Supporting Documents

Index of Documents

NOTE: The Department is not releasing surveillance video related to this incident pursuant to the reasoning noted in the redactions below.

Redactions

The Wisconsin Department of Corrections has redacted certain information from the records as required by law or in accordance with the Wis. Stat. § 19.35(1)(a) balancing test. The Department's Office of Legal Counsel determined that redaction of Sydni Briggs' name and publicly-available information that would otherwise be required under Wis. Stat. §938.78(2)(a) is not necessary in this case.

Redactions that have been made are noted below:

- **JUVENILE RECORDS:** Pursuant to Wis. Stat. §938.78(2)(a), no agency may make available for inspection or disclose the contents of any record kept or information received about an individual who is or was in its care or legal custody.

- **MEDICAL/HEALTH INFORMATION:** Medical/health information has been redacted pursuant to Wis. Stat. § 19.35(1)(a) balancing test. Although Wis. Stat. § 146.82 does not directly govern the medical/health information included in these records, the Department finds that the underlying public policy of protecting the confidentiality and privacy of personal medical/health information outweighs any public interest in disclosure of this information.
- **PROTECTED HEALTH INFORMATION:** The disclosure of Protected Health Information (PHI), as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. 160.103, is governed by Wis. Stat. § 146.816 and 45 C.F.R.164.500 – 534. No exceptions for disclosure apply in this instance.
- **VIDEO – SURVEILLANCE FOOTAGE:** Per Wis. Stat. §19.35 (1)(am)(2c), the security in state correctional institutions is explicitly recognized under the public records law as being an overriding public interest and is sufficient to justify limited access or non-access to a recording. Here, the department's security concerns are based in large part on the video recording being disseminated or shown to the general public. The video recording of the requested subject matter was taken by our security camera system in the institution. This video demonstrates our surveillance abilities and limitations such as resolution, range, scope, and area of coverage. The disclosure of this information would allow inmates or the public to circumvent the institution's surveillance system, thereby jeopardizing the security of the institution and the safety of the inmates and staff. The safety of staff and inmates, the rehabilitation of prisoners, and the orderly and secure administration of institutions justifies the denial of access to the requested video recording. Under the circumstances, the public interest in protecting the safety of inmates and staff outweighs the public interest in access to these materials.

Employee Investigations

Employee investigations related to this incident may be obtained by filing a public records request with the DOC Communications Office at DOCMedia@wisconsin.gov.

FULL SETTLEMENT AGREEMENT AND FINAL RELEASE OF ALL CLAIMS

SYDNI BRIGGS, by and through HER GUARDIAN, KELI WENDT, (hereinafter "SYDNI BRIGGS"), in consideration of EIGHTEEN MILLION NINE-HUNDRED THOUSAND DOLLARS and 00/100 ($18,900,000.00), to be paid in cash and future Periodic Payments referenced below in paragraphs 1a through 1d, does here forever release and discharge ANDREW YORDE, STACEY DAIGLE, JAMES LARKIN, TONI MOORE, DARRELL STETZER, CASSANDRA JENNINGS, JOHN OURADA, LEXINGTON INSURANCE COMPANY, ALLIED WORLD INSURANCE COMPANY, A SUBSIDIARY OF ALLIED WORLD ASSURANCE COMPANY HOLDINGS, GMBH, THE STATE OF WISCONSIN DEPARTMENT OF CORRECTIONS, THE STATE OF WISCONSIN and collectively their employees, officers and insurers (hereinafter collectively referred to as the "Released Parties") from any and all claims and causes of action, in any way arising out of or related to an incident involving Sydni Briggs that occurred on or around November 9, 2015, at Copper Lake School, W4380 Copper Lake Avenue, Irma, County of Lincoln, State of Wisconsin. This incident is more particularly described in Case No. 3:17-cv-00062-jdp in the United States District Court for the Western District of Wisconsin, but this Full Settlement and Final Release of All Claims (hereinafter "Release") is not limited just to the claims asserted in the lawsuit; it includes any and all claims that could have been asserted in that lawsuit.

This Release by SYDNI BRIGGS is also made for and binding upon her heirs, successors and assigns. By this agreement, any liability of subsidiaries, parent corporations, insurers, excess insurers, re-insurers, predecessors, political subdivisions, successors, officers, directors, agents or employees of the released parties is also released and discharged. Further, any other persons or

entities who are or might be liable, even though their identity or involvement in the incident may not be presently known, are fully released and discharged.

This Release fully extinguishes any and all claims and causes of action, including but not limited to those for: compensatory damages, punitive damages, subrogation claims, costs and fees, attorneys' fees and statutory damage awards. In making this Release, all rights to bring or maintain any other claims against anyone, including but not limited to third-party claims and cross-claims, are fully extinguished.

This Release also fully extinguishes any claims or causes of action under the Wisconsin Uniform Marital Property Act. SYDNI BRIGGS, by and through her Guardian, further agrees to indemnify and hold harmless the released parties against any claims which may be made by or on behalf of any child of SYDNI BRIGGS living or to be born for any claims or causes of action including those for emotional distress, loss of care, companionship, protection, services or benefits.

It is understood that the money paid for this unqualified Release is received not only as a full satisfaction for all known and unknown injuries and damages, but also is received for future injuries and damages. The extent of any future injuries and damages is unknown, but it is understood that it may result in a condition substantially different than it is today.

It is understood and agreed that this settlement is a full compromise of a disputed claim. With full knowledge and understanding of the contents of this Release, SYDNI BRIGGS, by and through her Guardian, voluntarily enters into this Settlement and does so without having relied on any statement or representation by the released parties, their representatives, or anyone retained by them.

SYDNI BRIGGS, by and through her Guardian, represents that no portion of this claim has

been assigned to anyone else and that no other person or entity has any legal right to pursue this claim or share in the proceeds of the Settlement, other than her attorneys with respect to attorneys' fees and costs. In making this representation, SYDNI BRIGGS, by and through her Guardian, agrees to indemnify and hold harmless the released parties for any money they may have to pay to any other person or entity asserting any claim arising out of or related to any injuries or damages she allegedly sustained in this incident, including any claims seeking reimbursement for Medicare conditional payments or otherwise based upon subrogation, derivation, or assignment, although this specifically does not include any claim for subrogation or reimbursement by or through Medicaid. Also, SYDNI BRIGGS, by and through her guardian, will indemnify the released parties for any reasonable expenses incurred in defending such claims, provided that the released parties first offer to tender the defense of any such claims to Briggs.

The sums paid pursuant to this Release specifically include payment for any and all liens or claims by whomsoever made, including but not limited to liens or claims based on Medicare payments or other subrogees, government claims or liens, Department of Public Aid liens, and attorneys' liens, with the exception of any lien asserted by BadgerCare Plus/Medicaid, asserted through the Wisconsin Department of Health Services. While the Released Parties shall bear responsibility for any lien asserted by BadgerCare Plus/Medicaid asserted through the Wisconsin Department of Health Services, SYDNI BRIGGS, by and through her Guardian, agrees to satisfy any and all other valid liens or claims related to the subject matter of this settlement which any person or entity may establish a right to under Wisconsin Law, and to that extent, SYDNI BRIGGS, by and through her Guardian, agrees to indemnify the released parties for any payment of such valid liens if the undersigned, after notice, fails to do so.

SYDNI BRIGGS, by and through her Guardian, represents and warrants that SYDNI BRIGGS is not Medicare eligible and that Medicare has not made any conditional payments for medical services or products received by SYDNI BRIGGS (pursuant to 42 U.S.C. § 1395y(b) and the corresponding regulations) and related to the accident, injury, or illness giving rise to this settlement. Further, SYDNI BRIGGS represents and warrants that if Medicare has made any conditional payments related to the accident, injury, or illness giving rise to this settlement, then within sixty (60) days of the execution of this Agreement, SYDNI BRIGGS shall reimburse Medicare, as required by Medicare Secondary Payer law, including the Medicare regulations at 42 C.F.R. § 411.24(g) and (h). The Parties agree that all representations and warranties made herein shall survive settlement. This settlement is based upon a good faith determination of the parties to resolve a disputed claim. The parties have not shifted responsibility for medical treatment to Medicare in contravention to 42 U.S.C. §1395y(b). The parties resolved this matter in compliance with both state and federal law. The parties made every effort to adequately protect Medicare's interest and incorporate such into the settlement terms.

SYDNI BRIGGS, by and through her Guardian, agrees that, in the event of a breach of these representations and warranties, the Released Parties shall be entitled to an off-set against any remaining payments due SYDNI BRIGGS equal to the amount of any payments made as a result of said breach, up to the total amount of any conditional payments unpaid by SYDNI BRIGGS and related to the injuries or illnesses giving rise to this settlement. SYDNI BRIGGS, by and through her Guardian, agrees to indemnify, hold harmless and defend the Released Parties against any loss, cost, expense, or liability imposed on or incurred by the Released Parties arising from, relating to or concerning Medicare conditional payments related to the injury or illness giving rise to this

settlement.

It is understood in making this Release, that SYDNI BRIGGS will have no rights to make claims against anyone, including the parties released, for more money even if later dissatisfied with this settlement for any reason whatsoever.

The following provisions are agreed to in relation to the structure of settlement and annuities:

I. **PAYMENTS**

In consideration of the Release set forth above, the State of Wisconsin and its insurers, Lexington Insurance Company (hereinafter "Lexington") and Allied World Insurance Company, a subsidiary of Allied World Assurance Company Holdings, GmbH (hereinafter "Allied World") on behalf of the Defendants, hereby agree to pay SYDNI BRIGGS $18,900,000.00 in the following manner:

a. The sum of $4,733,467.19, paid jointly by the State of Wisconsin and its insurers, for SYDNI BRIGGS, SYDNI BRIGGS's attorney fees, case expenses and liens, payable solely to Atterbury, Kammer & Haag, S.C., Trust Account; and payment of $750,000.00 payable to The Sydni Briggs Irrevocable Special Needs Trust, both payments to be paid within sixty (60) days of Briggs providing Attorney Hall with a copy of this Agreement signed by her Guardian and her Attorney. If these payments are not received on or before the due date, interest in the form of liquidated damages shall accrue and be owed in the amount of $2,000 per day from the due date until said payments are received in full.

b. The sum of $2,900,000.00, paid by the State of Wisconsin, payable solely to Atterbury, Kammer & Haag, S.C., Trust Account, for SYDNI BRIGGS's attorney fees, case expenses and liens, to be paid no later than July 1, 2019. If this payment is not received on or before July 1, 2019, interest in the form of liquidated damages shall accrue and be owed in the amount of $1,000 per day from July 1st until payment is received in full.

c. The Periodic Payments described below through purchase of an annuity by Allied World Insurance Company at a total cost of $5,516,532.81 (cost of annuity being disclosed as a condition of settlement):

PAYEE: The Sydni Briggs Irrevocable Special Needs Trust

- $17,900.00 to be paid monthly, for the lifetime of Sydni Briggs, beginning July 1, 2018, guaranteed forty (40) years. Final guaranteed payment to be paid on June 1, 2058

d. The Periodic Payments described below through purchase of an annuity by Lexington Insurance Company and Allied World Insurance Company at a total cost of $5,000,000.00 ($4,900,000.00 to be contributed by Lexington Insurance Company and $100,000.00 to be contributed by Allied World Insurance Company (cost of annuity being disclosed as a condition of settlement):

PAYEE: The Sydni Briggs Irrevocable Special Needs Trust

- $15,909.23 to be paid monthly, for the lifetime of Sydni Briggs, beginning July 1, 2018, guaranteed forty (40) years. Final guaranteed payment to be paid On June 1, 2058

All sums set forth herein constitute damages on account of personal physical injuries or physical sickness, within the meaning of Section 104 (a) (2) of the Internal Revenue Code of 1986, as amended.

