Prison Rape Elimination Act (PREA) Audit Report
Community Confinement Facilities

☐ **Interim** ☒ **Final**

Date of Report 10/23/19

Auditor Information

Name: Dave Cotten	**Email:** dave@preaauditing.com
Company Name: PREA Auditors of America, LLC	
Mailing Address: 14506 Lakeside View Way	**City, State, Zip:** Cypress TX 77429
Telephone: 713-818-9098	**Date of Facility Visit:** June 20 & 21, 2019

Agency Information

Name of Agency: Great Falls Pre-Release Services, Inc. (GFPRC)		**Governing Authority or Parent Agency** *(If Applicable)*: Click or tap here to enter text.	
Physical Address: 1019 15th Street North		**City, State, Zip:** Great Falls MT 59401	
Mailing Address: Click or tap here to enter text.		**City, State, Zip:** Click or tap here to enter text.	
Telephone: 406-727-0944		**Is Agency accredited by any organization?** ☐ Yes ☒ No	
The Agency Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Agency mission: Great Falls Pre-Release Services, Inc. provides a cost-effective alternative to incarceration for offenders through a variety of community-based correctional treatment programs. Great Falls Pre-Release Services, Inc. is dedicated to ensuring public safety and trust through professional, quality services which facilitate personal growth through positive change and individual responsibility of assigned offenders.

Agency Website with PREA Information: http://www.gfprc.org/

Agency Chief Executive Officer

Name: Paul R. Cory	**Title:** Executive Director
Email: Paul@gfprc.org	**Telephone:** 406-455-9350

Agency-Wide PREA Coordinator

Name: Mike Scott	**Title:** Program Manager/PREA Coordinator
Email: MScott@gfprc.org	**Telephone:** 406-455-9350
PREA Coordinator Reports to: Paul Cory, ED	**Number of Compliance Managers who report to the PREA Coordinator** 0

Facility Information

Name of Facility:	Great Falls Pre-Release Services, Inc.			
Physical Address:	1019 15th Street North Great Falls, MT 59401			
Mailing Address (if different than above):	Click or tap here to enter text.			
Telephone Number:	406-455-9350			
The Facility Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit	
☐ Municipal	☐ County	☐ State	☐ Federal	
Facility Type:	☐ Community treatment center	☒ Halfway house	☐ Restitution center	
	☐ Mental health facility	☐ Alcohol or drug rehabilitation center		
	☐ Other community correctional facility			

Facility Mission: Great Falls Pre-Release Services, Inc. provides a cost-effective alternative to incarceration for offenders through a variety of community-based correctional treatment programs. Great Falls Pre-Release Services, Inc. is dedicated to ensuring public safety and trust through professional, quality services which facilitate personal growth through positive change and individual responsibility of assigned offenders.

Facility Website with PREA Information: http://www.gfprc.org/

Have there been any internal or external audits of and/or accreditations by any other organization? ☐ Yes ☒ No

Director

Name: Paul R. Cory	**Title:** Executive Director
Email: Paul@gfprc.org	**Telephone:** 406-455-9320

Facility PREA Compliance Manager

Name: Mike Scott	**Title:** Program Manager/PREA Coordinator
Email: MScott@gfprc.org	**Telephone:** (406)455-9350

Facility Health Service Administrator

Name: Gail Hopewell		**Title:** Nurse	
Email: gail@gfprc.org		**Telephone:** 406-455-9370	
Facility Characteristics			
Designated Facility Capacity: 240		**Current Population of Facility:** 210	
Number of residents admitted to facility during the past 12 months			382
Number of residents admitted to facility during the past 12 months who were transferred from a different community confinement facility:			0
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:			359
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:			358
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:			0
Age Range of Population:	☒ Adults 19 to 69	☐ Juveniles 0	☐ Youthful residents 0
Average length of stay or time under supervision:			112.2 days
Facility Security Level:			Minimum
Resident Custody Levels:			Minimum
Number of staff currently employed by the facility who may have contact with residents:			72
Number of staff hired by the facility during the past 12 months who may have contact with residents:			16
Number of contracts in the past 12 months for services with contractors who may have contact with residents:			2
Physical Plant			
Number of Buildings: three		**Number of Single Cell Housing Units:** 0	
Number of Multiple Occupancy Cell Housing Units:		109	
Number of Open Bay/Dorm Housing Units:		8	

Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.): **From camera map provided, the facility has approximately 30 cameras covering most common areas.**

Each of the three housing units has a control room (called a CO Office) which has monitors for viewing the video cameras placed thorough that facility. Cameras are connected to digital video recorders and capable of video playback, some capable of footage up to thirty days past. Footage is recorded based upon detected movement so the more movement detected, the less footage will be available. Camera placement is unique to each building. Common areas are all under surveillance; dining areas, recreation areas, dining rooms, kitchens, laundry rooms, passageways, lobbies, classrooms, facility entrances, external grounds and parking areas. Some, but not all, stairwells are under camera surveillance. Areas not under camera surveillance include resident bedrooms, bathrooms, secured maintenance, mechanical, and storage rooms, staff offices, staff and visitor restrooms, any area secured to resident access. Since the last audit in 2016 the facility has added

several new cameras and upgraded many existing cameras to High Definition. Senior management has the capability to access cameras in each facility from their office computer desktops.	
Medical	
Type of Medical Facility: none	Click or tap here to enter text.
Forensic sexual assault medical exams are conducted at:	Benifis Hospital Emergency Room
Other	
Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	14
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	1

Audit Findings

Audit Narrative

The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

The on-site PREA Audit of the Great Fall Pre-Release Center (GFPRC) was conducted on June 20 & 21, 2019. The audit was conducted by Dave Cotten, a certified National PREA auditor, under contract with the PREA Auditors of America, LLC. This was GFPRC's second National PREA Audit. Approximately six weeks prior to the on-site visit, GFPRC posted notifications of the upcoming audit with the auditor's contact information to allow for residents to contact the auditor prior to the audit. The auditor received no correspondence prior to the on-site but did receive one letter from a resident after the on-site visit. The resident was providing information regarding allegations at another facility. The allegations were referred to the other facility by the auditor, but no further action was taken as the information was not relative to this audit. The auditor did contact the Montana Coalition Against Domestic and Sexual Violence who indicated they have had no reports of sexual violence reported from the facility within the last 12 months. GFPRC provided the auditor with file documentation electronically approximately four weeks prior to the on-site visit. From this documentation, the auditor completed as much of the auditor compliance tool as possible prior to the on-site visit.

An initial in-brief was held at 9:00 a.m. on 6/20/19 with Director Cory and PREA Coordinator/PCM Mike Scott, facility PREA Liaison Sheena Jarvey, Security Supervisor Joshua Weist, Facility Services Director Jeff Barnhart and Treatment Services Director Alan Scanlon. Staff introduced themselves and provided professional background as did the auditor. The Director provided the auditor with an overview of GFPRC and the offender population it serves.
The auditor was given a complete tour of the facility by the PREA Coordinator and PREA Liaison. Throughout the tour, the auditor observed the notices of this PREA audit in all the buildings, as well as posters that called attention to the facility's Zero Tolerance Policy and how to report allegations of sexual abuse and sexual harassment. The auditor recommended additional posters placed more visible to residents and specifically close to, or at, the resident phones. The auditor also recommended windows be placed in doors to utility rooms residents can access with no visibility.

The auditor did note several shower curtains creating blind spots in a high-risk area but were easily fixable, and/or shower towel hooks allowing for potential staff cross gender viewing of residents in a state of undress. These issues were discussed at the time of the on-site and are further addressed in the below findings of related standards.

Following the tour, the auditor began the interviews and reviews of training and personnel files, offender files, and documents.

Seventeen (17) random residents were interviewed. Those interviewed were randomly selected, by the auditor, from a list of all the offenders by their housing assignment at the facility. Only two residents who identify as LBG were interviewed as well as one resident who reported previous sexual abuse who also requested to be interviewed. There were no LEP or disabled residents and no residents who identified as transgender or intersex.

Twelve (12) random staff were interviewed who were randomly selected by the auditor from all three shifts and/or other areas of the operation. As all security staff are also first responders, two of the random staff were interviewed as first responders. Including first responders, fourteen (14) interviews were conducted with nine (9) specialized staff. On-site interviews included the Agency Director/human resource director, Facility Director, PREA Manager, a nurse, staff who conduct screening for risk of abuse or victimization, one staff who is on the incident review team, monitors for retaliation, conducts intake and is the administrative investigator, one contractor and one volunteer. One staff at the Benifis Hospital was interviewed but declined to be identified.
The auditor also interviewed one contractor for Benefis Substance Abuse program and one volunteer. In total, twenty-seven (27) staff/contractor/volunteer interviews were conducted as part of the audit.
It should be noted that since this is a small facility, some of the employees have multiple responsibilities so some individuals were interviewed more than once if their duties covered more than one specialized area.

The auditor was impressed by what the random staff's knowledge of PREA, the zero-tolerance policy, resident rights regarding PREA and first responder duties.

When the on-site audit was completed, the auditor conducted a short de-brief on June 21, 2019. The auditor gave an overview of the audit and thanked the Director and his staff for their hard work and commitment to the Prison Rape Elimination Act.

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

Great Falls Pre-Release Center is a 240-bed adult re-entry facility housing both male and female adult residents based on contracts with the Federal Bureau of Prisons, the Montana Department of Corrections and local jurisdictions. The average daily population is 174 for the last twelve months. There were 158 residents during the onsite visit. GFPRC is comprised of three buildings, all being living units and identified as East Campus with State only residents, Women's Campus and West Campus with State and Federal residents. West Campus and Women's Campus are connected by a secured breezeway. The primary administration is in the West Campus building. Female offenders, federal and state, are housed together but separate from the male population.

The facility, as a community corrections, has one nurse for on-site medical services and no on-site criminal investigators. Local law enforcement is called for emergency situations and criminal investigations. Residents are responsible for their own medical care except in the case of sexual abuse as outlined in policy. The East Campus is the newest and most updated facility with more and better camera and other security systems.

The facility provides community service programs and a large number of residents have gainful employment with local businesses. Also provided is post-conviction alternative to incarceration for local jail confinees, overseen by parole/probation. The veterans program provides residents who have served in the armed services a separate housing area and separate programs to assist in addressing specific veteran related concerns associated with or possibly contributing to criminal behavior.

Summary of Audit Findings

*The summary should include the number of standards exceeded, number of standards met, and number of standards not met, **along with a list of each of the standards in each category**. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.*

***Auditor Note:** No standard should be found to be "Not Applicable" or "NA". A compliance determination must be made for each standard.*

Number of Standards Exceeded: one (1)

115.241- Screening for risk of victimization and abusiveness

Number of Standards Met: Forty (40)

211, 212, 213, 215, 216, 217, 218, 221, 222, 231, 232, 233, 234, 235, 242, 251, 252, 253, 254, 261, 262, 263, 264, 265, 266, 267, 271, 272, 273, 276, 277, 278, 282, 283, 286, 287, 288, 289, 401 & 403

Number of Standards Not Met: none (0)

Summary of Corrective Action (if any)

During the audit process, the auditor found GFPRC to not meet fourteen standards as listed below. The agency/facility took numerous actions to correct most of the deficiencies prior to submitting the interim report. Eleven of the fourteen were found to meet standard, due to the actions taken, prior to the submittal of the interim report on 8/2/19.

