PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: January 21, 2017

Auditor Information			
Auditor name: Anthony T. Dodd Sr.			
Address: P.O. Box 13551, Milwaukee, WI 53213-0551			
Email: Anthony.dodd@milwaukeecountywi.gov			
Telephone number: 414-364-4412			
Date of facility visit: June 22-24, 2016			
Facility Information			
Facility name:	Facility (A) Parsons House &	Facility (B) Glover House	
Facility physical address:	2930 N. 25th Milwaukee, WI 53206 /	2404 N. 50th Milwaukee, WI 53210	
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number:	Parsons 414-445-3301	Glover 414-442-3700	
The facility is:	☒ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☐ Community treatment center ☒ Halfway house ☐ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Parsons House- Helen Johnson / Glover House- Tedi Gentry			
Number of staff assigned to the facility in the last 12 months: Parsons 21, Glover 7			
Designed facility capacity: Parsons 40 Glover 25			
Current population of facility: Parsons 30, Glover 0 as of June 24, 2016			
Facility security levels/inmate custody levels: Low (staff secure)			
Age range of the population: 18 and over (Adult)			
Name of PREA Compliance Manager: Helen Johnson/ Tedi Gentry		**Title:** Program Directors	
Email address: hjohnson@wiscs.org & tgentry@wiscs.org		**Telephone number:** 414-445-3301/ 414-442-3700	
Agency Information			
Name of agency: Wisconsin Community Services			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 3732 West Wisconsin Aveune, Suite 200, Milwaukee, WI 53208			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 414-290-0400			
Agency Chief Executive Officer			
Name: Clarence Johnson		**Title:** Excecutive Director	
Email address: cjohnson@wisc.org		**Telephone number:** 414-290-0400	
Agency-Wide PREA Coordinator			
Name: Robert Young		**Title:** Quality Assurance Coordinator	
Email address: ryoung@wiscs.org		**Telephone number:** 414-531-9466	

AUDIT FINDINGS

NARRATIVE

The Prison Rape Elimination Act (PREA) on-site audit of the Wisconsin Community Services' (WCS) Parsons House and Joshua Glover House Federal Residential Reentry Centers was conducted on June 22-24, 2016 by the Department of Justice Certified PREA Auditor Anthony Dodd Sr., (The Dodd Group, LLC). The pre-audit preparation included a thorough review of all documentation, reports, records, and materials submitted by each facility, along with data included in the completed Pre-Audit Questionnaire. The documentation reviewed included agency's policies, procedures, forms, minutes of meetings, education/training materials, organizational charts, posters, brochures, rosters and other PREA related materials that were provided to demonstrate compliance with the PREA standards. The auditor assisted the PREA Coordinator during the pre-audit with recommendations regarding sexual abuse/harassment investigations, as well as being available around the clock to answer questions related to improvements or alterations for policies and procedures.

The Pre-Audit Questionnaire and companion documentation were delivered by the PREA-Coordinator on April 28, 2016, allowing 54 calendar days to review the submitted documents prior to arriving on-site Wednesday, June 22-24, 2016. Each of the community confinements standards were substantiated by a policy or procedure, and multiple recent documented examples demonstrating compliance or attempted compliance with each standard. The PREA-Coordinator, Administration, along with staff were accommodating, and demonstrated a genuine concern to keeping residents free of sexual abuse and sexual harassment.

On Monday, June 20, 2016 the auditor was notified via email that the Glover House facility had an in-house resident total of only five. Management concluded that it would be fiscally responsible, without compromising safety and security, to move the five Glover House residents to the Parsons House until the number of residents increased. The Glover House still was operating and functioning with staff members and case workers who were meeting and tending to the needs of home confinement "residents." The PREA Coordinator was informed that the auditor would not deviate from the schedule as previously planned. The auditor was still required to interview random staff, volunteers, contractors, and conduct a tour of the facility which still could be accomplished. The PREA-Coordinator was advised the auditor would interview residents from the Glover House who were transferred to the Parsons House, when on-site at the Parsons House (Thursday, June 23, 2016).

On Wednesday, June 22, 2016 the auditor arrived at the Glover House facility at 0750 hours, to conduct interviews of random staff, specialized staff, directors, and volunteers. The PREA Coordinator provided the auditor with a secure conference room that was used to conduct the confidential interviews. The auditor interviewed the following: Contract Administrator, Property Management Vendor, Program Director/PREA Compliance Manager, PREA Coordinator, Case Managers, and Two Resident Monitors. (The auditor conducted interviews of all staff that were on duty and working in the facility on the above date). Staff were questioned using the DOJ's protocols that questioned their PREA training and overall knowledge of the agency's zero tolerance policy, reporting methods, the response protocols when a resident alleges sexual abuse, and first responder duties. The auditor reviewed training curriculum files, training completion records, resident orientation pamphlets, schedules, risk assessments tools, PREA information posters within the facility, and daily census reports.

On the above date at 1500 hours, the auditor toured the facility escorted by the PREA Coordinator and observed the facility configuration, location of cameras and mirrors, staff supervision of would be residents, layout of the residents "living quarters" including shower/toilet areas, placement of PREA zero-tolerance posters and PREA informational resources (including in Spanish), security monitors, residents entrance, metal detector, exercise room, cafeteria, and educational room. The auditor noted that shower areas allowed residents to shower separately and shower stalls had plastic curtains for additional privacy. Notices of the PREA audit were posted throughout the facility in common areas and every floor. The tour concluded at 1630 hours.

On Thursday, June 23, 2016 the auditor arrived at the Parsons House facility at 0850 hours to conduct interviews of random residents, staff, specialized staff, directors, and volunteers. The PREA Coordinator provided the auditor with a secure office, that was used conduct the confidential interviews. The auditor was given a "status sheet" that contained the current "head count" of all the residents in the facility. The count for the facility totaled 30 residents, however the "in count" totaled 12 residents. The remaining residents were at a work site, school, counseling services, or granted a community pass. The auditor conducted a total of 13 resident interviews on the above date, one resident returned from his work site during the on-site tour. The auditor made it a priority to interview residents that were housed at the Glover House. A total of three out of the five residents who were transferred from the Glover House were interviewed, one was released, and one was on a work site. Based on the above totals, the auditor conducted 100% percent of the possible number of total residents available in the facility.