II. CONSENT TO QUALIFIED ASSIGNMENT

SYDNI BRIGGS acknowledges and agrees that Allied World Insurance Company shall make a "qualified assignment" within the meaning of Section 130(c) of the Internal Revenue Code of 1986, as amended, of the released parties' and/or the Insurer's liability to make the Periodic Payments set forth in 1(c) above to BHG STRUCTURED SETTLEMENTS INC. (the "Assignee").

SYDNI BRIGGS acknowledges and agrees that Lexington Insurance Company shall make a "qualified assignment" within the meaning of Section 130(c) of the Internal Revenue Code of 1986, as amended, of the released parties' and/or the Insurer's liability to make the Periodic Payments set forth in 1(d) above to PRUDENTIAL ASSIGNED SETTLEMENT SERVICES CORP. (the "Assignee").

The Assignees' obligation for payment of the Periodic Payments shall be no greater than that of released parties and/or the Insurer(s) (whether by judgment or agreement) immediately preceding the assignment of the Periodic Payments obligation.

Any such assignment(s), if made, shall be accepted by SYDNI BRIGGS without right of rejection and shall completely release and discharge the released parties and the Insurer(s) from the Periodic Payments obligation assigned to the Assignees. SYDNI BRIGGS recognizes that, in the event of such assignments, the Assignees shall be the sole obligors with respect to the Periodic Payments obligations, and that all other releases with respect to the Periodic Payments

obligations that pertain to the liability of the released parties and the Insurer(s) shall thereupon become final, irrevocable and absolute.

III. RIGHT TO PURCHASE AN ANNUITY

For its own convenience, the Allied World Insurance Company or its Assignee shall fund its obligation as described more specifically in 1(c) above through the purchase of an annuity from BERKSHIRE HATHAWAY LIFE INSURANCE COMPANY OF NEBRASKA (the "Annuity Issuer").

For its own convenience, Lexington Insurance Company or its Assignee shall fund its obligation as described more specifically in 1(d) above through the purchase of an annuity from PRUDENTIAL INSURANCE COMPANY OF AMERICA (the "Annuity Issuer").

The Annuity Issuers, at the direction of the Insurer(s) or its/their Assignees, shall mail all Periodic Payments directly to the Payee described in 1(c) and 1(d) above. The Payee shall be responsible for communicating a current mailing address to the Insurers' Assignees, and for communicating any changes of mailing address to the Insurers' Assignees in a reasonable and prompt manner. Any delay in payment due to Payee's failure to so inform the Insurers' Assignees will result in no penalty to the released parties or the Insurer(s) for any reason.

IV. PAYEE'S BENEFICIARY

Any payments to be made after the death of any Payee pursuant to the terms of the Settlement Agreement shall be made to such person or entity as shall be designated in writing by Payee to the Insurers' Assignees. If no person or entity is so designated by Payee, or if the person designated is not living at the time of the Payee's death, such payments shall be made to the Estate of the Payee. No such designation, nor any revocation thereof, shall be effective unless it

is in writing and delivered to the Insurers' Assignees. The designation must be in a form acceptable to the Insurers' Assignees before such payments are made.

V. PAYEE'S RIGHT TO PAYMENTS

Payee acknowledges that the Periodic Payments cannot be accelerated, deferred, increased or decreased by SYDNI BRIGGS or any Payee; nor shall SYDNI BRIGGS or any Payee have the power to sell, mortgage, encumber or anticipate the Periodic Payments, or any part thereof, by assignment or otherwise.

VI. NON-ASSIGNMENT BY PAYEE

The periodic payments to be received by Payee as described more specifically in 1(c) and 1(d) above are not subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge or encumbrance by SYDNI BRIGGS or any Payee.

VII. DISCHARGE OF OBLIGATION

The obligation assumed by the Assignee to make each Periodic Payment shall be fully discharged upon the mailing of a valid check or electronic funds transfer in the amount of such payment on or before the due date to the last address on record for the Payee or Beneficiary with the Annuity Issuer. If the Payee or Beneficiary notifies the Assignee that any check or electronic funds transfer was not received, the Assignee shall direct the Annuity Issuer to initiate a stop payment action and, upon confirmation that such check was not previously negotiated or electronic funds transfer deposited, shall have the Annuity Issuer process a replacement payment.

VIII. COMMUTATION (BERKSHIRE HATHAWAY)

Following Sydni Brigg's death, the remaining and unpaid certain payments listed above in 1(c) above and below as Commutable Payments will be commuted in exchange for a lump sum

equal to 95% of the present value of the unpaid Commutable Payments, as calculated by the Annuity Issuer. The present value will be computed using a discount rate equal to the annual effective yield on the date of death of Sydni Briggs of the highest yielding U.S. treasury strip available as reported in the Wall Street Journal (or an equivalent source of such information), plus 200 basis points (2 percentage points). If the date of death is not a business day, the yield on the next business day will be used. The commutation payment will be determined within 30 days after the Annuity Issuer is notified in writing of the death of Sydni Briggs.

The commutation payment will be paid to the person, persons, or entity named as the Contingent Payee under the Annuity Contract.

The payee designation for a specific payment may be irrevocable, and nothing herein shall imply that any Commutable payment is eligible for transfer to any other person. However, if Sydni Briggs has transferred any amount of a specific payment to any other person pursuant to an order of a court under applicable state law, the amount so transferred will not be considered to be a Commutable Payment. The amount so transferred will first be deducted from that portion of the specific payment which is not listed below as a Commutable Payment. If the amount transferred cannot be fully satisfied exclusive of that portion listed below as Commutable Payment, any remaining amount necessary to satisfy said transfer shall be deemed to have been removed from the Commutable Payments hereunder:

$17,900.00 to be paid monthly, beginning July 1, 2018, guaranteed forty (40) years. Final guaranteed payment to be paid on June 1, 2058

IX. COMMUTATION (PRUDENTIAL)

If Sydni Briggs dies on or before the date that all of the Guaranteed Payments become due,

100% of any remaining and unpaid Guaranteed Payments shown in the Payment Schedule referenced above in 1(d) will be commuted and paid in a lump sum. The commuted value of such payments will be determined using a discount rate equal to the effective rate of interest used to establish the Certificate, plus 1%. The commuted value will be paid to the last validly designated Beneficiary(ies).

[THIS AREA INTENTIONALLY LEFT BLANK]

The statements in this Full Settlement and Final Release are contractual terms, and are not mere recitals. Any questions concerning this Release shall be determined and governed by the terms of this Release and the law of the State of Wisconsin.

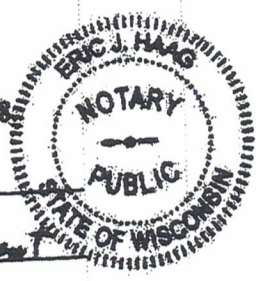
I have read this Release, which consists of 12 pages, have had it explained to me by my lawyer, and understand that it is a final and complete compromise and full settlement of all claims for which I have been fully compensated.

BY THE PLAINTIFF:

Dated this 15 day of March, 2018.

Keli Wendt, GFA
Sydni Briggs, by her Guardian, Keli Wendt

Subscribed and sworn to before me this
15 day of March, 2018.



Notary Public, State of Wisconsin
My Commission ~~Expires~~ is permanent

CONSENT OF ATTORNEY:

As attorney for Sydni Briggs, I have reviewed and consent to the terms of this Settlement with Sydni Briggs.

Eric Haag
Attorney for Sydni Briggs

BY THE RELEASED PARTIES:

Dated this 20th day of MARCH, 2018.

Samuel C. Hall Jr.

SAMUEL C. HALL, JR.
Special Counsel, State of Wisconsin

DocuSigned by:
Kathy A. Martin 3/20/2018
90CCC1170F0744F...

LEXINGTON INSURANCE COMPANY
Authorized Representative

List of Changes

- The youth complaint process has been overhauled so youth place complaints directly into locked boxes that are only accessible to the CLS/LHS Superintendent and Youth Complaint Examiner and hired a full-time Youth Complaint Examiner who reports directly to the Superintendent.
- DJC has hired a Juvenile Mental Health Director position to provide dedicated management-level coordination and oversight of mental health services for juveniles.
- DOC has reassigned a Nurse Coordinator position to solely focus on Juvenile Corrections to provide dedicated coordination and oversight of health care services for juveniles.
- DOC has increased the on-site availability of advanced medical care from 8 hours per week to 40 hours per week.
- All medication at CLS/LHS is passed by licensed medical staff.
- DOC has established a seven-week Youth Counselor Pre-Service Academy which is required of all newly-hired security staff. The Academy includes instruction in use-of-force training, professional communication, verbal de-escalation tactics, and documenting use-of-force incidents, as well as several modules tailored specifically to working with juveniles.
- At the time the Youth Counselor Pre-Service Academy was established, all current CLS/LHS security staff were required to complete the full use-of-force training curriculum, including instruction in professional communication, verbal de-escalation, and documentation of use-of-force incidents.
- All security staff are required to wear body cameras and record interactions with youth.
- Additional fixed cameras have been added to eliminate blind spots throughout the institution.
- Additional handheld cameras have been purchased to document use-of-force incidents in addition to body cameras.
- Notification protocols were standardized, requiring notices to parents of youth injuries and notices to committing counties of youth injuries and serious incidents.
- All youth injuries, regardless of cause, are reviewed on a regular basis by DOC, DJC, and CLS/LHS leadership.
- All staff assaults are reviewed on a regular basis by DOC, DJC, and CLS/LHS leadership.
- Division of Juvenile Corrections leadership are meeting on a regular basis with county juvenile justice contacts.
- $556,000 and 3.25 FTE positions in the 2017 – 2019 biennial budget to expand mental health services for female youth at Copper Lake School.
- $1.4 million and 9.0 FTE positions in the 2017 – 2019 biennial budget to convert to provide permanent positions for nursing staff administering medication at Copper Lake School/Lincoln Hills School.
    - NOTE: that there is a $1.2 million offset in program revenue, so the net increase is approximately $200,000.
- Raised the maximum age of youth with an adult conviction eligible for placement at a juvenile correctional facility from 16 to 18 to comply with the Prison Rape Elimination Act.
- $1.3 million and 8.25 FTE security positons in the 2017 – 2019 biennial budget to move towards PREA compliance.
- $556,000 and 3.25 FTE positions in the 2017 – 2019 biennial budget to expand mental health services for female youth at Copper Lake School.

- Established a low behavior risk unit for youth who are making progress and demonstrating pro-social conduct.
- Established Targeted Intervention Program (TIP) unit to house high-risk youth and youth with the most significant programming needs.
- Established a CLS/LHS Youth Advisory Council, which includes youth from throughout the facility who provide input into various aspects of institution operations.
- Made changes to school and treatment schedules to maximize the amount of time youth spend out of their room engaged in productive activity.
- Non-security staff have all had the opportunity to complete verbal de-escalation and defensive tactics training.
- Expanded on-site and on-call Psychological Services Unit coverage at CLS/LHS.
- Staff from across CLS/LHS have received CIP training, which equips staff with tactics to deescalate and safely resolve situations involving mentally ill and trauma-affected youth.
- DJC has implemented an electronic incident reporting system, replacing the prior paper-based system. All incident reports are entered directly into the system, enabling leaders to quickly search for incidents and confirm that all staff have completed reports. Additionally, the system includes robust search capabilities that allow analysis of reports.