In several of the "actions taken" the report refers to directives from the Executive Director to address the deficiencies of meeting the standard. Per the PREA Coordinator these directives were posted in each CO office's PREA binder which currently holds the entire PREA policy and associated checklists, forms, etc… All directives were provided to the auditor.

On 8/2/19, at the conclusion of the pre-audit, on-site audit and post on-site audit process to this point, the auditor found the Great Falls PRC meets all standards except; 115.117--Hiring and promotion decisions, 115.251--Resident Reporting and 115.254—Third Party Reporting. Details are noted below.

Due to the above standards not being met, the facility was under a corrective action plan (CAP) not to exceed 180 days from the submission of the interim report to the facility on August 2, 2019. The final report must be submitted to the facility and the Department of Justice through the PREA Resource Center prior to January 29, 2020. However, the final report can be filed at any time prior to that should the agency/facility show it meets all elements of all standards. On 10/16/19, due to actions taken as noted throughout this report, the agency/facility was found to meet (exceed on one) the requirements of all standards.

115.211- Corrective action: As identified in the "checklist of policies/procedures and other documents" that was provided to the facility prior to the audit, the agency/facility needs to provide an organizational chart showing the PREA Coordinator position and its standing in upper level management. Or; a letter or memo to file, signed by the director appointing the PREA Coordinator.

Action taken: On July 1, 2019 the Executive Director issued a memo designating Mike Scott as the PREA Coordinator for the Great Falls Pre-release Services, Inc. The memo directs Mr. Scott to report directly to the Executive Director. The agency/facility now meets all elements of this standard.

115.213-- Corrective Action: GFPRC needs to provide a written staffing plan addressing all elements of standard 115.213 section (a). Facility staff are referred to the PREA Resource Center's white paper on "Developing and Implementing a PREA-Compliant Staffing Plan". Annual reviews, addressing elements in (b) of the standard, for the last three years need to be provided to the auditor.

Action Taken: The facility provided an updated staffing plan for FY 2020 addressing the elements of the standard which included a review of 2019.

115.215-- Corrective actions: (1) GFPRC needs to add or reposition towel and clothing hooks near the shower allow residents to hang or retrieve towels or clothing without being unclothed outside the shower.
(2) Implement policy and procedure that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing…. Provide policy to the auditor.

Action taken: (1) GFPRC completed the adding or repositioning of the clothing hooks prior to the auditor completing the on-site visit. (2) The facility updated the facility operations manual to include "all residents have the right to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine checks. Staff of the opposite gender are required to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing." Updated policy was provide prior to submittal of original report. With the actions taken as noted, the facility now meets all elements of the standard.

115.217-- Corrective action: GFPRC needs to provide verification of compliance with elements (f) The agency shall ask all applicants and employees who may have contact with residents directly about

previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct; (g) Material omissions regarding such misconduct, or the provision of materially false information, are grounds for termination; and (h) Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.

The facility needs to provide documentation verifying (f) and (g) are addressed with all current staff. Recommendation for completing this task was discussed with the auditor, the agency head and the PREA Coordinator.

Action taken: On July 29, 2019, the Executive Director issued a directive to all current staff addressing elements (f), (g) and (h) of the standard. Action taken on 7/29/19 addresses policy and addresses the requirements with current staff.
On 8/2/19, the facility provided an updated voucher for new hire form with required questions being asked of all new hires.

115.221-- Corrective action: GFPRC needs to address in policy or other documentation, such as an MOU with the local hospital, element (c) f this standard. OR documentation of the facility's efforts to obtain an MOU with the local SANE agency.

Action taken: GFPRC has requested an MOU with Benefis Health System to provide SANE and medical care for victims of sexual assault. MOU has been provided to Benifis. The MOU was signed by the Executive Director of GFPRC on 7/18/19. Benifis, per PREA Coordinator, has agreed verbally but has not yet signed the MOU agreement.

115.235-- Corrective action: Assigned medical staff need to complete appropriate specialized training. On-line training provided on the NIC or PREA Resource Center websites are available.

Action taken**:** The only medical staff assigned to the facility provided a certificate of completion for the NIC on-line course titled PREA 201 for Medical and Mental Health Practitioners. Completion date is 7/15/19.

115.251— Corrective action: While the system is in place, GFPRC needs to ensure the reporting method identified meets the practice of receiving reports from residents of GFPRC and third parties and the method includes all elements of this standard, such as:
Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency?
Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?
Does that private entity or office allow the resident to remain anonymous upon request?
Upon discussion with the facility, this will be accomplished through training and checklist.
Upon notice of updated practice or training completion, the auditor will test the system.

Action taken: On 7/29/19 a checklist was provided to the auditor. The checklist outlines staff receiving a 3rd party report required actions.
On 10/4/19, the auditor was notified the updated training was completed as noted above and the auditor did test the reporting methods which resulted in a positive outcome. On 10/16/19, the agency "Alternatives" received the auditor's call and provided appropriate responses to what their actions would be with a report from a GFPRC resident, or a third party, of sexual abuse. This included questions asked of the caller and to whom the report and information would be forwarded and when.

115.254—Corrective action: While the system is in place, GFPRC needs to ensure the reporting method identified meets the practice of receiving reports from third parties with appropriate information being retrieved and provided to GFPRC.
Upon discussion with the facility, this will be accomplished through training and checklist.
Upon notice of updated practice or training completion, the auditor will test the system.

Action taken: On 7/29/19 a checklist was provided to the auditor. The checklist outlines staff receiving a 3rd party report actions.
On 10/4/19, the auditor was notified the updated training was completed as noted above and the auditor did test the reporting methods which resulted in a positive outcome. On 10/16/19, the agency "Alternatives" received the auditor's call and provided appropriate responses to what their actions would be with a report from a GFPRC resident, or a third party, of sexual abuse. This included questions asked of the caller and to whom the report and information would be forwarded and when.

115.261-- Corrective action: The files initially provided did not contain documentation on the standard. The facility needs to provide documentation to support compliance with this standard.

Action Taken: The facility provided the necessary documentation to support compliance with this standard.

115.267-- Corrective actions: The files initially provided did not contain documentation on the standard. The facility needs to provide documentation to support compliance with this standard. A review of policy found a minimal statement to protect residents from retaliation. No mention of staff. Elements (a), (c) & (e) need addressed in entirety.

Action taken: On July 24, 2019 the Executive Director issued a directive to all staff addressing all elements of this standard. The reported victim's Correctional Treatment Specialist (CTS), the screening officer or the PREA Coordinator (or liaison) are the assigned monitors.

115.273-- Corrective action: The facility needs to provide file documentation to support compliance with this standard. The facility needs to address elements (c) & (d) and provide to the auditor.

Action taken: On July 29, 2019 the Executive Director issued a directive to all staff addressing all elements of this standard using verbiage directly from the standard.

115.277-- Corrective actions: GFPRC needs to provide file documentation to indicate compliance with this standard to include policy or other documentation to reflect: Any contractor or volunteer who

engages in sexual abuse is prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.

-and-

The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

Action taken: On July 29, 2019 the Executive Director issued a directive to all staff addressing all elements of this standard using verbiage directly from the standard.

115.278-- Corrective action: The facility needs to provide file documentation to address elements (b)- Sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories, (c)- The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed & (e)- The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

Action taken: On July 29, 2019 the Executive Director issued a directive to all staff addressing all elements of this standard using verbiage directly from the standard.

115.283-- Corrective action: GFPRC needs to address element (h)-- The facility shall attempt to 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.

Action taken: On July 29, 2019 the Executive Director issued a directive to all staff addressing all elements including element (h) of this standard using verbiage directly from the standard.

PREVENTION PLANNING

Standard 115.211: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by The Auditor to Complete the Report

115.211 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.211 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities?
  ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: Great Falls Pre-Release Services Policy "Prison Rape Elimination Act of 2003 (PREA)": Great Falls Pre-Release Services, Inc. has a zero tolerance to the sexual abuse or sexual harassment of residents under their supervision. Great Falls Pre-Release Services, Inc. recognizes these residents as victims of a crime and will immediately respond to all allegations, investigate reported incidents, pursue disciplinary action, and refer for investigation and prosecution those staff and residents who perpetrate such conduct.

Policy also states the PREA Coordinator is responsible for developing, implementing and overseeing efforts to comply with the PREA standards in all GFPRC, Inc. facilities. And; the PREA Liaison conducts training, investigations and assists the Coordinator.

Executive Directive issued by the Executive Director.

Other documentation: Zero Tolerance poster(s)

Observations and interviews: In an interview with the PREA Coordinator, he states he generally has time and does have the authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities. He does delegate to he PREA Liaison occasionally as needed. He does develop policy and procedure through the management team and meets with them regularly outlining issues or problems and recommendation for correction.

Corrective action: As identified in the "checklist of policies/procedures and other documents" that was provided to the facility prior to the audit, the agency/facility needs to provide an organizational chart showing the PREA Coordinator position and its standing in upper level management. Or; a letter or memo to file, signed by the director appointing the PREA Coordinator.

Action taken: On July 1, 2019 the Executive Director issued a directive designating Mike Scott as the PREA Coordinator for the Great Falls Pre-release Services, Inc. The memo directs Mr. Scott to report directly to the Executive Director.

Findings: As no documentation was provided to the auditor to reflect the appointment of the PREA Coordinator or an organizational chart reflecting the position, the agency/facility was not originally compliant with (b) of this standard. Based on policy, other documentation, observations, interviews and the action taken as noted above, prior to the initial report being submitted, the agency/facility now meets all elements of this standard.

Standard 115.212: Contracting with other entities for the confinement of residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.212 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☐ Yes ☐ No ☒ NA

115.212 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.212(a)-1 is "NO".) ☐ Yes ☐ No ☒ NA

115.212 (c)

- If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) ☐ Yes ☐ No ☒ NA

- In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Not applicable as GFPRC does not contract for the confinement of residents.

Standard 115.213: Supervision and monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.213 (a)

- Does the agency develop for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No
- Does the agency document for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the physical layout of each facility in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the composition of the resident population in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration any other relevant factors in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

115.213 (b)

- In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (N/A if no deviations from staffing plan.)
  ☐ Yes ☐ No ☒ NA

115.213 (c)

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns? ☒ Yes ☐ No

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: Policy addresses the standard by requiring the agency director to develop and document a staffing plan with the facility director.

Other documentation: Staff schedule for May 19, 2019
Memo titled "staffing patterns"
Updated staffing plan for y 2020

Observations and interviews: Through staff interviews it was determined the facility has a staffing plan and annual reviews are conducted. Adequate staffing levels to protect residents against sexual abuse are discussed at these reviews. Video monitoring is a part of this plan. The staffing plan is documented and retained by the Executive Director and has been upgraded as outlined in the 2019 review discussed in the FY 2020 plan. The facility has a plan in place for a call list in the event of excessive call-ins, and there have been no deviations of the staffing plan noted during the past 12 months.