The auditor also conducted interviews of the following; Program Director/PREA Compliance Manager, Case Mangers, Residents Monitors, and Specialized Staff. Residents were interviewed using the recommended DOJ's protocols that questioned their knowledge of a variety of PREA protections. The auditor questioned generally and specifically their knowledge of reporting mechanisms available to them regarding sexual abuse or sexual harassment, and staff application of their sexual abuse zero-tolerance policy.

On the above date at 1515 hours, the auditor toured the facility escorted by the PREA Coordinator and observed the facility configuration, location of cameras and mirrors, staff supervision of residents, layout of residents' living quarters including shower/toilet areas, placements of PREA zero-tolerance posters and PREA informational resources (including in Spanish), security monitors, residents entrance, metal detector, exercise room, cafeteria, education room, and lounge area. Notices of the PREA audit were posted throughout the facility in the common areas and every floor. The auditor also viewed the in-take area where new residents are screened, then orientated by staff. A random case-manager's office and file cabinet were also inspected, with both being secure. Random risk assessment forms were inspected and appeared to be competently and correctly completed. The tour concluded at 1607 hour.

On Friday, June 24, 2016 at approximately 0900 hours, the auditor arrived at the Wisconsin Community Service (WCS) Administration located 3732 West Wisconsin Avenue, Suite 320 (third floor small conference room) to conduct interviews of the Agency Head Designee/ Associate Executive Director, Human Resources Director, Religious Volunteer, and Environmental/ Janitorial Service Vendor. The auditor asked questions recommended by the DOJ's protocols that questioned reporting, investigations and procedure methods regarding sexual abuse and sexual harassment. Random documents were viewed, and duplicated by the auditor such as random employees' backgrounds, random volunteers' background, and the job application questionnaire.

The Federal Bureau of Prisons (located 200 West Adams Street, Room 2915, Chicago, Illinois, 60606) handles administrative investigations regarding PREA allegations and was contacted via phone, as was the Sexual Assault Treatment Center (located 945 North 12th, Street, Milwaukee, WI 53233) who WCS's facilities Glover and Parson House would use as a resource for medical assessments and treatment, counseling, crisis intervention and emotional support, and evidence collection if needed.

All interviews were recorded via a digital voice recorder (Olympus WS-801). All individuals were notified the interviews would be recorded and were given the option to decline.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Wisconsin Community Service (WCS) operates two Federal Residential Adult Reentry Centers, The Parsons House, located at 2930 North 25th Street, Milwaukee, WI 53206 and The Glover House, and located 2404 North 50th Street, Milwaukee, WI 53210. The Parsons House is a co-ed adult, 40 The Prison Rape Elimination Act (PREA) on-site audit of the Wisconsin Community Services' (WCS) Parsons House and Joshua Glover House Federal Residential Reentry Centers was conducted on June 22-24, 2016 by the Department of Justice Certified PREA Auditor Anthony Dodd, (The Dodd Group, LLC). The pre-audit preparation included a thorough review of all documentation, reports, records, and materials submitted by each facility along with the data included in the completed Pre-Audit Questionnaire. The documentation reviewed included agency's policies, procedures, forms, minutes of meetings, education/training materials, organizational charts, posters, brochures, posters, rosters and other PREA related materials that were provided to demonstrate compliance with the PREA standards. The auditor assisted the PREA Coordinator during the pre-audit with recommendations regarding sexual abuse/harassment investigations, as well as being available around the clock to answer questions related to improvements or alterations for policies and procedures.

The Parsons House is a three story, co-ed adult facility, with the entrance being on the first floor. Residents who enters the facility must bypass a metal detector, and are subject to random pat-down searches from staff. Staff have the option to use hand-held metal detectors as needed. The Resident Monitor's Office at the entrance of the facility houses video camera monitoring equipment that provides video feed from internal and external cameras. Video cameras are strategically placed and monitor all entrances into the building. Internal cameras monitor the hallways on all three levels, however during the on-site tour blind spots were noted in the stairwell areas. Video cameras were placed in the laundry area, kitchen area, and other common day room areas. The third floor provides a "lounge area" for the residents in which they can watch movies or play card games. The area appeared very clean, with one video camera viewing activities. The dining room of the facility offers an estimated capacity to seat 20 individuals with two overlooking cameras. The workout area of the facility also appeared to be clean, and had 1 camera overlooking activities. The facility has administrative offices that are only accessed by the Program Director or Case Managers; residents do not have access to these areas without supervision. The facility is staff secure to residents who are not permitted to leave without authorization. Female residents are housed on the second floor, west end hallway of the facility. Female residents (1 at the time of tour) have access to a private showers and restrooms. A hallway door provides separation from the female residents' living quarters and male residents' living quarters. At all times there are two resident monitors that provides safety and security to the facility. One Resident Monitor is male and the other resident monitor is female. Having resident monitors of different genders at all times provides The Parsons House with the ability to minimize risks or exposure to liability regarding cross-gender searches of residents.

The Glover House is a two story, 20 bed capacity adult male facility that includes a basement making it a three level operating facility. Residents who enters the facility must bypass a metal detector and are subject to random pat-down searches from staff. Staff have the option to use hand-held metal detectors as needed. The Resident Monitors' Office is located close to the entrance of the facility, and those who enter are required to report in at the office before entry is granted. Cameras are tactically placed at the west and east ends of each floor of the hallways to monitor appropriate traffic. Administrative offices and 1 conference room are placed on the entrance level of the facility, and residents are not permitted to enter either without being properly supervised. A multi-purpose area with television is also located on the entrance level of the facility, with 1 camera monitoring daily activities. The exercise room is located in the basement, on the west end of the facility with one camera monitoring activity. External cameras are placed outside of the facility's entrance to monitor residents and potential visitors. The Glover House is adjacent to the Milwaukee Police District 3 Communication Center, which adds additional security, and rapid response if needed.

SUMMARY OF AUDIT FINDINGS

The agency reported in the past 12 months there have not been any allegations of sexual abuse, however there have been 4 sexual harassment allegations (2 in 2015) resulting in 4 administrative investigations conducted by the Federal Bureau of Prisons that resulted in unsubstantiated findings for all 4 investigations.

