports audited related to alleged incidents occurring between January 2010 and December 2017.

In 23 of the 42 cases in the sample, at least some key information was missing.[11] As described above, the most frequently occurring missing data was a signature by a Supervisor. Where data was vital to an analysis, cases with missing information were excluded from that specific analysis. Where the analysis is conducted on less than 42 cases, this is clearly stated in the report.

For the majority of investigation reports included in the audit, no specific information has been included about alleged victims or perpetrators because the audit is aimed at understanding investigation quality and not the patterns of sexual abuse and harassment.

[11] It was not possible to use standard data cleansing techniques of removing cases from the sample if they had data missing owing to the high proportion of cases that this would have eliminated (55%).

Sample

As explained in the Methodology section above, PREA Closing Reports were selected at random but with care taken to build a sample that accurately reflects the full range of allegations that are received. Therefore, the 42 Closing Reports related to the following:

- **12** (29%) related to **Staff on Inmate Sexual Abuse/ Assault**
- **13** (31%) related to **Staff on Inmate Sexual Harassment**
- **10** (24%) related to **Inmate on Inmate Sexual Assault/Abuse**
- **7** (17%) related to **Inmate on Inmate Sexual Harassment**

The majority of alleged victims were men (n=32, 76%). Five allegations (12%) were from women and five (12%) were from victims who self-identified as transgender women.

Of the 42 allegations, 74% (n=31) occurred within five facilities (AMKC, OBCC, EMTC, GMDC and RMSC).[12] The specific number of allegations for each facility are as follows:

Table 1: Facility location where alleged PREA incident occurred

Facility Name	**Number and percentage[13] of allegations of audit sample**
AMKC	10 (24%)
OBCC	6 (14%)
EMTC	5 (12%)
GMDC	5 (12%)
RMSC	5 (12%)
RNDC	4 (10%)
GRVC	3 (7%)
MDC	2 (5%)
BKDC	2 (5%)
Total	***42 (100%)***

[12] Information on DOC facilities available at https://www1.nyc.gov/site/doc/about/facilities.page.
[13] Figures have been rounded up to the nearest integer.

FINDINGS

The following section summarizes the findings from the audit of 42 investigation Closing Reports, focusing on those that correlate directly with the Board's Minimum Standards and, where relevant, the requirements of the PREA standards more broadly.

1) **Timely interviews were conducted with the majority of alleged victims.**[14]

In 36 of the 42 cases (86%), the investigator interviewed the alleged victim within 72 hours, as required. Of the remaining six cases, on two occasions the victim refused. On one occasion the victim was not identified by the person reporting the alleged incident (in this case the allegation had been made by a third party who did not provide the name of the alleged victim). In one case, the allegation was received after the alleged victim had been released from custody and the investigators had to locate the individual in the community (which they did successfully). In another case the interview did not take place until approximately four days after the allegation was received and in the final case it was not clear from the investigation report why the alleged victim was not interviewed.

2) **Only one (2%) of the 42 Closing Reports audited was completed[15] within 90 days, as required by the Board's Minimum Standards.**[16]

Twenty-eight investigations were not closed within the required time period and the remaining 13 reports were incomplete so it was not possible to establish when the investigation was closed. As part of the audit, the Board examined the timeframes between ID receiving the allegation and the report being signed and dated by the investigator, supervisor, and a second, more senior member of supervisory staff respectively. This additional analysis is included at Appendix 3 at the end of this report.

[14] Minimum Standard 5-30(o) requires that all persons in custody subject to alleged sexual abuse or sexual harassment must be interviewed within 72 hours of the referral date, absent unusual circumstances (which must be documented).

[15] An investigation was only considered complete when a supervisory member of staff had signed the report. The Department's Division Order # 04/16, dated July 2015: Section III. P states that: "The investigator shall submit the final report to the ID Supervisor within 60 days (excluding pass days and legal holidays) of the incident being reported".

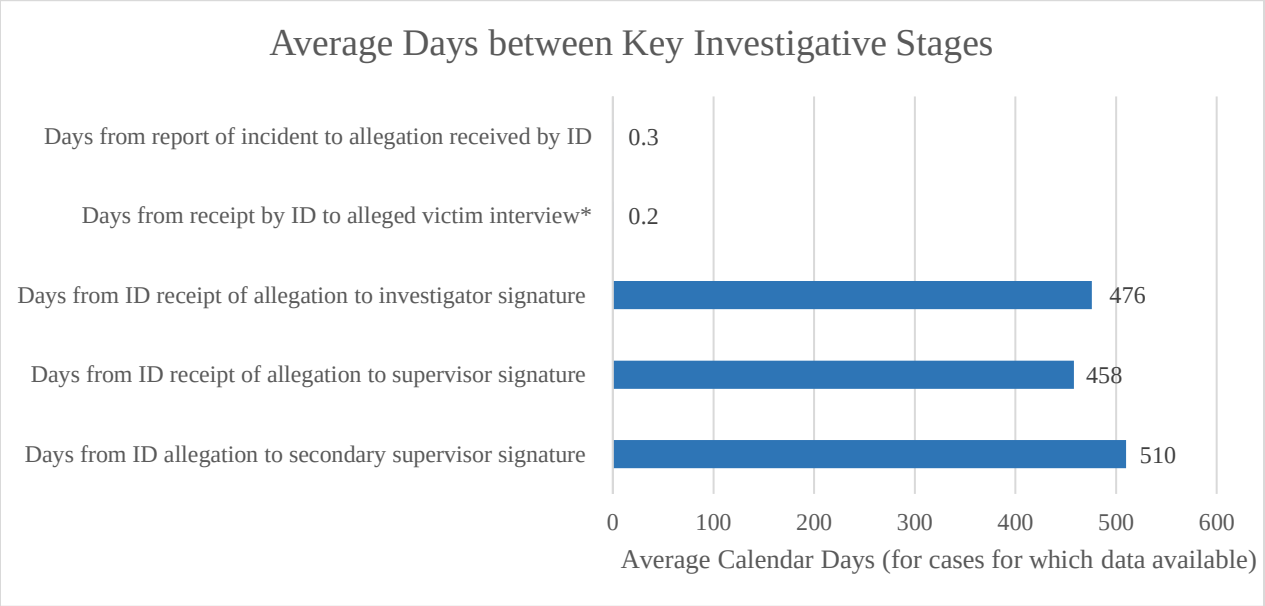
[16] See *supra* note 7.

