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Governor

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State of Wisconsin Department of Corrections

To: Secretary Scott Neitzel
Department of Administration

From: Secretary Jon Litscher
Department of Corrections

Date: May 18, 2016

Re: Copper Lake School / Lincoln Hills School PREA Audit

Following the PREA Audit report dated February 18, 2016 for Copper Lake School and Lincoln Hills School, I believe it is important to provide you with additional context regarding the PREA audit and the Department's actions to meet the standards.

The audit measured the facility on 41 standards; the auditor determined that Copper Lake and Lincoln Hills Schools met 37 standards, did not meet 2 standards, and 2 standards were not applicable. Although the auditor determined the schools met the majority of the standards, the Department disagrees with the auditor's conclusions on the two unmet standards. Included below is additional information on the Department's position regarding the two unmet standards along with additional information on the audit and the Department's ongoing efforts to ensure PREA compliance.

Standard 115.313 Supervision and monitoring

This standard includes requirements such as staffing plans, video monitoring and supervisory and management rounds. The auditor found Copper Lake and Lincoln Hills School to be compliant with this standard in October 2015, during the corrective action period. However, in the final audit report the auditor found the schools do not meet this standard because of the current US Department of Justice Investigation and change in CLS/LHS leadership, stating that "more time must pass under the direction of the new leadership to ensure that all standards most recently met continue in a positive direction and with the forward momentum. The unannounced rounds by upper level managers must have a longer period of time to become more institutionalized within the facility as the upper level management has changed." Similarly, the report states that "as the DOJ investigation is in progress, it is prudent to await the outcome of that investigation to determine if changes are necessary to ensure sexual safety of youth housed at LHS/CLS."

DOC notes that the audit process allows facilities to come into compliance during the corrective action period and does not specify a minimum period of time during which the improvements must be in place. Given this and the fact that the auditor previously informed the DOC that Copper Lake and Lincoln Hills School were compliant with this standard, DOC disagrees with the finding of noncompliance. Nevertheless, we assure you that the new facility leadership remains committed to ongoing compliance and that we continue to meet this standard.

Standard 115.352 Exhaustion of administrative remedies

This standard deals with one of the several ways youth can report sexual abuse or harassment. Specifically, if a facility has a normal grievance or complaint process through which a resident could report sexual abuse or

harassment, the facility must meet specific requirements with respect to time limits, reporters, and emergency grievances.

The long-standing practice at Lincoln Hills and Copper Lake School is to route complaints submitted through the youth complaint system that allege sexual abuse and harassment through the PREA complaint process to ensure that all of the PREA requirements are met. DOC's Executive Directive 72, which covers all DOC facilities including Lincoln Hills and Copper Lake School, clearly mandates compliance with the standards. However, DJC's internal policy containing these requirements was not updated and signed by the end of the corrective action period. This has since occurred. I want to reiterate that any potential PREA allegation, whether received through the youth complaint system or any other reporting mechanism are handled in accordance with PREA standards regardless of the specific policies for the general youth complaint reporting system.

In reviewing the final audit report for Copper Lake School and Lincoln Hills School, I would encourage you to note the following statements from the PREA auditor:

- As a result of the random youth interviews, the auditor reported that the youth felt safe at the facility and that all youth recounted at least two methods of reporting.
- The auditor reported not being limited in any way from speaking with staff or youth or inspecting any area of the facility.
- The auditor reported completing interviews of 14 youth with varying lengths of stay and at least one youth from all housing units. The youth were selected randomly by the auditor from provided youth rosters.
- The auditor reported completing interviews of 10 random staff from provided staff rosters.
- The auditor reported completing interviews of 13 specialized staff.
- The auditor reviewed 17 case files of reported sexual abuse and / or sexual harassment allegations and reported that all investigations were handled appropriately and per the standard.
- As a result of the random staff interviews, the auditor reported that staff were familiar with how to perform their responsibilities in prevention, detection, and responding to incidents of sexual abuse and sexual harassment and were able to relay signs to watch for in youth who may have experienced sexual abuse or sexual harassment.
- The auditor reported that staff was aware of the proper procedures to follow if they were to be first responders to a sexual abuse or sexual harassment incident.
- The auditor reported that the on-site tour confirmed ample youth supervision / monitoring capabilities.
- The auditor reported that the facility offers all youth access to forensic medical examinations following an allegation of sexual abuse, performed by a local hospital, without financial cost to the youth and where evidentiary or medically appropriate.
- The auditor reported that the facility provides victim advocacy services from outside community agencies to youth who allege sexual abuse.
- The auditor reported that the facility ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.
- The auditor reported that almost all youth felt comfortable making a report directly to staff.
- The auditor reported that all youth knew there was a grievance process in which they could also speak with the Superintendent.
- The auditor reported that staff accepts reports made verbally, in writing, anonymously, and from third parties and promptly documents any verbal reports.
- As a result of interviews with specialized staff and random staff, the auditor reported that there is evidence to support that the facility requires all staff to take immediate action to protect youth from imminent sexual abuse.

In the past twelve months, the Wisconsin Department of Corrections has implemented the following positive changes in furtherance of its efforts to comply with federal PREA standards:

- Complete revision and distribution of Executive Directive 72 – Sexual Abuse and Sexual Harassment in Confinement (PREA).
- Created and assigned an on-line interactive training curriculum for all staff, in accordance with the employee training requirements under PREA.
- Increased the amount of staff trained to investigate sexual abuse and sexual harassment from 40 to over 170.
- Trained all facility based PREA Victim Service Coordinators.
- Created and assigned an on-line interactive specialized training curriculum for medical and mental health staff.
- Revised and distributed inmate and youth PREA handbooks.
- Created new PREA posters displayed in all confinement facilities.
- Created new inmate education curriculum and distributed to facilities.
- Created a PREA screening tool to help identify those at high risk of perpetrating or high risk of victimization to inform housing decisions.
- Implemented an outside reporting line for inmates and youth, in collaboration with an outside agency.
- Updated existing forms and created new forms to enhance implementation and compliance efforts.
- Created an on-line reporting mechanism to receive third-party reports of sexual abuse or sexual harassment.
- Started a cross-divisional work group to create a new PREA database to house all incident-reported data and screening tool.
- Fostered a partnership with the Wisconsin Coalition Against Sexual Assault to enhance state-wide education and response to victims of sexual abuse.

**Final PREA Audit Report on Juvenile Facilities
(Date of Report: 02-18-2016)
COVER SHEET**

PREA AUDIT REPORT INTERIM FINAL
 JUVENILE FACILITIES

Date of report: 02-18-16

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: <i>(If different from above)</i>			
Facility telephone number: (715) 536-8386			
The facility is:	<input type="checkbox"/> Federal	<input checked="" type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
Facility Type:	<input checked="" type="checkbox"/> Correctional	<input type="checkbox"/> Detention	<input type="checkbox"/> Other
Name of facility's Chief Executive Officer:			
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: <i>(if applicable)</i>			
Physical address: 3099 E. Washington Ave. Madison WI 53707-7925			
Mailing address: <i>(if different from above)</i> PO Box 7925, Madison WI 53707-7925			
Telephone Number: (608) 240-5900			
Agency Chief Executive Officer			
Name: John Paquin		Title: Administrator	
Email address: john.paquin@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 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 who work 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 was developed. Details of corrective actions are written under each applicable standard within this report. In addition, how the facility implemented those corrective actions is also included.

During the last month of the corrective action period the auditor was notified that the facility was under investigation by the Department of Justice. The facility has initiated little to no contact with the auditor regarding the DOJ investigation, the change in its leadership, or the administrative investigation process currently underway. This lack of transparency at a critical point and during the last month of the corrective action period makes it extremely difficult for the auditor to issue compliance. It is unknown to the auditor what issues the Department of Justice investigators are focusing on. On December 3, top administrators to include the Superintendent of LHS/CLS and the Administrator of Division of Juvenile Corrections were replaced.