Corrective Action: GFPRC needs to provide a written staffing plan addressing all elements of standard 115.213 section (a). Facility staff are referred to the PREA Resource Center's white paper on "Developing and Implementing a PREA-Compliant Staffing Plan". Annual reviews, addressing elements in (b) of the standard, for the last three years need to be provided to the auditor.

Action Taken: The facility provided an updated staffing plan for FY 2020 addressing the elements of the standard which included a review of 2019.

Findings: The facility originally did not meet the standard. No documentation was provided to verify elements of the standard. While there was document addressing staffing patterns based on the elements of the standard, a more comprehensive staff plan was needed as well as a review from within the last 12 months. Based on policy, other documentation, observations, interviews and the action taken as noted above the agency/facility now meets all elements of this standard. Actions were taken prior to submittal of original report.

Standard 115.215: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.215 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
  ☒ Yes ☐ No

115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if less than 50 residents)
- ☒ Yes ☐ No ☐ NA

- Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if less than 50 residents) ☒ Yes ☐ No ☐ NA

115.215 (c)

- Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No

- Does the facility document all cross-gender pat-down searches of female residents? ☒ Yes ☐ No

115.215 (d)

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

- Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? ☒ Yes ☐ No

115.215 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? ☒ Yes ☐ No

- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.215 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: GFPRC Operations Manual, section 32-Search Procedures addresses elements (a), (b) & (c) of the standard. The policy directs only males will search males and only females will search females. Any strip search must receive prior approval of the Executive Director or Acting Executive Director. Body cavity searches may only be conducted by medical professional only upon receiving written prior approval of the ED.

Interviews and observations: Random staff interviewed stated they always announce themselves when entering housing units or bathrooms of opposite gender residents. All staff stated they have never seen a cross gender pat search or strip search performed and would not do so. All staff stated they had been trained in transgender/intersex pat searches. All staff stated they knew not to perform a search to determine genital status. Random residents interviewed stated staff always announce themselves and felt they were never in a position that they had to be naked in front of opposite gender staff. Female residents stated they never felt held up to wait for a female staff to pat search them.

Corrective action: (1) GFPRC needs to add or reposition towel and clothing hooks near the shower allow residents to hang or retrieve towels or clothing without being unclothed outside the shower. (2) Implement policy and procedure that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing…. Provide policy to the auditor.

Action taken: (1) GFPRC completed the adding or repositioning of the clothing hooks prior to the auditor completing the on-site visit. (2) The facility updated the facility operations manual to include "all residents have the right to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine checks. Staff of the opposite gender are required to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing." Updated policy was provided prior to submittal of the original report.

Findings: Original findings were: (1) The facility does not meet the standard as some areas required residents be out of the shower to hang or retrieve a towel or clothing prior to entering the shower or upon completion. (2) The standard requires the facility to implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing…. While practice is in place, GFPRC did not provide the auditor with such policy.

Based on policy, observations, interviews and the action taken as noted above, prior to the initial report being submitted, the agency/facility now meets all elements of this standard.

Standard 115.216: Residents with disabilities and residents who are limited English proficient

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.216 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No

- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.216 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No

- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.216 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: Executive Directive issued by the Executive Director.

Other documentation: Handout for staff PREA refresher training advising staff only staff or the approved vendor can interpret for a resident unless in immediate danger.

Interviews and observations: All staff indicated residents should not be allowed to interpret for other residents and only staff should interpret. The agency head stated they rarely have LEP residents but would use Google Translate as necessary. There were no LEP residents at the time of the on-site.

Findings: Based on the limited need for translators and the interviews indicating a translator service would be used, the facility meets the elements of this standard. The auditor recommends addressing this in policy and, if staff are used to translate, verification by the facility or agency head, in writing, that the translator is proficient in the language. **Update:** On July 29, 2019, the Executive Director issued a directive to all staff addressing each element of this standard to include local translator services.

Standard 115.217: Hiring and promotion decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.217 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.217 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents? ☒ Yes ☐ No

115.217 (c)

- Before hiring new employees, who may have contact with residents, does the agency: Perform a criminal background records check? ☒ Yes ☐ No

- Before hiring new employees, who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

115.217 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.217 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? ☒ Yes ☐ No

115.217 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No

- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.217 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? ☒ Yes ☐ No

115.217 (h)

- Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Policy: Staff handbook requires potential employees are required to submit to a reference, employment and background checks through NCIC prior to employment.
Executive Directive issued by the Executive Director.

Other documentation: FBOP requirements for background checks. The 'statement of works" document requires all employees charged with, arrested for or convicted of any felony or misdemeanor, to immediately inform and provide a written report to the director.

Interviews and observations: PAQ indicates 16 persons have been hired in the last 12 months who have had background checks completed.

Corrective action: GFPRC needs to provide verification of compliance with elements (f) The agency shall ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct; (g) Material omissions regarding such misconduct, or the provision of materially false information, are grounds for termination; and (h) Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.

The facility needs to provide documentation verifying (f) and (g) are addressed with all current staff. Recommendation for completing this task was discussed with the auditor, the agency head and the PREA Coordinator.

Action taken: On July 29, 2019, the Executive Director issued a directive to all staff addressing elements (f), (g) and (h) of the standard.
On 8/2/19, the facility provided an updated voucher for new hire form with required questions being asked of all new hires.

Findings: Originally the agency/facility did not meet the standard. Elements (f), (g) and (h) needed addressed in policy and practice prior to compliance. Action taken on 7/29/19 addresses policy and addressing the requirements with current staff.
Actions taken on 8/2/19 addressed the standard as it relates to hiring staff.

Standard 115.218: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.218 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☐ Yes ☐ No ☒ NA

115.218 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Interviews and observations: There have been no upgrades to facilities or electronic monitoring devices since the last audit. In interviewing the facility director, additional cameras were added to the current system and more have been requested, but not yet approved.

Findings: Based on the above information, the facility meets the standard.

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.221 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

115.221 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

115.221 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No

- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No

- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.221 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? ☒ Yes ☐ No

- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

115.221 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? ☒ Yes ☐ No

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

115.221 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Other documentation: MOU with YMCA of Great Falls to provide victim advocacy and emotional support for victims of sexual abuse.
Request for MOU with Great Falls Police Department.
Letter from Great Fall Police declining to enter into an MOU for criminal investigation as requested by GFPRC. Letter indicates the PD is obligated to investigate all criminal acts reported to include those at GFPRC.
MOU with Benefis Medical System (unsigned by Benifis)

Interviews and observations: The facility reports no incidents occurred resulting in SANE/SAFE or other sexual assault exams were required.
An interview with a person in the emergency room stated they do SANEs for any persons in the area as requested by law enforcement. Hospital staff declined to be identified.
MDOC or FBOP may investigate based on the resident's status and relative jurisdiction and have related policy in place to meet this standard. Cases may be referred to the Great Falls Police Department, who are not subject to this audit. Victim advocacy and emotional support services are available through MOU with YMCA.
The facility does not conduct criminal investigations therefore elements (a) & (b) are not applicable to their circumstances.

Corrective action: GFPRC needs to address in policy or other documentation, such as an MOU with the local hospital, element (c) of this standard. OR documentation of the facility's efforts to obtain an MOU with the local SANE agency.

Action taken: GFPRC has requested an MOU with Benefis Health System to provide SANE and medical care for victims of sexual assault. MOU has been provided to Benifis. The MOU was signed by the Executive Director of GFPRC on 7/18/19. Benifis, per PREA Coordinator, has agreed verbally but has not yet signed the MOU agreement.

Findings: The original finding was that GFPRC did not meet standard as the facility did not have in policy or other documentation that a SANE will be provided. With the actions taken above combined with other documentation, including other agency MOUs previously provided and interviews conducted the facility meets the elements of this standard.

Standard 115.222: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.222 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? ☒ Yes ☐ No

115.222 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No

- Does the agency document all such referrals? ☒ Yes ☐ No

115.222 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Policy: GFPRC PREA policy requires: H.

1. GFPRS, Inc. staff, contract employees, and volunteers who receive information, regardless of its source, concerning resident on resident sexual abuse, who observe an incident of resident on resident sexual abuse, or staff on resident sexual abuse must immediately report the information or incident directly to PREA Staff or to the Executive Director who will notify law enforcement. Staff will immediately report any staff neglect or violation of responsibilities that may have contributed to the incident or retaliation.

2. For State residents, the Montana Department of Corrections (MDOC) considers reports of sexual abuse a Priority One Incident which must be reported to the Montana State Prison Command Post at (406) 846-6059 and the MDOC Programs & Facilities Bureau Chief at (406) 580-7991 using the MT DOC Priority Incident Report.
WDOC policy #4 and FBOP policy require all incidents be investigated by the appropriate investigative agency all of whom have the authority to investigate criminal cases.
I. Investigative Protocols of Sexual Abuse or Harassment

1. The PREA Coordinator and PREA Liaison in conjunction with the Executive Director will conduct an initial investigation in non-emergency sexual abuse cases.

a. Sexual assault cases will normally be investigated by the Great Falls Police Department.

b. As soon as it becomes apparent that any administrative investigation may result in criminal charges the investigation will cease, and all case notes and evidence turned over to the Great Falls Police Department.

2. The PREA Coordinator will submit an incident report regarding the investigation. GFPRS, Inc. imposes a standard of a preponderance of evidence for determining whether allegations of a sexual abuse or sexual harassment are substantiated. Preponderance of evidence means that more than 50% of the evidence supports the allegation.

3. If there is a question as to whether an incident deemed inappropriate is covered under PREA, the MDOC Programs & Facilities Bureau Chief at (406) 580-7991 will be contacted for direction.

4. The departure of the alleged abuser or victim from employment or control of the Center does not provide a basis for terminating an investigation.

5. Great Falls Pre-Release Services, Inc. prohibits requiring residents who allege sexual abuse to submit to a polygraph examination or other truth telling device as a condition for proceeding with an investigation.

Other documentation: Review of GFPRC website which includes the entire PREA policy and outlines the investigative process.

Interviews and observations: The facility reports two allegations of sexual abuse or harassment were received in the last 12 months and both resulted in administrative investigations.

Findings: Based on policy, practice and interviews, the agency/facility meet the elements of this standard. The PREA policy is posted on the agency/facility website. The GFPD investigates any criminal allegations at the facility to include sexual abuse.

TRAINING AND EDUCATION

Standard 115.231: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.231 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

115.231 (b)

- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No

- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☐ Yes ☒ No

115.231 (c)

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No

- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.231 (d)

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: GFPRC PREA Policy:
K. Staff Training

1. All GFPRS, Inc. staff, contract employees, and volunteers with direct and/or incidental contact with residents will receive documented PREA training during orientation and sign a PREA Staff Training Certification Sheet. Attendance at the annual PREA training or its make-up training session is mandatory.

2. Training will include but is not limited to:
a. Review of this policy, the Prison Rape Elimination Act of 2003, Transition Center Personnel Handbook, and any other applicable state or federal laws.

b. Prevention, detection, reporting and response policies and procedures.
c. Zero tolerance policy for sexual abuse and sexual harassment;
d. Recognition of sexual abuse, predatory residents, potential victims, and/or staff involvement;
e. Facility procedures on sharing confidential information; and
f. Reporting procedures; and
g. The staffs right to be free from retaliation.

