

**NYC Department of Correction – September 2018  
Response to NYC Board of Correction PREA Investigations Audit**

**Subject of the NYC Board of Correction Audit**

In May 2018, the New York City Board of Correction (“The Board”) selected 42 investigation closing reports to review. In June 2018, the New York City Department of Correction (“DOC”) revised its PREA closing memorandum to the newer “PREA Allegation Short Form.” The Board provided feedback on this form, which the Department will incorporate into a revised version of the Short Form. This audit of PREA investigations was only of closing memorandums and not of actual investigation case files; upon request, DOC’s Investigation Division is prepared to discuss its investigations further with the Board.

The 42 audited reports were broken down categorically as follows: 13 related to Staff on Inmate Sexual Abuse/Assault; 12 related to Staff on Inmate Sexual Harassment; 10 related to Inmate on Inmate Sexual Assault/Abuse; 7 related to Inmate on Inmate Sexual Harassment. 76% of the alleged victims were male; 12% were female; 12% identified themselves as transgender female.

**FINDINGS**

**Finding #1: Timely Interviews were Conducted with the Majority of Alleged Victims**

The Board found that in 36 out of 42 cases reviewed (86%), DOC interviewed the alleged victim within 72 hours. The Board acknowledged that out of the remaining 6 cases, 2 of the alleged victims refused to be interviewed and 1 of the alleged victims was never named or able to be identified (the complaint was a third party complaint).

Additionally, the Board found that 1 of the alleged victims was released from custody so the interview was delayed because DOC had to locate the individual, 1 of the alleged victims was interviewed four days after the incident, and 1 of the alleged victims was not interviewed and the closing report was unclear as to why.

“[T]he Board’s audit demonstrated that, in the vast majority of cases, initial investigative tasks *are* conducted promptly upon notification of an allegation”

**Response:**

With the exception of two alleged victims (one who was interviewed four days after the incident instead of three and one who was outside of DOC custody and thus had to be located within the community), DOC interviewed all identified alleged victims who wished to proceed with a complaint.

The one instance noted by the Board where the alleged victim was not interviewed involved a third party allegation in which the victim was unidentified, and, despite further investigation, was unable to be identified.

DOC is pleased that the Board acknowledged its timely interviews of alleged victims of sexual harassment and sexual abuse.

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**Finding #2: Only 2% of the 42 Audited Investigations were Completed within 90 Days**

The Board found that although “[i]t was clear that many of the initial investigative tasks (such as interviewing the alleged victim) were carried out promptly”, there were delays in closing the cases.

**Response:**

DOC is encouraged by the Board’s findings, as it mirrors the message DOC has been conveying: cases are thoroughly investigated within the first 72 hours of an allegation; however, due to understaffing and administrative delays such as procuring facility and medical paperwork, PREA investigators found themselves responding so often to allegations that they were unable to close out their investigations in a timely manner. DOC’s investigators will always prioritize a potential victim over paperwork. As a result, a backlog developed.

DOC has conceded that it is working through a large backlog that dates back to 2015 allegations. In April 2018, DOC was afforded additional investigator and supervisory lines in order to appropriately staff its Investigation Division. In that same month, DOC devised an interim plan to address the backlog as DOC onboarded and trained new PREA investigators. That solution yielded a 64 case closure in 6 weeks’ time. In June 2018, DOC again met with the Board and provided its Corrective Action Plan to address the remaining backlog, with a goal of closing the backlogged cases by February 2019. In July 2018, six more investigators joined the PREA investigation team. By the end of August 2018, an additional 250 cases had been closed. In early September 2018, a new Deputy Director – a retired NYPD Special Victims Detective – joined the PREA team.

The Corrective Action Plan is working; DOC is on track to meet its aggressive goal of closing the backlog by February 2019 and coming into substantial compliance with the 90-day investigation deadline soon after.

**Finding #3: Alleged Perpetrators were Interviewed in 55% (23) of the Investigations Audited**

Of the remaining 19 cases, 9 alleged perpetrators were other inmates (and 5 of the 9 refused to speak with investigators); 10 alleged perpetrators were staff members (1 of the staff members was out sick; 1 could not be reached after numerous attempts; 2 staff members were not identified by the alleged victim; and in 6 cases, there was no clear explanation as to why the staff member was not interviewed).