A facility's compliance with the PREA standards is a fluid process. A facility may meet the standards at any given point in time, but circumstances may change, that may make them non-compliant (and vice versa) at a later date. The auditor looks at the previous reporting period to gauge the overall culture of the facility with regard to sexual safety for youth. When there is such a major change within the organizational structure, such as that experienced by LHS/CLS in December, the facility's culture may change. The auditor is stating simply that these changes are so recent; the auditor cannot draw a definitive conclusion that the many changes implemented over the corrective action period will be sustained or institutionalized over time. Therefore, the auditor is stating it cannot be determined that the Lincoln Hills School/Copper Lake School is in compliance with the standards and is recommending that they undergo the audit process again after the DOJ investigation is complete and the facility has an opportunity to stabilize under its new administration.

Number of standards exceeded: **0**

Number of standards met: **37**

Number of standards not met: **2**

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 Managers 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: The facility continues to document unannounced visit by intermediate and higher-level supervisors. The auditor required that unannounced rounds include the Superintendent and other higher-level agency management at least once per month. At the time of the audit the Unit Manager had made numerous rounds on 1st and 2nd shift. The auditor required that unannounced rounds should be performed on the 3rd shift. The auditor required a policy, post order or other written documentation that outlines the procedure for responding to resident cell notification lights. The auditor required documentation of remedial training provided to all living unit staff on response time for resident notification lights. On 10/28/15 Superintendent Ourada issued an executive directive to his senior leadership that they must complete a documented unannounced visit during the 10:30 pm – 6:30 am (3rd Shift) at least once per month and document the round on the DOC 2747 Daily Living Inspection form found in each living unit. On 12/17/15 the auditor was notified by the PREA director that the facility is under an investigation by the Department of Justice. In response to issues that came to light through this investigation, the top administrators to include the Superintendent of LHS/CLS and the Administrator of Division of Juvenile Corrections were replaced in December. In light of these recent developments, the auditor feels that more time must pass under the direction of the new leadership to ensure that all standards most recently met continue in a positive direction and with the forward momentum. The unannounced rounds by upper level managers must have a longer period of time to become more institutionalized within the facility as the upper level management has changed. The standard requires that a facility consider findings from judicial findings of inadequacy. As the DOJ investigation is in progress, it is prudent to await the outcome of that investigation to determine if changes are necessary to ensure sexual safety of youth housed at LHS/CLS. In addition, this standard requires that the facility reassess at least annually, or more frequently if necessary, whether adjustments to the staffing plan or resources devoted to supervision and monitoring are needed. The auditor feels that in light of these recent developments, the facility needs more time to reassess if the resources devoted to supervision and monitoring are adequate.

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 a 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 facility.

Corrective Action: The auditor requested the effective policy Executive Directive #42 that has been revised to include requiring a background check every five years. On 12/9/15 the PREA director provided Executive Directive 42 that is effective and posted for all employees. This directive requires background checks every five years as well as upon promotion according to the standard. The auditor required a signed, written statement from the person or office that has completed background checks on all current LHS/CLS employees, contractors and volunteers. On 1/14/16 the PREA Director provided a letter from the LHS/CLS Superintendent certifying that all criminal background checks have been completed for all current employees, contractors, and volunteers.

The auditor requested that the LHC/CLS provide a document sample in which the facility asks all applicants and employees who may have contact with residents directly about previous sexual misconduct. On 12/9/15 the PREA director provided the Application Supplement Background Check (form 1098D). This form is used to gather information on all prospective employees and asks all applicants and employees who may have contact with residents directly about previous sexual misconduct as required by the standard.

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 Rhineland. 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 auditor required the agency to publish its investigative policy on its website that describes the responsibilities of the facility and the investigating entity conducting investigations of sexual abuse or sexual harassment allegations. On 1/14/16 the PREA Director provided the link to the agency website and the auditor verified that Wisconsin DOC Executive Directive #72 which governs investigations at LHS/CLS was posted.

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.

Corrective Action: The auditor required the facility provide a signature sheet stating the volunteers and contractors have understood the PREA training they have received rather than just verifying they were trained on a tracking sheet. On 08/24/15 the facility provided a revised signature sheet that specifically volunteers & contractors sign acknowledging understanding rather than just a check-off sheet next to their name.