3. GFPRRS, Inc. will provide specialized training for staff that responds to and/or investigates allegations of sexual abuse. Training will include crime scene management, victim sensitivity, and crisis intervention.

Other documentation: GFPRC Employee Acknowledgement signature form.
Refresher training handout for Community Confinement Professional Communication and Boundaries.
Lesson Plans for PREA training.
Training certificates for PCM
Staff refresher training schedule reflecting PREA training in July and search training in February

Interviews and observations: PREA Coordinator states staff meetings and trainings occur to provide employees with current policies regarding sexual abuse and harassment. The facility also conducts PREA refresher training every July and all staff must attend.
As this facility houses both males and females, training is tailored to both.
Interviews with random staff indicates all staff have received appropriate training as outlined in the elements of this standard.
Auditor reviewed several randomly selected employee acknowledgement forms. (signed)

Findings: Policy is in place as noted above. Based on the policy, interviews and review of training materials, the facility meets the elements of this standard. Staff are obviously trained in PREA related information which is somewhat limited due to no incidents occurring within the facility. As staff would rarely experience responding to an incident of sexual abuse, their knowledge is limited to classroom training and no experience. Auditor recommends PREA response carry cards for all staff to reference if/when an incident does occur. Auditor further recommends exercise drills involving the response to a simulated sexual abuse.

Standard 115.232: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.232 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? ☒ Yes ☐ No

115.232 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and

contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

115.232 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: GFPRC PREA Policy:
K. Staff Training

1. All GFPRS, Inc. staff, contract employees, and volunteers with direct and/or incidental contact with residents will receive documented PREA training during orientation and sign a PREA Staff Training Certification Sheet. Attendance at the annual PREA training or its make-up training session is mandatory.

2. Training will include but is not limited to:
a. Review of this policy, the Prison Rape Elimination Act of 2003, Transition Center Personnel Handbook, and any other applicable state or federal laws.
b. Prevention, detection, reporting and response policies and procedures.
c. Zero tolerance policy for sexual abuse and sexual harassment;
d. Recognition of sexual abuse, predatory residents, potential victims, and/or staff involvement;
e. Facility procedures on sharing confidential information; and
f. Reporting procedures; and
g. The staffs right to be free from retaliation.

Other documentation: The PREA Acknowledgement provided in file is for employees and does not identify contractors/volunteers or the type of training received. However, volunteers complete the same training which covers the above elements.
Training curriculum
Attendance rosters with staff and contractors

Interviews and observations: The facility reports 14 volunteers or contractors have been trained or re-trained on PREA. Contractors and volunteers were interviewed and showed good knowledge of their responsibilities under PREA to include how to report and what to watch for.

Findings: The facility meets the elements of this standard, based on the information provided. The documents provided to all staff and volunteers/contractors do not reflect volunteers/contractors on the form. Recommend a separate form be developed for volunteers/contractors or add this to current form.

Standard 115.233: Resident education

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.233 (a)

- During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No
- During intake, do residents receive information regarding agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.233 (b)

- Does the agency provide refresher information whenever a resident is transferred to a different facility? ☐ Yes ☒ No

115.233 (c)

- Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills? ☒ Yes ☐ No

115.233 (d)

- Does the agency maintain documentation of resident participation in these education sessions? ☒ Yes ☐ No

115.233 (e)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: GFPRC PREA Policy states:
B. Resident Orientation and Education

1. During orientation and within seven days of arrival, all residents will receive information about sexual abuse and sexual harassment regardless of their program status. Designated staff shall communicate the information verbally and in writing, in a manner that is clearly understood by residents, including those with limited English proficiency, deaf, visually impaired or otherwise disabled, as well as for residents with limited reading ability. Residents will be given the opportunity to review appropriate policies and/or procedures for grievances and PREA, ask questions, and receive answers. Information provided will include, but is not limited to:

    a. Presentation of this policy
    b. Resident Grievance procedures

c. GFPRs, Inc. ZERO tolerance policy
d. The right to be free from sexual abuse and sexual harassment
e. Self-protection methods
f. Prevention and intervention
g. Treatment and counseling
h. Reporting incidents
i. Protection against retaliation
J. Agency policies and procedures for responding to incidents
k. Consequences of false allegations.

2. Staff will document verification of resident orientation and education on PREA by completing the Resident PREA acknowledgement forms and place them in the resident's file.
    a. The PREA Intake Briefing Sheet will be covered within the first 24 hours of reporting aboard and before being assigned to a room. This will be read and explained by the Compliance Officer conducting the check-in.
    b. The PREA Resident Training Certification will be conducted by the PREA Liaison during the Center Indoctrination period (first week).
3. Additional training will be provided as required and as needed at facility/treatment management team discretion.

Other documentation: PREA Initial Intake Briefing Sheet
PREA Intake Briefing
Resident Orientation certification
Resident Orientation and Handbook on Identifying and Addressing Sexual Abuse

Interviews and observations: The PAQ indicates 382 residents received education as outlined in (a) above with none being transferred from other facilities.
Interviews with intake staff indicate all residents receive information on zero tolerance, how to report sexual abuse or harassment, their right to not be sexually abused, their right to not be retaliated against for reporting, etc…, within the first 24 hours of arrival and before housing placement. Additional orientation is conducted weekly which is more in depth and includes discussing the PREA Handbook. Interviews with random inmates indicate they do receive intake briefing immediately and receive orientation within the first week after arrival. Inmates generally were aware and stated they were trained on the elements covered in this standard. The facility reports no incidents of needing translators recently, they are prepared with the use of Google translate. Posters were noted throughout the facility and handbooks were reviewed. Auditor reviewed randomly selected resident PREA acknowledgement forms. There were no LEP or disabled residents for interview.

Findings: Based on policy, training information, the inmate PREA handbook and other documentation, the facility meets the elements of this standard.

Standard 115.234: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.234 (a)

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

115.234 (b)

- Does this specialized training include: Techniques for interviewing sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).]
  ☒ Yes ☐ No ☐ NA

115.234 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).]
  ☒ Yes ☐ No ☐ NA

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: GFPRC PREA Policy states:
K. 3. GFPRS, Inc. will provide specialized training for staff that responds to and/or investigates allegations of sexual abuse. Training will include crime scene management, victim sensitivity, and crisis intervention.

Other documentation: Training Certificate for administrative investigator.

Interviews and observations: Interview with the recently assigned and not yet fully trained investigator and a brief discussion with the currently assigned and trained investigator indicate the facility investigator would only investigate non-criminal sexual harassment cases or cases not involving the collection of physical, bodily or trace evidence. Both were aware of the preponderance of evidence standard.

Findings: Based on the above policy and interviews, the facility meets the standard as they conduct no criminal investigations and they have a trained administrative investigator.

Standard 115.235: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.235 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.235 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? N/A if agency medical staff at the facility do not conduct forensic exams.) ☐ Yes ☐ No ☒ NA

115.235 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? ☒ Yes ☐ No

115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? ☒ Yes ☐ No

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? [N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.] ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Other documentation: Training completion certificate for the single medical staff (nurse) assigned to the facility.

Interviews and observations: A medical staff is assigned to work at the facility but has not yet received specialized training. The nurse has attended the mandatory training for all employees, therefore was aware of many of the elements.

Corrective action: Assigned medical staff need to complete appropriate specialized training. On-line training provided on the NIC or PREA Resource Center websites are available.

Action taken: The only medical staff assigned to the facility provided a certificate of completion for the NIC on-line course titled PREA 201 for Medical and Mental Health Practitioners. Completion date is 7/15/19.

Findings: The facility did not meet the standard at the time of the on-site visit as the assigned medical staff had not received appropriate specialized training. Based on observations, interviews and the above action taken with other documentation showing the nurse completed the appropriate training the facility now meets this standard.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.241 (a)

- Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents? ☒ Yes ☐ No

- Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents? ☒ Yes ☐ No

115.241 (b)

- Do intake screenings ordinarily take place within 72 hours of arrival at the facility? ☒ Yes ☐ No

115.241 (c)

- Are all PREA screening assessments conducted using an objective screening instrument? ☒ Yes ☐ No

115.241 (d)

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated?
  ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent?
  ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident's own perception of vulnerability? ☒ Yes ☐ No

115.241 (e)

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse? ☒ Yes ☐ No

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses? ☒ Yes ☐ No

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse?
  ☒ Yes ☐ No

115.241 (f)

- Within a set time period not more than 30 days from the resident's arrival at the facility, does the facility reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening? ☒ Yes ☐ No

115.241 (g)

- Does the facility reassess a resident's risk level when warranted due to a: Referral?
  ☒ Yes ☐ No

- Does the facility reassess a resident's risk level when warranted due to a: Request? ☒ Yes ☐ No

- Does the facility reassess a resident's risk level when warranted due to a: Incident of sexual abuse? ☒ Yes ☐ No

- Does the facility reassess a resident's risk level when warranted due to a: Receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness? ☒ Yes ☐ No

115.241 (h)

- Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section? ☒ Yes ☐ No

115.241 (i)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: GFPRC PREA Policy, D. 2. states:
Great Falls Pre-Release Services, Inc. will assess each offender using the GFPRS, Inc. Risk of Sexual Victimization and Abusiveness instrument (RSVA) within 72 hours of intake to identify and manage residents who are potentially vulnerable and potentially dangerous, to provide safe housing, adequate protection, and programmatic resources to meet their needs.

a. The RSVA-R (Reassessment) with be conducted within thirty days of the initial assessment and immediately upon reentry should a resident be temporarily removed to a secure facility and then returned to the Center.

b. Residents will be reassessed with the RSVA-R instrument when warranted due to a referral, request, incident of sexual assault or report of additional information that bears on risk of sexual victimization or abusiveness.

Other documentation: Blank Risk or Sexual Victimization & Abusiveness (RSVA) Screening Instrument
Blank Risk or Sexual Victimization & Abusiveness Re-assessment (RSVA_R) Screening Instrument
Lists of assessment counts for a one-year period and re-assessment counts for one-year period
RSVA & RSVA-R Screening Instructions (excellent)

Interviews and observations: Auditor reviewed randomly selected completed assessments within 72 hours and re-assessment within 30 days. Facility reports 318 residents entered the facility and remained for more than 30 days and 325 entered and remained for 72 hours. In an interview with a staff responsible for risk screenings, he indicates confinees are interviewed with the risk assessment being a part of the orientation process within 72 hours. Interviews are done in private following the assessment tool. He was very knowledgeable of the process. Assessments would occur anytime need was identified. Only correctional treatment specialists, management and PREA staff have access to the completed documents. Random residents interviewed indicate these questions are asked at arrival, but many did not remember being asked again after the initial. The auditor was shown the method of tracking to ensure all assessments and re-assessments are conducted in a timely manner.

Findings: Based on the above policy, procedures, other documents, including completed risk assessments and re-assessments, and interviews of staff and confinees, the facility exceeds the requirements set forth in this standard. The screening tool instruction sheet as well as the tracking method are excellent tools which exceeds standards.