It was only possible to calculate the time between allegations being received by ID and completion (signature of a secondary supervisor) in 30 of the 42 cases (71%). In the other 12 cases one or both of these dates were missing from the report. For the 30 cases in which the data was available, the average time between receipt by ID and final signature by a secondary supervisor was 510 calendar days (with a range of 38 days and 899 days).[17]

Board staff examined the timeframes between key investigative stages of the cases in the audit sample, shown in the chart below. It was clear that the key initial investigative task of interviewing the alleged victim was carried out promptly. However, the lack of specific information on the steps following prevented a thorough understanding of precisely where delays occurred. This is further discussed in a subsequent section of this report.

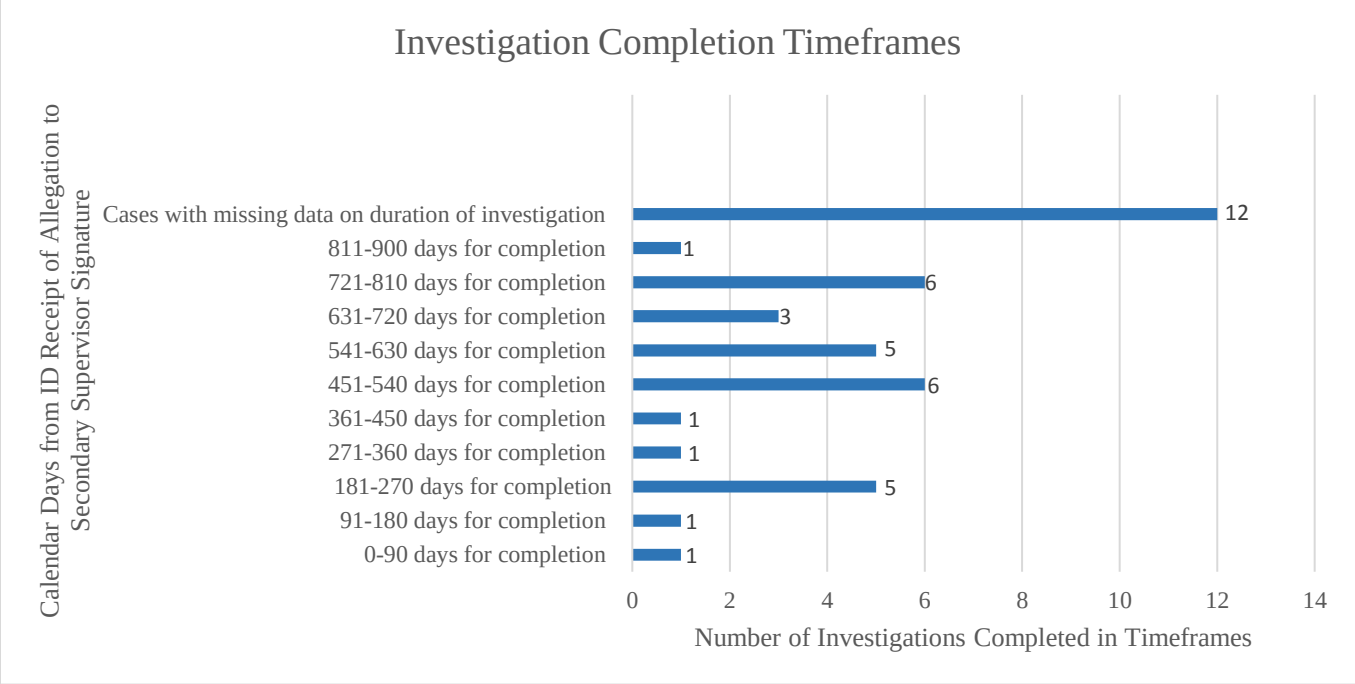
[17] Median was 540 calendar days.

Table 2: Average Days between Key Investigative Stages for Cases Audited



**Data on average days from ID receipt to alleged victim interview excludes one 'outlier' case in which the alleged victim was interviewed 360 days after the allegation was received. In this case, the allegation was received after the alleged victim was released and investigators therefore conducted the interview by telephone after locating the individual. There is no clear explanation as to why it took 360 days for the interview to take place*.

Table 3: Days taken to Complete Audited Cases



3) Alleged perpetrators were interviewed in 55% (n=23) of the investigations audited.[18]

Of the 19 cases where there was no perpetrator interview, the alleged perpetrator refused the interview in five cases (all of these noted refusals were from alleged perpetrators who were people in custody, not staff). Of the remaining 14 cases with no perpetrator interview, four involved allegations against people in custody but did not identify the alleged perpetrator. The remaining ten cases involve alleged staff perpetrators and are discussed below.

In one case, the investigator notes that the staff member against whom the allegation has been made was out sick. There is no indication as to whether any subsequent attempts were made to interview this staff member upon return to work. In another case the investigator records that attempts were made to contact the alleged perpetrator but that the staff member did not respond.

[18] Minimum Standard 5-30 (c), in accordance with PREA Standard 115.71 (c), requires that investigators must interview alleged victims, perpetrators and witnesses.

In two cases it was recorded that the alleged staff perpetrator was not identified and in one case the victim withdrew their allegation when interviewed by investigators. In the remaining five cases involving allegations against staff, investigators appear to have relied upon reviewing camera footage of events and/ or statements by staff instead of conducting interviews.

The Board audited 12 cases in which the allegation was one of sexual abuse by a member of staff. In half of those reports (n=6) it is not clear whether the allegation was referred to the New York City Department of Investigation (DOI)[19], a procedure which is required by Mayoral Executive Order 16[20] and by the Department's Division Order on Elimination of Sexual Abuse and Sexual Harassment.[21]

4) **Witnesses were interviewed in 45% (n=19) of the investigations audited.** [22]

In five of the 23 cases where witnesses were not interviewed, investigators recorded that attempts were made but that potential witnesses refused the interview. In one case it is recorded that the alleged victim specifically requested that no witnesses be approached. Of the other 17 cases it is not clear from the report why no witnesses were interviewed (e.g. there weren't any witnesses or witnesses could not be located).

5) **It was impossible to conclude whether interviews were generally conducted in private and confidential locations.**[23]

Of the 36 cases where an alleged victim interview took place, only nine (25%) investigators provided the location of the alleged victim interview. Of those cases: three interviews were described as being conducted in the 'housing unit'; two were carried out in 'housing unit

[19] In response to a draft of this report, DOC advised the Board that all 12 sexual assault allegations were referred to DOI as required. In order to ensure that this information is consistently recorded in the future, DOC has agreed to include this as a required element in their revised Closing Report template.
[20] N.Y.C. Exec. Order No. 16 (July 26, 1978), https://www1.nyc.gov/site/doi/report/reporting-obligation.page
[21] Division Order # 04/16, dated July 2015: Section III. J states that: "Upon receipt of clearance from the Inspector General of the Department of Investigation (DOI), ID shall conduct investigations for sexual misconduct that involve staff on allegations".
[22] See *supra* note 18.
[23] The Board's Minimum Standard 5-30 (q) requires that request for statements or interviews of people in custody must be made off the living unit and cannot be made within sight of other people in custody or staff involved in the incident. It also requires that interviews of people in custody must be conducted in a private and confidential setting.

pantries'; two were described as taking place in 'visits'; one was conducted over the telephone and one took place in the 'housing unit day room.' Because of the lack of specific detail included within the reports, it is not possible to say conclusively how many, if any, of the alleged victims in the audit sample were interviewed confidentially.

