

***Supplementary 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

April 2019

EXECUTIVE SUMMARY

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. The Board's Minimum Standards on the elimination of sexual abuse and sexual harassment in correctional facilities¹ require DOC to meet federal PREA requirements and a number of additional regulations around timely and robust investigation methodology and accurate reporting.

In September 2018 the New York City Board of Correction (or the Board) published an audit of the New York City Department of Correction's (DOC or the Department) Closing Reports of investigations into allegations by people in custody of sexual abuse or harassment. The report found significant deficiencies in the Department's process for reviewing allegations of sexual abuse and harassment and offered recommendations for the Department to adopt in order to improve the quality and timeliness of investigations.

In response to the audit's findings, and as an indication of the urgent need for reform, the Board approved a unanimous resolution in October 2018. The Resolution required the Department to produce a Corrective Action Plan for implementing: (1) the audit's eight recommendations; (2) any other steps necessary for the Department to achieve compliance with Minimum Standards §5-30 and §5-40; and (3) a computerized case management system for sexual assault and sexual harassment allegations.

In February 2019, the Department provided a corrective action plan including a response to the Board's eight recommendations issued in the audit:

¹ 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](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)

Board’s September 2018 Recommendations:	Department of Correction February 2019 Response:
<p>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.</p>	<p>The Department completed this goal. Training was conducted on October 3, 2018 and October 11, 2018. A section for crime scene details was added to the PREA Investigation Closing Report.</p>
<p>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.</p>	<p>The Department completed this goal. Training was completed in October 2018 and the Department met its original target date of September 2018 (set forth in its June 2018 Corrective Action Plan) to increase the number of Supervising Investigators to six (6). The Department now has an adequate amount of supervisory staff to oversee PREA investigators. The Department acknowledges that this recommendation requires ongoing supervisory training and is committed to supplying said training.</p>
<p>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</p>	<p>The Department completed this goal. The Closing Report was amended twice, to accommodate the Board’s feedback (once on September 13, 2018 and again, to its current version on November 19, 2018) and the Department has been sending the newly</p>

<p>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.</p>	<p>revised memo every time a case is closed, within five business days of case closure, pursuant to the Board’s Minimum Standards.</p>
<p>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. 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.</p>	<p>The Department completed this goal. The Department has assessed, prior and subsequent to the Board’s audit, the reasons for delays in its investigations. As mentioned in the June 2018 Corrective Action Plan, inadequate staffing coupled with an increase in sexual abuse and harassment allegations created a backlog.</p>
<p>5. The Board should conduct an annual audit of the Department’s PREA</p>	<p>The Department committed to complying with the above in its written response to the</p>

<p>Closing Reports to monitor their quality and timeliness.</p>	<p>Board’s audit back in September 2018. The Department’s position on this matter has not changed.</p>
<p>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</p>	<p>The Department completed this goal. On November 20, 2018, the Department instituted a policy for conducting PREA investigations in a confidential setting. This policy was codified in the Department’s Investigation Division Order 4/16, which was circulated to Investigation Division investigators. Additionally, the PREA Investigation Closing Report was amended to include this information.</p>
<p>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 the information; and whether there was relevant historical information available about the alleged perpetrator.</p>	<p>The Department completed this goal November 19, 2018. The revised Closing Memo accounts for the above-mentioned categories.</p>
<p>8. Investigative staff should attempt to notify victims of the outcome of investigations, regardless of whether</p>	<p>The Department completed this goal on October 7, 2018. On that date, the Department instituted a policy for notifying all</p>

they are still in the Department's custody.	complainants of the outcome of their PREA allegations, regardless of their incarceration status. This policy was also added to the aforementioned Investigation Division Order 4/16, and the Closing Report was amended to account for this information.
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This report is a supplement to the September 2018 BOC audit.² The supplement finds some areas of continuing concern and others of progress. The findings suggest additional work is necessary to implement the existing DOC reforms and, ultimately, to evaluate whether the reforms have led to each and every investigation meeting the Minimum Standards for timely, robust, and comprehensive investigations and thus meaningful outcomes for complainants. Particular work is needed to ensure investigators clearly articulate the key elements of their investigations in their Closing Reports. Each Report provides a crucial window into the robustness of the investigation and should be viewed as the primary way to formally document and integrate the evidence, steps, and decisions in each investigation, thereby also demonstrating that the Minimum Standards have been met. It is the only memo in an investigation file that integrates the various parts of the investigation file. In addition, the Closing Reports can and should provide the Department with an important tool for their own quality assurance mechanisms.