Standard 115.242: Use of screening information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.242 (a)

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments? ☒ Yes ☐ No

115.242 (b)

- Does the agency make individualized determinations about how to ensure the safety of each resident? ☒ Yes ☐ No

115.242 (c)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No

- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

115.242 (d)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? ☒ Yes ☐ No

115.242 (e)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? ☒ Yes ☐ No

115.242 (f)

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay,

bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Policy: GFPRC PREA Policy states: Great Falls Pre-Release Services, Inc. will assess each offender using the GFPRS, Inc. Risk of Sexual Victimization and Abusiveness instrument (RSVA) within 72 hours of intake to identify and manage residents who are potentially vulnerable and potentially dangerous, to provide safe housing, adequate protection, and programmatic resources to meet their needs.

Other documentation: Blank Risk or Sexual Victimization & Abusiveness (RSVA) Screening Instrument
Blank Risk or Sexual Victimization & Abusiveness Re-assessment (RSVA_R) Screening Instrument
RSVA & RSVA-R Screening Instructions (excellent)

Interviews and observations: Interviews with staff indicate, Residents are housed accordingly based on the assessment tool. The goal is to place confinees with their protection in mind. Assessment tools identify potential victims or predators which is placed in a data base for staff to ensure appropriate placement of each. The above mentioned screening tool instructions states: "Information gathered by the risk screening instrument will be used to make informed decisions regarding housing, room, employment and programming assignments with the goal of keeping as separate as possible those residents a high risk of being sexually victimized from those at high risk of being sexually abusive. In all cases, individualized determinations shall be made about how to ensure the safety of each resident."

Findings: Based on policy, other documents and observations the facility meets the elements of this standard. Although the facility rarely sees a transgender or intersex resident, the auditor recommends the facility address element (c) in policy.

REPORTING

Standard 115.251: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.251 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.251 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

115.251 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.251 (d)

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: GFPRC PREA Policy states:
C. Resident Reporting
1. Reporting Incident
a. Residents who are victims of, or have knowledge of, sexual abuse should immediately report the incident to any staff member; or
b. Residents may utilize the formal grievance procedure to report sexual abuse in accordance with facility procedures found in Chapter Five of the Resident Handbook; however, residents are not required to use the formal grievance process to report allegations of sexual abuse. Staff receiving such grievances will process them as high priority and will immediately notify the Executive Director who will begin the investigative process.
c. Residents who submit a report alleging sexual abuse by a staff member should not submit the report to the staff member who is the subject of the complaint. Said staff member will not be involved in the investigation of the claim against him/her.
d. Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates may assist residents in filing requests for administrative remedies relating to the allegations of sexual abuse and may file requests on behalf of residents.
e. Residents may report sexual abuse while confined at another facility. GFPRS, Inc. has a reciprocal Memorandum of Understanding (MOU) with Alternatives, Inc. that requires GFPRS, Inc. staff to receive and report third party reports.

1. On duty staff will accept all verbal reports or allegations of sexual abuse or sexual harassment from Alternatives, Inc. staff or residents and immediately contact the GFPRS, Inc. PREA Coordinator or PREA Liaison. If after hours, leave a detailed phone message and then document the details in a written report, which will be emailed to the Alternatives, Inc. by PREA staff. Staff will keep all reports confidential.

2. The Executive Director of GFPRS, Inc. must contact the head of the agency or facility where the alleged sexual abuse occurred no later than 72 hours after receiving the allegation.

2. Residents are not required to file written reports; however, staff who receive verbal reports from residents are required to file written incident reports as set forth in this policy. If a resident should decline third party assistance in filing a grievance alleging sexual abuse, staff will document the resident's decision.

3. Additional methods for reporting incidents include; calling the Alternatives, Inc. PREA Coordinator at (406) 294-9608 or dialing 9-1-1.

4. All reports of sexual abuse and sexual harassment are to remain confidential to protect the victim from retaliation from both other residents and staff.

5. Substantiated deliberately malicious or false reports by residents or other parties will result in disciplinary action.

Other documentation: Poster and refresher training brochure indicating methods of reporting. Added 7/29/19-Checklist for staff to retrieve appropriate information.

Interviews and observations: Interviews with staff and residents indicate both are aware of reporting methods or know where to get the information and confirm the above is correct. Many residents and staff knew residents could report verbally, in writing, in a grievance or through a third party and that the report could remain anonymous.
A phone call to "Alternatives, Inc." confirmed the reporting method to be available however, a call to Alternatives did not produce the results needed for compliance with element (b) for the private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials. One call made during the on-site resulted in Alternatives staff referring the auditor (caller) to the PREA compliance manager, who stated they would report the call to the facility head who would contact the GFPRC. The second call, made on 7/22/19 resulted in the caller (auditor) who asked what would happen if he were a resident from GJPRC or a third party calling to report a sexual abuse incident, the caller was transferred to the PREA Manager's extension. The voice mail picked up and a message was left. A third call was made on 7/29/19 with an operator taking name and that this may be a call that would report sexual abuse at GFPRC, but asking no questions or obtaining detailed information.

Findings: Based on the above policy, procedures, other documentation and interviews/observations the facility meets this standard except as noted below. Numerous ways to report are provided and the information is readily available to residents.
Although "Alternatives, Inc." is identified as the method of reporting via a hotline phone number, three attempts by the auditor to evaluate the system did not result in the facility meeting element (b) of this standard.
PAQ indicates staff must report sexual abuse or harassment of residents to either PREA staff or the Executive Director, auditor recommends adding staff reporting methods to policy or other document to show how staff are informed of this.

Corrective action: While the system is in place, GFPRC needs to ensure the reporting method identified meets the practice of receiving reports from residents of GFPRC and third parties and the method includes all elements of this standard, such as:
Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency?
Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?
Does that private entity or office allow the resident to remain anonymous upon request?
Upon discussion with the facility, this will be accomplished through training and checklist.
Upon notice of updated practice or training completion, the auditor will test the system.

Action taken: On 7/29/19 a checklist was provided to the auditor. The checklist outlines staff receiving a 3rd party report required actions.
On 10/4/19, the auditor was notified the updated training was completed as noted above and the auditor did test the reporting methods which resulted in a positive outcome. On 10/16/19, the agency "Alternatives" received the auditor's call and provided appropriate responses to what their actions would be with a report from a GFPRC resident, or a third party, of sexual abuse. This included questions asked of the caller and to whom the report and information would be forwarded and when.

Standard 115.252: Exhaustion of administrative remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.252 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. ☐ Yes ☒ No ☐ NA

115.252 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.252(d)(3)] , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)
  ☒ Yes ☐ No ☐ NA

- Are those third parties also permitted to file such requests on behalf of residents? (If a third-party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)
  ☒ Yes ☐ No ☐ NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)
  ☒ Yes ☐ No ☐ NA

115.252 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.).
  ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)
  ☒ Yes ☐ No ☐ NA

- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.252 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: GFPRC PREA policy states:
C. Resident Reporting
1. Reporting Incident

b. Residents may utilize the formal grievance procedure to report sexual abuse in accordance with facility procedures found in Chapter Five of the Resident Handbook; however, residents are not required to use the formal grievance process to report allegations of sexual abuse. Staff receiving such grievances will process them as high priority and will immediately notify the Executive Director who will begin the investigative process.
c. Residents who submit a report alleging sexual abuse by a staff member should not submit the report to the staff member who is the subject of the complaint. Said staff member will not be involved in the investigation of the claim against him/her.
d. Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates may assist residents in filing requests for administrative remedies relating to the allegations of sexual abuse and may file requests on behalf of residents.

2. Residents are not required to file written reports; however, staff who receive verbal reports from residents are required to file written incident reports as set forth in this policy. If a resident should decline third party assistance in filing a grievance alleging sexual abuse, staff will document the resident's decision.

And:

J. Documentation
3. At the completion of an investigation (within 90 days), the PREA Investigator will notify the Executive Director and the victim of the outcome in writing. The Sexual Assault Response Checklist (Checklist #9 in the Emergency Checklists Binder) will be utilized for this purpose.
4. If a decision has not been reached within 90 days, a 70-day extension may be granted. The resident will be notified in writing of the extension and by which date a decision will be made.

Other documents: The resident handbook outlines the grievance procedure and the emergency grievance process.

Interviews and observations: The facility reports no grievances (or emergency grievances) were filed in the last 12 months alleging sexual abuse.

Findings: Based on policy and the resident handbook, the facility meets the elements of this standard.

Standard 115.253: Resident access to outside confidential support services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.253 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.253 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☒ Yes ☐ No

115.253 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? ☒ Yes ☐ No

- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Other documentation: GFPRC posting for residents outlining how they can obtain emotional support through victim advocates via phone number and address for the YMCA of Great Falls. Posting notifies residents of the free and confidential services and defines when contact or information must be shared. MOU with YMCA for providing phone number, address and access to residents for emotional support.

Interviews and observations: MOUs are in place and provide for confidentiality. Phone number and address is provided to residents through postings and in the resident handbook.
Interviews with residents indicate they were aware services would be available but did not know specifically who provided those services.

Findings: MOUs are in place and provide for confidentiality. Phone number and address is provided to residents through postings and in the resident handbook. Based on this information, the facility meets the elements of this standard.

Standard 115.254: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.254 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: GFPRC PREA policy outlines third party reporting.

Other documentation: Posters with 3rd party reporting methods.
MOU with Alternatives for accepting reports of sexual abuse or harassment.
Review of GFPRC website with PREA policy and MOU links.
Added 7/29/19-Checklist for staff to retrieve appropriate information.

Interviews and observations: Website provides third parties with phone numbers to call to report sexual abuse or harassment of a resident. Staff and resident knowledge of 3rd party reporting was minimal. Recommend more emphasis in education and training. One call made during the on-site resulted in Alternatives staff referring the auditor (caller) to the PREA compliance manager, who stated they would report the call to the facility head who would contact the GFPRC. The second call, made on 7/22/19 resulted in the caller (auditor) who asked what would happen if he were a resident from GJPRC or a third party calling to report a sexual abuse incident, the caller was transferred to the PREA Manager's extension. The voice mail picked up and a message was left. The call was returned shortly. A third call was made on 7/29/19 with an operator taking name and that this may be a call that would report sexual abuse at GFPRC, but asking no questions or obtaining detailed information.

Findings: Based on the above policies, other documentation and interviews, the facility meets this standard except in actual practice. As noted in the observations of the standard in this report, several attempts to report did not result in a report actually being taken or properly forwarded to the GFPRC. As "Alternatives, Inc." is identified as the third-party method relative information should be taken to ensure GFPRC receives needed information to initiate investigation.

Corrective action: While the system is in place, GFPRC needs to ensure the reporting method identified meets the practice of receiving reports from third parties with appropriate information being retrieved and provided to GFPRC.
Upon discussion with the facility, this will be accomplished through training and checklist.
Upon notice of updated practice or training completion, the auditor will test the system.