In addition, alleged perpetrator interviews took place in 23 cases, but investigators document interview location in only four reports. Of those four interviews, three were with staff. Two interviews took place at ID's Headquarters and the last took place at another DOC office building. The one interview of an alleged perpetrator who was a person in custody interview for which the location was recorded took place in the housing unit.

Of the 19 interviews carried out with witnesses, the location is only recorded in two instances. In both cases the interviews took place in the housing unit. Again, as with the location of victim and perpetrator interviews, the lack of specific detail included within the reports makes it impossible to conclude how many, if any, of the witnesses in the audit sample were interviewed confidentially.

6) In almost all cases, alleged victims were reported as being offered some post-incident services after DOC received their allegation. [24]

i) <u>In nearly all cases, alleged victims were reported as being seen by medical and mental health services.</u>

In 39 of the 42 cases audited (93%), the alleged victim was reported as being seen by medical and mental health staff following the allegation. In two cases the data was missing and in the final case the alleged victim refused both services.

ii) <u>In nearly all cases, alleged victims were reported as being seen by victim services.</u>

[24] Minimum Standard 5-37, in accordance with PREA Standard 115.82, requires that people in custody who are victims of sexual abuse must be provided with timely and unimpeded access to free emergency medical treatment and crisis intervention services.

In 38 of the 42 cases (90%), referral is recorded as being made. The data are missing in three cases and, in the last case, the alleged victim refused the referral.

iii) <u>There were no hospital or urgent care referrals in the 22 allegations of sexual assault or abuse.</u>

It is important to note that, based on the information provided in the investigation reports, there is no evidence to suggest that these decisions were inappropriate. However, the reports do not contain enough information to demonstrate this conclusively. In two cases the data is missing.

7) In 41% of sexual abuse allegations (n= 9), there is insufficient information recorded regarding the establishment of a crime scene.[25]

In one of the 22 allegations of sexual abuse the investigator secured a crime scene. In this case, a witness referred to bodily fluid on bedding. In 12 further abuse allegations, the investigator recorded brief information about why they had not established a crime scene. In nine of the 22 cases (41%) there was insufficient information included about this aspect of the investigation. More comprehensive explanation of the decisions made by investigators on the securing of crime scenes would improve the thoroughness of their reports.

[25] Minimum Standard 5-10 (a) to (c), in accordance with PREA Standard 115.21 (a) to (c), requires that the Department follow a uniform protocol that maximizes the potential for obtaining usable physical evidence for administrative proceeding and criminal prosecutions. In addition, the Department's Division Order # 04/16, dated July 2015, section IV. H states that: "Investigators must determine whether or not a crime scene has been established. Upon release to the scene, ID investigators will assume control of the crime scene. If no crime scene has been established, investigators will immediately determine the location of the crime scene and establish a crime scene, if applicable. If circumstances surrounding the allegation dictate reasons not to establish a crime scene, reasons shall be recorded in the case folder."

8) In about a quarter of cases, the investigations included a review of all available testimonial evidence such as monitoring information, records and witness statements. [26]

In 11 of the 42 cases (26%), the investigator demonstrated that they reviewed all available evidence.[27] In 18 cases (43%) it is only possible to ascertain that a partial review of available evidence has taken place. In the remaining 13 cases (31%) it appears from the information in the Closing Reports that relevant available evidence was not reviewed.

9) Just over half of the investigations included a review of physical evidence.[28]

Physical evidence (such as Genetec, handheld video footage or evidence such as bedding or clothes) appeared to be assessed more consistently than testimonial evidence. In 23 of the 42 cases (55%), physical evidence was directly referred to in the Closing Report. In 15 cases (36%), physical evidence appeared to have been only partially assessed and in 4 cases (10%), there was no indication at all of what physical evidence was available and what had been assessed. Reports did not consistently refer to what evidence has been considered but discounted as a useful source. For example, it was not always possible to ascertain whether Genetec video evidence was unavailable – or whether it was available but had been determined not to be relevant to the investigation.

10) Investigators generally failed to review prior allegations against the alleged perpetrator.[29]

The investigator included information about prior allegations against the alleged perpetrator in only 4 of the 42 cases (10%). It was not clear from the remaining 90% of cases whether the

[26] The Board's Minimum Standard 5-30 (f), in line with PREA standard 115.71 (f), requires that all investigations must include an effort to determine whether staff actions or failures to act contributed to the abuse, and must be documented in written reports that include a description of the physical, testimonial and documentary evidence, the reasoning behind credibility assessments, and investigative facts and findings.
[27] This includes direct or indirect evidence such as electronic monitoring data, statements or incident reports.
[28] See *supra* note 26.
[29] The Board's Minimum Standard 5-30 (c) requires that Investigator must review prior complaints and reports of sexual abuse involving the suspected perpetrator. This is also a requirement of PREA Standard 115.71 (c).

alleged perpetrator's history had not been reviewed by the investigator – or whether it had been reviewed and deemed not relevant to the current allegation.

11) In half of the cases, the investigator adequately performed credibility assessments.[30]

In 21 cases (50%) the report included a clear indication of how the investigator decided on the credibility of the various witnesses.[31] In the other 50% there is no meaningful discussion of the how the investigator has explored the credibility of the individuals providing evidence.

12) In half of the cases, the investigator adequately described their reasoning of what is substantiated.

In 21 cases (50%) the report included a clear indication of how the investigator has decided on what is substantiated. In the other 50% there is no specific explanation of what elements of the allegation have been verified or disproved.

13) One of the 42 investigations concluded that staff actions or failures contributed to the incident.[32]

In this case, the allegation was one of sexual assault by one person in custody against another. Investigators determined that the member of staff in question had failed to carry out the required observation checks thus provided a lack of supervision in the area in which the sexual assault occurred and had falsified records in relation to this.

14) DOC found forty-one of the 42 allegations (95%) unsubstantiated or unfounded.