Overall, the interviews of the residents reflected they were aware of and understood the agency's zero tolerance policy regarding sexual abuse and sexual harassment, and understood their right to be free from all forms of sexual abuse. Residents received literature at intake that provides information regarding sexual abuse and how to report it. Residents are also shown a 15 minute, PREA orientation video that explains in depth the multiple ways of how to report sexual abuse and how to protect themselves from sexual abuse. Residents expressed that they felt safe and all staff including administrators were "doing a good job" as it related to keeping them secure. Residents constantly stated they knew who and how to contact available resources and emotional support, due to the information they were given at intake, and the PREA posters posted in the hallways of each facility.

Staff interviewed appeared they understood their duties and responsibilities to kept residents free from sexual abuse and sexual harassment. All staff indicated they had received detailing training regarding the agency's zero tolerance policy for sexual abuse and sexual harassment. Staff articulated in detailed fashion how they would respond to an allegation of sexual abuse or sexual harassment if they were the first responder on the scene. The agency's PREA Coordinator expressed that he has been given ample time to complete his duties regarding creating the agency's policies and procedures. The PREA Coordinator expressed that administrators take his input seriously and value his professional opinion. During the PRE-Audit and Post Audit of each facility, the PREA Coordinator responded promptly to every inquiry and assured that the PREA standards that are not met during the Interim Audit would be corrected and institutionalized for the Final Audit. Administrators interviewed conveyed their goals were to prevent any form of sexual abuse and sexual harassment to residents, and expressed a willingness to exceed what was expected. The auditor felt Administrators were knowledgeable, dedicated, and enthusiastic in regards to improving the quality of life and safety for their staff and residents, and also for the subsequent Audit.

JANUARY 2017 CORRECTIVE ACTIVE PLAN:

The July 21, 2016 Interim Compliance Report reflected that there were six standards that were not in compliance. The corrective action period not to exceed 180 days, began on July 22, 2016. The agency's PREA Coordinator immediately began to address areas found to be not in compliance. The PREA Coordinator along wih the agency was found by the auditor to be very pro-active and inquisitive on the handling of each non-compliant standard. On many of the stardards in questions, the auditor found the agency to go above and beyond what was required.

Number of standards exceeded: 1 (115.216)

Number of standards met: 36

Number of standards not met: 0 for the Final Audit and 6 for the Interim Audit (115.217, 115.232, 115.272, 115.287, 115.288, 115.289)

Number of standards not applicable: 2 (115.212, 115.266)

Standard 115.211 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.

The Parsons and Glover House has implemented a zero tolerance policy regarding sexual abuse and sexual harassment. The policy thoroughly explains the agency's approach to preventing, detecting, and responding to all forms of sexual abuse and sexual harassment. The policy contains necessary definitions, sanctions and descriptions of the agency's strategies and responses to sexual abuse and sexual harassment. The policy explains the agency's procedure regarding administrations review of PREA allegations and data.

Their policy stated the agency's commitment to a designated PREA Coordinator, who is currently Robert Young. The policy expressed that the PREA Coordinator have sufficient time and authority to oversee efforts to comply with PREA standards. Mr. Young, who also serves as the agency's Quality Assurance Coordinator. He indicated that he is provided with sufficient time to conduct his duties as the PREA Coordinator. Helen Johnson is the PREA Compliance Manager at the Parsons House and Tedi Gentry is the PREA Compliance Manager at the Glover House. Each indicated they are provided with sufficient time, resources, and authority to develop, implement and oversee each respected facility's efforts to comply with the PREA standards.

Evidence Reviewed: Pre-Audit Questionnaire, Policy, Interviews of Staff and Residents, Tour of Each Facility

Standard 115.212 Contracting with other entities for the 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.

The above standard is NOT APPLICABLE. WCS does not contract with external entities to house any of its residents. The agency states there have not been any contracts of this type on or after August 20, 2012, however in the event the agency does deem it necessary to contract with other entities for the confinement of residents in the future, they have a policy in place that states the contracting entity must adopt and comply with PREA standards.

Evidence Reviewed: Pre-Audit Questionnaire, Interviews, Policy

Standard 115.213 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 agency operates under the Bureau of Prisons' (BOP) Statement of Work, Chapter 2, page 10 that indicated that at least two positions (one male and one female if the facility is co-ed) has to be filled, 7 days a week, and 24 hours per day, dedicated solely to the purpose of supervision and safety of federal offenders. A review of random schedules of each facility indicated that the agency has been in compliance with their contract and the standard. Resident Monitors are on duty for 12 hours shifts, and each facility has 2 dedicated Case Managers, 1 Employment Specialist, and a Program Director that are on duty to provide supervision and monitoring as well. (Based on the facility capacity).

The agency and members from each facility conduct bi-weekly meeting in which the prevalence of PREA allegations, ways to prevent sexual abuse and sexual harassment, ways to improve monitoring and awareness regarding PREA were discussed.

Each facility provided documentation of their staffing schedule. In incidents where the staffing plan was not met, the facility provided justifiable deviations from the plan such as resident population decrease, sick staff, training, funeral leave, home/work site visit, and vacation. Through interviews and reviewing the schedule, on occasions did the above occur, other staff worked the allotted hours, providing adequate staffing levels. The agency does have a policy that discusses reassessment of the staffing plan based on the physical layout of each facility, and the composition of the resident population would be reviewed at least once per year. The policy includes the PREA Compliance Manager at each facility to document rational decisions regarding staffing plans levels, staffing patterns, and video monitoring systems.

It was discovered through interviews with multiple staff personnel that each facility received an upgrade in 2015 to their video monitoring system that will allow for more storage of data, memory, and high definition of video. Resident Monitors are now able to playback video, in which before they could not. The upgrade to the video monitoring will provide 24 hours of cameras footage that will allow for 40 days' worth of playback before the system purges the data. The additions of video monitoring assisted with limiting blind spots in each facility. Resident Monitors are now able to view the exterior of each facility for added security.