Action taken: On 7/29/19 a checklist was provided to the auditor. The checklist outlines staff receiving a 3rd party report required actions.
On 10/4/19, the auditor was notified the updated training was completed as noted above and the auditor did test the reporting methods which resulted in a positive outcome. On 10/16/9, the agency "Alternatives" received the auditor's call and provided appropriate responses to what their actions would be with a report from a GFPRC resident, or a third party, of sexual abuse. This included questions asked of the caller and to whom the report and information would be forwarded and when.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.261 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.261 (b)

- Apart from reporting to designated supervisors or officials, do staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

115.261 (c)

- Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- Are medical and mental health practitioners required to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.261 (d)

- If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws? ☒ Yes ☐ No

115.261 (e)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: GFPRC PREA policy states:
H. Staff Reporting
1. GFPRS, Inc. staff, contract employees, and volunteers who receive information, regardless of its source, concerning resident on resident sexual abuse, who observe an incident of resident on resident sexual abuse, or staff on resident sexual abuse must immediately report the information or incident directly to PREA Staff or to the Executive Director who will notify law enforcement. Staff will immediately report any staff neglect or violation of responsibilities that may have contributed to the incident or retaliation.
2. For State residents, the Montana Department of Corrections (MDOC) considers reports of sexual abuse a Priority One Incident which must be reported to the Montana State Prison Command Post at (406) 846-6059 and the MDOC Programs & Facilities Bureau Chief at (406) 580-7991 using the MT DOC Priority Incident Report.
3. If either the alleged victim or abuser is a Federal resident, The Federal Bureau of Prisons requires reports of sexual abuse to be reported using the Significant Incident Report email format to the Regional Reentry Manager in Sacramento CSE/CommCorr~@bop.gov or after hours, to the Western Sector Duty Officer (Email address will vary by Duty Officer, check with the On-call CTS or the Walkaway/Escape Binder).
4. Any employee or volunteer who fails to report an allegation, or coerces or threatens another person to submit inaccurate, incomplete, or untruthful information with the intent to alter a report may face disciplinary action, up to and including termination, even on a first offense.

Policy also states: “All reports of sexual abuse and sexual harassment are to remain confidential to protect the victim from retaliation from both other residents and staff.”

Interviews and observations: All staff interviewed were well aware of reporting procedures to include how to report, confidentiality, urgency, etc…. Medical is minimally provided by the facility and the nurse interviewed understood the limits of confidentiality and required reporting to include required reporting for any resident under the age of 18 or considered an at risk adult.

Corrective action: The files provided initially did not contain documentation on the standard. The facility needs to provide documentation to support compliance with this standard.

Action Taken: The facility provided the necessary documentation (GFPRC PREA Policy), as noted above, to support compliance with this standard.

Findings: Based on the above policies and interviews, the facility meets this standard.

Standard 115.262: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.262 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: While policy does not directly address the standard, the actions defined in policy response to an incident or threat indicates the facility would immediately take action to protect the resident.
D. Prevention

1. All staff and residents must be alert to signs of potential situations in which sexual abuse and sexual harassment might occur and be capable of identifying the following indicators of sexual abuse and sexual harassment:

    a. Overly friendly behavior of staff and/or residents;
    b. The exchange of money, favor, etc.

2. Great Falls Pre-Release Services, Inc. will assess each offender using the GFPRS, Inc. Risk of Sexual Victimization and Abusiveness instrument (RSVA) within 72 hours of intake to identify and manage residents who are potentially vulnerable and potentially dangerous, to provide safe housing, adequate protection, and programmatic resources to meet their needs.

    a. The RSVA-R (Reassessment) with be conducted within thirty days of the initial assessment and immediately upon reentry should a resident be temporarily removed to a secure facility and then returned to the Center.
    b. Residents will be reassessed with the RSVA-R instrument when warranted due to a referral, request, incident of sexual assault or report of additional information that bears on risk of sexual victimization or abusiveness.

E. Intervention

1. Staff who receive an initial report of sexual abuse must separate the victim from the alleged assailant to protect the victim and prevent further violence.

2. Staff who receive an initial report of sexual abuse are required to promptly intervene on the victim's behalf to ensure the victim receives prompt medical and psychological assistance, as appropriate to his or her needs and the circumstances of the alleged offense. Victims of sexual abuse must have an assessment for potential risk of suicide.
3. In the event an active sexual assault is occurring, staff is to immediately call for security staff back-up and will follow appropriate security procedure which include:
    a. Separating the alleged victim from the alleged perpetrator;
    b. Contract the Executive Director and upon his authorization, contact the Great Falls Police Department via 9-1-1 services.
    c. Do not allow the alleged victim or abuser to take any action that could destroy any physical evidence (washing, brushing teeth, changing clothes, urinating, defecating smoking, drinking or eating).
    d. Providing medical and mental health assistance for the alleged victim as soon as possible;
    e. Taking reasonable measures to identify, isolate and separate witnesses;
    f. Securing the incident scene so items cannot be removed or introduced;
    g. Allowing only assigned investigator to assess the scene.

4. Psychological trauma may occur in individuals such as witnesses and staff members, as well as the victim of the sexual assault. Mental Health staff must be made available to support and assist those in need, i.e., Staff LCPC, Registered Nurse, etc.
5. Staff who receive a report of sexual abuse on a resident by a staff member shall take the report directly to the Executive Director.

F. Services Provided for Victims
    1. Staff will coordinate available services to residents who allege that they are victims of sexual abuse.

2. Facility administration will ensure that residents who allege that they are victims of sexual abuse will have access to the following services:
a. Medical examination, documentation, and treatment of injuries, including testing for pregnancy, HIV and other sexually transmitted diseases. These services will be provided without financial cost to the alleged victim, regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident;
b. Coordinate with a qualified mental health professional for crisis intervention counseling and long-term follow-up; and
c. Social, family, and peer support; and
d. Reasonable measures taken to protect and prevent retaliation and future assault through housing changes, emotional support services, and removal of alleged abusers from contact with the victim(s).

Other documentation: The facility reports no incidents of substantial risk of imminent sexual abuse of a resident was reported in last 12 months.

Interviews and observations: All random staff interviewed responded well on what to do if they receive information that a resident may be at imminent risk of sexual abuse. Most stated, separate, isolate and all stated they would report immediately.
The Director/PREA Coordinator stated any resident discovered to be at risk is isolated and separated pending further investigation.

Findings: Based on the above policies, other documentation and interviews, the facility meets this standard.

Standard 115.263: Reporting to other confinement facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.263 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? ☒ Yes ☐ No

115.263 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

115.263 (c)

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

115.263 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: GFPRC PREA policy states: H. 6. Reports of incidents that occurred in another facility shall be forwarded to the Executive Director who shall immediately notify the head of the facility where the alleged abuse occurred and/or proper jurisdictional agency of that resident in accordance with the agency's reporting protocols requirements.

Interviews and observations: The facility reports no incidents of facility to facility reports of sexual abuse or harassment within the last 12 months.
Interviews with the agency head and facility head indicates they have good knowledge of the process and would ensure investigation begins immediately and within 72 hours of the report. All incidents are documented as are all investigations.

Findings: Based on the above policies and interviews, the facility meets this standard.

Standard 115.264: Staff first responder duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.264 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser? ☒ Yes ☐ No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any

actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

115.264 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: GFPRC PREA policy states:
E. Intervention

1. Staff who receive an initial report of sexual abuse must separate the victim from the alleged assailant to protect the victim and prevent further violence.

2. Staff who receive an initial report of sexual abuse are required to promptly intervene on the victim's behalf to ensure the victim receives prompt medical and psychological assistance, as appropriate to his or her needs and the circumstances of the alleged offense. Victims of sexual abuse must have an assessment for potential risk of suicide.

3. In the event an active sexual assault is occurring, staff is to immediately call for security staff back-up and will follow appropriate security procedure which include:
a. Separating the alleged victim from the alleged perpetrator;
b. Contract the Executive Director and upon his authorization, contact the Great Falls Police Department via 9-1-1 services.

c. Do not allow the alleged victim or abuser to take any action that could destroy any physical evidence (washing, brushing teeth, changing clothes, urinating, defecating smoking, drinking or eating).
d. Providing medical and mental health assistance for the alleged victim as soon as possible;
e. Taking reasonable measures to identify, isolate and separate witnesses;
f. Securing the incident scene so items cannot be removed or introduced;
g. Allowing only assigned investigator to assess the scene.

4. Psychological trauma may occur in individuals such as witnesses and staff members, as well as the victim of the sexual assault. Mental Health staff must be made available to support and assist those in need, i.e., Staff LCPC, Registered Nurse, etc.

5. Staff who receive a report of sexual abuse on a resident by a staff member shall take the report directly to the Executive Director.

Other documentation: GRPRC Sexual Assault Response & Containment Checklist

Interviews and observations: All random staff were well aware of first responder duties and all security staff are considered first responders due, in part, to the small size of the facility. Some staff could not remember some specifics, such as, don't wash, brush teeth, etc…, but the majority of the staff did have sufficient knowledge to indicate they have been trained. A checklist is available for staff use however, the auditor recommends carry cards for first responders.

Findings: Based on the above policies, other documentation and interviews, the facility meets this standard.

Standard 115.265: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.265 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation: : GRPRC Sexual Assault Response & Containment Checklist
GFPRC Sexual Assault Response Team Checklist

Interviews and observations: The above-mentioned checklists specifies duties as required by this standard for first responders and facility leadership. The flow chart shows the reporting to medical, and referral to SANE/SAFE, and investigations (local law enforcement). In an interview with the facility director, he was well aware of the standard and the coordinated response plan for the facility.

Findings: Based on the documentation and interviews, the facility meets this standard.

Standard 115.266: Preservation of ability to protect residents from contact with abusers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.266 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☒ Yes ☐ No

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation: Collective Bargaining Agreement by and between Great Falls Pre-Release Service, Inc. and Teamsters Local Union No. 2

Interviews and observations: In interviewing the Director/PREA Coordinator, the agency and facility are not for profit organizations with employees represented by the local union.
Article 14, Discharge, of the agreement allows for employees to be removed due to breach of employer rules, incompetence, failure to meet work standards, etc… Nothing in the agreement limits the employer's ability to remove pending investigation.

Findings: Based on the above documentation and interviews, the facility meets this standard.

Standard 115.267: Agency protection against retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.267 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.267 (b)

- Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations? ☒ Yes ☐ No

115.267 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident housing changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignments of staff? ☒ Yes ☐ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.267 (d)

- In the case of residents, does such monitoring also include periodic status checks?
  ☒ Yes ☐ No

115.267 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?
  ☒ Yes ☐ No

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy:
F. Services Provided for Victims
d. Reasonable measures taken to protect and prevent retaliation and future assault through housing changes, emotional support services, and removal of alleged abusers from contact with the victim(s).
Executive Directive issued by the Executive Director.

Interviews and observations: In interviewing the staff responsible for the monitoring for retaliation, staff indicate; no limit on how long she would monitor or if the resident left the facility, residents may be moved to different areas of the facility or out of the facility if needed to protect against retaliation, monitor house changes, disciplinary changes, major behavioral changes, drug use, job performance, etc…and she would interview regularly.