One allegation was substantiated and resulted in a recommendation on staff training (an inmate on inmate harassment allegation). In another case (the above case of alleged sexual assault by one person in custody against another referenced at point 13), the allegation was unfounded but

[30] Credibility assessments were deemed adequate if they included a discussion of the consistency and plausibility of the account provided by the individual and whether objective evidence corroborated the account.
[31] The Board's Minimum Standard 5-30 (e) requires that the credibility of a victim, suspect or victim must be assessed on an individual basis and cannot be determined by the person's status as a person in custody or as staff. This is in accordance with PREA Standards 151.71 (e) and (f).
[32] See *supra* note 26.

charges against a staff member resulted from their failure to conduct adequate checks and their related falsification of records.

In a third case, ID found the allegation of staff on inmate abuse during a search to be unfounded, however, they brought charges against the staff member in relation to the inappropriate use of chemical agent during the search.

15) Victims were informed of the investigation results in a quarter of cases audited.[33]

In 11 of the 42 cases (26%) the alleged victim was still in DOC custody at the conclusion of the investigation. In nine of 11 (82%) of these cases a determination letter was sent. In 26 cases (62%) the alleged victim is recorded as no longer in DOC custody (and thus DOC is not required by the Minimum Standards to send a determination letter). Two of those individuals were sent determination letters regardless. In the remaining five cases (12%), the information about determination letters and the alleged victim's location is missing.

[33] The Board's Minimum Standard 5-32 (a), in line with PREA standard 115.73 (a), requires that, at the conclusion of an investigation, DOC informs the alleged victim whether the allegation has been determined to be substantiated, unsubstantiated or unfounded.

DISCUSSION & RECOMMENDATIONS

This section of the report synthesizes the finding from the audit and outlines the Board's recommendations on the specific steps needed to improve the Department's PREA investigation Closing Reports.

1) **There are significant gaps in the Department's investigations of sexual abuse and sexual harassment in the City's jails.**

In 55% of cases audited (n=23) at least some required information was missing from the Closing Report. The most frequently occurring omission was a date and signature[34] by a supervisor and/or a second more senior member of supervisory staff: 14 of the 42 (33%) cases did not have one or both of these signatures recorded. Without the signatures of a supervisory member of staff, it is not clear that an investigation was subjected to appropriate oversight and scrutiny before it was closed.

In two cases (5%) the dates recorded for key investigative events, such as the interviewing of a victim, were clearly inaccurate (such as indicating that the victim interview took place before the alleged incident).

Some of the omissions are particularly significant. The alleged victim was interviewed in 39 of the cases but in only nine of those did the investigator provide information on where that interview took place. This means that in 76% of the cases (n=30) it is not possible to know whether DOC is meeting the Minimum Standards' requirement to conduct interviews confidentially and away from housing areas.[35]

In the majority of the reports audited, it was not clear how investigators had identified who to interview and who they did not need to interview. It is crucial, given the complexity of investigations, that the reports produced are clear and informative about the methodology that

[34] Different versions of the reporting form state different titles as the required secondary supervisory signature: some reference a Deputy Commissioner while others refer to Deputy Director.
[35] See *supra* note 18.

has been used. By way of example, one allegation that was examined as part of this audit was against a staff member. The individual was on sick leave and so, it would appear, was not interviewed. There is no explanation of how long this person was unavailable or whether any interview was ever carried out. In addition, there is no indication that this was questioned by the supervising staff members who ultimately signed the investigation report.

It is noteworthy that in only one of the 42 cases audited, a secure crime scene is reported as being established. While it is entirely reasonable that a crime scene is not always warranted, in 41% of the allegations of sexual abuse there is no explanation of how this decision was reached. The preservation of evidence is of crucial importance to any investigation and it should be routine practice to record what attempts have been made to do so as part of an investigation report.

RECOMMENDATION 1: ***The Department should re-train investigative staff to record complete and comprehensive information in relation to every stage of their investigation, including the reasons why apparently key interviews do not take place and the steps taken to determine the need to secure a crime scene.***

RECOMMENDATION 2: ***The Department must ensure that supervisory investigative staff are adequately trained and resourced to appropriately oversee PREA investigations. This should include working with investigators to address omissions in Closing Reports before they are finalized.***

2) **The investigation reporting format, including the Department's June 2018 update to the form, is not sufficient to record the detail regarding the precise investigative steps that have been taken in relation to interviews and available evidence.**

DOC recently made revisions to the template report used by ID investigators. While there are some positive additions in the revised version, other sections have been removed which may result in less rather than more comprehensive recording of information.

It is positive that the revised version of the report form includes a prompt for the author to record the details of the referrals to medical and support services for victims. However, the new form, in contrast to the previous version, does not contain separate sections such as 'summary of video evidence' or 'summary of staff reports.'

On both the original and revised report template, there is an insufficient requirement to record the detail regarding the precise investigative steps that have been taken in relation to interviews. Neither report template appears to prompt the author to explain the reasoning for who they interview or attempted interviews and where and how they do this.

The form needs to prompt Investigators to record more precise information on interviews such as who is interviewed, on what basis and when and where the interview took place. For example, if an alleged perpetrator was not interviewed, the report should clearly explain the steps the investigator took to attempt the interview.

RECOMMENDATION 3: ***The Department should amend the Closing Report template to ensure that investigators can clearly follow the requirements and record the comprehensive information required by the Board's Minimum Standards and the PREA Standards. The form should include sections and guidance for fully explaining the different sources of evidence the investigation has considered or decided not to consider. In addition, the report template should be electronic and require that all elements are populated before the report can be completed.***

3) **The PREA investigations audited were not completed in a timely manner. Significant delays in an investigation threaten the legitimacy and accuracy of its outcomes.**

Of the 42 Closing Reports, only one (2%) was closed within the 90 days required by the Board's Minimum Standards.[36] Twenty-eight were not closed within the required time period and the

[36] See *supra* note 7.

remaining 13 investigation reports were incomplete so it was not possible to establish when the investigation was closed.

For the cases in which data was available, the average time between an allegation being received by ID and an investigator signing the complete investigation report was 476 calendar days. This equates to approximately one year and four months: 13 months longer than is required by the Minimum Standards.

However, as previously outlined, an investigation cannot be considered closed until it has been reviewed and endorsed by a supervisory member of staff. A supervisor's signature was missing in one-third (33%) of the cases. Where there was a supervisor's signature, the majority (65%) were signed on the same day the investigator signed. The Board encourages prompt investigations and supports a process that does not build in delays at the supervisory level. However, it is concerning that in many cases investigations that appear to have omissions and gaps which a supervisor should have identified, were signed by supervisors on the same day as investigators. By way of example, in eight investigations where the supervisor signed the report on the same day as the investigator, there was no perpetrator interview and this does not appear to have been questioned by the supervisor. Given the flaws observed by the Board as part of this audit, it is concerning that supervisors do not appear to be identifying these gaps and requiring that they be rectified.