DEPARTMENT OF CORRECTIONS
Division of Juvenile Corrections
DOC-1846 (Rev 5/2014)

WISCONSIN

INCIDENT REPORT - DJC

		INCIDENT REPORT NUMBER:	
FACILITY: Copper Lake School	LOCATION OF INCIDENT. Ida B. Wells Room #6	DATE OF INCIDENT. 11/09/15	TIME OF INCIDENT 07 54
STAFF MEMBER COMPLETING REPORT (Print or Type). A Yorde		STAFF MEMBER TITLE: Youth Counselor	

TYPE OF INCIDENT (Check all that apply)

- ☐ ESCAPE
- ☐ ASSAULT
- ☒ CELL ENTRY
- ☒ SELF HARM
- ☐ MISCONDUCT
- ☐ YOUTH PLACED IN RESTRAINTS
- ☐ FIRE
- ☐ USE OF FORCE
- ☐ DISTURBANCE
- ☒ MEDICAL OCCURRENCE
- ☐ ABSENT WITHOUT LEAVE
- ☐ USE OF CHEMICAL AGENT – TYPE:
- ☐ OTHER- SPECIFY

NAME OF PRINCIPAL PERSON INVOLVED:	STATUS:	DOC #:
Sydni Briggs	☒ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	631939
NAME OF STAFF PRESENT DURING INCIDENT: YCA Stetzer, YCA Daigle, [redacted]	NAME OF SUPERVISOR PRESENT DURING INCIDENT SYC Skolaski	

NAMES OF ADDITIONAL INDIVIDUALS INVOLVED

NAMES OF WITNESSES (Other than those listed above)	STATUS (Youth, Staff, Visitor, Other)	DOC # IF YOUTH
	☐ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	
	☐ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	
	☐ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	
	☐ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	

IF PERSON(S) INJURED – SPECIFY STATUS (Check all that apply)	WAS ANYONE HOSPITALIZED/ GIVEN MEDICAL TREATMENT	WAS THERE ANY PROPERTY DAMAGE	WAS THERE ANY CONTRABAND INVOLVED:
☒ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	☐ NO ☒ YES – SPECIFY WHO. Youth Briggs	☐ NO ☒ YES – SPECIFY: torn and cut clothing	☒ NO ☐ YES – SPECIFY

DESCRIPTION OF INCIDENT

(State all relevant facts including circumstances leading up to and/or causing incident, contributing factors and, if any evidence If anyone was injured, include the name of the person and the extent of the injury. Include all verbal statements)

DISTRIBUTION: Original – Program Supervisor, Copy – Security Director,

While working my assigned post in Ida B. Wells living unit, I, YC Yorde, observed the following emergency incident A few minutes after 7:50am, after completing a bathroom call for high hall, I noticed there were a few call lights on in low hall, including youth Briggs'(#631939)(room #6). At this time, I went near her door and asked: "What do you need Ms Briggs?" and got no response. I knocked on her door and asked the same question over again, again with no response I then looked into youth Briggs' room, only to notice her hanging from her door(to the left of the window as you look at it from the hallway), using what appeared to be multiple strands that had been ripped up from her pink t-shirt At this time, I activated my body alarm, notifying communications that there was an emergency in Ida B. Wells and stated verbally: "Emergency in Wells, we have an unresponsive youth in room #6, low hall, Ida B Wells" At this time, YCA Stetzer arrived at room #6 with a 911 knife and YCA Stetzer and I entered youth Briggs' room to remove youth Briggs from her hanging ligature and also to cut the strands around her neck away. [redacted] At this time, YCA Stetzer removed the part of the ligature that was allowing her to hang from her door with the 911 knife and we got youth Briggs on the floor to remove the portion of the ligature tied around her neck. YCA Stetzer removed the ligature around youth Briggs' neck with the 911 knife, loudly verbalized that he needed the A E.D., [redacted]. YCA Daigle arrived at the door with the A.E D in her hands At this time, YCA Daigle "tagged" me out and her and YCA Stetzer, along with [redacted] until the Emergency Medical Team, that had been called by communications at 7:56am, arrived

SIGNATURE OF STAFF MEMBER COMPLETING REPORT	DATE SIGNED
C Yorde A Yorde	11/9/15

ACTIONS TAKEN AS A RESULT OF INCIDENT:

ACTION:	REASON(S) FOR ACTION.

SIGNATURE OF PERSON AUTHORIZING ACTION	TITLE	DATE SIGNED.

FURTHER TAKEN BY SUPERVISOR / SUPERINTENDENT / DESIGNEE:

ACTION	REASON(S) FOR ACTION:

SIGNATURE OF SUPERVISOR / SUPERINTENDENT / DESIGNEE.	DATE SIGNED

DISTRIBUTION: Original – Program Supervisor, Copy – Security Director,

DEPARTMENT OF CORRECTIONS
Division of Juvenile Corrections
DOC-1846 (Rev 5/2014)

WISCONSIN

INCIDENT REPORT - DJC

		INCIDENT REPORT NUMBER.	
FACILITY: CLS	LOCATION OF INCIDENT: Wells Lower Day Rm.6	DATE OF INCIDENT: 11/09/15	TIME OF INCIDENT: 7:54 AM
STAFF MEMBER COMPLETING REPORT (Print or Type) Stetzer, Darrell		STAFF MEMBER TITLE: YCA	

TYPE OF INCIDENT (Check all that apply)

- ☐ ESCAPE
- ☐ ASSAULT
- ☒ CELL ENTRY
- ☒ SELF HARM
- ☐ MISCONDUCT
- ☐ YOUTH PLACED IN RESTRAINTS
- ☐ FIRE
- ☐ USE OF FORCE
- ☐ DISTURBANCE
- ☒ MEDICAL OCCURRENCE
- ☐ ABSENT WITHOUT LEAVE
- ☐ USE OF CHEMICAL AGENT – TYPE.
- ☐ OTHER- SPECIFY.

NAME OF PRINCIPAL PERSON INVOLVED: Briggs Sydni	STATUS: ☒ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	DOC # 631939
NAME OF STAFF PRESENT DURING INCIDENT: YC Yorde, YCA Daigle, [redacted]	NAME OF SUPERVISOR PRESENT DURING INCIDENT: SYC Skolaski	

NAMES OF ADDITIONAL INDIVIDUALS INVOLVED:

NAMES OF WITNESSES (Other than those listed above)	STATUS (Youth, Staff, Visitor, Other)	DOC # IF YOUTH
	☐ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	
	☐ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	
	☐ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	
	☐ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	

IF PERSON(S) INJURED – SPECIFY STATUS (Check all that apply)	WAS ANYONE HOSPITALIZED/ GIVEN MEDICAL TREATMENT	WAS THERE ANY PROPERTY DAMAGE	WAS THERE ANY CONTRABAND INVOLVED
☒ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	☐ NO ☒ YES – SPECIFY WHO: Briggs	☐ NO ☐ YES – SPECIFY:	☐ NO ☒ YES – SPECIFY: pink T shirt

DESCRIPTION OF INCIDENT (State all relevant facts including circumstances leading up to and/or causing incident, contributing factors and, if any evidence If anyone was injured, include the name of the person and the extent of the injury. Include all verbal statements.)

DISTRIBUTION. Original – Program Supervisor, Copy – Security Director,

On November 11th, 2015 at or around 7:54 AM while running security out time YC Yorde went down the GP hallway to check on a call light. He got to the door and immediately yelled for help and for all the girls to go in and alarmed for an emergency. I ran down the hall and entered the room with Yorde where youth Briggs was hanging from a ligature tied to her top door hinge I cut her down from the door and pulled her to the center of the floor YC Moore and YCA Daigle arrived on scene and I told them to get the AED YCA Daigle ran down the hall and came back with it I [redacted] and checked her vitals as YCA Daigle ran down for the AED Once in the room YCA Daigle opened the AED and I placed the pads on her and started the AED. After the original scan I started CPR and [redacted] arrived. [redacted] and YCA Daigle and myself took turns doing chest compressions. At some point [redacted] The AED fired on the first cycle and just monitored after that. [redacted] A Sherrif's deputy arrived and started taking information before the EMTs arrived. Once EMTs arrived [redacted] and YCA Daigle stepped back to give them room. [redacted] After continued CPR Briggs [redacted]. Briggs was loaded on a gurney and I [redacted]. We belted her to the gurney and they took her out to the ambulance I ran and got her [redacted] I was told to stop and take a breath by Mr Ourada so I gave control over to those above me and went out side to take a break. End of report

SIGNATURE OF STAFF MEMBER COMPLETING REPORT	DATE SIGNED.
YCA STETZER	11/09/15

ACTIONS TAKEN AS A RESULT OF INCIDENT:

ACTION.	REASON(S) FOR ACTION:

SIGNATURE OF PERSON AUTHORIZING ACTION	TITLE	DATE SIGNED

FURTHER TAKEN BY SUPERVISOR / SUPERINTENDENT / DESIGNEE:

ACTION.	REASON(S) FOR ACTION:

SIGNATURE OF SUPERVISOR / SUPERINTENDENT / DESIGNEE	DATE SIGNED

DEPARTMENT OF CORRECTIONS
Division of Juvenile Corrections
DOC-1846 (Rev 5/2014)

WISCONSIN

INCIDENT REPORT - DJC

		INCIDENT REPORT NUMBER:	
FACILITY. Copper Lake School	LOCATION OF INCIDENT: Wells Rm 6	DATE OF INCIDENT. 11/09/2015	TIME OF INCIDENT: 7 50 a.m
STAFF MEMBER COMPLETING REPORT (Print or Type). Toni Moore		STAFF MEMBER TITLE· Youth Counselor	

TYPE OF INCIDENT (Check all that apply)

- ☐ ESCAPE
- ☐ ASSAULT
- ☒ CELL ENTRY
- ☒ SELF HARM
- ☐ MISCONDUCT
- ☐ YOUTH PLACED IN RESTRAINTS
- ☐ FIRE
- ☐ USE OF FORCE
- ☐ DISTURBANCE
- ☒ MEDICAL OCCURRENCE
- ☐ ABSENT WITHOUT LEAVE
- ☐ USE OF CHEMICAL AGENT – TYPE
- ☐ OTHER- SPECIFY:

NAME OF PRINCIPAL PERSON INVOLVED. Briggs Sydni	STATUS· ☒ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	DOC # 631939
NAME OF STAFF PRESENT DURING INCIDENT: YCA Stetzer, YCA Daigle, YC Yorde, [redacted], and [redacted], YC J Larkin	NAME OF SUPERVISOR PRESENT DURING INCIDENT: SYC Skolaski, SYC Cornelius	

NAMES OF ADDITIONAL INDIVIDUALS INVOLVED.

NAMES OF WITNESSES (Other than those listed above)	STATUS (Youth, Staff, Visitor, Other)	DOC # IF YOUTH
	☐ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	
	☐ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	
	☐ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	
	☐ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	

IF PERSON(S) INJURED – SPECIFY STATUS (Check all that apply)	WAS ANYONE HOSPITALIZED/ GIVEN MEDICAL TREATMENT	WAS THERE ANY PROPERTY DAMAGE	WAS THERE ANY CONTRABAND INVOLVED
☒ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	☐ NO ☒ YES – SPECIFY WHO·	☐ NO ☒ YES – SPECIFY: Pink T-shirt	☒ NO ☐ YES – SPECIFY:

DESCRIPTION OF INCIDENT	(State all relevant facts including circumstances leading up to and/or causing incident, contributing factors and, if any evidence. If anyone was injured, include the name of the person and the extent of the injury. Include all verbal statements)

DISTRIBUTION: Original – Program Supervisor, Copy – Security Director,

While working my assigned post in IDB Wells Safety unit on 11/09/2015 and approximate above time I witnessed the following incident, While standing on upper day monitoring the security youth who had their out-time I heard YC Yorde yell and then I heard the personal alarm stating that there was an emergency in Wells At that time all the security girls were sent back to their rooms and secured I ran down the hall to room number 6 and heard YCA Stetzer yelling youth Briggs name There was no response by the youth YCA Stetzer yelled for someone to get the AED I yelled to YCA Daigle to grab the AED. She ran into the booth and got the machine and ran back to room #6 to assist YCA Stetzer. I then saw SYC Skolaski who asked, "Where is the emergency" I said down the hall and pointed toward Youth Briggs room and I said it's medical. He called for medical to come to Wells over his radio I then waited by the back door for [redacted] to let her in the door and let her know what was happeneing. I yelled to her that staff was applying the AED and She yelled back to [redacted]. SYC Skolaski heard [redacted] and called communications to call 911 [redacted] and at that time YC Larkin called HSU and asked for more help [redacted] and assissted YCA Stetzer, YCA Daigle, and [redacted] until EMS arrived on scene and then transported her to the hospital.