Improvements are needed to ensure that Closing Reports include thorough explanations of how investigators reached their conclusions regarding what is and is not substantiated in the allegations they are investigating. In addition, improvements are needed in how investigators explain their findings on the credibility of alleged victims, witnesses, and perpetrators. It is crucial that Closing Reports include this information: without it, it is impossible to understand the determinations made by investigators. The Board observed some examples of good quality explanations which are discussed later in this report.

² NYC Board of Correction Audit Report on DOC's Sexual Assault and Sexual Harassment (PREA) Closing Reports (September 2018), https://www1.nyc.gov/assets/boc/downloads/pdf/Reports/BOC-Reports/PREA_ClosingReports_FINAL_09.24.18_update.pdf

For this supplementary report, Board staff reviewed a sample of 20 investigation Closing Reports related to incidents occurring between November 2017 and December 2018. These reports were selected because they were closed in the first two weeks of February 2019 and thus represented the most recently closed cases received by the Board. As with the September 2018 audit, this audit includes aggregate information about these investigations (such as the categories of allegation, the outcomes and the time taken to complete the investigation). In addition, this report documents instances where there have been improvements, or a decline, in the quality of the investigations most recently audited when compared with those reviewed in 2018.

Board staff designed its 2018 audit and this supplement 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 of alleged sexual abuse or sexual harassment and provide a copy to the Board within five business days of completion.³

The Board advises some caution in generalizing these findings because of the recentness of Department's reform commitments and limited sample. However, the 20 Closing Reports reviewed do provide insight into the quality and timeliness of the Department's recent investigations and the findings of this report can assist in their continued efforts towards improvement.

The Department was provided with a draft of this report as part of the Board's fact-checking process. The Department gave comprehensive feedback, which included additional information on ten cases which had not been included in the respective Closing Reports. This information related to the sending of determinations letters to alleged victims, the timing and location of interviews, decisions on separation orders, and access to medical treatment. The Board did not amend the findings of the audit to reflect this additional, previously unseen material. The scope of the review was to assess the quality of the Closing Reports. The existence of information separate to and often contradictory to those reports – but which should have been recorded

³ Since June 2018, the Department has been submitting Closing Reports to the Board on a weekly basis.

within them – indicates that the Department needs to take steps to ensure that Closing Reports are an accurate and comprehensive record of every aspect of the investigation.

The Board’s annual audit will be published in the fall of 2019.

Key Findings:

1. There continue to be considerable delays in the Department’s investigations into PREA allegations: the mean time to case closure for the 20 cases reviewed was 350 calendar days. Only two cases were closed within the 90-day period required by the Minimum Standards.⁴
2. The Board remains concerned that interviews are not always carried out with alleged victims and alleged perpetrators. These interviews are crucial to understanding the details of the allegation and in allowing the investigator to test and weigh the available evidence. In some of the cases reviewed, there appears to have been too much reliance on Genetec footage or existing statements, rather than conducting interviews.
3. When interviews are conducted, they are not always in private and confidential locations.
4. There have been considerable improvements in the inclusion of historic information about alleged victim and alleged perpetrator, such as prior allegations of abuse or harassment.
5. There have also been considerable improvements in the inclusion of an analysis of the testimonial and physical evidence in the Closing Reports.

⁴ In its feedback, the Department noted that its PREA investigators’ efforts had been focused on closing a significant backlog during this time period. Thus, investigators were working to close partially investigated, old cases so the time to case closure is not an accurate reflection of the time it would take an investigation starting today to close. The Board’s fall 2019 audit will further review this claim.

6. The Board remains concerned about the inclusion of any credibility assessments and the reasoning for what is found to be substantiated or unsubstantiated and the quality of those assessments.

7. There continue to be a number of documentation problems in the Closing Reports.
 - a. While there has been some improvement in how investigators record the location of victim interviews, the recording of the location of witness and alleged perpetrator interviews persists as a problem.
 - b. The Board remains concerned that decisions regarding the establishment of crime scenes are not recorded adequately.
 - c. There are different Closing Report formats used by investigators, leading to discrepancies and inconsistencies in what information is collected and recorded for each closed case.