Evidence Reviewed: Schedules, BOP Contract, Pre-Audit Questionnaire, Interviews, Tour, Policy

Standard 115.215 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 agency does not conduct strip searches and body cavity searches of residents and limits the cross-genders pat down searching of residents. Male staff are not allowed to pat-search female residents, only in exigent circumstances and with a supervisor's approval. Policy prohibits staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status.

Each facility provides residents with separate showers, and bathrooms to perform bodily functions, and an area to change clothes for privacy. Residents are able to perform the above activities without being in view of staff of the opposite gender. Staff of the opposite are required to announce their presence when entering areas or units where a resident are present. Based on the review of policies and interviews

of residents, the agency has been in compliance.

The agency has provided training to staff regarding how to conduct cross-gender pat down searches and searches of transgender and intersex residents in a professional manner. (February 2016)

Evidence Reviewed: Pre-Audit Questionnaire, Policy, Training Curriculum, Interviews

Standard 115.216 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.

The agency's policy requires the Parsons and Glover House to ensure that residents with disabilities, or who have a special need have an equal opportunity to participate in or benefit from all aspects of WCS's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

The agency's policy states that interpreters from the agency shall be used to communicate with residents who are deaf and hard of hearing. This was verified through numerous interviews with staff, directors, and residents. The BOP would also provide interpreters to the agency if necessary. Numerous PREA informational posters were located throughout each facility in English and Spanish.

The agency's policy requires they are current with the Civil Rights calculation, stating if 15 percent of the resident population speaks a foreign language, WCS must provide materials to ensure effective communication through video or written presentations. WCS has not exceeded 15 percent of residents who speak a foreign language in the past 12 months however their policy includes WCS will take reasonable step to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment regardless.

WCS has a qualified mental health professional with appropriate certifications who is able to offer residents with mental disabilities a proper platform to be heard. WCS has 3 Civil Rights Compliance Officers who specialize in Civil Rights, Disability, and Limited English Proficient. WCS has the capabilities to provide PREA videos to residents with subtitles in English, Spanish, or Hmong. WCS provides residents who are blind the benefit of Braille, and Civil Rights Compliance posters that includes information about WCS services and programs.

Evidence Reviewed: Pre-Audit Questionnaire, Policy, Interviews, Tour and Observations

Standard 115.217 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.

The agency's policy prohibits the hiring or promoting or anyone who may have contact with residents who has engaged in sexual abuse in a prisons, jail, lockup, community confinement facility, juvenile facility, or other institution, included those who have been convicted of engaging or attempting to engage in a sexual activity in the community facilitated by force, overt or implied threats of force, coercion, or if the victim did not consent or was unable to consent or refuse. Those who have been civilly or administratively adjudicated to have engaged in the illegal activity above. The above policy also includes enlisting the services of contractors.

The agency's policy includes the agency shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor.

Upon review of random WCS's volunteer criminal background record checks, the auditor found the above policy to be adhere to, however during interviews it was discovered that some contractors' employees who have the opportunity to have contact with residents were not properly vetted by WCS , but rather "trusted" through the vetting system of the contractor. This matter will be included in the Corrective Action Plan.

The agency's policy calls for criminal background checks to be conducted on all employees, volunteers, and continuing contractors every FOUR years. It is the Human Resource responsibility along with the PREA Coordinator that documentation are maintained regarding criminal background checks on all employees every four years.

A review of WCS's application for employment indicated they DO NOT ask applicants who may have contact with residents' specific questions regarding being involved in any sexual abuse or sexual harassment incidents whether criminally or administratively, or any sexual misconduct convictions or allegations at a previous employment. Upon interview with the Human Resource Director, there was nothing provided that would indicate that during the oral interview of the applicants, the above questions are asked and investigated. The agency's policy does require that questions related to sexual misconduct are asked of all applicants who may have contact with residents, however the auditor in "good faith" cannot confirm this policy is adhere to at this time. Will be included in the Corrective Action Plan.

The agency does disclose to applicants that material omissions regarding such misconduct or false information are grounds for termination. This was verified by a random sample of the applicant of employment. The agency's policy provides that WCS will cooperate with requests from employers on former employees of WCS any substantiated allegations of sexual abuse, sexual harassment, or sexual misconduct.

Corrective Action Plan: All contractors and employees of contractors that may have contact with residents have a background check performed by the agency. Questions related to past sexual misconduct allegations of applicants will be added to the questionnaire of the agency for hiring.

Verification of Correction Action since the Audit: The agency provided proof that backgrounds checks of all contractors were being conducted including having the contractors sign a "PREA Acknowledgment" form regarding the agencies' zero tolerance policies. The agency also provided evidence of the newly added questions to applicants regarding past/present allegations of sexual misconduct.

Evidence Reviewed: Pre-Audit Questionnaire, Interviews, Policy, Job Application, Random Examples of Employee's Files, and Tour of both facilities

Standard 115.218 Upgrades to facilities and technologies

☐ 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 reported that there have been no acquisitions of new facilities or substantial expansions, modifications or retrofitting of the current Residential Center facilities, Parsons and Glover House. The Parsons and Glover House have external and internal video camera monitoring. Cameras are strategically located on all external entrances/exits from the facilities. Cameras in both facilities are located in the hallways, common areas (dining room, exercise room, kitchen, and laundry rooms). Cameras are not placed in residents' sleeping areas and the shower/toilet areas. Video cameras are operated and monitored 24/7 with the upgraded capabilities to review footage of up to 40 days previous. The video monitoring systems were upgraded within both facilities in 2015, with an emphasis on blind spots, sight lines, and inaccessible areas. Interviews with facility leadership indicated that placement of cameras, and the availability of blind spots are discussed often to keep enhancing safety for all residents and staff. The auditor is very confident with the agency's commitment for preventing sexual abuse and sexual harassment in the future with discussions of technical upgrades.

Evidence Reviewed: Pre-Audit Questionnaire, Interviews, Tour of both facilities, Policy

Standard 115.221 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 agency refers all allegations regarding sexual assaults to the City of Milwaukee Police Department who has a Sensitive Crimes Unit that is trained and extremely qualified in investigating sexual assaults, and following the protocols of treating the needs of the victim and evidence collection.

The agency also refers all sexual abuse and sexual harassment allegations to the Bureau of Prisons (BOP) as well, and the BOP conducts all administrative investigations and will notify the agency of the conclusion of the case.