There are also some concerning instances of excessive delays in the conclusions of investigations. In one case, there was a delay of 899 days between the date the allegation was received by ID and the date a final supervisory signature was added to the report. It is important to acknowledge that much of the investigatory work in this case was carried out promptly and so it is unclear why there was an extended delay in concluding it.

The requirements of both the PREA Standards and the Board's Minimum Standards clearly articulate that timely investigations of allegations are imperative to accurate and just outcomes. It is particularly concerning to the Board that, in audited reports, there were no clear investigative reasons for the delays. Indeed, the Board's audit demonstrated that, in the vast majority of cases,

initial investigative tasks ***are*** conducted promptly upon notification of an allegation. It is imperative that the Department examines what causes the delays in meeting the timeliness requirements in these investigations and establish how to address these issues.

RECOMMENDATION 4: ***The Department must take steps to address the extended delays in completing PREA investigations as a matter of urgency, including conducting an internal audit of the reason for delays in investigations being concluded. The Department should identify if (and how many) additional staff numbers (both investigative and supervisory) and training are required to complete all investigations thoroughly and within 90 days of allegation. The City should make available additional resources as necessary. In addition, the Department should use the internal audit to identify specifically where revisions to the investigative process can improve the timeliness and quality of the investigations.***

RECOMMENDATION 5*: The Board should carry out an annual audit of the Department's PREA Closing Reports to monitor their quality and timeliness.*

4) The Department's PREA investigations do not include adequate information about investigative methodology such as interviewing and evidence analysis.

i) Interviewing

It is concerning that there are examples of attempts made to interview staff but then a lack of information about whether these attempts were ever successful. In a sizable number of cases (12%, n=5) there is a direct allegation against a member of staff and an inadequate explanation for why that staff member was not interviewed.

In addition to concerns about the decisions on when to conduct interviews, there are also significant gaps in the information about the location of interviews when they do take place. Because of the lack of specific detail included within the reports, it is not possible to say conclusively how many, if any, of the alleged victim, perpetrator or witness interviews took place confidentially, a specific requirement of the Minimum Standards and PREA Standards.[37]

[37] See *supra* note 7.

RECOMMENDATION 6: ***The Department must ensure that investigative and supervisor staff are aware of, and comply with, the requirements of the Board's Minimum Standard 5-30 (q), including only conducting interviews of people in custody outside of the housing area and in a private and confidential setting. All Closing Reports should include information about the location of interviews conducted as part of the investigation.***

ii) Analysis of evidence, including prior allegations against perpetrator

It was only clear in 11 of the 42 cases (26%) audited that the investigator had reviewed all available evidence. In addition, in only half of the cases reviewed did the investigator adequately discuss how they established the credibility of the victim, perpetrator or witnesses. Similarly, in half of the cases it is not clearly articulated exactly which elements have been verified or disproved.

In 90% of cases it was not possible to determine whether the alleged perpetrator's prior history of allegations had been reviewed but determined not relevant – or whether they had not been examined. All of the above are important elements of a thorough and robust investigation and it is crucial that they are adequately articulated in Closing Reports.

RECOMMENDATION 7: ***The Department must ensure that PREA Closing Reports contain comprehensive information about the evidence analysis carried out as part of the investigation. Specifically, reports need to refer to: who is selected for interviews and why; how the investigator established the credibility of their information; and whether there was relevant historical information available about the alleged perpetrator.***

5) **The majority of alleged victims who were still in DOC custody at the conclusion of the investigation were advised of the outcome but that meant that only a quarter of alleged victims learned about the conclusion of the investigation into their claim.**

In 11 of the 42 cases (26%) the alleged victim was still in custody at the conclusion of the investigation. This is not surprising since the average length of stay in DOC custody is 68 days.[38] The Board was encouraged to observe that the majority of those individuals (82%, n=9) received notification of the outcome. More encouraging still was that in another two cases a letter was sent to the victim even when they were no longer in the Department's custody, a practice that the Board believes should become routine.

<u>RECOMMENDATION 8:</u> Investigative staff should attempt to notify victims of the outcome of investigations, regardless of whether they are still in the Department's custody.

[38] Data available at: https://www1.nyc.gov/assets/doc/downloads/press-release/DOC_At%20a%20Glance-entire_FY%202018_073118.pdf

Appendix 1: Case Summary Details

Key:

N=No

Y=Yes

P=Partial

Table 1: Case summaries for allegations of Staff on Inmate Sexual Abuse/Assault

Case number	3	5	11	12	22	24	31	32	34	35	36	38	Totals (cases=12)
Date allegation received by ID	04/25/16	05/04/16	08/05/16	08/12/16	04/01/16	04/14/17	03/08/17	03/14/17	10/25/17	12/23/17	11/24/17	10/11/17	N/A
Alleged victim interviewed within 72 hours	Y	Y	Y	N	Y	Y	Y	Missing data	Y	Attempted	Y	Y	Yes=9 No=1 Attempted=1 Missing date=1
Calendar days between allegation received by ID and signed as complete by Investigator	589	571	Missing data	Missing data	661	701	Missing data	Missing data	239	186	208	168	Calculation for 8 cases: Mean no of days=414
Calendar days between allegation signed by Investigator and signed by Supervisor	0	Missing data	Missing data	Missing data	6	5	Missing data	Missing data	5	0	0	1	Calculation for 7 cases: Mean no of days=2
Investigation completed within 90 days	N	N	Missing data	Missing data	N	N	Missing data	Missing data	N	N	N	N	N=8 Data missing=4
Interviewed alleged victim	Y	Y	Y	Y	Y	Y	Y	Y	Refused	Y	Y	Y	Y=11 Refused=1
Location of victim interview	Missing data	Missing data	Missing data	Telephone	Missing data	Missing data	Missing data	Missing data	n/a	Missing data	Missing data	Missing data	Telephone=1 Data missing=10 N/a = 1
Interviewed alleged perpetrator	Y	Y	N	Y	Y	Y	N	N	N	Y	N	N	Y= 6 N=6
Location of perpetrator interview	Missing data	Missing data	n/a	Missing data	ID HQ	Missing data	n/a	n/a	n/a	Missing data	n/a	n/a	ID HQ=1 Missing data=5 N/a=6
Interviewed witnesses	Y	Y	N	N	Refused	N	N	Y	N	N	No-at victim's request	Y	Y=4 No=6 Refused=1 No at victim's request=1
Location of witness interview	Missing data	Missing data	n/a	n/a	n/a	n/a	n/a	Missing data	n/a	n/a	n/a	Missing data	N/a=8 Missing data=4
Secure crime scene	N	N	N	N	N	N	N	N	N	N	N	N	N=12