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METHODOLOGY

In 2018 Board staff designed an audit to determine whether DOC'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 DOC investigators complete a report summarizing each investigation into sexual abuse or harassment.⁵ These are referred to as PREA Closing Reports.

Board staff chose to audit 20 Closing Reports received by the Board in the first two weeks of February 2019. These reports were among the most recent reports received by the Board at the time the sample was pulled.

Board staff reviewed PREA Closing Reports using an audit 'Pro Forma' to assess investigations consistently. 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. Using the Pro Forma, Board staff recorded basic information about the allegations, investigation outcomes, and investigative methods used by DOC. The same Pro Forma was used to record information in the Board's September 2018 Closing Report audit.

In 12 of the 20 cases in the sample, at least some information was missing from the closing report.⁶ The most frequently missing data was a signature by a Supervisor (n=8). 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 20 cases, this is clearly stated in the report.

⁵ 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.

⁶ 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 (60%).

Sample

As explained in the Methodology section above, PREA Closing Reports were selected to reflect cases closed most recently and thus reflect any changes the Department has implemented in the months since the Board's September 2018 audit. The 20 Closing Reports audited included:

- **9 (45%) related to Staff on Inmate Sexual Abuse/Assault**
- **5 (25%) related to Inmate on Inmate Sexual Assault/Abuse**
- **5 (25%) related to Staff on Inmate Sexual Harassment**
- **1 (5%) related to Inmate on Inmate Sexual Harassment**

The majority of alleged victims were men (n=16, 80%). Four allegations (20%) were from women, one of whom identified as transgender.

The 20 allegations occurred across ten facilities. The specific number of allegations for each facility are as follows:

Table 1: Facility location where alleged PREA incident occurred

Facility Name⁷	Number and percentage of allegations of audit sample
BKDC	3 (15%)
OBCC	3 (15%)
RMSC	3 (15%)
AMKC	2 (10%)
GRVC	2 (10%)
Horizon Juvenile Center (HOJC)	2 (10%)
WF	2 (10%)
EMTC	1 (5%)
MDC	1 (5%)
RNDC	1 (5%)
Total	20 (100%)

⁷ Information on DOC facilities available at <https://www1.nyc.gov/site/doc/about/facilities.page>.

FINDINGS

The following section summarizes the findings from the audit of 20 Closing Reports, focusing on those report sections that correlate directly with the Board's Minimum Standards and, where relevant, the requirements of the PREA standards more broadly.

1) Only two⁸ of the 20 Closing Reports audited were completed⁹ within 90 days, as required by the Board's Minimum Standards.¹⁰

Eighteen investigations (90%) were not closed within the required time period of 90 days. Of the 20 investigations, 18 (90%) had been signed by a secondary supervisory member of staff. For the 18 investigations with a supervisory signature, the average (mean) time between allegations being received by ID and completion (signature of a secondary supervisor) was 350 calendar days (with a range of 53 days and 708 days).¹¹

In 30% of the 20 cases (n=6), the first supervisory signature was missing. This is consistent with the findings of the Board's 2018 audit when 29% (n=12) of Closing Reports were missing at least one supervisory signature.

While the Board acknowledges that it will take efforts over a sustained period to reduce the backlog, it emphasizes again the necessity of timely investigations. Additionally, it is important that the Department evaluate and understand why DOC continues to close investigations without the required supervisory reviews.

⁸ These investigations were closed in 53 and 62 days respectively.

⁹ An investigation was only considered complete when a secondary 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".

¹⁰ See *supra* note 7.

¹¹ Median was 354 calendar days.

- 2) **Interviews were conducted with 15 of 20 alleged victims.¹² In two additional cases, it was not documented why these interviews did not take place, and in three other cases, the alleged victim either refused to be interviewed or could not be identified.**

In 15 of the 20 cases (75%), the investigator interviewed the alleged victim. 13 interviews were recorded as taking place within the first 72 hours, as required. In the other two cases it was not possible to determine compliance from the Closing Report because the investigator did not include information about the timing of the interview.