The agency offers (free of charge) residents the opportunity to have access to a forensic medical examination, at the Sexual Assault Treatment Center (SATC), located 945 North 12th Street, Milwaukee, WI 53233, where specially trained personnel provides trauma-informed and supportive services while collecting and preserving evidence for investigations. The SATC offers victims of sexual abuse 24 hours a day services that includes crisis intervention, medical assessments and treatment, emotion support and counseling, medical and legal evidence collection, pregnancy risk assessments, screening for sexually transmitted infections, and provides liaisons services with the Sensitive Crimes, D.A. Office, and the Department of Human Services. The SATC provides specially trained Sexual Assault Nurse Examiners (SANE) to conduct forensic evaluations.

Interviews of staff indicated they understood the protocol regarding being the "first responder" of allegations of sexual abuse, and the preservation of evidence.

Standard 115.222 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 agency policy requires that all allegations of sexual abuse and sexual harassment be referred to the Bureau of Prisons (BOP), and if criminal, the agency shall immediately contact the Milwaukee Police Department. The policy requires the agency to ensure an investigation is completed for all allegations related to this standard.

Agency's Director, PREA Coordinator, along with staff demonstrated an overall comprehension of compliance with the standard. The agency reported the Parsons House had 3 allegations of sexual abuse or sexual harassment in the past 12 months, and Glover House had 1 allegation of sexual abuse or sexual harassment in the past 12 months. The agency reported all allegations resulted in administrative investigations conducted by the BOP, and 0 were referred to MPD for criminal investigations. The agency published on its website its policy regarding referring all allegations of sexual abuse and sexual harassment that is criminal in nature to the proper law enforcement authorities (MPD).

Evidence Reviewed: Pre-Audit Questionnaire, Interviews, Policy, Websites, and Interviews with the Bureau of Prisons

Standard 115.231 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 agency's policy requires that all new employees have in-depth training on PREA, and how to prevent, detect, and respond to allegations of sexual abuse and sexual harassment. Annual refreshers training on PREA is also a requirement for all staff. A review of the PREA training materials shows training on the 11 specific topics found in the standard. The agency uses a system titled RELIAS, which appeared detailed in its curriculum regarding training in the appropriate PREA Standards, and offers testing grades to demonstrate proper comprehension of the material, and digitally documents the name of the testing employee. The agency tailored training based on the gender of the residents in each facility, and requires that if employees are reassigned to or from another facility, they will receive additional training.

Evidence Reviewed: Pre-Audit Questionnaire, Interviews, Policy, Training Records, Training Curriculum, Test Results

Standard 115.232 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 agency's policy require that all contractors, and volunteers who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment policies and procedures. Through interviews and the Pre-Audit Questionnaire it was noted and discovered although contractors and volunteers have been "spoken" to regarding the agency's policies and their responsibilities related to PREA, as of the date of the on-site audit, there has not been formal training provided to contractors and volunteers. The agency's made the auditor aware that they are working on formal training in a classroom environment for the contractors and volunteers. Most volunteers and contractors interviewed demonstrated a general knowledge regarding the agency's zero-tolerance policy for sexual abuse and sexual harassment, however all indicated they are scheduled for proper training in the future.

The agency requires all contractors and volunteers sign a PREA Acknowledgement form.

Corrective Action Plan: Documented training for volunteers and contractors related to the agency's PREA policy.

Verification of Corrective Action since the Audit: The PREA Coordinator has provided documentation of training and orientations of contractors and volunteers. Each contractor and volunteer articulated a general understanding of their responsibilities related to PREA.

Evidence Reviewed: Pre-Audit Questionnaire, Interviews, Policy, PREA Acknowledgments forms

Standard 115.233 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.

The agency reported the Parsons House received 159 residents, and the Glover House received 109 residents in the past 12 months, and all have been provided information regarding the agency's PREA policies and how to report allegations. All the residents were/are orientated during the intake process which usually occurs within the first day. They are given pamphlets with PREA information included in them.

Incoming residents are also shown an orientation video of how to report sexual abuse and sexual harassment, and their rights to be free from sexual abuse and sexual harassment. The agency provides residents who may have limit English proficiency, deaf, visually impaired, disabled, or limited reading skills formats accessible to obtain this information as well. The agency maintains documentation of resident's participation in these PREA education sessions.

During the on-site tour of each facility, it was noted that information regarding PREA is continuously, readily available, and visible to residents. Each facility displayed PREA posters in common areas of the facility with the information of other entities they can report allegations. Posters were displayed in English and Spanish. PREA brochures in English and Spanish were available on the bulletin boards of each facility.

Evidence Reviewed: Pre-Audit Questionnaire, Policy, Interviews, PREA posters, Tours & Observations, Review of Random Resident Files, and Review of Resident Orientation Packets

Standard 115.234 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 agency does not conduct its own investigations involving sexual abuse or sexual harassment. All administrative investigations are conducted by the Federal Bureau of Prisons, on behalf of the agency. All criminal investigations are referred to and conducted by the Milwaukee Police Department (MPD).

The Milwaukee Police Department is legally responsible to use Miranda for criminal investigations. The Milwaukee Police Department has an established relationship with the Sexual Assault Treatment Center which provides additional resources for the victim, and evidence collection for the investigation. The Federal Bureau of Prison investigators are trained to conduct proper and sensitive investigations. The Bureau of Prisons has an Internal Affairs Office that monitors and oversees all administrative investigation. Investigations are initiated within 48 hours of receiving the referral and investigations are required to be completed within 120 days of referral.

Evidence Reviewed: Pre-Audit Questionnaire, Interviews of BOP staff, MPD Website, BOP Website, and Policy

Standard 115.235 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.

The agency does not provide medical care on site, however in the event that medical care is needed as it relates to sexual abuse, the agency has a policy in place to transport residents to the Sexual Assault Treatment Center (SATC) who has trained medical and mental health care professionals. The agency will provide residents (free of charge) access to emotional support, counseling, and advocates. The SATC has specially trained Sexual Assault Nurse Examiners who provides forensic evaluations and emotional support for victims. Staff and nurses at the SATC are properly trained annually regarding the PREA compliance standards. The SATC is an extension of Aurora Health Care Clinic.