Review of physical evidence	Y	Y	P	P	P	P	Y	Y	Y	Y	Y	Y	Y=8 Partial=4
Reports that patient seen by medical	Y	Y	Inaccurate report (Victim not identified)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y=10 N=1 Reporting error=1
Reports that patient seen by Mental Health	Y	Y	Inaccurate report (Victim not identified)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y=12 Reporting error=1
Reports that patient informed of victim services	Y	Y	Inaccurate report (Victim not identified)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y=11 Reporting error=1
Report that patient seen by urgent care	N	N	N	N	N	N	N	N	N	N	N	N	N=12
Report that patient referred to hospital	N	N	N	N	N	N	N	N	N	N	N	N	N=12
Review of testimonial evidence, witnesses, monitoring etc.	P	Y	P	N	P	P	P	N	N	Y	P	P	Y=2 N=3 P=7
Review of prior allegation against perpetrator	N	N	N	N	N	N	N	N	N	N	N	N	N=12
Describes reasoning of credibility assessments	N	Y	N	N	N	N	Y	N	Y	Y	Y	N	N=7 Y=5
Describes reasoning of what is substantiated	N	N	N	N	N	N	Y	N	Y	Y	Y	N	N=8 Y=4
Gives account of facts	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y=12
Finds staff actions contributed to incident	N	N	N	N	N	N	N	N	N	N	N	N	N=12
Finds staff failures or omissions contributed to incident	N	N	N	N	N	N	N	N	N	N	N	N	N=12
Outcome of investigation	U	U	U	U	U	U	U	U	U	U	U	U	U=12

Determination letter sent	N	N	Data missing	N	N	N	Y	Y	N	Y	Y	N	N=7 Y=4 Missing data=1

Table 2: Case summaries for allegations of Inmate on Inmate Sexual Abuse/ Assault

Case number	2	10	14	20	23	27	37	40	41	42	Totals (cases=10)
Date allegation received by ID	05/14/16	09/19/14	08/21/16	12/29/16	04/12/16	02/25/16	07/03/16	09/28/16	09/03/16	08/05/16	N/A
Alleged victim interviewed within 72 hours	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y=9 N=1
Calendar days between allegation received by ID and signed as complete by Investigator	886	33	388	187	708	513	626	638	662	684	Calculation for 10 cases: Mean number of days=533
Calendar days between allegation signed by Investigator and signed by Supervisor	Missing data	0	0	1	0	49	0	0	0	0	Calculation for 9 cases: Mean number of days=6
Investigation completed within 90 days	N	Y	N	N	N	N	N	N	N	N	N=9 Y=1
Interviewed alleged victim	Y	Y	Y	Y	Y	Refused	Y	Y	Y	Y	Y=9 Refused=1
Location of victim interview	Missing data	Missing data	Missing data	Missing data	Missing data	n/a	Missing data	Missing data	Housing Unit	Missing data	N/A=1 Housing Unit=1 Missing data=8
Interviewed alleged perpetrator	Y	N	N	Y	Refused	Y	N	Y	Y	Refused	Y=5 N=3 Refused=2
Location of perpetrator interview	Missing data	n/a	n/a	Missing data	n/a	Missing data	n/a	Missing data	Housing Unit	n/a	N/A=5 Housing Unit=1 Missing data=4
Interviewed witnesses	N	N	N	Y	Y	Refused	N	Y	Y	Y	Y=5 N=4 Refused=1
Location of witness interview	n/a	n/a	n/a	Missing data	Missing data	n/a	n/a	Missing data	Missing data	Missing data	N/A=5 Missing data=5
Secure crime scene	N	N	N	Y	N	N	N	N	N	N	N=9 Y=1
Review of physical evidence	P	N	P	Y	Y	P	P	P	Y	Y	P=5 Y=4 N=1
Reports that patient seen by medical	Y	Y	Y	Y	Y	Missing data	Y	Y	Y	Y	Y=9 Missing data=1
Reports that patient seen by Mental Health	Y	Y	Y	Y	Y	Missing data	Y	Y	Y	Y	Y=9 Missing data=1

Reports that patient informed of victim services	Missing data	Y	Y	Y	Y	Missing data	Y	Y	Y	Y	Y=8 Missing data=2
Report that patient seen by urgent care	N	Missing data	N	N	N	Missing data	N	N	N	N	N=8 Missing data=2
Report that patient referred to hospital	N	Missing data	N	N	N	Missing data	N	N	N	N	N=8 Missing data=2
Review of testimonial evidence, witnesses, monitoring etc.	N	N	P	Y	Y	P	N	N	Y	Y	Y=4 N=4 P=2
Review of prior allegation against perpetrator	N	N	N	Y	N	N	N	N	N	N	N=9 Y=1
Describes reasoning of credibility assessments	N	N	Y	Y	Y	N	Y	Y	Y	Y	Y=7 N=3
Describes reasoning of what is substantiated	N	N	Y	Y	Y	N	Y	Y	Y	Y	Y=9 N=1
Gives account of facts	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y=10
Finds staff actions contributed to incident	N	N	N	N	N	N	N	N	N	N	N=10
Finds staff failures or omissions contributed to incident	N	N	N	Y	N	N	N	N	N	N	N=9 Y=1
Outcome of investigation	U	U	U	CH	U	U	U	U	U	U	U=9 CH=1
Determination letter sent	N	Missing data	N	Y	N	Missing data	N	N	Missing data	N	N=6 Missing data=3 Y=1

Table 3: Case summaries for allegations of Staff on Inmate Sexual Harassment

Case number	1	4	9	13	16	17	18	21	25	26	28	29	39	Totals (cases=13)
Date allegation received by ID	02/03/16	04/05/17	06/14/16	08/24/16	10/2/16	11/24/16	Missing data	04/28/16	01/31/17	01/27/17	Missing data	02/01/16	11/14/17	N/A
Alleged victim interviewed within 72 hours	Y	Y	Y	Y	Y	Missing data	Y	Y	Y	Y	Y	Y	Y	Y=12 Missing data=1
Calendar days between allegation received by ID and signed as complete by Investigator	548	Missing data	532	Missing data	353	Missing data	Missing data	790	425	464	161	750	224	Calculation for 9 cases: Mean number of days=472
Calendar days between allegation signed by Investigator and signed by Supervisor	0	Missing data	0	Missing data	23	Missing data	Missing data	Missing data	28	0	0	1	0	Calculation for 8 cases: Mean number of days=7
Investigation completed within 90 days	N	Missing data	N	Missing data	N	Missing data	Missing data	Missing data	N	N	N	N	N	N=8 Missing data=5
Interviewed alleged victim	Y	No - victim not identified	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y=12 N=1
Location of victim interview	Missing data	n/a	Missing data	Missing data	Housing Unit	Missing data	Housing Unit Pantry	Missing data	Missing data	Missing data	Missing data	Missing data	Housing Unit Pantry	Missing data=9 Housing Unit Pantry=2 Housing unit = 1 N/A=1
Interviewed alleged perpetrator	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	Y=9 N=4
Location of perpetrator interview	Missing data	ID HQ	Missing data	Missing data	Alleged perpetrator's office	Missing data	Missing data	Missing data	Missing data	n/a	n/a	n/a	n/a	Missing data=7 N/A=4 ID HQ=1 Alleged Perpetrator's office=1
Interviewed witnesses	Y	Y	Y	N	N	Y	N	N	Y	N	N	N	Y	Y=6 N=7
Location of witness interview	Housing Unit	Missing data	Missing data	n/a	n/a	Housing Unit Pantry	n/a	n/a	Missing data	n/a	n/a	n/a	Missing data	N/A=7 Missing data=4 Housing Unit=1 Housing Unit Pantry=1
Secure crime scene	N	N	N	N	N	N	N	N	N	N	N	N	N	N=13
Review of physical evidence	Y	Y	Y	P	Y	P	P	P	Y	N	Y	N	Y	Y=7 P=4 N=2