The Board also mentions here that for the 13 Staff on Inmate sexual abuse allegations it audited, none of the closing reports indicate whether the allegations were referred to the New York City Department of Investigation (DOI).

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### **Response:**

There are a number of reasons why an alleged perpetrator may not be interviewed; with respect to the cases audited by the Board, the following is relevant:

- 4 alleged perpetrators refused an interview (all 4 were alleged inmate perpetrators, not staff)
- 2 alleged victims recanted
- In 4 instances, Genetec video confirmed that the allegation was unfounded and thus no interview was necessary
- In 5 instances the alleged perpetrator was unidentified (4 of the 5 were alleged inmate perpetrators, not staff)
- In 2 instances, the investigation determined that the allegation arose out of a legal, proper pat frisk
- In 1 instance, DOC obtained a written report from the alleged perpetrator,
- In 1 instance, DOC had insufficient evidence to determine the identity of the alleged perpetrator

Regarding the 13 Staff on Inmate sexual abuse cases mentioned: after further investigation, only 11 of those cases actually alleged sexual abuse of an inmate by a staff member. Two cases were misidentified by the Board. One was actually an Inmate on Inmate sexual abuse allegation and one was a Staff on Inmate sexual harassment allegation (which was cleared to DOC by DOI).

Of the 11 Staff on Inmate sexual abuse allegations, every one of them was cleared by DOI for DOC to investigate. DOC's closing memorandum does not prompt investigators to list whether DOC referred the case to DOI. DOC has revised its Short Form, pursuant to the Board's audit, and has included this prompt.

### **Finding #4: Witnesses were Interviewed in 45% (19) of the Investigations Audited**

The Board found that in 19 of the 42 cases reviewed, witnesses were interviewed. Of the remaining cases: in 5 cases, witnesses refused to be interviewed; in 1 case, the alleged victim specifically requested that investigators not approach any potential witnesses; of the other 17 cases, the closing report is unclear why witness interviews were not conducted.

### **Response:**

There are a number of reasons why additional witnesses (if they exist) may not be interviewed; with respect to the 17 cases without interviews, the following is relevant:

- In 3 cases, witnesses were interviewed, however the closing memorandum was unclear
- In 3 cases, Genetec video confirmed that the allegation was unfounded
- In 3 cases, the inmate recanted or gave insufficient information to conduct witness interviews

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- In 1 case, a photo array was conducted with the alleged victim with negative results
- In 3 cases, no witnesses could be identified
- In 2 cases, the allegation came long after the incident and witnesses were no longer present
- In 2 cases, the alleged victim was unable to give a time or date of incident, thus DOC was unable to procure witnesses.

### **Finding #5: It was not Possible to Conclude whether Interviews were Conducted in Confidential Locations**

The Board found that “[o]f the 36 cases where an alleged victim was interviewed, only nine of the 36 (25%) investigators provided the location of the alleged victim interview.”

#### **Response:**

DOC will provide the Board, along with this response, a copy of its revised closing memorandum. Among the revisions incorporated in the form is a place for investigators to document the location of interviews.

### **Finding #6: In Almost All Cases, Alleged Victims were Offered Post-Incident Services**

The Board found that:

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

In 38 of the 42 cases (90%), the alleged victim was referred to victim services. Data is missing in three cases and in one case, the alleged victim refused said services.

In 39 of the 42 cases (93%), no referral was made to a hospital or urgent care, but nothing about the cases suggest that such a referral would be appropriate.

#### **Response:**

DOC is pleased that the Board is able to corroborate DOC’s success in this area.

With respect to the 2 cases missing data on medical and mental health services: one of the cases was misidentified by the Board and is a harassment case (medical services not needed); the inmate in second case was seen in the clinic and refused treatment, thus DOC should be deemed 100% compliant in this category.

### **Finding #7: A Crime Scene was Established in One of the Cases Audited**

The Board found that although the lack of crime scenes may be warranted (especially, for example, in harassment cases), DOC should specify its reasoning in its closing reports.