Evidence Reviewed: Pre-Audit Questionnaire, Interviews, Tour of SATC, Policy

Standard 115.241 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 agency policy requires that all residents have an initial needs assessment/screening performed by a Case Manager within 72 hours of entering the facility. Through interviews with residents and staff, it was discovered the assessments were taking place with 24 hours of intake. The agency uses an objective screening tool that assesses a resident's risk for sexual victimization and abusiveness by assessing whether the resident has a mental, physical, or developmental disability, the age of the resident, the physical build of the resident, whether the resident has been previous incarcerated, criminal history, prior convictions of sex offenses, whether the resident is gay, lesbian, bisexual, transgender, intersex or gender non-conforming, previous sexual victimization experience, and resident's own perception of vulnerability.

Upon interviews and random of inspections during the on-site visit it was noted each facility has implemented appropriate controls on the dissemination of the information received at intake. Case Managers conduct the screening and all residents' files are kept locked in a Case Manager's office. Based on interviews of residents and staff, the auditor is satisfied that residents are not disciplined for refusing to answer any questions from the assessment tool. The agency policy states that residents are reassessed within 30 days if additional information is received that may influence their risk level.

Evidence Reviewed: Pre-Audit Questionnaire, Interviews of Residents, Case Managers, Staff, Policy, Tour, Review of Assessment Tool, Resident Files

Standard 115.242 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 agency's policy requires the information obtained from the risk screening tool be used to make informed classification and program assignments with the goal of keeping separate those residents who are considered high risk for being sexually victimized from those at high risk from being sexually abusive.

The agency policy requires transgender and intersex resident facility, housing, programming assignment shall be determined on a case-by-case basis, and whether placement would ensure the resident's health and safety, and whether placement would present management or security problems. Transgender and intersex resident's own view with respect to his or her safety shall also be given serious consideration. All residents, including transgender and intersex are given the opportunity to shower separately from other residents.

Evidence Reviewed: Pre-Audit Questionnaire, Policy, Tour of facilities, Interviews

Standard 115.251 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 agency provides residents multiple internal ways to report sexual abuse and sexual harassment, retaliation, and staff misconduct. Residents receive education regarding reporting at intake and orientation. The reporting methods include verbally relaying the allegation to a staff member, contractor, volunteer or PREA Compliance Manager; calling 911 if necessary, submitting a written grievance, having a third-party submit an oral or written complaint on behalf of the resident. Residents are educated they can file a report of sexual abuse or sexual harassment on behalf of another resident.

Residents are allowed to have certain cell-phones in the facility, allowing residents more avenues to report any sexual abuse privately. Residents also have access to pay phones within the facility with information of them on how to report sexual abuse or sexual harassment to an outside entity such as the Bureau of Prisons, Milwaukee Police Department, and Sexual Assault Treatment Center.

Interviews of residents indicated they had a comprehensive knowledge of the avenues that are available to them to report sexual abuse and sexual harassment. They understood what PREA was, and their right to be free from sexual abuse and sexual harassment. All residents interviewed expressed a knowledge of the grievance process and understood reports can be made anonymous upon request.

Evidence Reviewed: Pre-Audit Questionnaire, Policy, Interviews of Random Residents, Posters, Tour

Standard 115.252 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 agency does not impose a time limit on when a resident may submit a grievance regarding allegations of sexual abuse. The agency does not require residents to use an informal grievance process or to attempt to resolve the matter with staff. Residents are given avenues to report allegations of sexual abuse to staff who are not the subject of the complaint. Agency policy requires a decision on the merits of the grievance regarding sexual abuse be made within 90 days of the filing. The agency requires that emergency grievances alleging a resident is subject to a substantial risk of imminent sexual abuse receive an initial response within 48 hours, and concluded within 5 calendar days. The agency allows third parties to file a grievance of behalf of the resident, with the approval from the alleged victim.

The agency reported the Parsons House and Glover House had 0 grievances filed pertaining to allegations of sexual abuse within the past 12 months.

Evidence Reviewed: Pre-Audit Questionnaire, Policy, Interviews of Random Residents

Standard 115.253 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 agency has attempted to enter into a Memoranda of Understanding with the Sexual Assault Treatment Center (SATC). The agency through the use of SATC offers sexual assault treatment services and support to victims free of charge. Advocates provide support, crisis intervention, information and referral services to the victim. The SATC contact information are available on the bulletin board of the hallways and common areas in each facility. The facility informs residents the extent to which reports of sexual abuse will be forwarded to authorities in accordance with mandatory reporting laws.

Evidence Reviewed: Pre-Audit Questionnaire, Policy, Tour, Interviews, Tour of SATC, Website

Standard 115.254 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 allows third parties to report and assist the resident in filing grievances that alleges sexual abuse or sexual harassment. Third parties are able to contact the Parsons House and Glover House staff directly, contact the Program Director, PREA Coordinator, the BOP, SATC, MPD, and the COPE Hotline. Third parties are also able to report allegations of sexual abuse through email and through a link provided on the agency's website.

Evidence Reviewed: Pre-Audit Questionnaire, Interviews, Website, Policy, Posters, Tour

Standard 115.261 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 agency's policy require all staff to immediately report any knowledge , suspicion, or information regarding incidents of sexual abuse or

sexual harassment that occurred in a facility, whether or not it is part of the agency. Based on interviews, and the review of policy, staff exhibited knowledge they are not to reveal any information related to sexual abuse to anyone other than to the extent necessary as specified in the policy. Staff understood they had a duty to report third parties reports of sexual abuse and sexual harassment allegations as well. Staff exhibited knowledge they have a duty to report all forms of retaliation as related to PREA allegations. Training documents with curriculum were reviewed and found to have included the above duties.

Evidence Reviewed: Pre-Audit Questionnaire, Policy, Interviews, Training Curriculum

Standard 115.262 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.

The agency reported there have not been any incidents in the past 12 months where the facility determined a resident was subject to substantial risk of imminent sexual abuse. Review of policy and interviews with the PREA Coordinator and Facility Program Directors demonstrated that protective measures would be taken in the event it was found that a resident was at imminent risk of sexual abuse. Protective measures were explained in detailed in to the auditor's satisfaction, as noted in the agency's policies and PREA standards.