SIGNATURE OF STAFF MEMBER COMPLETING REPORT:	DATE SIGNED
K Moore	11-9-15

ACTIONS TAKEN AS A RESULT OF INCIDENT:

ACTION.	REASON(S) FOR ACTION.

SIGNATURE OF PERSON AUTHORIZING ACTION	TITLE	DATE SIGNED

FURTHER TAKEN BY SUPERVISOR / SUPERINTENDENT / DESIGNEE:

ACTION	REASON(S) FOR ACTION:

SIGNATURE OF SUPERVISOR / SUPERINTENDENT / DESIGNEE	DATE SIGNED

DEPARTMENT OF CORRECTIONS
Division of Juvenile Corrections
DOC-1846 (Rev 5/2014)

WISCONSIN

INCIDENT REPORT - DJC

		INCIDENT REPORT NUMBER:	
FACILITY: Coppper Lake School	LOCATION OF INCIDENT. Wells Living Unit	DATE OF INCIDENT. 11-09-2015	TIME OF INCIDENT: 0754
STAFF MEMBER COMPLETING REPORT (Print or Type)· Stacey Daigle		STAFF MEMBER TITLE: YCA	

TYPE OF INCIDENT (Check all that apply)

- ☐ ESCAPE
- ☐ ASSAULT
- ☒ CELL ENTRY
- ☒ SELF HARM
- ☐ MISCONDUCT
- ☐ YOUTH PLACED IN RESTRAINTS
- ☐ FIRE
- ☐ USE OF FORCE
- ☐ DISTURBANCE
- ☒ MEDICAL OCCURRENCE
- ☐ ABSENT WITHOUT LEAVE
- ☐ USE OF CHEMICAL AGENT – TYPE
- ☐ OTHER- SPECIFY:

NAME OF PRINCIPAL PERSON INVOLVED: Sydni Briggs	STATUS: ☒ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	DOC #. 631939
NAME OF STAFF PRESENT DURING INCIDENT: Darrell Stetzer, [redacted], Stacey Daigle and Sydni Briggs	NAME OF SUPERVISOR PRESENT DURING INCIDENT: Mark Skolaski	

NAMES OF ADDITIONAL INDIVIDUALS INVOLVED.

NAMES OF WITNESSES (Other than those listed above)	STATUS (Youth, Staff, Visitor, Other)	DOC # IF YOUTH
Darrell Stetzer	☐ YOUTH ☒ STAFF ☐ VISITOR ☐ OTHER	
Andy Yorde	☐ YOUTH ☒ STAFF ☐ VISITOR ☐ OTHER	
[redacted]	☐ YOUTH ☒ STAFF ☐ VISITOR ☐ OTHER	[redacted]
[redacted]	☐ YOUTH ☒ STAFF ☐ VISITOR ☐ OTHER	[redacted]

IF PERSON(S) INJURED – SPECIFY STATUS (Check all that apply)	WAS ANYONE HOSPITALIZED/ GIVEN MEDICAL TREATMENT	WAS THERE ANY PROPERTY DAMAGE	WAS THERE ANY CONTRABAND INVOLVED
☒ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	☐ NO ☒ YES – SPECIFY WHO: Sydni Briggs	☐ NO ☒ YES – SPECIFY. Torn and cut clothing	☒ NO ☐ YES – SPECIFY.

DESCRIPTION OF INCIDENT

(State all relevant facts including circumstances leading up to and/or causing incident, contributing factors and, if any evidence. If anyone was injured, include the name of the person and the extent of the injury Include all verbal statements.)

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DEPARTMENT OF CORRECTIONS **WISCONSIN**
Division of Juvenile Corrections
DOC-1846 (Rev 5/2014)

On 11-09-2015 at approx 0754 in the morning, I YCA Stacey Daigle was working my assigned post in Wells Living Unit Staff A Yorde activated his body alarm because of a medical self harm incident in youth Sydni Briggs room. S Briggs had placed a ripped up t-shirt around her neck and secured it to the door hinge inside her room. Youth Briggs turned on her call light, [redacted] to use her t-shirt as a noose around her neck A Yorde and D Stetzer entered room due to an immediate emergency of suicide attempt. A yell came down the hallway to grab the AED machine. I activated my body alarm stating we needed medical to Wells imediately I ran to the staff booth grabbed the AED as instructed and returned with it to youths room Youth Briggs was unresponsive on room floor [redacted] D. Stetzer and myself applied the patches for AED machine AED was activated [redacted] while D. Stetzer and myself traded off with chest compressions. [redacted] Emergency Medical Team from Tomahawk was dispatched [redacted] until Emergency Medical Team arrived at Copper Lake School EMT entered Well[redacted]

SIGNATURE OF STAFF MEMBER COMPLETING REPORT	DATE SIGNED
Stacey Daigle YCA	11-9-15

ACTIONS TAKEN AS A RESULT OF INCIDENT:

ACTION	REASON(S) FOR ACTION
Youth was transported to Hospital	Self Harm attempt

SIGNATURE OF PERSON AUTHORIZING ACTION	TITLE	DATE SIGNED

FURTHER TAKEN BY SUPERVISOR / SUPERINTENDENT / DESIGNEE:

ACTION	REASON(S) FOR ACTION:

SIGNATURE OF SUPERVISOR / SUPERINTENDENT / DESIGNEE	DATE SIGNED

DISTRIBUTION: Original – Program Supervisor, Copy – Security Director,

DEPARTMENT OF CORRECTIONS
Division of Juvenile Corrections
DOC-1846 (Rev 5/2014)

WISCONSIN

INCIDENT REPORT - DJC

		INCIDENT REPORT NUMBER	
FACILITY. CLS	LOCATION OF INCIDENT· Wells	DATE OF INCIDENT· 11/09/15	TIME OF INCIDENT: 7.54
STAFF MEMBER COMPLETING REPORT (Print or Type)· Jim Larkin		STAFF MEMBER TITLE YC	

TYPE OF INCIDENT (Check all that apply)

- ☐ ESCAPE
- ☐ ASSAULT
- ☒ CELL ENTRY
- ☒ SELF HARM
- ☐ MISCONDUCT
- ☐ YOUTH PLACED IN RESTRAINTS
- ☐ FIRE
- ☐ USE OF FORCE
- ☐ DISTURBANCE
- ☒ MEDICAL OCCURRENCE
- ☐ ABSENT WITHOUT LEAVE
- ☐ USE OF CHEMICAL AGENT – TYPE.
- ☐ OTHER- SPECIFY.

NAME OF PRINCIPAL PERSON INVOLVED. Sydni Briggs	STATUS ☒ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	DOC #: 631939
NAME OF STAFF PRESENT DURING INCIDENT. YCA S. Daigle YCA Stetzer YC Yorde YC Moore [redacted] [redacted]	NAME OF SUPERVISOR PRESENT DURING INCIDENT SYC Skolaski	

NAMES OF ADDITIONAL INDIVIDUALS INVOLVED·

NAMES OF WITNESSES *(Other than those listed above)*	STATUS (Youth, Staff, Visitor, Other)	DOC # IF YOUTH
	☐ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	
	☐ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	
	☐ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	
	☐ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	

IF PERSON(S) INJURED – SPECIFY STATUS (Check all that apply)	WAS ANYONE HOSPITALIZED/ GIVEN MEDICAL TREATMENT	WAS THERE ANY PROPERTY DAMAGE	WAS THERE ANY CONTRABAND INVOLVED
☒ YOUTH ☐ STAFF ☐ VISITOR ☐ OTHER	☐ NO ☒ YES – *SPECIFY WHO* Youth Briggs	☒ NO ☐ YES – *SPECIFY·*	☒ NO ☐ YES – *SPECIFY*

DESCRIPTION OF INCIDENT

(State all relevant facts including circumstances leading up to and/or causing incident, *contributing factors and, if any evidence* If anyone was injured, include the name of the person and the extent of the injury Include all verbal statements)

On the above date and approximate time YC Yorde yelled get everybody in, who's got the 911 knife. YCA Stetzer then ran down low hall to Youth Briggs' room and YCA Daigle followed I YC Larkin remained at the booth and made sure all the girls made it in their rooms. YCA Daigle then came running to the booth and said get the AED I ,YC Larkin, then got the AED from the bathroom and gave it to YCA Daigle YCA Daigle then ran back down to Youth Briggs' room. A couple

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of minutes later [redacted] arrived at Wells and [redacted] room and [redacted] I YC Larkin then called the LHS HSU and told [redacted] that [redacted] I YC Larkin remained at the booth and continued to do checks, the girls I was assiged to monitor and also monitored the rest of the girls in the building while the emergency was going on until I was relieved

SIGNATURE OF STAFF MEMBER COMPLETING REPORT	DATE SIGNED
	11/09/15

ACTIONS TAKEN AS A RESULT OF INCIDENT:

ACTION	REASON(S) FOR ACTION.

SIGNATURE OF PERSON AUTHORIZING ACTION	TITLE	DATE SIGNED

FURTHER TAKEN BY SUPERVISOR / SUPERINTENDENT / DESIGNEE:

ACTION	REASON(S) FOR ACTION

SIGNATURE OF SUPERVISOR / SUPERINTENDENT / DESIGNEE	DATE SIGNED

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DEPARTMENT OF CORRECTIONS
Division of Juvenile Corrections
DOC-1837 (Rev 7/2014)

WISCONSIN

CENTRAL OFFICE NOTIFICATION OF UNUSUAL INCIDENTS

INSTRUCTION: Attach additional pages and/or other relevant information, if necessary. If the incident occurs during standard business hours, the report must be sent to the administrator and the assistant administrator by 4:30 pm on that day. For incidents occurring during nonstandard business hours, the report should be forwarded no later than 8:00 am the next working day following the incident

INSTITUTION/FIELD OFFICE	LOCATION OF INCIDENT	DATE OF INCIDENT	TIME
CLS	Ida B. Wells Living Unit	11/09/2015	07:54 a m.

TYPE OF INCIDENT (Check all that apply)

- ☐ Chemical Agents
- ☐ Major Disturbance
- ☐ Battery to Staff by Youth
- ☐ Restraints--immobilizing
- ☐ Battery to Youth by Youth
- ☒ Medical Emergency
- ☐ Use of Force by Staff
- ☐ AWOL
- ☐ Life Threatening Self-Harm
- ☐ Significant Property Damage
- Other (specify)
- ☐

NAME OF STAFF INVOLVED	POSITION	SENIORITY DATE
Mark Skolaski	SYC	08/22/2005
Natasha Cornelius	SYC	
Andrew Yorde	YC	05/21/2012
Daryl Stetzer	YCA	07/15/2013
Stacy Daigle	YCA	06/06/2011
Toni Moore	YC	01/13/2014
James Larkin	YC	10/26/1998
Jessica Flater	SW	
Luke Severt	SW	
[redacted]	[redacted]	
[redacted]	[redacted]	
Sue Malicki	YC	12/28/1980

IF PERSON(S) INJURED/ILL (CHECK ALL THAT APPLY)

- ☒ Youth
- ☐ Visitor
- ☐ Staff
- ☐ Other

NAME OF PERSON INJURED / ILL	NATURE OF INJURY / ILLNESS
Sydni Briggs	[redacted]

NAME OF YOUTH	J-NUMBER	DOB	PROGRAM PLACEMENT	STG AFFILIATION	EXPIRATION DATE	COMMITTING OFFENSE/COUNTY
Sydni Briggs	631939	[redacted]	Ida B Wells	N/A	11/11/16	[redacted] Theft, [redacted] - Rock County.