In two of the cases audited it appeared the alleged victim was not interviewed and it was not documented why these interviews did not take place. In the three remaining cases, investigators appropriately documented their efforts to conduct the interviews. In these three cases, the alleged victim either refused to be interviewed or could not be identified (the allegation had been made by a third party who did not provide the name of the alleged victim).

The Board's findings suggest that the Department needs to examine whether the training conducted in October 2018 has adequately addressed this issue.

- 3) **Alleged perpetrators were interviewed in nine of 17 cases in which it was reasonable to expect an interview to take place.¹³**

Alleged perpetrators were identified in 17 of the 20 cases. In one case, the alleged perpetrator was on non-disciplinary leave. Interviews were conducted in nine (53%) of the 17 cases in which it would have been reasonable to expect an interview to take place. This means that in seven cases (35% of those audited for this report) it is not clear from the closing report why the alleged perpetrator was not interviewed. Five of the seven cases involved DOC staff members. In each of these seven cases, the Closing Reports suggest that investigators relied upon reviewing camera footage of events and/or statements by staff instead of conducting interviews with the accused. Interviews are a crucial source of evidence for investigators: it allows them to test the other

¹² 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).

¹³ Minimum Standard 5-30 (c), in accordance with PREA Standard 115.71 (c), requires that investigators must interview alleged victims, perpetrators and witnesses.

available evidence (such as documentary information and camera footage) and to explore inconsistencies or gaps in what is available to them. In addition, interviews can and should form an important part of how investigators assess the reliability and credibility of the evidence reviewed to reach their overall determinations on the case. An over-reliance on documentary evidence and camera footage is a repeat of an issue that the Board highlighted in its 2018 audit.

The Board audited nine cases in which the allegation was one of sexual abuse by a member of staff. In six of those reports (67%) it is not clear whether the allegation was referred to the New York City Department of Investigation (DOI),¹⁴ a procedure which is required by Mayoral Executive Order 16¹⁵ and by the Department's Division Order on Elimination of Sexual Abuse and Sexual Harassment.¹⁶

As with alleged victim interviews, the Board's findings suggest that the Department needs to examine whether the training conducted in October 2018 has adequately addressed the issue of investigators omitting key interviews and what additional mechanisms would prevent this.

4) Witnesses were interviewed in the majority of the investigations audited.

Witnesses were interviewed in 14 cases (70%). Of the six cases where witnesses were not interviewed, two Closing Reports provided reasonable explanations as to why interviews did not take place (reasonable explanations included a lack of specific time or location of the alleged incident after efforts were made to identify them).¹⁷ In the other four cases, investigators did not provide adequate explanations for why witness interviews were not conducted. When compared to the Board's findings in its 2018 report, there has been some improvement in this aspect of the Department's Closing Reports. The Board's 2018 audit found that in 40% (n=17) of cases reviewed, investigators did not provide an adequate explanation for why they had not interviewed witnesses. In this most recent audit, this was the case in 20% of cases (n=4).

¹⁴ In response to a draft of this report, DOC confirmed for the Board that all nine sexual assault allegations were referred to DOI as required and were subsequently cleared for DOC to investigate.

¹⁵ N.Y.C. Exec. Order No. 16 (July 26, 1978), <https://www1.nyc.gov/site/doi/report/reporting-obligation.page>

¹⁶ 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".

¹⁷ In these two cases, the investigators conducted alleged victim and perpetrator interviews, as appropriate.

5) There have been improvements in how investigators record the location of victim interviews, but there remain omissions on location details of alleged perpetrator and witness interviews.¹⁸ Additionally, investigators continue to conduct interviews in spaces that are not private and confidential.

Of the 15 cases where an alleged victim interview took place, 12 (80%) reports provided the location of the alleged victim interview. This compares to only 25% of reports (n=9) recording the location of these interviews in the cases audited in 2018. Of the twelve most recent cases: five interviews were described as being conducted in the ‘housing unit’; two were carried out in cells; one took place in ‘a hallway’: one in ‘a stairwell’; one in a hospital; one in a Mental Health Unit; and another in ‘intake’. It is encouraging to see the location of alleged victim interviews being recorded more consistently. However, many of the aforementioned locations do not seem to be private, confidential, nor suitable space for such a sensitive interview. In one case the investigator helpfully described the location as ‘unused office space’, which allowed the Board to conclude that the location was appropriate.