Evidence Reviewed: Pre-Audit Questionnaire, Interviews, Policy

Standard 115.263 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.

The agency reported that in the past 12 months, each facility has not received any allegations that a Parsons House or Glover House resident may have been sexually abuse while confined at another facility. The agency policy states the facility Program Director shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred, within 72 hours after receiving the allegation. The agency is required to document such notification.

Evidence Reviewed: Pre-Audit Questionnaire, Interviews, Policy

Standard 115.264 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.

The agency reported that in the past 12 months, there have been 0 allegations that a resident was sexually abused. There were no victims available for interview by the auditor. During random interviews, staff demonstrated a complete and thorough comprehensive of their responsibilities in the event of being a first responder to allegations of sexual abuse according to the agency's policies and PREA standards. Staff from both facilities clearly understood their duties and difference of requirements pertaining to an alleged victim and an alleged abuser. Review of the agency's policy indicated all the necessary requirements set forth by the PREA standards, and included the responsibilities if the first responder is not a security staff member.

Evidence Reviewed: Pre-Audit Questionnaire, Interviews, Policy, Training Documentation

Standard 115.265 Coordinated response

☐ 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 developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse. The agency has listed specific duties that first responders and administrators at each facility are to adhere to. The agency coordinated response states that victims are immediately taken to the Sexual Assault Treatment Center, and investigators from the Milwaukee Police Department, and Bureau of Prisons are immediately notified. The Sexual Assault Treatment Center is open 24/7 with specially trained sexual assault treatment staff that offer the necessary support to victims.

Evidence Reviewed: Pre-Audit Questionnaire, Interviews, Policy

Standard 115.266 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.

The above standard is NOT APPLICABLE due to the agency not being unionized and not having a collective bargaining agreement.

Standard 115.267 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 agency reported in the past 12 months there have been 0 incidents of retaliation reported, known, or suspected. The agency PREA policy clearly states that retaliation against any resident or staff member that reports sexual abuse and sexual harassment or participates in an investigation is not tolerated.

The agency reported the PREA Compliance Manager at each facility is responsible for monitoring any form of retaliation and multiple protection measures are in place with knowledge of such. The agency's policy requires the PREA Facility Compliance Manager monitor the conduct and treatment of residents or staff who reported sexual abuse and sexual harassment of residents, for at least 90 days following a report of sexual abuse or sexual harassment. Interviews of PREA Compliance Managers indicated they understood their roles and the agency's policy of preventing any forms of retaliation. (Alleged staff or residents abusers will be removed from contact with victims.)

Evidence Reviewed: Pre-Audit Questionnaire, Interviews, Policy

Standard 115.271 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 agency does not conduct its own investigations into allegations of sexual abuse or sexual harassment. The Federal Bureau of Prisons (BOP) conduct all administrative investigations for the agency and the City of Milwaukee Police Department will be notified of all sexual abuse and sexual harassment allegations in which conduct appears to be criminal.

The agency reported there were 0 substantiated allegations of conduct that appeared to be criminal that were referred for prosecution, therefore 0 criminal investigations.

The Federal Bureau of Prison investigators are trained to conduct proper and sensitive investigations. The Bureau of Prisons has an Internal Affairs Office that monitors and oversees all administrative investigations. Administrative investigators are trained every year on how to conduct sexual abuse and sexual harassment investigations. Interviews indicated that BOP's investigators understood that investigations are not terminated solely because the source of the allegation recants the allegation, or if an alleged abuser or victim departs during the investigation. The agency, policy and BOP investigator indicated full cooperation if an outside agency requested assistance and access for a sexual abuse investigation.

Evidence Reviewed: Pre-Audit Questionnaire, Interviews, Policy, and BOP's procedures

Standard 115.272 Evidentiary standard 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.

During the interview of BOP's local investigator, it was noted there was not a full comprehension of what standard was used to constitute a determination in the outcome of an administrative investigation. The preponderance of the evidence or lower standard was not noted during the interview or explained.

Corrective Action Plan: BOP investigators will implement and demonstrate a knowledge regarding which uniform standards are used for determining whether sexual abuse or sexual harassment cases can be substantiated.

Verification of Corrective Action since the Audit: The BOP Office of Internal Affairs provided the agency and this investigator its policies and procedure for investigations. The standards of the investigations are consistent with preponderance of the evidence, if whether or not an incident likely occurred. Investigations report are all examined by a supervisor who has been trained of the standard needed to sustain or not sustain an administrative case.

Evidence Reviewed: BOP's policies, Reports, Website, Interviews, and Emails

Standard 115.273 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 that any resident who makes an allegation that they suffered sexual abuse at the Parsons House or Glover House is informed verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the Federal Bureau of Prisons. The policy includes whether a resident allegation includes a staff member, and if the staff member is no longer employed at the facility, has been indicted and charged related to sexual abuse within the facility.

The agency reported there have been a total of 0 administrative/criminal investigations for sexual abuse. Due to being neither allegations nor investigations, the auditor was unable to review any notification documentation for this standard.

Evidence Reviewed: Pre-Audit Questionnaire, Interviews, Policy

Standard 115.276 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 reported there have not been any staff in the past 12 months who have violated agency sexual abuse or sexual harassment policies. There has not been any staff who has been terminated or who has resigned due to investigations involving PREA related incidents. In the past 12 months, one staff member was placed on administrative leave regarding sexual harassment of a resident while the investigation ensued and concluded. In the past 12 months, there has not been staff reported to law enforcement or licensing boards for violating agency sexual abuse or sexual harassment policies.

The agency's policy requires that staff be subject to disciplinary action up to and including termination of employment for violations of sexual abuse, sexual harassment, or sexual misconduct. Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse.

Evidence Reviewed: Pre-Audit Questionnaire, Interviews, Policy

Standard 115.277 Corrective action 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 reported there have been 0 contractors/volunteers reported to law enforcements or relevant licensing bodies in the past 12 months for engaging in sexual abuse of residents. The agency's policy states that contractors or volunteers who engages in sexual abuse is prohibited from contact with residents and shall be reported to law enforcements agencies and to relevant licensing bodies. The agency shall take appropriate remedial measures to prohibit further contact with residents.