Corrective actions: The files initially provided did not contain documentation on the standard. The facility needs to provide documentation to support compliance with this standard. A review of policy found the above minimal statement to protect residents from retaliation. No mention of staff. Elements (a), (c) & (e) need addressed in entirety.

Action taken: On July 24, 2019 the Executive Director issue a directive to all staff addressing all elements of this standard. The reported victim's Correctional Treatment Specialist (CTS), the screening officer or the PREA Coordinator (or liaison) are the assigned monitors.

Findings: Based on the above policies, interviews and actions taken, the facility does meet the elements of this standard.

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.271 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).]
  ☒ Yes ☐ No ☐ NA

115.271 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234? ☒ Yes ☐ No

115.271 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses?
  ☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.271 (d)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☐ Yes ☒ No

115.271 (e)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?
  ☒ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.271 (f)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.271 (g)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

115.271 (h)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? ☒ Yes ☐ No

115.271 (i)

- Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years? ☒ Yes ☐ No

115.271 (j)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation? ☒ Yes ☐ No

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? [N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: GFPRC PREA policy states in paragraph I. PURPOSE:
To establish procedures for implementation of the Prison Rape Elimination Act of 2003. Great Falls Pre-Release Services, Inc. has zero tolerance relating to the sexual harassment, assault or rape of assigned residents and recognizes these offenders as crime victims. Great Falls Pre-Release Services, Inc. will immediately respond to allegations, fully investigate reported incidents, pursue disciplinary action, and refer for investigation and prosecution those who perpetrate such conduct.

and;

paragraph IV, H. Staff Reporting
1. GFPRS, Inc. staff, contract employees, and volunteers who receive information, regardless of its source, concerning resident on resident sexual abuse, who observe an incident of resident on resident sexual abuse, or staff on resident sexual abuse must immediately report the information or incident directly to PREA Staff or to the Executive Director who will notify law enforcement. Staff will immediately report any staff neglect or violation of responsibilities that may have contributed to the incident or retaliation.

and;

paragraph IV, I Investigative Protocols of Sexual Abuse or Harassment
1. The PREA Coordinator and PREA Liaison in conjunction with the Executive Director will conduct an initial investigation in non-emergency sexual abuse cases.
a. Sexual assault cases will normally be investigated by the Great Falls Police Department.
b. As soon as it becomes apparent that any administrative investigation may result in criminal charges the investigation will cease, and all case notes and evidence turned over to the Great Falls Police Department.
2. The PREA Coordinator will submit an incident report regarding the investigation. GFPRS, Inc. imposes a standard of a preponderance of evidence for determining whether allegations of a sexual abuse or sexual harassment are substantiated. Preponderance of evidence means that more than 50% of the evidence supports the allegation.
3. If there is a question as to whether an incident deemed inappropriate is covered under PREA, the MDOC Programs & Facilities Bureau Chief at (406) 580-7991 will be contacted for direction.
4. The departure of the alleged abuser or victim from employment or control of the Center does not provide a basis for terminating an investigation.
5. Great Falls Pre-Release Services, Inc. prohibits requiring residents who allege sexual abuse to submit to a polygraph examination or other truth telling device as a condition for proceeding with an investigation.

and;

paragraph IV, L. 3. The Executive Director will securely retain records including incident and investigative reports, offender information, case disposition, medical and counseling findings, and recommendations for post release treatment and/or counseling. These records shall be retained for as long as the alleged abuser is incarcerated or employed by GFPRS, Inc., plus five years.

Other documentation: Training certificates for a staff completion of NIC's PREA Investigator course.

Interviews and observations: GFPRC will only investigate sexual abuse if it is determined by the GFPD that no criminal actions are apparent. One staff is currently trained and one in in the process. In interviewing the trainee who will be conducting future administrative investigations, she states she will initiate an investigation upon receipt of the allegation, will gather and preserve evidence within the scope of an administrative investigation, interview alleged victims/suspects/witnesses, will not handle compelled interviews (GFPD), will assess credibility on an individual basis without prejudice, will attempt to determine whether staff action or failures to act contributed to the incident and will document all aspects of the investigation. Any/all allegations indicating any criminal behavior is immediately referred to GFPD. She states the investigation will continue to conclusion regardless of the alleged abuse or victim's location or status. She or the PREA Coordinator will act as liaison between the agency/facility and the GFPD on criminal cases. PREA Coordinator and director confirmed this in interviews.

Findings: Based on the above policies, other documentation and interviews, the facility meets this standard.

Standard 115.272: Evidentiary standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.272 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Policy: GFPRC PREA policy IV, H. 2. States: The PREA Coordinator will submit an incident report regarding the investigation. GFPRS, Inc. imposes a standard of a preponderance of evidence for determining whether allegations of a sexual abuse or sexual harassment are substantiated. Preponderance of evidence means that more than 50% of the evidence supports the allegation.

Interviews and observations: In an interview with one staff who could complete administrative investigations, she stated the level of evidence to determine substantiated or not is the preponderance of evidence.

Findings: Based on the above policies, observations and interviews, the facility meets this standard.

Standard 115.273: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.273 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☒ Yes ☐ No

115.273 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.273 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.273 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility?
  ☒ Yes ☐ No

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?
  ☒ Yes ☐ No

115.273 (e)

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Policy: GFPRC PREA policy IV, J. 3. states: At the completion of an investigation (within 90 days), the PREA Investigator will notify the Executive Director and the victim of the outcome in writing. The Sexual Assault Response Checklist (Checklist #9 in the Emergency Checklists Binder) will be utilized for this purpose.
Executive Directive issued by the Executive Director.

Other documentation: Two incidents of reporting to residents the investigative finding of substantiated, unsubstantiated or unfounded.

Interviews and observations: In interviews with the PREA Coordinator and staff responsible for administrative investigations, both stated the resident is notified as noted in the standard. The facility staff indicate they have had two cases requiring notification to a resident.

Corrective action: The facility needs to provide file documentation to support compliance with this standard. The facility needs to address elements (c) & (d) and provide to the auditor.

Action taken: On July 29, 2019 the Executive Director issued a directive to all staff addressing all elements of this standard using verbiage directly from the standard.

Findings: Originally the facility did not meet standard. While the policy states the outcome of the investigation would be provided to the victim, no mention of the requirements of elements (c) or (d). Upon completion of the actions taken as noted above the facility now meets the standard based on that, established policy and interviews with staff.

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.276 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.276 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

115.276 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☒ Yes ☐ No

115.276 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies unless the activity was clearly not criminal? ☒ Yes ☐ No

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: The GFPRS personnel handbook indicates employees may be subject to disciplinary actions, up to and including termination for violating standards of workplace behavior or other applicable policies or procedures. Written warnings or reprimands, suspension without pay, demotion and/or termination of employment are among the formal disciplinary actions appropriate for violations of policy and/or procedure.
Policy requires all suspected criminal behavior be investigated by local law enforcement therefore providing them with the knowledge of termination.

Observations and interviews: Policy does not address element (d) specifically. The facility reports there is no historical data due to no incident occurring within the last 12 months.

Findings: Based on the above policies and interviews, the facility meets this standard. The auditor recommends adding element (d) to policy the better address the standard and provide employees/contractors with that information.

Standard 115.277: Corrective action for contractors and volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.277 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No

- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies unless the activity was clearly not criminal? ☒ Yes ☐ No

- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.277 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Policy: Executive Directive issued by the Executive Director.

Interviews and observations: In an interview with the facility director, he states contractors or volunteers would be removed immediately pending investigation. If warranted, they would be barred further access and would be reported to local law enforcement and any relative licensing bodies.

Corrective actions: GFPRC needs to provide file documentation to indicate compliance with this standard to include policy or other documentation to reflect: Any contractor or volunteer who engages in sexual abuse is prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.

-and-

The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

Action taken: On July 29, 2019 the Executive Director issued a directive to all staff addressing all elements of this standard using verbiage directly from the standard.

Findings: Based on lack of provided documentation to indicate compliance with the elements of this standard, the facility did not meet the standard at the time of the on-site. Interviews indicate compliance and with the addition to the above directive of 7/29/19, the facility now meets the standard.

Standard 115.278: Interventions and disciplinary sanctions for residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.278 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.278 (b)

- Are sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

115.278 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.278 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a condition of access to programming and other benefits? ☐ Yes ☒ No

115.278 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.278 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

115.278 (g)

- Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: GFPRC resident handbook addressing resident discipline.
Executive Directive issued by the Executive Director.

Other documentation: GFPRC poster encouraging residents to report states: Where a resident is acting in good faith and with a reasonable belief that the abuse occurred, discipline is not appropriate.

Observations and interviews: Medical staff report the facility does not offer therapy to treat underlying issues of abuse.
The facility head states residents will be charged and, if convicted under the penal code, may be removed from the facility, and; the facility does not offer therapy or counseling to address underlying reasons for sexual abuse and any abuser would be removed from the facility.

Findings: Based on the above policies and other documentation, the facility does not meet this standard.

Corrective action: The facility needs to provide file documentation to address elements (b)- Sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories, (c)- The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed & (e)- The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

Action taken: On July 29, 2019 the Executive Director issued a directive to all staff addressing all elements of this standard using verbiage directly from the standard.

Findings: Based on policy, interviews and the actions taken, the facility meets the elements of the standard. The facility does not offer therapy or counseling to address underlying reasons for sexual abuse and any abuser would be removed from the facility.

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.282 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?
  ☒ Yes ☐ No

115.282 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262? ☒ Yes ☐ No

- Do security staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.282 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

115.282 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?
  ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: GFPRC PREA policy states: E. Intervention

1. Staff who receive an initial report of sexual abuse must separate the victim from the alleged assailant to protect the victim and prevent further violence.
2. Staff who receive an initial report of sexual abuse are required to promptly intervene on the victim's behalf to ensure the victim receives prompt medical and psychological assistance, as appropriate to his or her needs and the circumstances of the alleged offense. Victims of sexual abuse must have an assessment for potential risk of suicide.
3. In the event an active sexual assault is occurring, staff is to immediately call for security staff back-up and will follow appropriate security procedure which include:
    a. Separating the alleged victim from the alleged perpetrator;
    b. Contract the Executive Director and upon his authorization, contact the Great Falls Police Department via 9-1-1 services.
    c. Do not allow the alleged victim or abuser to take any action that could destroy any physical evidence (washing, brushing teeth, changing clothes, urinating, defecating smoking, drinking or eating).
    d. Providing medical and mental health assistance for the alleged victim as soon as possible;
    e. Taking reasonable measures to identify, isolate and separate witnesses;
    f. Securing the incident scene so items cannot be removed or introduced;
    g. Allowing only assigned investigator to assess the scene.
4. Psychological trauma may occur in individuals such as witnesses and staff members, as well as the victim of the sexual assault. Mental Health staff must be made available to support and assist those in need, i.e., Staff LCPC, Registered Nurse, etc.
5. Staff who receive a report of sexual abuse on a resident by a staff member shall take the report directly to the Executive Director.