Reports that patient seen by medical	Y	Inaccurate report? Victim not identified	Y	Y	Y	Y	Y	Missing data	Y	Y	Y	Y	Y	Y=11 Missing data=1 Inaccurate reporting=1
Reports that patient seen by Mental Health	Y	Inaccurate report? Victim not identified	Y	Y	Y	Y	Y	Missing data	Y	Y	Y	Y	Y	Y=11 Missing data=1 Inaccurate reporting=1
Reports that patient informed of victim services	Y	Inaccurate report? Victim not identified	Y	Y	Y	Y	Y	Missing data	Y	Y	Y	Y	Y	Y=11 Missing data=1 Inaccurate reporting=1
Report that patient seen by urgent care	N	N	N	N	N	N	N	Missing data	N	N	N	N	N	N=12 Missing data=1
Report that patient referred to hospital	N	N	N	N	N	N	N	Missing data	N	N	N	N	N	N=12 Missing data=1
Review of testimonial evidence, witnesses, monitoring etc.	Y	N	Y	Y	N	N	P	P	Y	P	P	N	N	N=5 P=4 Y=4
Review of prior allegation against perpetrator	N	N	N	Y	Y	N	N	N	Y	N	N	N	N	N=10 Y=2
Describes reasoning of credibility assessments	N	Y	Y	N	N	N	N	Y	Y	Y	N	N	Y	Y=6 N=7
Describes reasoning of what is substantiated	N	Y	Y	N	N	Y	N	N	Y	Y	N	N	Y	Y=6 N=7
Gives account of facts	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y=13
Finds staff actions contributed to incident	N	N	N	N	N	N	N	N	N	N	N	N	N	N=13
Finds staff failures or omissions contributed to incident	N	N	N	N	N	N	N	N	N	N	N	N	N	N=12
Outcome of investigation	U	U	U	U	U	U	U	U	U	U	U	U	U	U=13
Determination letter sent	N	Yes- but not to victim	N	N	N	N	Y	Missing data	N	N	N	N	N	N=10 Y= 1 Y (but not to victim)=1 Missing data=1

Table 4: Case summaries for allegations of Inmate on Inmate Sexual Harassment

Case number	**6**	**7**	**8**	**15**	**19**	**30**	**33**	**Totals (cases=7)**
Date allegation received by ID	05/20/16	06/16/16	06/20/16	11/10/16	12/07/16	02/12/17	03/14/17	N/A
Alleged victim interviewed within 72 hours	Y	Y	Y	Y	Y	Y	Y	Y=7
Calendar days between allegation received by ID and signed as complete by Investigator	553	Missing data	Missing data	Missing data	Missing data	477	363	Calculation based on 3 cases: Mean number of days=464
Calendar days between allegation signed by Investigator and signed by Supervisor	0	Missing data	Missing data	Missing data	Missing data	0	Missing data	Calculation based on 2 cases: mean number of days=0
Investigation completed within 90 days	N	Missing data	Missing data	Missing data	Missing data	N	N	Missing data=4 N=3
Interviewed alleged victim	Y	Y	Y	Y	Y	Y	Y	Y=7
Location of victim interview	Missing data	Visits	Visits	Missing data	Missing data	Housing Unit	Missing data	Missing data=4 Visits=2 Housing Unit=1
Interviewed alleged perpetrator	Y	Y	Refused	Y	Refused	N	Refused	Y=3 Refused=3 N=1
Location of perpetrator interview	Missing data	Missing data	n/a	Missing data	n/a	n/a	n/a	N/A=4 Missing data=3
Interviewed witnesses	Y	Refused	N	Y	Y	Y	Y	Y=5 Refused=1 N=1
Location of witness interview	Missing data	n/a	n/a	Missing data	Missing data	Missing data	Missing data	Missing data=5 N/A=2
Secure crime scene	N	N	N	N	N	N	N	N=7
Review of physical evidence	Y	P	P	Y	Y	Y	Y	Y=5 P=2
Reports that patient seen by medical	Y	Y	Y	Y	Y	Y	Y	Y=7
Reports that patient seen by Mental Health	Y	Y	Y	Y	Y	Y	Y	Y=7
Reports that patient informed of victim services	Y	Y	Y	Y	Y	Y	Y	Y=7
Report that patient seen by urgent care	N	N	N	N	N	N	N	N=7
Report that patient referred to hospital	N	N	N	N	N	N	N	N=7
Review of testimonial evidence, witnesses, monitoring etc.	P	P	N	Y	P	P	P	P=5 Y=1 N=1
Review of prior allegation against perpetrator	N	N	N	N	N	N	N	N=7
Describes reasoning of credibility assessments	Y	N	N	Y	N	N	Y	N=5 Y=3

Describes reasoning of what is substantiated	Y	Y	N	Y	N	N	Y	Y=4 N=3
Gives account of facts	Y	Y	Y	Y	Y	Y	Y	Y=7
Finds staff actions contributed to incident	N	N	N	N	N	N	N	N=7
Finds staff failures or omissions contributed to incident	N	N	N	N	N	N	N	N=7
Outcome of investigation	U	U	U	SUB	U	U	U	U=6 SUB=1
Determination letter sent	N	Y	Y	Y	N	N	Y	Y=4 N=3