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### **Response:**

In most of the closing memoranda reviewed in this audit, the information the Board is seeking exists, but was set forth in the summary section as opposed to the crime scene section. In the summary section, for example, it was documented in some cases that too much time had passed between the alleged incident and the report for a crime scene to be useful. In other cases, the documentation mentions that no physical evidence existed.

The PREA investigators will be reminded to include this information more consistently in the crime scene section of the closing report.

### **Findings #8 and #9: Reviews of Evidence**

The Board found that in 26% of the cases, the investigator demonstrated that they reviewed all available evidence, and that physical evidence such as Genetec video was most consistently assessed. However, the Board determined that the reports were not consistently describing what evidence was reviewed, what was considered but discounted, and, in some cases, the Board believed that evidence was not reviewed.

### **Response:**

DOC will encourage its staff to more completely and consistently describe in the closing memorandum what evidence they reviewed, and will retrain staff on evidentiary analysis.

### **Findings #10 and 11: Investigators Generally Failed to Review Prior Allegations against Alleged Perpetrator**

The Board found that in only 4 of the 42 cases (10%) did the investigator include information about prior allegations against the alleged perpetrator. The Board was not able to conclude whether this inquiry was completed in the other 90% of cases because that information was missing from the closing reports.

### **Response:**

It is DOC policy for the investigators to conduct such an inquiry. Although PREA investigators were, in fact, considering alleged perpetrator history, they will be reminded to indicate this in the newly revised closing memorandum.

### **Findings # 12 and #13: In Half of the Cases, the Investigator Adequately Performed Credibility Assessments and Described their Reasoning of what is Substantiated**

The Board indicated that there should be greater discussion in the closing reports about determinations of the credibility of those interviewed, and how the investigator decided to substantiate/unsubstantiate elements of the allegation.

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**Response:**

DOC will encourage investigators to be more specific in their closing report summaries on these topics.

**Findings #14 and #15: DOC Substantiated 1 of the 42 Allegations and Found Staff Misconduct in 2 Additional Incidents**

Of the 42 cases reviewed, one was substantiated – an Inmate on Inmate sexual harassment incident.

In another case, DOC unfounded an inmate on inmate sexual abuse allegation but uncovered staff misconduct in that there was a failure to conduct adequate checks of the area and that the staff member falsified documents.

In a third case, DOC unfounded a staff on inmate sexual abuse claim, but charged the staff member with inappropriate use of chemical agents during the search.

**Response:**

Although it was not the purpose of the audit, DOC is pleased that the Board sees that DOC investigates all allegations thoroughly, in that even if a PREA allegation is found to be discredited, DOC will investigate and hold staff accountable for all categories of misconduct.

**Finding #16: Victims were Informed of the Investigation Results in 82% of Cases where Victims were Still Incarcerated; 26% Overall.**

The Board found that in 11 cases, the alleged victim was still in DOC custody; in 9 of the 11 cases (82%), a determination letter was sent.

The Board found that in 26 of the 42 cases, the inmate was no longer in DOC custody, so DOC was not obligated to send a letter; however, a letter was sent to 2 individuals anyway. In the remaining five cases, there was no information about a determination letter in the closing memorandum

**Response:**

Although the Department was successful in sending letters, as mandated, in 82% of cases, investigators will be reminded to send determination letters – and document the sending of the letter – in all cases.

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**RECOMMENDATIONS**

As a result of its audit, the Board made several recommendations. DOC will:

1. Retrain investigators to “record complete and comprehensive information in relation to every stage of their investigation”.
2. Revise its closing memorandum with the Board’s suggestions. A template will be sent contemporaneously with this response, for the Board’s review.
3. Continue to implement its Corrective Action Plan in the pursuit of closing backlogged cases by February 2019, and achieving substantial compliance with the 90-day deadline.
4. Comply with the Board’s desire to conduct yearly audits.
5. Ensure that interviews are conducted in a private, confidential setting.
6. DOC will make best efforts to inform alleged victims who have been released from DOC custody of the outcome of their cases.

**Conclusion**

The Department of Correction appreciates the Board’s hard work in conducting this audit and looks forward to further collaboration and discussions with the Board in accomplishing its goals; refining the PREA investigative process and timely case closure.