INCIDENT (Detailed explanation of what happened)

On 11/09/2015 at approximately 7:54 a m an emergency alarm was activated in Ida B Wells Living Unit This alarm was followed by YCA Daigle transmitting over the radio that there was an emergency in "low hall" and the health services unit needed to respond. I responded to Ida B Wells Living Unit and upon entering the building was notified by YC Yorde that youth Briggs, Sydni J#631939 had been found by him, suspended from the inside of her room door by a t-shirt that was tied tightly around her neck Prior to my arrival YC Yorde and YCA Stetzer had cut the ligature and moved youth Briggs to the floor. [redacted] Therefore, YCA Stetzer and YCA Daigle began to perform CPR with the use of an AED. At this time, I contacted the communications center, who in turn contacted 911 and an ambulance was dispatched to our location This call was initiated at 7:56 a m At this time, [redacted] I further notified the Superintendent Mr. Ourada of the incident, as well as Health Services Supervisor Ratkovich. [redacted] with a portable oxygen unit, which was supplied to youth Briggs

At approximately, 8:10 a m a Lincoln County Sherriff's Office Deputy Lazarz arrived and at approximately 8:14 a.m the ambulance from the [redacted] arrived at Ida B. Wells Living Unit [redacted]. They left LHS/CLS grounds at 8:28 a m in route for the [redacted]. YC Malicki accompanied youth [redacted] to the [redacted] via an institution van It was later learned that youth Briggs was air lifted from the [redacted] to [redacted]

Other actions taken during this incident included the removal of all general population youth from Ida B Wells Living Unit to the O'Keefe building, where the youth were met by social worker Flatter and numerous PSU staff for debriefing. The security youth in Ida B Well's living unit were all placed under 5 minute self-harm checks and were met with by PSU staff. All staff involved in the incident and working at CLS on this date were relieved from their posts and gathered at a central location for debriefing by Superintendent Ourada, Deputy Superintendent Peterson and Security Director Peterson. Numerous peer support staff were contacted and individually met with each of the staff involved in the incident. Furthermore, a plan was developed to continue to relieve staff from their posts in Ida B. Well's living unit as necessary in the coming days Staff were also provided information regarding the ability to modify their work schedules over the next several days, as necessary and a central information center was established in the Supervising Youth Counselor's office to provide updates to staff on the youth's condition. A formal debriefing for all outgoing and incoming staff will also be organized for the remainder of today's shifts The youth's mother and county worker were notified of the incident and youth's current location The youth's room was sealed at the request of the Lincoln County Sheriff Department for further investigation on 11/10/15. Finally, a schedule was arranged for LHS/CLS to remain at the hospital with youth Briggs until her return to Copper Lake School

ACTION TAKEN (Be specific)

[redacted]
911 was contacted and youth Briggs was transported to the [redacted]
Youth Briggs was later air lifted to [redacted]
Peer supporters and PSU staff met with all employees involved in incident
[redacted].
Youth in Ida B Well's living unit were placed on 5 minute observation checks.
Staff involved in incident was debriefed by the Superintendent, Deputy Superintendent and Security Director.
A plan was enacted to address employee work schedules over the next several days.
Youth's mother and county worker were updated on the incident
An information center was established to provide accurate updates to staff.
Shift debriefings were established for all incoming and outgoing employees.

SIGNATURE OF STAFF COMPLETING REPORT	PRINT NAME	DATE
Mark Skolaski	Mark Skolaski	11/09/2015

DEPARTMENT OF CORRECTION
Division of Juvenile Corrections
DOC-565A (Rev 12/2011)

WISCONSIN

COUNSELOR'S LOG - Security

Log Date	Living Unit
11/09/2015	IDA B WELLS

Shift	Counselors	Initials	Shift	Counselors	Initials
0630 - 1430	Stelzer / Esterholm	DS	1430 - 2230	K. Trake - V's	KT
	Yurske	AY	1430-2230	Matchey / Schmidt	Gm
	Moore,		1430-2230	Towne TA V's / Esterholm.	
	S. Dugle V's / L..... V's		2230 - 0630	Gerz / Zoellner	JG/EZ

MOVEMENT Youth's on Furlough, Off-grounds, TVR's, Transfers, Visits, etc

Beginning Count: 17

[redacted] @9:00

Ending Count: 15 + 1 OG + 1 Med = 16

VISUAL MONITORING / STAFF INITIALS

0630 DS	0845 RL	1100 RL	1315 AL	1530 Gm	1745 Gm	2000 JJ	2200 Gm	0015 J	0230 J	0445 J
0645 DS	0900 RL	1115 RL	1330 AL	1545 Gm	1800 Gm	2015 Gm	2215 Gm	0030 J	0245 J	0500 J
0700 DS	0915 AL	1130 RL	1345 RL	1600 Gm	1815 RL	2030 TN	2230 J	0045 J	0300 J	0515 J
0715 DS	0930 AL	1145 AL	1400 RL	1615 RL	1830 RL	2045 Gm	2245 J	0100 J	0315 J	0530 J
0730 RL	0945 RL	1200 AL	1415 RL	1630 RL	1845 RL	2000 Gm	2300 J	0115 J	0330 J	0545 J
0745 RL	1000 RL	1215 RL	1430 Gm	1645 RL	1900 Gm	2100 JJ	2315 J	0130 J	0345 J	0600 J
0800 RL	1015 AL	1230 RL	1445 Gm	1700 RL	1915 Gm	2115 JJ	2330 J	0145 J	0400 J	0615
0815 RL	1030 AL	1245 RL	1500 Gm	1715 RL	1930 Gm	2130 JJ	2345	0200 J	0415 J	
0830 RL	1045 AL	1300 AL	1515 Gm	1730 RL	1945 RL	2145 Gm	2400 J	0215 J	0430 J	

MAJOR CONFINEMENTS

Youth	Offense	Where Located	Confinement Level	Date & Time In	Date & Time Out	Authorized By
[redacted]		[redacted]			9:00	

LIST CONTACTS, IR'S, FAMILY COUNSELING, HEARINGS RESULTS, ETC.

Youth	Staff	Group/Individual	Subject

Wells Incident of November 09, 2015 @ Approx. 0754 am

Real time	Video footage time
0754-Alarm sounded	0639-Youth Briggs out of room for Breakfast
0756-911 Called/CPR Initiated	0644-Waiting to use the restroom, In/Out of line
0756-SYC Skolaski on scene	0646-Youth Briggs in the restroom
0800- Confirmation that 911 call was made	0648- Youth Briggs out of restroom
0800-Superintendent Ourada notified	0649-Sat down to eat breakfast
0810-LCSD Deputy Lazarz on scene	0656-Finished eating (got up from table)
0814-EMS on scene	0658-Waiting at railing for [redacted]
0828-EMS off scene (with Youth Briggs)	0659-At the YC booth speaking to staff
0830-Youth Brigg's room sealed	0700-[redacted]
0835-Room opened by SYC Cornelius (LCSD Deputy Lazarz to process scene)	0701-Waiting at railing
0850-Room re-sealed and locks changed	0702-YCA Stetzer walks youth Briggs to her room
	0721-Youth Briggs call light turned on
	0744-YC Yorde doing a hall check
	0745-YC Yorde sounds alarm and keys door
	0745-YCA S. Daigle retrieved AED
	0746-SYC Skolaski on scene
	0746-[redacted]
	0751-[redacted]
	0753-SYC Cornelius/Security Director Peterson on scene
	0754-CUS L. McAllister on scene
	0758-Deputy Superintendent Peterson on scene
	0759-Superintendent Ourada on scene
	0800-Moved non-involved youth from low-hall

0801-All CLS youth placed on a 5 min OBS status

0802-LCSD Lazarz on scene w/YCA Fleming

0806-EMS on scene

0814-EMS off scene w/youth Briggs in their care
(YC S. Malicki followed with transport vehicle)

Long term monitoring and [redacted] from this point on

PREA AUDIT REPORT ☑ INTERIM ☐ FINAL
JUVENILE FACILITIES

Date of report: 07-17-15

Auditor Information			
Auditor name: Candy Snyder			
Address: 12279 Brady Drive, Custer SD 57730			
Email: Candy.Snyder@state.sd.us			
Telephone number: (605) 673-2521			
Date of facility visit: June 15 to June 18, 2015			
Facility Information			
Facility Name: Lincoln Hills School – Copper Lake School			
Facility physical address: W4380 Copper Lake Road, Irma, WI 54442			
Facility mailing address: *(If different from above)*			
Facility telephone number: (715) 536-8386			
The facility is:	☐ Federal	☑ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility Type:	☑ Correctional	☐ Detention	☐ **Other**
Name of facility's Chief Executive Officer: John Ourada			
Number of staff assigned to the facility in the last 12 months:			
Designed facility capacity: LHS – 388 CLS - 40			
Current population of facility: LHS – 224 CLS - 29			
Facility security levels/inmate custody levels: Minimum to Maximum			
Age range of the population: 15 to 17			
Name of PREA Compliance Manager: Rick Peterson			
Email address: Rick.Peterson@wisconsin.gov			
Agency Information			
Name of agency: Wisconsin Division of Juvenile Corrections			
Governing authority or parent agency: *(if applicable)*			
Physical address: 3099 E. Washington Ave. Madison WI 53707-7925			
Mailing address:*(if different from above) PO Box 7925, Madison WI 53707-7925*			
Telephone Number: (608) 240-5900			
Agency Chief Executive Officer			
Name: Paul Westerhaus		**Title:** Administrator	
Email address: paul.westerhaus@wisconsin.gov		**Telephone number:** (608) 240-5901	
Agency Wide PREA Coordinator			
Name: Christine Preston		**Title:** PREA Coordinator	
Email address: Christine.Preston@wisconsin.gov		**Telephone number:** (608) 240-5113	

AUDIT FINDINGS

NARRATIVE:

The audit of Lincoln Hills School and Copper Lake School, in Irma, Wisconsin was conducted on June 15-18, 2015 by Candy Snyder, a Certified PREA auditor.

Audit notices were properly posted six weeks in advance of the dates of the on-site audit, and an audit pre-questionnaire with supporting documentation had been sent to the auditor in advance of the on-site audit dates.

An entrance meeting was held with facility staff, to include the following persons in attendance:

John Ourada, Superintendent
Wendy A. Peterson, Deputy Superintendent
Christine Preston, PREA Director
Leigha Weber, PREA Program and Policy Analyst
Steve Wierenga, Director of the Office of Special Operations
Matt Theiler, Corrections Unit Supervisor and Interim PREA Compliance Manager
Rick Peterson, Security Director and PREA Compliance Manager
Vincent Ramos, Ph.D., Chief Psychologist

Following the entrance meeting, Matt Theiler, Christine Preston and Leigha Weber accompanied the auditor on the facility tour. In the afternoon of the first day, the auditor began interviewing specialized staff. Suitable and private accommodations were made for the auditor to conduct interviews. The auditor was not limited in any way from speaking with staff or youth or inspecting any area of the facility. The auditor was given access to the facility at all hours of the day in order to conduct interviews with staff on all shifts. Facility administrators and staff were extremely polite and accommodating throughout the audit.

On the second day of the audit the auditor began with an interview of the Human Resource Manager and a review of the application and hiring process, and employee background checks. Day two continued with the completion of interviews of specialized staff. Those interviews included the state PREA coordinator, both the previous and the newly appointed PREA compliance managers, the facility investigator, the facility superintendent, the chief psychiatrist, the human resources administrator, the volunteer coordinator, a teacher, a social worker, staff responsible for the intake process and the administrator for the Division of Juvenile Corrections.

Mr. Peterson provided a copy of all unit staff schedules, staff rosters and youth rosters. On the second and third days the auditor completed interviews of 14 youth with varying lengths of stay and at least one youth from all housing units. There were no residents who were limited English speaking or had hearing/vision impairment to be in interviewed and there were no residents who identified as LGBTI.

Also on days two and three the auditor completed interviews of ten (10) random staff from the roster provided. These interviews represented staff from various shifts, varying degrees of longevity, diverse job classifications and worked within varying housing units. All required interviews were conducted on-site during the four days of the audit.