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 auditor required the facility 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. On 9/29/15 the facility further outlined resident education program to include a three step process. 1) This training consists of a Living Unit Orientation upon arrival that covers the basics of PREA, what it is, who they can contact if they have a PREA related issue and the phones and PREA numbers associated with it. The PREA numbers are framed and posted directly above the phones. 2) Then within 72 hours the Social Worker goes through the PREA handbook with the youth. After they have thoroughly explained the PREA Handbook the youth are given a test which the Social Worker puts their name on and is placed in the youth file. 3) Then on a quarterly basis each Unit Supervisor does a refresher training with all the youth in their respective living unit. The facility provided documentation to support this training process to the auditor.

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: The auditor required documented evidence that they have received the specialized training as outlined in this standard. On 12/16/15 the facility provided documented evidence that practitioners participated in the NCCHC PREA Specialized Training Medical and Mental Health Care Standards.

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 began screening youth upon entry shortly before the on-site portion of the audit. However, they had not completed screenings for youth who were already present when they began their screening. The auditor also recommended changing the screening tool. Instead of the screener 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. Following the on-site portion of the audit they did go back and begin screening previously admitted residents and completed that process in November. They also developed a database to track all screened youth and provided that to the auditor. In addition, the facility replaced their screening tool as recommended by the auditor.

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 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: The auditor required the facility screen all residents utilizing the screening tool to ensure appropriate housing and placement decisions have been made. Following the on-site portion of the audit the facility did go back and screen previously admitted residents to ensure proper housing 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: The auditor required that the 888 line is implemented in order to have a reporting method outside of the DOC. The facility implemented the 888 line on 9/17/15, informed youth and placed new posters with these calling instructions throughout the facility. The 777 line is still active and dials directly to the DOC Investigations team at the DOC central office in Madison.

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. 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 auditor required that the youth complaint policy 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 auditor also required that a statement is included in both the policy and the attached chart that there are no timeframes required for the reporting of sexual abuse. In addition, the auditor required that the policy 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 Rhineland. 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 auditor required the agency post on their website how to report sexual abuse and sexual harassment on behalf of a resident. On 1/14/16 the agency posted to its website instructions on 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 auditor required that the facility 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. The facility began a formal review process on 7/27/15 for all incidents. They meet every Monday and Thursday and review all incidents that have happened since the last meeting. The review session includes the Superintendent, Deputy Superintendent, Security Director, Chief Psychologist, Health Services Director, Education Director, Teacher Supervisor, Correction Unit Supervisor's and all Supervising Youth Counselor's that are on shift at the time of the meeting. As a group they review all incidents and immediately come up with a corrective plan of action and decide who is responsible for that corrective action. Then at the next meeting there is follow up to make sure the situation has been addressed. They provided the auditor with a sample of the incident review meeting and database that tracks their incident review. The auditor recommended that this document contain the date that the review was completed.

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 auditor required the agency to prepare an annual report assessing the agency's progress in addressing sexual abuse and post this annual report on the agencies website. This annual review was completed and posted on the Agency's website on January 14, 2016.

<http://doc.wi.gov/Documents/WEB/ABOUT/OVERVIEW/OFFICEOFTHESECRETARY/PREAUNIT/2014%20PREA%20Juvenile%20Facilities%20Annual%20Report.pdf>

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.

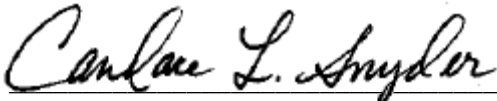
The Agency posts PREA related data on the Agency's website. For 2014 the data for Lincoln Hills School/Copper Lake School is included in the facilities annual report. Data collected is retained via limited access and through a secure server for at least ten (10) years.

<http://doc.wi.gov/About/DOC-Overview/Office-of-the-Secretary/Prison-Rape-Elimination-Act-Unit>

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.


Auditor Signature

February 19, 2016

Date