Standard 115.278 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.

The agency reported there have been 0 administrative/criminal findings of resident-on-resident sexual abuse at the Parsons House of Glover House in the past 12 months.

It should be noted the agency prohibits ALL sexual activity between residents and will discipline residents for sexual activity.

The agency's policy states that residents shall be subject to disciplinary sanctions following an administrative finding the resident engaged in resident-on-resident sexual abuse. The policy states the disciplinary process shall consider a resident's mental disabilities, or mental illness and if it may have contributed to his or her behavior. The policy makes clear that residents will not be subject to disciplinary actions if found to have sexual contact with a staff members due to not being able to legally consent. If sexual contact between resident and staff was forced by the resident, then disciplinary actions commence and incident would be referred for criminal prosecution.

The agency's policy includes that residents who make allegations of sexual abuse and sexual harassments in good faith but does not establish evidence sufficient to substantiate that allegation, shall not be exposed to disciplinary actions.

Evidence Reviewed: Pre-Audit Questionnaire, Interviews, Policy

Standard 115.282 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.

The agency reported no resident victims of sexual abuse in the past 12 months. Based on policy, and interviews, all victims of sexual abuse would be immediately transported to the Sexual Assault Treatment Center (SATC) where forensic medical exams are conducted by Sexual Assault Nurse Examiners (SANE). The SATC is fully operated and open 24/7 for around the clock access. Treatment services to the victim shall be provided without financial costs, and regardless of whether the victim names the abuser or cooperates with any investigation arising from the incident.

Evidence Reviewed: Pre-Audit Questionnaire, Interviews, Policy, Tour of SATC

Standard 115.283 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 reported no resident victims of sexual abuse within the past 12 months, therefore the auditor was unable to interview any resident victims or review any corresponding documentation of practice. The agency's policy requires that resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. All victims are transported to the Sexual Assault Treatment Center (SATC) who offers medical and mental health evaluations, treatments, follow-up services, treatment plans, and referrals for continued care when released from custody. Resident victims would be offered pregnancy and sexual transmitted infections test as medically appropriate, without cost to the victims.

The facility shall conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.

Evidence Reviewed: Pre-Audit Questionnaire, Interviews, Policy

Standard 115.286 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 agency reported no criminal or administrative investigations that alleged sexual abuse at either facility in the past 12 months. The agency does have a PREA TEAM that meets weekly to discuss how to improve policies and procedures, monitoring, and the prevention of incidents that may arise regarding sexual abuse. The agency's policy does include provisions establishing a formalized sexual abuse incident review team, with instructions on how to manage the meeting, and the purpose and goals of the meeting. Interviews with the PREA Coordinator and the PREA Compliance Managers indicated a comprehension of the policies governing the incident review team, and its purpose.

Evidence Reviewed: Pre-Audit Questionnaire, Interviews, Policy, Review of Minutes

Standard 115.287 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 agency collects accurate, and uniform data for every allegation of sexual abuse/ sexual harassment and staff sexual misconduct at each facility, however the agency has not aggregated its findings nor created an annually report.

The agency maintains, reviews, and collects data as needed from all available incident-based documents. The incident-based data has the necessary information to answer all questions from the Survey of Sexual Violence (SSV-1) conducted by the Department of Justice. If requested, the agency will provide data to the Department of Justice.

The agency does not contract for the confinements of its residents, therefore is not required to obtain data from other private facilities.

Corrective Action Plan: Have PREA-Coordinator aggregate data of allegations of sexual abuse in each facility using a standardized instrument and set of definitions. The PREA-Coordinator shall comprised each facility's annual report and corrective action plans, after the conclusion of the review.

Verification of Corrective Action since the Audit: The PREA Coordinator provided a uniform data report of all allegations of sexual abuse and sexual harassment at each facility. The report included corrective action plans and up-dates with regards to pat-down searching, training refreshers, and discussion of PREA issues at monthly meetings.

Evidence Reviewed: Pre-Audit Questionnaire, Interviews, Policy, Review of Minutes, Review of Annual Report and Corrective Action Plan

Standard 115.288 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 agency's PREA Coordinator reported that an annual report of incident-based data of sexual abuse has not been generated for each facility however the report will be produced in the future, and made available to the public upon approval by the agency's head. Interviews of administration addressed that meetings and discussions are taking place in order to assess and improve the effectiveness of sexual abuse prevention, detection, and responses, however the auditor is unable to properly verify due to the lack of preparing an annual report of its findings and corrective actions plans for each facility, as well as the agency as a whole.

Corrective Action Plan: PREA-Coordinator shall aggregated data of all sexual abuse allegations for administrators to review. The agency shall review the collected data and document corrective action plans related to the data, and any previous years correction plan, with an assessment of progress. (Policies and procedures, training, problem areas, prevention and detection, investigations)

Verification of Corrective Action since the Audit: : The PREA Coordinator provided a uniform data report of all allegations of sexual abuse and sexual harassment at each facility. The report included corrective action plans and up-dates with regards to pat-down searching, training

refreshers, and discussion of PREA issues at monthly meetings. The agency's website provides information on PREA Standards for Community Confinement and PREA data in Wisconsin.

Evidence Reviewed: Pre-Audit Questionnaire, Website, Interviews, Policy, Review of Minutes, Review of Annual Report and Corrective Action Plan

Standard 115.289 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 does collect data of sexual abuse and sexual harassment incidents, and retains them securely as noted during the on-site tour.

The agency's policy requires the agency make such information readily available publicly however at this time has failed to do so. The PREA-Coordinator addressed the standard and stated the above standard will be corrected as soon as possible.

Corrective Action Plan: Information regarding each facilities data pertaining to sexual abuse allegations be made public at least annually through its website. Personal identifiers shall be removed. Sexual abuse collected data shall be kept for 10 years.

Verification of Corrective Action since the Audit: The agency has provided on it's website data and information regarding Wisconsin PREA allegations. No personal identifiers noted.

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.

Anthony T. Dodd Sr. The Dodd Group, LLC — January 21, 2017

Auditor Signature — Date