On the fourth day the auditor reviewed investigative files. There were 17 sexual assault/harassment allegation cases reported within the past year with only one substantiated case. Investigative files were reviewed and all were handled appropriately and per the standards. One case is still under investigation. An exit briefing was held with the facility Superintendent, the Deputy Superintendent and both the previous and the current PREA Compliance Managers.

DESCRIPTION OF FACILITY CHARACTERISTICS:
The Lincoln Hills School (LHS) for boys is a secure campus comprised of an administrative/office building, a school building, a chapel and eight housing units for male youth.

The administrative building consists of a control room, an intake area, a visit area, offices, laundry, kitchen, secure storage area, staff dining hall, conference rooms, medical clinic, and social work offices. The school building consists of classrooms, library, welding shop, gymnasium, Victims Impact program area, and a maintenance shop. The housing units for boys include eight housing units: Krueger, Dubois, Miller, Rodgers, Douglass, Curtis, Black Elk and Adams. Krueger is the secure detention unit for males and therefore each individual room has a toilet/sink unit. At the time of the audit Miller did not have youth assigned as it was undergoing remodeling. A ninth unit, Roosevelt, is no longer in use. The housing units are all of similar construction with few differences and include a central control staff area, shower and toilet area, dayroom/classroom, kitchen, storage room two offices and two wings comprised of 25 individual rooms that sleep one to two youth each.

The Copper Lake School (CLS) for girls is a secure campus within the secure LHS campus. CLS is comprised of an administrative building [Hughes] and two units for girls Wells and King. The housing units are all of similar construction and include a central control staff area, shower and toilet area, dayroom/classroom, kitchen, storage room two offices and two wings comprised of 25 individual rooms that sleep one to two youth each.

The facility is equipped with a surveillance monitoring system with 199 cameras throughout the facility.

Lincoln Hills School opened in the summer of 1970. From 1972 through 1994, both boys and girls were placed in the institution. In 2011, Copper Lake School for Girls opened at the Lincoln Hills site. LHS also serves as a secure detention resource for nearby counties.

Their mission is to provide community protection and hold youth fully responsible for their behaviors while offering them skill-building opportunities that contribute to victim and community restoration.

To further this objective, the LHS/CLS provides an extensive range of programs, treatment and other services described under Type 1 Secured Juvenile Correctional Facilities. Youth attend high school education classes. Their vocational programs include welding, woodworking and computer business applications. Youth participate in groups that help develop pro-social goals/skills and create increased awareness of the impact of crime on victims.

The LHS/CLS houses secure detention youth, adjudicated youth and sanctioned youth.

SUMMARY OF AUDIT FINDINGS:
Residents reported feeling safe at LHS/CLS. All residents reported at least two methods of reporting. The facility had posters placed throughout the facility. The residents stated they had a handbook provided upon intake to refer to throughout their stay.

Staff were familiar with how to perform their responsibilities in prevention, detecting and responding to incidents of sexual abuse and sexual harassment. Staff were able to relay to the auditor signs to watch for in residents who may have experienced sexual abuse or harassment. The facility staff assigned to monitor for retaliation were aware of the duties necessary to detect and monitor for retaliation. Specialized staff were knowledgeable in their roles.

The interviews of residents reflected all were aware of PREA, had received written material and acknowledged their familiarity with how to report allegations of sexual abuse and sexual harassment. During the interviews staff indicated they were knowledgeable about PREA and their responsibilities related to reporting requirements. They were also aware of the proper procedures to follow if they are the first responders to any PREA related allegation.

Through the pre-audit and on-site audit processes, the auditor determined that several standards were not met. A corrective action plan for compliance has been developed. Details of corrective actions are written under each applicable standard within this report.

Number of standards exceeded: **0**

Number of standards met: **26**

Number of standards not met: **13**

Non-Applicable standards: **2**

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Wisconsin DOC Executive Directive #72 "Sexual Abuse and Sexual Harassment in Confinement (PREA)" includes a zero-tolerance statement, the approach in implementing prevention, detection and response, definitions of prohibited behaviors, strategies, and intent to prosecute perpetrators fully. This directive also details prevention, detection, and response protocols. At the time of the on-site portion of the audit this directive was still in draft form. The auditor received the signed directive on June 22, 2015. The PREA Coordinator (Director) and the PREA Compliance Managers were very knowledgeable and they have done a tremendous amount of work in a short time in order to bring both the state of Wisconsin and the LHS/CLS into compliance with PREA Standards. The youth receive detailed information about rights and reporting during their admission processes. The agency PREA Coordinator is a full-time position and is assisted by a PREA Program and Policy Analyst. The initial facility PREA Compliance Manager who also serves as a Corrections Unit Director has taken the lead on the facility's PREA compliance activities and reports to the facility Superintendent and to the agency PREA Coordinator. He appeared to have sufficient time to conduct his duties and was present during this audit. The facility is currently in the midst of a change of duties and the newly appointed PREA Compliance Manager who also serves, as the Security Director was present throughout the audit process. Both the previous and newly appointed PREA Compliance Mangers appear to work very well together and have stated that they will both continue to work in tandem on PREA related issues.

Standard 115.312 Contracting with other entities for confinement of residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

This standard is not applicable. The facility does not contract for the confinement of its residents with other private agencies/entities.

Standard 115.313 Supervision and monitoring

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☑ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The newly signed agency directive relating to staffing plan, video monitoring, unannounced rounds and staffing ratios clearly documents PREA requirements. The staffing plan was recently developed and should be reviewed during management team meetings to ensure proper coverage is met. The daily work schedules were provided and are consistent with the staffing plan. The facility uses a utility staff member that can fill-in within the various units to ensure adequate staff supervision. Typically deviations from the staffing plan were due to employee illnesses, vacation and training. The facility only recently began documenting unannounced rounds and provided a "Daily Living Unit Inspection" report. The report is posted on the back of the door of each living unit and the upper/mid-level managers are expected to initial when they conduct required unannounced visits on all shifts. Staff is prohibited from alerting other staff of unannounced rounds as noted in the policy. The facility tour confirmed ample resident supervision/monitoring capabilities. Numerous video cameras were strategically located throughout the facility and were in good working order. However, the auditor noticed on the tour that there were notification lights over the door of individual living cells that had been lit by the resident and were not immediately responded to by the staff. The unit manager stated that procedure dictates the staff within the staff office use the two-way intercom system to determine the youth's need and immediately extinguish the light. They will provide remedial training for all living unit staff on responding to the notification lights immediately. There were neither judicial findings of inadequacy nor findings of inadequacy from any investigation agency/oversight bodies.

Corrective Action: Continue to document unannounced visit by intermediate and higher-level supervisors. The rounds should occasionally include the Superintendent and other higher-level agency management at least once per month. Currently the Unit Manager has made numerous rounds on 1^{s} and 2nd shift. However, the 3rd shift should be visited at least once per month. Provide a policy, post order or other written documentation that outlines the procedure for responding to resident cell notification lights. Provide documentation of remedial training provided to all living unit staff on response time for resident notification lights.

Standard 115.315 Limits to cross gender viewing and searches

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility does not conduct cross-gender pat-down searches except in exigent circumstances. The facility has adequate staff coverage to ensure there are no cross gender strip searches, cross gender visual body cavity searches, and cross gender pat-down searches. There have not been any of these types of searches of youth. The facility has policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Such policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit. The facility does not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it is determined during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner.

The agency trains security staff on how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

A memorandum was issued from the Superintendent to all staff of LHS and CLS on January 28, 2015 requiring announcements of cross-gender staff on duty in living areas and other areas such as gymnasium locker rooms etc. The auditor observed these announcements in many areas during the tour and it was relayed through both the staff and youth interviews. There were some youth who reported that it is not consistent yet with all staff. The auditor recommends strengthening this process by supervisory staff modeling and consistent reminders at weekly shift briefs and staffing meetings.

There is an observation window between the staff duty desk and toilet/shower area that is drawn when a resident is showering or toileting. Staff of the same gender as the resident can open the curtain to monitor for supervision, but the curtain allows for privacy.

Standard 115.316 Residents with disabilities and residents who are limited English proficient.

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Wisconsin DOC Executive Directive #71 Language Assistance Policy and Implementation for Addressing Needs of Offenders with Limited English Proficiency (LEP) requires all facilities within the DOC to provide access to vital documents, important information and health services during their confinement. In addition, the auditor viewed posters and was provided a Sexual Abuse Prevention and Intervention Handbook that was written in Spanish. There are posters within the visit area about providing assistance for LEP Needs. The Division of Juvenile Corrections Limited English Proficiency Policy dated October 2012 outlines how services are obtained through the Wisconsin VendorNet.

The agency takes appropriate steps to ensure residents with disabilities (for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

Interpretive services have not been needed during the review period; however the DOC has a solid policy and plan to secure appropriate services through private professional contractors.

The policy states the facility does not rely on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety. The auditor recommends that staff training be strengthened in the area of not using resident interpreters and how to secure interpretive services. Although administrators were very familiar with the process of securing interpretive services, line staff are a little less knowledgeable and one stated that they probably could use a resident interpreter.

Standard 115.317 Hiring and promotion decisions

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☑ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Wisconsin DOC Executive Directive #42 outlines the requirements for criminal background checks on employees or applicants. The directive states that criminal background checks are conducted on applicants before an offer of employment is made and on current employees when they move to positions with "significantly different duties." The current directive does not contain language that requires the periodic checking of employees. The auditor interviewed the human resources director and reviewed a random sampling of employee files to include line staff, interns, volunteers, as well as contracted staff and found the necessary background checks were ran prior to employment/service.

Executive Directive #42 is currently under revision to include language to comply with the PREA standard as follows: The Department shall conduct background checks either by running fingerprints or processing a criminal background check at least once every five years on current employees who may have contact with juveniles.

The facility does not consult any child abuse registry and stated that there is not a child abuse registry for the state of Wisconsin. The auditor did locate a memo from the Department of Children and Families (DCF) on their website in which they confirm that they do not have a child abuse registry and are not planning to develop one. In order to comply with the federal Adam Walsh Act the DFS completes a check by reviewing information maintained by the Department of Health and Family Services regarding substantiated reports of child abuse or neglect for caregivers and individuals in their household over 12 years of age.

The auditor could not find specified document in which they asked prospective applicants, contractors and volunteers who may have contact with residents directly about previous sexual misconduct described in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. There was no statement signed by prospective applicants, contractors and volunteers that imposed a continuing affirmative duty to disclose any such misconduct. The auditor provided a sample statement to the

Corrective Action: Provide the signed Executive Directive #42 that has been revised to include requiring a background check every five years. Provide a signed, written statement from the person or office that has completed background checks on all current LHS/CLS employees, contractors and volunteers. Provide a document sample in which the facility asks all applicants and employees who may have contact with residents directly about previous sexual misconduct. The document must also contain a statement that there is a continuing affirmative duty to disclose any such misconduct.

Standard 115.318 Upgrades to facilities and technology

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility considers how technology enhances their ability to protect residents from sexual abuse. They have almost 200 cameras throughout the facility and have plan of converting many of the cameras systems that can be viewed remotely by senior administrators. The auditor recommended that they develop a plan to replace solid doors to storerooms and other areas with doors that have a window light. This limits areas where youth can be isolated out of view of others. The auditor also recommended that they conduct a formal, annual facility review that assesses areas such as blind spots, camera coverage, lighting etc.

Standard 115.321 Evidence protocol and forensic medical examinations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility offers all residents of sexual abuse access to forensic medical examinations, with the St. Mary's Hospital in Rhineland or Aspirus Hospital in Wausau without financial cost, where evidentiary or medically appropriate. Such examinations are to be performed by Sexual Assault Nurse Examiners (SANEs) where possible.

The facility provides victim advocate services from the Women's Community, in Wausau or the Tri-County Council in Rhinelander. As requested by the victim, a victim advocate accompanies and supports the victim through the forensic medical examination process and investigatory interviews and are provide emotional support, crisis intervention, information, and referrals. To the extent the facility itself is not responsible for investigating allegations of sexual abuse, the facility requests that the investigating agency follow the requirements listed above.