Alleged perpetrator interviews took place in nine cases (45%), but investigators documented the location of the interview location in only four instances. Those locations were recorded as ‘a hallway’, ‘housing unit’, a Mental Health Unit and ‘a stairwell’. These locations also appear to be inadequate, lacking privacy and confidentiality while also denigrating the seriousness of the investigation.

Of the 14 interviews carried out with witnesses, the location is only recorded in three instances. The locations are recorded as ‘unoccupied office space’, a Mental Health Unit and ‘housing unit’. Again, as with the location of victim and perpetrator interviews, the omission of interview locations within the reports makes it impossible to conclude how many, if any, of the witnesses in the audit sample were interviewed confidentially.

¹⁸ 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.

As discussed above, interviews represent a crucial part of the investigatory process. All interviews must occur in confidential settings. Confidential interviews signal the seriousness of the matter investigated, ensure witnesses, alleged victims, and alleged perpetrators feel free to candidly discuss and provide evidence, and can reduce fear of retaliation, thereby improving the quality of information obtained during interviews.

The Board is encouraged by the circulation of the Department's Division Order instituting a policy for conducting PREA interviews in confidential settings and the revisions to the Closing Report template. However, further work is clearly needed to ensure that these requirements are fully understood and that investigators are conducting interviews in private and confidential spaces and providing the necessary information in the Closing Report.

6) In the majority of cases, alleged victims were reported as being offered some post-incident services after DOC received their allegation¹⁹ but there were some inconsistent practices among cases.

- i) In 79% of cases (n=15), alleged victims were reported as being seen by medical staff. Of the four cases where there was no medical service referral, in one case the investigator identified that a medical referral had been overlooked by the staff initially responding to the allegation and so made a referral, meaning that there was a delay of one day in the referral. Another case involved an unidentified victim, and in the two remaining cases, the investigator recorded that a referral for medical care was not necessary as the allegation was one of harassment and not a physical injury. While the Minimum Standards do not require a medical referral for sexual harassment complaints, there is an inconsistency in DOC practice for harassment allegations. This audit included three other investigations into similar alleged incidents and the alleged victim was reportedly referred for medical care

¹⁹ 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 those cases. It is not clear why some alleged harassment victims received access to these services and others did not.

- ii) In most cases, alleged victims were reported as being seen by mental health, victim, and ministerial services.

In 17 of the 20 cases (85%), a referral to the above services is recorded as being made. Again, of the three cases in which these referrals were not made, one related to an unidentified victim and two related to harassment allegations. It is not clear why these services were not deemed necessary for those two alleged harassment victims.

- iii) There was one hospital referral in the 14 allegations of sexual assault or abuse.

Based on the information available in the Closing Report it appears that the hospital referral may have related to restraint injuries sustained during a Use of Force rather than stemming from the alleged sexual assault. However, the alleged victim reported that the sexual assault took place during the Use of Force, and the report does not clarify the precise reason for the hospital referral. Of the other 13 sexual assault cases where a hospital referral may have been a reasonable outcome, the investigation reports did not contain enough detail to confirm whether the lack of referral was appropriate.

7) Crime scenes were not established in any of the 20 investigations. In the majority of sexual abuse allegations, there was insufficient information recorded to know whether a crime scene should have been established.²⁰

While the decisions not to establish crime scenes may have been justified, in only 44% of the 14 sexual abuse allegations (n=4) did the investigator provide a satisfactory explanation for why

²⁰ 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

crime scene procedures were unnecessary. In the interests of thoroughness, and as articulated in the Board's 2018 audit report, Closing Reports need to include a comprehensive explanation of investigators' decision-making on this element of their investigation. A lack of crime scene may be appropriate: there may have been a long period of time since the incident or no specific location identified. In some cases reviewed by the Board, investigators included such reasoning, and this is something that should be done routinely in Closing Reports.

The omission of this information in Closing Reports is something that continues to be a concern to the Board. Further work is needed to address this issue.

8) In the majority of cases, the investigations included a review of available testimonial evidence such as monitoring information, records, and witness statements.²¹ This is a considerable improvement when compared to the results of the 2018 audit.