Appendix 2: Audit Pro Forma

General case information			
Type of allegation (select from list)	Staff on Inmate sexual assault/ abuse ◯ Inmate on Inmate sexual assault/ abuse ◯ Staff on Inmate sexual harassment ◯ Inmate on Inmate sexual harassment ◯		
Indication that allegation is related to use of force?	Yes- and formally recorded as such ◯ Yes- but not formally recorded as such ◯ No ◯		
Facility and specific location within it			
Timeframes			
	Date	**No. of calendar days**	**No. of working days**
Date of incident			
Date reported			
Date received by ID			
Date case opened			
Date case assigned			
Inmate making allegation interviewed within 72 hours of ID receiving allegation			
Any staff person suspended/ placed on modified duty/ reassigned to no inmate contact within 72 hours pending investigation			
Indication of staff immunity?			
Staff interviews completed within 30 days of immunity grants			
	Date signed by investigator	**Calendar days between Ref. to ID and Investigator signature**	**Working days between Ref. to ID and Investigator signature**
Time between case opened and 'closed' (days between **referral to ID** and then **signed by investigator**)			
	Date signed by Supervisor	**Calendar days between Investigator signature & Supervisor signature**	**Working days between Investigator signature & Supervisor signature**
Time from **investigator sign-off** to **supervisor signature**			

	Date signed by most senior DOC staff	**Calendar days between Supervisor signature & most senior DOC signature**	**Working days between Supervisor signature & most senior DOC signature**
Time from **supervisor sign-off** to **most senior signature**			
Investigation completed within 90 days of receipt of allegation?			
Investigation methodology			
Investigator with specialist training (record names of investigator and cross reference at latter date with training records?)			
Interviewed alleged victim			
Location of alleged victim interview			
Interviewed alleged perpetrator			
Location of alleged perpetrator interview			
Interviewed witnesses			
Location of witness interviews			
Compelled interviews conducted			
Location of compelled interviews			
Secure crime scene established. If not, is there an explanation of why not?			
Review of physical evidence: CCTV, DNA, documentary			
Report records that patient seen by Medical	Yes ◯ No ◯		
Report records that patient seen by Mental Health	Yes ◯ No ◯		
Report records that patient informed of Victim Services	Yes ◯ No ◯		
Report records that patient seen by Ministerial Services	Yes ◯ No ◯		
Report records that patient seen by Urgent Care	Yes ◯		

	No ◯
Report records that patient referred to Hospital	Yes ◯ No ◯
Report records that Sexual Abuse Evidence Kit (SAEK) Prepared	Yes ◯ No ◯
If SAEK prepared, details of when/ where are recorded	Yes ◯ No ◯ N/A ◯
Report records that NYPD Complaint Report (NYPDCR) prepared	Yes ◯ No ◯
If NYPDCR prepared, details of when/ where are recorded	Yes ◯ No ◯ N/A ◯
Report records that property voucher completed	Yes ◯ No ◯
If property voucher prepared, details of when/ where are recorded	Yes ◯ No ◯ N/A◯
Report records that Lab Assessment requested	Yes ◯ No ◯
If Lab assessment requested, details of when/ where are recorded	Yes ◯ No ◯ N/A◯
Review of testimonial evidence: witnesses, relevant monitoring data	
Review of prior allegations made by alleged victim	
Review of complaints in relation to alleged perpetrator	
Inclusion of allegations of incidents at other facilities reported to those facilities	
Investigation outcomes	
Describes reasoning of credibility assessments	
Describes reasoning of assessment of what is and what isn't substantiated	
Gives account of facts established	
Provides summary of findings	

Staff actions contribute to incident	
Staff failures or omissions contribute to incident	
Report of outcomes to inmate who made allegation. If not, any explanation of why not	
Outcome of investigation	Substantiated ◯ Unsubstantiated ◯ Charges ◯ No charges ◯
Inmate alleged victim still in custody at closing	Yes ◯ No ◯
Determination letter sent	Yes ◯ No ◯
Brief notes on case	

Appendix 3: Timeframes Between Investigative Stages

i) Time elapsed between received by ID and investigator signature

In 11 of the 42 cases (26%) there was no investigator signature on the report. For the 31 cases where this data was available, the average time between an allegation being received by ID and an investigator signing the complete investigation report was 476 calendar days.

ii) Time elapsed between investigator signature and supervisor signature

In 14 of the 42 cases (33%) there was no supervisor signature on the report. Of the remaining 28 cases, two did not have an investigator signature. For the 26 cases where both signatures were provided, the average (mean) time between the investigator signature and the supervisor signing the report was five calendar days.[39] It is important to note, however, that in 17 of the 26 cases (65%) the investigator and supervisor signatures occur on the same day. In three of the 26 cases with data, there is an extended period between the investigator and supervisor signatures (23, 28 and 49 days respectively). These three cases are 'outliers' as all other cases for which there is a date, the reports were signed by a supervisor within six days of the investigator's signature.

iii) Time elapsed between supervisor signature and secondary supervisor signature

In 11 of the 42 cases (26%) there was no secondary supervisor signature on the report. Of the remaining 31 cases, five did not have a supervisor signature. For the 26 cases where both signatures were provided, the average (mean) time between the supervisor signature and the secondary supervisor signing the report was 28 calendar days. [40] In the majority of the 26 cases for which there was data (54%, n=14), the secondary supervisor signature occurred on the same day as the supervisor's signature. In the other 12 cases, there was a

[39] Median was 0 calendar days.
[40] Median was 0 calendar days.

wide variation in the time between the report being signed by the supervisor and the secondary supervisor with a range of between five and 181 days.[41]

[41] The time periods between the signature were as follows: five days (*two cases*); 11 days; 14 days; 20 days; 34 days; 61 days; 75 days; 97 days; 108 days; 124 days and 181 days respectively.

Appendix 4: Revisions

To allow for the Department to provide feedback on the report and draft a public response, Board staff shared a draft of this report with the Department prior to publication, as is the Board's practice. Board staff appreciates the Department's thoughtful and timely response, published alongside this report.

Responsive to the Department's feedback, Board staff made the following changes:

- The Department notes three cases it believes were mis-categorized in the report (ie a sexual harassment allegation was counted as a sexual abuse allegation). Board staff corrected one of the three cases. Board staff believe the other two were categorized correctly. One of these two was a result of miscommunication between the Board and the Department.
- Amended the report to reflect that in 12 of the 22 cases involving an allegation of sexual abuse, although no crime scene was established, the investigator did include some information about the reasons for this.
- Amended the report to reflect that, in the vast majority of cases, the alleged victim was interviewed within the required 72 hours however, the audit did not find that all key investigative steps were completed within this time so the report only refers to alleged victim interviews.
- Amended the report to reflect that in all cases where the perpetrator interviews did not take place (n=19), it was possible to ascertain the reasons why this did not happen.
- Amended the report to reflect that in six of the 12 cases involving an allegation of staff assaults on a person in custody, the investigator did make some reference to DOI being informed of the allegation. In the other six cases, there was no record of this. The report was also revised to reflect information from DOC that all 12 such cases were reported to DOI as required.