Standard 115.322 Policies to ensure referrals of allegations for investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☑ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. Wisconsin DOC Executive Directive #72 "Sexual Abuse and Sexual Harassment in Confinement (PREA)" states that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior.

The facility has four investigators who have received the required training for conducting administrative investigation and the required information to protect evidence. All potential criminal investigations are referred to the Lincoln County Sheriff's office in Merrill, WI. The facility has a very good working relationship with the investigator from Lincoln County Sheriff's office. The facility documents all such referrals.

Corrective Action: The Agency must publish its policy on its website that describes the responsibilities of the facility and the investigating entity conducting investigations of sexual abuse or sexual harassment allegations.

Standard 115.331 Employee training

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The auditor reviewed lesson plans, the PowerPoint and reviewed signatures on the PREA acknowledgement form. The information presented in training was confirmed through interviews with random staff. The PREA Compliance Manager provided an updated PowerPoint in the areas that the auditor recommended strengthening the training curriculum. The auditor recommended the signature sheets specifically outline the 11 points spelled out by the standards and the trainee acknowledge understanding of those 11 specified points.

Standard 115.332 Volunteer and contractor training

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☑ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The auditor reviewed lesson plans, the PowerPoint and interviewed the Volunteer Coordinator and was provided the tracking sheet on volunteer and contractor training. The information presented in training was confirmed through interviews with random staff.

Corrective Action: The facility needs to provide a signature sheet stating the volunteers and contractors have understood the PREA training they have received.

Standard 115. 333 Resident education

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☑ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

During the intake process, residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. Once the resident is assigned to a housing unit the resident is provided with further training. There are posters throughout the facility and in every housing unit. All youth receive a Sexual Abuse /Assault Prevention and Intervention handbook and all youth receive a LHS/CLS Handbook that outlines PREA information. The facility has components in place to provide the initial training and the more comprehensive training, but the comprehensiveness of the training varies between the living units – some do a better job than others. All youth reported receiving the initial training and the handbook, but the responses varied on the comprehensive training when interviewing youth from different living units.

Corrective Action: The facility must provide signed documentation from the resident indicating they participated in these education sessions. Some living unit staff review the PREA training continually. However, there should be signed documentation each time this is done and the PREA Compliance Manager should ensure that all housing units are consistently giving the more comprehensive training to residents.

Standard 115.334 Specialized training: Investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility complies with specialized training as indicated by certificates of participation in the NIC Course PREA Investigating Sexual Abuse in a Confinement Setting and interview with investigative staff. In addition to the general training provided to all employees the facility ensures that the in house investigators have received training in conducting investigations in confinement settings. This training includes techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence

required to substantiate a case for administrative action or prosecution referral. The facility maintains documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations.

Standard 115.335 Specialized training: Medical and mental health care

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☑ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Through interviews with medical and mental health staff it is apparent they are knowledgeable in how to detect and assess signs of sexual abuse and sexual harassment; how to preserve physical evidence of sexual abuse; how to respond effectively and professionally to victims of sexual abuse and sexual harassment; and how and to whom to report allegations or suspicions of sexual abuse and sexual harassment. However, the facility does not maintain documentation that medical and mental health practitioners have received the specialized training.

Corrective Action: Provide documented evidence that medical and mental health practitioners have received the specialized training. There is specialized training on both the National Institute of Corrections website and the Ending Violence Against Women International website.

Standard 115.341 Screening for risk of victimization and abusiveness

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☑ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The auditor reviewed policy and then interviewed random residents and intake staff responsible for screening. Only limited staff have access to the risk screening form. The process for screening is relatively new but staff had a clear understanding of the process. However, no youth interviewed remembered being asked any screening questions. Two youth stated they may have been asked those questions by a social worker, but did not specifically remember it.

The standard requires that usually within 24 hours but no later than 72 hours of the resident's arrival at the facility and periodically throughout a resident's confinement, the facility maintains and uses information about each resident's personal history and behavior to reduce the risk of sexual abuse by or upon a resident.

The facility has recently implemented a screening tool and reported not all of the screenings are complete. In addition, the screening tool does not consider any gender non-conforming appearance, mannerisms, or self-identification (LGBTI). The screener does not ask the youth if they identify as gay, lesbian, straight, bisexual or transgendered. During the staff interviews many staff felt uncomfortable with questions relating to LGBTI status.

Corrective Action: The facility must provide documented evidence of screenings performed on all youth. The auditor recommends changing the screening tool. Instead of the screening looking for inappropriate physical behaviors (boys wearing makeup, sexual behavior) that the screener ask youth "Do you identify as gay, lesbian, straight, bisexual or transgendered?" The auditor recommends that the word inappropriate in this instance be replaced with non-conforming appearance or mannerisms.

Standard 115.342 Use of screening information

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☑ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility is doing a good job with placements based on all information obtained to make housing, bed, program, education and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse. However, they were not using a specific screening tool until recently and not all residents have been formally screened utilizing the screening instrument. The facility has had no transgender or intersex residents, but both policy and interviews indicate that a transgender or intersex resident's own views with respect to his or her own safety are be given serious consideration. It is also indicated that transgender and intersex residents will be given the opportunity to shower separately from other residents. The facility does not place lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed or other assignments solely on the basis of such identification or status, nor does the facility consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. The facility indicates through both policy and interviews that they will consider on a case by case basis assignment to a male or a female living unit whether the a placement would ensure the resident's health and safety, and whether the placement would present management or security problems. Facility procedure is to relocate a resident to another living unit rather than using isolation as a means for protecting the resident's safety.

Corrective Action: Screen all residents utilizing the screening tool to ensure appropriate housing and placement decisions have been made.

Standard 115.351 Resident reporting

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☑ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility provides multiple internal ways for residents to privately report sexual abuse and sexual harassment, or retaliation. The facility provides a PREA Reporting hotline (777 line) that currently reports to the Department of Corrections Investigations team in the DOC central office in Madison. The Agency has plans to implement a reporting line to the Attorney General's office by dialing 888 that meets the standard of one method for reporting to an entity that is not a part of the DOC.

Almost all youth reported feeling very comfortable reporting directly to their staff or another person within the facility that they felt comfortable with. They all reported there is a grievance process in which they could also speak with the Superintendent. The staff accepts reports made verbally, in writing, anonymously, and from third parties and promptly documents any verbal reports. The facility provides residents with access to tools necessary to make a written report.

Corrective Action: Until the 888 line is implemented the facility does not have at least one method for reporting to a public or private entity or office that is not part of the DOC.

Standard 115.352 Exhaustion of administrative remedies

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☑ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility has Policy 7.02 Youth Complaint and Appeal Process. However, there are no time limits on when a resident may submit a grievance regarding an allegation of sexual abuse. The policy allows for the assistance by a compliant mediator/supervising youth counselor. However it does not allow for assistance by third parties, including fellow residents, staff members, family members, attorneys, and outside advocates in completing administrative remedies relating to allegations of sexual abuse, and for them to file such requests on behalf of residents.

There is no provision in the policy for the filing of an emergency complaint alleging that a resident is subject to a substantial risk of imminent sexual abuse.

Corrective Action: The policy must be updated to allow for third parties to assist the youth in completing a complaint form or filing out a complaint form on behalf of the youth. The policy must establish procedures for the filing of an emergency complaint alleging that a resident is subject to a substantial risk of imminent sexual abuse.

Standard 115.353 Resident access to outside confidential support services.

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility provides residents with access to outside victim advocates for emotional support services related to sexual abuse by providing victim advocate services from the Women's Community, in Wausau or the Tri-County Council in Rhinelander. As requested by the victim, a victim advocate accompanies and supports the victim through the forensic medical examination process and investigatory interviews and are provide emotional support, crisis intervention, information, and referrals. The auditor recommends that training be strengthened so that all staff and youth know specifically the names of the organizations that provide victim advocate services. There were a few that only referenced internal social workers and mental health staff.

The facility provides residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians.

Standard 115.354 Third-party reporting

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☑ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency has not identified a method to receive third-party reports of sexual abuse/harassment nor distributed the information publicly on how to report sexual abuse and sexual harassment on behalf of a resident.

Corrective Action: The agency must post on their website how to report sexual abuse and sexual harassment on behalf of a resident.

Standard 115.361 Staff and agency reporting duties

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility requires all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

The agency also requires all staff to comply with any applicable mandatory child abuse reporting laws.

Apart from reporting to designated supervisors or officials and designated State or local service agencies, staff are prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions.

Medical and mental health practitioners are required to report sexual abuse to designated supervisors and officials as well as to the designated State or local service agencies where required by mandatory reporting laws. Such practitioners are required to inform the residents at the initiation of services of their duty to report and the limitation of confidentiality.

Upon receiving any allegation of sexual abuse, the Superintendent or designee promptly reports the allegation to the appropriate agency office and to the alleged victim's parents or legal guardian, unless the facility has official documentation showing the parents or legal guardian should not be notified.

The facility reports all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators.

Standard 115.362 Agency protection duties

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Through interviews with the Superintendent, PREA Coordinator, PREA Compliance Manager and random staff there is evidence to support that the facility requires all staff to take immediate action to protect the resident from imminent sexual abuse. There have been no instances that the facility determined that a resident was subject to risk of imminent sexual abuse.

Standard 115.363 Reporting to other confinement facilities

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Through interviews with the Superintendent, PREA Coordinator, PREA Compliance Manager and random staff and policies and procedures properly document reporting actions which will be taken upon receiving an allegation of sexual abuse of a resident while at another facility with such action initiated no later than 72 hours and actions documented. The auditor recommends that during training to staff this be reinforced. Notification must be from Superintendent to Superintendent. There was a few staff that were unaware of this requirement. There have been no instances of these allegations received regarding abuse at other facilities.

Standard 115.364 Staff first responder duties

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility policies comply with all elements of this standard (separate alleged victim/abuser, preservation and protection of crime scene, to include collection of physical evidence as soon as possible, including the request of the victim not to take any actions which could destroy any physical evidence) and all staff has been trained accordingly. Interviews with random staff including first responders confirmed knowledge of policy requirements and staff expectations.

Standard 115.365 Coordinated responses

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility has a PREA Checklist with operating practice, which coordinates actions to be taken when an incident occurs. This plan coordinates actions among staff first responders, medical/mental health staff, investigators and facility leadership. Staff interviews and interviews with the Superintendent indicate staff are aware of their responsibilities to coordinate responses within the facility.

Standard 115.366 Preservation of ability to protect residents from contact with abusers

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

There are no barriers preventing the Superintendent from removing alleged staff, volunteer, or contractor sexual abusers from contact with residents pending the outcome of the investigation and a determination of discipline.

Standard 115.367 Agency protection against retaliation

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility has a written policy related to protection against retaliation. The PREA Compliance Manager is charged with monitoring for retaliation. Should any other person who cooperates with a sexual misconduct investigation express fear of retaliation; appropriate protective measures will be taken. Retaliation monitoring will be discontinued should the allegation be unfounded. Measures include housing changes, removing contact of alleged staff/resident abusers and emotional support services for those who fear retaliation. Interviews with the PREA Compliance Manager confirmed his duties and responsibilities. There have been no instances of alleged retaliation. The auditor recommended the PREA Compliance Manager keep a logbook of each time he has made contact with a resident or staff to follow-up that there has been no retaliation.

Standard 115.368 Post-allegation protective custody

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

This standard is not applicable. The facility does not use segregated housing of residents as a means to keep them safe from sexual misconduct. Interviews confirmed the prohibition of segregated housing for this purpose.

Standard 115.371 Criminal and administrative agency investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The auditor reviewed agency investigative files. The facility had one substantiated incident of sexual abuse in April 2015. The incident was properly investigated as outlined by agency policy and PREA standards.