In 17 of the 20 cases (85%), the investigator demonstrated that they reviewed available testimonial and/ or documentary evidence.²² This compares with only 26% of cases (n=11) reviewed during the Board's previous audit and represents a much-improved approach to this aspect of the Closing Reports.

9) The majority of investigations included a review of physical evidence.²³ This again represents an improvement when compared to the results of the Board's previous audit.

Physical evidence (such as Genetec, handheld video footage, or evidence such as bedding or clothes) appeared to be reviewed in 80% of cases (n=16). The 2018 audit found reviews of physical evidence in only 55% of cases (n=23). Although this improvement is positive, the most recently reviewed reports shared some of the weaknesses noted in the Board's previous audit. The most

scene, if applicable. If circumstances surrounding the allegation dictate reasons not to establish a crime scene, reasons shall be recorded in the case folder."

²¹ 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.

²² This includes direct or indirect evidence such as electronic monitoring data, statements, or incident reports.

fundamental of these was the fact that Closing Reports did not routinely reference what evidence has been considered but discounted. For example, it was not always possible to ascertain whether Genetec video evidence was unavailable – or whether it was available but had been determined to be irrelevant to the investigation. In some cases, the explanation for the lack of Genetec video was confusing: one case references the ‘time lapse since the alleged incident’ but there appears to have been a delay of only one day since the alleged event.

10) Investigators consistently included information about prior allegations against the alleged perpetrator.²⁴ This is a considerable improvement compared to the findings of the 2018 audit.

In 17 of the 20 cases (85%) investigators included information about prior allegations against the alleged perpetrator. In the three cases where this information was not included, there was a legitimate explanation for this (the alleged perpetrator had not been identified). The previous audit found that information on alleged perpetrators was included in only 10% of investigations. The Department has made considerable improvements in this aspect of their investigations.

The progress that has been made in these three specific areas (reviewing prior allegations against the alleged perpetrator, physical evidence, and testimonial evidence) is encouraging. The Board acknowledges the Department’s improvement efforts and hopes to see them continue.

11) In over half of the cases, the investigator adequately performed credibility assessments.²⁵

In 11 cases (55%) the report included a clear indication of how the investigator decided on the credibility of the various people involved (alleged victim, suspect, and witnesses).²⁶ In the other 45% there is no meaningful discussion of the how the investigator has explored the credibility of

²⁴ 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).

²⁵ 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.

²⁶ The Board’s Minimum Standard 5-30 (e) requires that the credibility of a victim, suspect or witness 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).

the individuals providing evidence. This finding is generally consistent with the Board's 2018 audit, when only 50% of cases (n=21) were found to include an adequate explanation of how the investigator decided on the credibility of the relevant individuals.

While acknowledging the improvements in the recording of historical information about the alleged perpetrator, the Board does not consider that the Department's response adequately addresses the issue of a failure to provide credibility assessments. The Board found some good examples of such assessments: in one case the investigator documents the inconsistencies in the account provided by the alleged victim and compares each element of the allegation with the other sources of evidence available to them. This level of detail demonstrates the steps that the investigator has taken to corroborate or discount specific aspects of the allegation and provides a clear picture of how their determination has been reached. This should be viewed as a fundamental aspect of every investigation.

In another Closing Report, the investigator explains each source of evidence they have reviewed. Importantly, they then discuss where there are consistencies and inconsistencies between the evidence. The investigator reviews Genetec footage, staff and inmate statements, injury reports and SECURUS phone calls but does not rely only upon these sources. Crucially, they carry out interviews, during which they appear to test the evidence. In their concluding explanation they weigh the different information they have assessed and explain the reasoning for their determination.

Unfortunately, there were many examples of credibility assessments that omitted such detailed analysis. The Department needs to train its investigative staff on how to carry out such assessments and its supervisory staff on how to ensure that they are of sufficient quality. Documented credibility assessments should be able to answer questions such as: Is the person's story consistent, both internally and when compared to extrinsic evidence? If not, are there reasonable explanations for the inconsistencies?

12) In a third of cases, the investigator adequately described their reasoning for finding an allegation substantiated, unsubstantiated, or unfounded.