Administrative investigations include efforts to determine whether staff actions/failures contributed to the abuse documented through written reports which will include physical/testimonial evidence, credibility reasoning assessments and investigative facts and findings. All written reports will be retained for at least seven (7) years from resident(s) discharge or until the age of majority is reached whichever is longer. Investigations will not be terminated due to the departure of an alleged abuser or victim. The facility will cooperate with outside investigators and will remain informed of the investigation progress.

Standard 115.372 Evidentiary standards for administrative investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Agency policy stipulates no standard higher than a preponderance of evidence will be used in making a determination of alleged sexual abuse/harassment. Through interviews with investigators, the agency PREA Coordinator, and the PREA Compliance Manager it was stated they use no standard higher than the preponderance of evidence in making final determinations of sexual abuse/harassment. The auditor did note that many of the cases were unsubstantiated and recommended that staff review the training and hold discussions on each case. If the written documentation leads the reader to believe the incident occurred then the case should be substantiated.

Standard 115.373 Reporting to residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Agency policy requires residents to be informed as to whether the allegation was substantiated, unsubstantiated or unfounded; whether the allegation involved staff, contractors, volunteers or another resident. If a sexual misconduct allegation is confirmed, the resident will be informed of the abuser's employment/volunteer/contractor status; and as appropriate of an indictment/conviction. Interviews with the Superintendent and the PREA Compliance Manager confirmed practices involving all standard components were in place. Information regarding the status of investigations is readily available and was provided to the auditor. The case file is notated that resident was made aware of the outcome. The auditor recommends that written documentation of the report to resident be assured through the resident's signature.

Standard 115.376 Disciplinary sanctions for staff

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Agency policy requires staff members who have violated sexual abuse, sexual harassment and retaliation policies are subject to disciplinary sanctions. No staff has violated agency sexual abuse, harassment or retaliation policies. Interviews conducted with the Superintendent and the PREA Compliance Manager verified that there had been no substantiated allegations at the facility during this audit period review. Interviews also confirmed that agency policy would be followed should disciplinary measures be required including a report to law enforcement and relevant licensing authorities should termination and/or resignation of staff occur.

Standard 115.377 Corrective actions for contractors and volunteers

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Agency policy states contractors and volunteers are subject to disciplinary actions including termination for violation of agency sexual abuse policy. There have been no contractors or volunteers accused of sexual misconduct in the audit review period. According to the Superintendent, should any violation of this type be substantiated, the facility has complete authority to administer remedial measures including prohibiting further contact with residents that they could be prohibited from entering the facility for violation of the facility's sexual abuse/harassment policies.

Standard 115.378 Disciplinary sanctions for residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

For incidents of youth-on-youth sexual abuse, sexual harassment or retaliation, administrative sanctions will be handed out following the formal disciplinary processes and applied commensurate with the level of infraction. The mental health provider indicated through the interview that a therapeutic approach is sought when administering sanctions. Thorough resident interviews youth stated they have good rapport with social workers and mental health professionals and feel that any level of counseling needed would be provided. A youth's access to general programming or education is not conditional on receiving interventions designed to address/correct underlying reasons or motivations for abuse.

Standard 115.381 Medical and mental health screenings; history of sexual abuse.

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Both through the PREA screening completed by intake staff and the screening completed by Medical staff upon intake, any resident that has experienced prior sexual victimization or has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, will be offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. Interviews confirmed agency policy expectations and staff were aware of their responsibilities including limiting information strictly to medical/mental health and other staff, as necessary. Medical and mental health staff was also aware of mandatory reporting laws for residents. The auditor recommended a standard location for documenting the date that this follow-up meeting was offered and whether the resident did or did not desire to have follow-up with a medical or mental health practitioner.

Standard 115.382 Access to emergency medical and mental health services

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

A review of facility policy documented PREA requirements for access to emergency medical and mental health services. In the event services after hours are not available by the facility medical and mental health staff, residents would be taken to either St. Mary's Hospital in Rhineland or Aspirus Hospital in Wausau. These services have not had to be used during the audit review period.

Standard 115.383 Ongoing medical and mental health care for sexual abuse victims and abusers

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Agency policy requires that medical and mental health evaluations and treatment is offered at no cost to sexual abuse victims and abusers. Medical and mental health staff verified this as a necessary practice. However, mental health staff stated that as soon as an incident was reported, a counseling session would be scheduled. When residents are transferred or discharged, a continuing care plan is developed for follow-up services consistent with those services provided in the community. Tests for sexually transmitted infections and pregnancy are offered, but no resident requested testing. If a youth will be taken to the local hospital, these tests will be offered there.

Standard 115.386 Sexual abuse incident reviews

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☑ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility does not conduct formal sexual abuse incident reviews following each sexual abuse investigation specifically answering the questions posed within the standard. The auditor recommended a consistent date each month is set for the review of any incidents from the previous month. This review should include upper-level staff, supervisors, investigators, medical and mental health staff.

Corrective Action: The facility shall devise a means of documenting a formal review process and ensure a review is completed within 30 days after each incident, unless the incident is unfounded.

Standard 115.387 Data collection

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility collects uniform data for all allegations of sexual abuse based on incident reports and investigation files. The facility collects uniform data for all allegations of sexual abuse based on incident reports, reports, and investigation files. Aggregate annual data is available and was provided to the auditor. The facility has provided this information to the Department of Justice through the Survey of Sexual Violence.

Standard 115.388 Data review for corrective action

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☑ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility has not held an annual review of data or prepared an annual report. This review should be attended by all upper level managers and should report findings and corrective actions as well as the progress made through the previous year in addressing sexual abuse

Corrective Action: The agency shall prepare an annual report assessing the agency's progress in addressing sexual abuse and post this annual report on the agencies website. The PREA Coordinator and Incident Review Team shall review all incidents for corrective action measures.

Standard 115.389 Data storage, publication and destruction

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☑ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Agency posts PREA related data on the Agency's website http://doc.wi.gov/About/DOC-Overview/Office-of-the-Secretary/Prison-Rape-Elimination-Act-Unit

Data collected is retained via limited access and through a secure server for at least ten (10) years.

AUDITOR CERTIFICATION

I certify that:

- ☑ The contents of this report are accurate to the best of my knowledge.
- ☑ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- ☑ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Candace L. Snyder

Auditor Signature

July 17, 2015

Date

Manager's Meeting
October 27, 2015

Present: John Ourada, Wendy Peterson, Rick Peterson, Audrey Gaedtke, Lori McAllister, Sandy Ratkovich, Mike Stockowitz, Jessica Legois, Mary Zenk, Matt Theiler, Wendell Quesinberry, Sue Holt, Rebecca Cleveland, John Holzinger, Recorder: Barb Wais

Manager/Supervisor Round Table

- Administration (John/Wendy)
  - PbS continues with the tracking of hours. Idle hours data was collected last week. This Saturday is the last data collection date with data entry being completed next week.
  - With the food truck, it works better to stack tray back in the pans.
  - BTM is updating roaming profiles. In the future, files saved to a desktop will not be accessible when signing on another computer.
  - A PREA audit concern is call light response times. In addition, expectations need to be set for youth with the use of call lights, maintaining consistency between the units.
  - Living unit record (counselor logs, staff notebooks, out time records) storage needs to be reviewed. Currently, records are being stored in several areas. A new procedure for living unit records is being developed.
  - Holiday/Christmas Season is approaching. Committee co-chairs this year will be Wendell Quesinberry, Christine Suter, and John Holzinger. As in the past, please assist in the various areas and let them know you are interested in assisting.

- Security (Rick)
  - Room searches are being done in some buildings, but not all. This is important and is to be done on an ongoing basis in all units.
  - On November 18th, duty officers and others will participate in an active shooter tabletop discussion/training at LHS with other local agencies. More information will be provided to participants.
  - The new food truck back bumper is not made for youth to step on it. Signs of wear and tear are already noticeable.
  - SYC Meunier attended Verbal and Influence training in Milwaukee last week. It will be used universally by DOC and other facilities such as Lad Lake, Homme Home, etc. Modification to POSC curriculum for CLS/LHS was discussed.

- HSU (Sandy)
  - Flu vaccines for youth are scheduled for next week Tuesday and Wednesday. HSU will administer these in the living units.
  - The next Infection Control meeting will be held this Thursday. Unit audits will start soon.

- Social Services/CLS (Lori/Matt/Mary/John/Christine)
  - Intern Debbie Merkel started last week and will be working with CLS.

Manager's Meeting
October 27, 2015

- Management Services (Jessica/Audrey/Jim/ Mike)
  - Steady progress continues with Miller living unit. Mid-November is the anticipated completion date.
  - PeopleSoft STAR Update: Travel Expense Reporting and P-Card training is available. We are asking that you wait to sign up for training until you have travel expenses to report or P-Card transactions to verify. If you are in this category, and cannot attend upcoming training, please contact the business office to schedule training. We will continue to offer monthly training session until everyone has been training throughout the year.
  - The following back-up documentation is required to now be scanned electronically and attached in PeopleSoft in addition to turning in the paper copy:
    - **Travel Expense Reports Back-up Documents Required to be Scanned:**
      - Non-fleet availability forms for mileage (except turn down rate)
      - Hotel receipts ***(new requirement to include, prepaid with PCARD)***
      - All meal and parking receipts
      - Preapproval documentation from supervisor (DOC-1042 TRAINING REQUEST, approval email, etc.)
    - **P-Card Back-up Documents Required to be Scanned:**
      - DOC-775 Request for Purchase with approvals from department head.
      - Credit Card Receipt
      - Receiving Report from LHS/CLS Storeroom

- Human Resource (Danielle)
  - For STARS/PeopleSoft, it will be important to maintain up-to-date information regarding supervisors and who they supervise for approving of payroll, etc.
  - The Treatment Specialist positions will be a broadband range, which means this will be a promotion for YC, YCA, SW, SW Sr. and a lateral transfer for SYC and CUS. For questions regarding this, contact HR Director Danielle Gallant.
  - See attached position review list.

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October Calendar
PbS Data Collection Month
28 – Teacher interviews
29 – bus visit/Douglass hosts, Bldg & Grnds Supt interviews
30 – DOC PREA Training deadline, ***Dual Choice/Open Enrollment ends***
31 – YCA Dave Anderson and YC Nick Trepasso's last day

November Calendar
WIAA Basketball starts
Restorative Justice Week (3rd week)
1 - Daylight Savings Time
3 – LHS Flu Clinic, CLS Safety Unit pre-bid walk-thru
4 – LHS Flu Clinic

7 – bus visit
11 – Veterans Day
12 – EMCC mtg, graduation, bus visit/Miller hosts, Families Count Session
14 – SYC mtg?
21 – bus visit
26 - Thanksgiving Holiday, bus visit/Miller hosts

Scott Walker
Governor

Edward F. Wall
Secretary

State of Wisconsin
Department of Corrections

Mailing Address

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M E M O R A N D U M

Date: October 23, 2015

To: CLS/LHS Executive Leadership Team members: Wendy Peterson, Deputy Superintendent; Rick Peterson, Security Director; Wendell Quesinberry, Education Director; Dr. Vincent Ramos, Psychological Services Supervisor; Jessica Legois, Management Service Director

FROM: John R. Ourada, Superintendent

Subject: PREA Standard 115.313 Supervision and Monitoring

In our recent PREA audit, the PREA Standard 115.313 on Supervision and Monitoring, Copper Lake School (CLS) & Lincoln Hills School (LHS) were found to not meet the standard.

In order to bring CLS/LHS into compliance with this standard, the following corrective action will be implemented beginning on November 1, 2015. As a member of the Executive Leadership Team, one of us will be expected to make documented unannounced visits during the 10:30 pm – 6:30 am (3rd Shift) at least once per month. The visits will be documented on the DOC 2747 Daily Living Inspection form found in each living unit. Likewise, when you visit the living units on the 6:30 am – 2:30 pm (1St Shift) and 2:30 pm-10:30 pm (2ndShift) these visits must also be documented on this form. The rotation for unannounced visits may be included in your Duty Officer schedule.

Please let me know if you have any questions.

cc: Matt Theiler
File