The investigator adequately explained how they reached their conclusions on what was and was not substantiated in only six cases (30%). In the other 70% of cases, there was a lack of specific information about which precise elements of the allegation have been verified or disproved. In at least two cases that the Board reviewed, there were key pieces of evidence that were referenced in testimonial or other evidence that were not adequately examined and assessed as part of the investigator's reasoning. For example, in one of these cases, reference is made to an injury observed on an alleged perpetrator shortly after the incident was believed to have taken place. Despite the mention of this injury, the investigator did not discuss whether they found evidence of it or whether the injury was potentially relevant to the allegation.

There has been a decline in this area when compared with the results of the 2018 report. In the previous audit, 50% of investigators (n=21) provided an adequate explanation of which facts were substantiated.

This finding is closely linked to the above point regarding credibility assessments. The substantiation finding is only reliable when the investigator's analysis of each piece of evidence available is well-documented and clearly leads to the subsequent finding as to whether the evidence meets a preponderance of evidence standard. As above, the Board considers that the Department needs to address this training need for investigative and supervisory staff.

13) DOC found all of the 20 allegations (100%) unsubstantiated or unfounded.

Of the 20 cases, 13 were found to be unsubstantiated and seven were unfounded. In a minority of the cases with unfounded determinations, it was not clear to the Board why the investigator had reached that determination rather than a finding of unsubstantiated. Specifically, the Board reviewed two cases which had been determined to be unfounded but where the facts presented were plausible and theoretically possible (in each case the incidents were alleged to have taken place at times and in places where both the victims and perpetrators were known to have been

present). Although the facts couldn't be corroborated independently of the alleged victim's account, it did not appear clear that the allegation itself was unfounded.

14) Victims were informed of the investigation results in a third of cases audited.²⁷

Of the alleged victims, nine of 20 were still in the Department's custody at the conclusion of the investigation. Closing Reports indicated that seven of those nine individuals were sent a determination letter explaining the outcome of the investigation. In addition, five of the 11 alleged victims who had left the Department's custody were also sent determination letters. The Department is not required to do this by the Minimum Standards but, in response to the Board's last audit, the Department agreed to make best efforts to inform alleged victims who have been released. It is encouraging to see that this has continued and appears to be happening more regularly. However, the Department should continue to work toward notifying all alleged victims.

15) There are inconsistent Closing Report formats being used by different investigators, leading to discrepancies in the information captured.

Board staff observed at least five different Closing Report formats in the sample of 20 investigations reviewed. Different investigators used different report templates during the same time period. This inconsistency makes meaningful comparisons between cases more difficult for the Board but also for the Department. It also appears to result in some investigators collecting information that others do not. By way of example, in 15 of the 20 cases, investigators recorded whether separation of the alleged victim and alleged perpetrator had been requested. The form used in these instances included a 'check box' next to this specific question.²⁸ In the other five cases, no reference was made to the issue of separation in the Closing Report and the form did

²⁷ 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.

²⁸ In eight of the 15 cases where the investigator documented whether separation had been requested, the separation box was marked 'yes' and the other seven were marked 'no'. Of the seven Closing Reports which indicated that separation had not been requested, the investigator gave reasonable explanations for this in four cases. In each of these four cases, either the alleged victim or alleged perpetrator had not been identified and it was therefore not possible to request separation.

not prompt that this information be included. The Department's stated policy is to separate alleged victims and perpetrators and it is therefore of particular concern that investigators are not consistently recording this key information. Crucially, even in cases where information on separation is recorded, it is not sufficiently detailed to indicate whether or when it achieves its aims of protecting victims. The Department should consider how investigators adequately record information on the following:

- When are separation orders executed?
- Who is responsible for ensuring they are carried out?
- Who decided how long they are in place for?
- Who monitors that the orders are complied with?

Despite the Department having updated the Closing Report Form, the Board's audit indicates that more attention is needed by supervisors to ensure all Closing Reports are completed using the revised Closing Report format for consistency in tracking and reporting.

Conclusion

In its two Corrective Action Plans, the Department of Correction committed to major improvements in its PREA investigations' staffing and practices. In the short time since DOC implemented its reforms, this supplemental audit suggests limited improvements and continued work necessary. The Board's fall 2019 audit of DOC's PREA investigation will provide a more comprehensive understanding of the impact of DOC reforms on the quality and timeliness of its investigations.