F. Services Provided for Victims

1. Staff will coordinate available services to residents who allege that they are victims of sexual abuse.
2. Facility administration will ensure that residents who allege that they are victims of sexual abuse will have access to the following services:
    a. Medical examination, documentation, and treatment of injuries, including testing for pregnancy, HIV and other sexually transmitted diseases. These services will be provided without financial cost to the alleged victim, regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident;
    b. Coordinate with a qualified mental health professional for crisis intervention counseling and long-term follow-up; and
    c. Social, family, and peer support; and
    d. Reasonable measures taken to protect and prevent retaliation and future assault through housing changes, emotional support services, and removal of alleged abusers from contact with the victim(s).

G. Examination of Sexual Abuse Victims

1. If the alleged sexual abuse is reported within 72 hours of the incident, staff will transport the victim to Benefis Hospital Emergency Room where a sexual assault nurse examiner (SANE) is on call 24 hours a day to treat sexual assault/rape victims and collect evidence as soon as possible. If requested by the victim, a victim advocate or qualified staff member may accompany and support the victim through the forensic medical examination process and investigatory interviews and provide support, crisis intervention, information, and referrals.

2. If the alleged sexual abuse is reported more than 72 hours after the incident, the resident will be referred to "in-house" health care providers who will:

a. Complete a patient history and conduct an examination to document the extent of physical injury to determine whether referral to another medical facility is indicated;

b. Offer to victims as appropriate, prophylactic treatment and follow-up care for sexually transmitted or other communicable diseases (e.g. HIV, Hepatitis B). If pregnancy results, such victims shall receive timely and comprehensive information about, and timely access to, all lawful pregnancy related medical services.

c. Submit a report to the Executive Director regarding interactions with the patient, treatment given, and medical recommendations.

d. The Executive Director and/or law enforcement may request that facility and program staff transport the victim to Benefis Hospital for evidence collection with the victim's permission.

e. If the victim refuses medical or mental health attention, staff will document refusal on the MT Department of Corrections Medical Treatment Refusal form.

Interviews and observations: An interview with an unnamed (requested) SANE at Benefis Hospital indicates they do SANE/SAFE as requested by victims and/or law enforcement. The hospital also provides emergency medical services for victims of sexual abuse. This person stated they would do the same for GFPRC.
An interview with the nurse indicates all will be provided immediately, but not at this facility.

Findings: Based on the above policies, other documentation and interviews, the facility meets this standard.

Standard 115.283: Ongoing medical and mental health care for sexual abuse victims and abusers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.283 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.283 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

115.283 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.283 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) ☒ Yes ☐ No ☐ NA

115.283 (e)

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.) ☒ Yes ☐ No ☐ NA

115.283 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.283 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.283 (h)

- Does the facility attempt to 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? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: GFPRC PREA policy states: E. Intervention

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2. Staff who receive an initial report of sexual abuse are required to promptly intervene on the victim's behalf to ensure the victim receives prompt medical and psychological assistance, as appropriate to his or her needs and the circumstances of the alleged offense. Victims of sexual abuse must have an assessment for potential risk of suicide.
3. In the event an active sexual assault is occurring, staff is to immediately call for security staff back-up and will follow appropriate security procedure which include:
    a. Separating the alleged victim from the alleged perpetrator;
    b. Contract the Executive Director and upon his authorization, contact the Great Falls Police Department via 9-1-1 services.
    c. Do not allow the alleged victim or abuser to take any action that could destroy any physical evidence (washing, brushing teeth, changing clothes, urinating, defecating smoking, drinking or eating).
    d. Providing medical and mental health assistance for the alleged victim as soon as possible;
    e. Taking reasonable measures to identify, isolate and separate witnesses;
    f. Securing the incident scene so items cannot be removed or introduced;
    g. Allowing only assigned investigator to assess the scene.

4. Psychological trauma may occur in individuals such as witnesses and staff members, as well as the victim of the sexual assault. Mental Health staff must be made available to support and assist those in need, i.e., Staff LCPC, Registered Nurse, etc.
5. Staff who receive a report of sexual abuse on a resident by a staff member shall take the report directly to the Executive Director.

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    b. Coordinate with a qualified mental health professional for crisis intervention counseling and long-term follow-up; and
    c. Social, family, and peer support; and
    d. Reasonable measures taken to protect and prevent retaliation and future assault through housing changes, emotional support services, and removal of alleged abusers from contact with the victim(s).: G. Examination of Sexual Abuse Victims

1. If the alleged sexual abuse is reported within 72 hours of the incident, staff will transport the victim to Benefis Hospital Emergency Room where a sexual assault nurse examiner (SANE) is on call 24 hours a day to treat sexual assault/rape victims and collect evidence as soon as possible. If requested by the victim, a victim advocate or qualified staff member may accompany and support the

victim through the forensic medical examination process and investigatory interviews and provide support, crisis intervention, information, and referrals.

2. If the alleged sexual abuse is reported more than 72 hours after the incident, the resident will be referred to "in-house" health care providers who will:

   a. Complete a patient history and conduct an examination to document the extent of physical injury to determine whether referral to another medical facility is indicated;

   b. Offer to victims as appropriate, prophylactic treatment and follow-up care for sexually transmitted or other communicable diseases (e.g. HIV, Hepatitis B). If pregnancy results, such victims shall receive timely and comprehensive information about, and timely access to, all lawful pregnancy related medical services.

   c. Submit a report to the Executive Director regarding interactions with the patient, treatment given, and medical recommendations.

   d. The Executive Director and/or law enforcement may request that facility and program staff transport the victim to Benefis Hospital for evidence collection with the victim's permission.

   e. If the victim refuses medical or mental health attention, staff will document refusal on the MT Department of Corrections Medical Treatment Refusal form.

Executive Directive issued by the Executive Director.

Corrective action: GFPRC needs to address element (h)-- The facility shall attempt to 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.

Action taken: On July 29, 2019 the Executive Director issued a directive to all staff addressing all elements including element (h) of this standard using verbiage directly from the standard.

Findings: Based on the above policies, observations and interviews, the facility meets this standard except element (h). Based on the action taken as noted above, element (h) has now also been addressed and the facility meets all elements of this standard.

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.286 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

115.286 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.286 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.286 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: GFPRC PREA policy paragraph IV, J. states: GFPRS, Inc. will conduct incident reviews at the conclusion of every sexual abuse investigation, unless the allegation has been determined to be unfounded. The Incident Review Team, consisting of upper level management, will meet within 30 days of the incident to identify policy, training, or other issues that indicate a need to change agency standards to better protect, detect, or respond to incidents of sexual abuse. The review process allows for input from supervisors, investigators, and medical or mental health practitioners. A report of the findings, along with recommendation for improvement will be forwarded to the Executive Director and PREA coordinator. GFPRS, Inc. will make such improvements or document the reasons for not doing so in the Annual Report.

Other documentation: Sexual Assault Response Team Checklist

Interviews and observations: In interviewing the Director/PREA Coordinator and staff responsible for incident reviews, the facility would conduct incident reviews, covering all elements of the standard, which are reviewed by the Director and PREA Coordinator of the agency. Recommendations are made from reviews.

Findings: Based on the above policies, other documentation and interviews, the facility meets this standard.

Standard 115.287: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.287 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.287 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

115.287 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.287 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? ☒ Yes ☐ No

115.287 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☐ Yes ☐ No ☒ NA

115.287 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: GFPRC PREA policy IV, L. Data Collection & tracking of Sexual Assaults

1. The PREA Coordinator or designee will complete the annual Survey of Sexual Victimization for each reported incident of sexual abuse and sexual harassment.
2. The PREA Coordinator will compile records and report statistical data to the State PREA Coordinator who will report to the Federal Bureau of Justice as required by the Prison Rape Elimination Act of 2003 annually. GFPRS, Inc. will maintain this data for at least ten years after the initial collection, unless Federal, State, or local law requires otherwise.
3. The Executive Director will securely retain records including incident and investigative reports, offender information, case disposition, medical and counseling findings, and recommendations for post release treatment and/or counseling. These records shall be retained for as long as the alleged abuser is incarcerated or employed by GFPRS, Inc., plus five years.
4. The Facility Director will review aggregated data and identify problem areas, take corrective action, compare the current year data with prior year data, and prepare an annual report of its findings for the Executive Director to review annually.
5. The annual report includes a comparison of the current years data and corrective actions with those from prior years and provide an assessment of the facilities progress in addressing sexual abuse. The annual report will be made public by being placed on GFPRS, Inc's website with all personal identifiers removed.

Other documentation: 2017 SSV

SSV incident forms

Interviews and observations: Review of GFPRC website with 2018 annual report showing comparison for years 2015, 2016, 2017 and 2018.

Findings: Based on the above policies, other documentation and observations, the facility meets this standard.

Standard 115.288: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.288 (a)

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.288 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

115.288 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.288 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy: GFPRC PREA policy IV, L. Data Collection & tracking of Sexual Assaults

1. The PREA Coordinator or designee will complete the annual Survey of Sexual Victimization for each reported incident of sexual abuse and sexual harassment.
2. The PREA Coordinator will compile records and report statistical data to the State PREA Coordinator who will report to the Federal Bureau of Justice as required by the Prison Rape Elimination Act of 2003 annually. GFPRS, Inc. will maintain this data for at least ten years after the initial collection, unless Federal, State, or local law requires otherwise.
3. The Executive Director will securely retain records including incident and investigative reports, offender information, case disposition, medical and counseling findings, and recommendations for post release treatment and/or counseling. These records shall be retained for as long as the alleged abuser is incarcerated or employed by GFPRS, Inc., plus five years.
4. The Facility Director will review aggregated data and identify problem areas, take corrective action, compare the current year data with prior year data, and prepare an annual report of its findings for the Executive Director to review annually.
5. The annual report includes a comparison of the current years data and corrective actions with those from prior years and provide an assessment of the facilities progress in addressing sexual abuse. The annual report will be made public by being placed on GFPRS, Inc's website with all personal identifiers removed.

Other documentation: 2018 annual report reflecting comparison to years 2015, 2016 and 2017.

Interviews and observations: posted on https://gfprc.org/resources/gfprc-prea-annual-report-2018.pdf

In an interview with the PREA Coordinator, he indicates should the need arise, all PII or security sensitive information would be redacted.

The agency head states he reviews approves annual reports. He reviews data to identify any potential issues needing addressed in the prevention, detection and response to sexual abuse.

Findings: Based on the above policies, other documentation and interviews, the facility meets this standard.

Standard 115.289: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.289 (a)

- Does the agency ensure that data collected pursuant to § 115.287 are securely retained? ☒ Yes ☐ No

115.289 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.289 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.289 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Policy: GFPRC PREA policy IV, L. Data Collection & tracking of Sexual Assaults

1. The PREA Coordinator or designee will complete the annual Survey of Sexual Victimization for each reported incident of sexual abuse and sexual harassment.

2. The PREA Coordinator will compile records and report statistical data to the State PREA Coordinator who will report to the Federal Bureau of Justice as required by the Prison Rape Elimination Act of 2003 annually. GFPRS, Inc. will maintain this data for at least ten years after the initial collection, unless Federal, State, or local law requires otherwise.
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5. The annual report includes a comparison of the current years data and corrective actions with those from prior years and provide an assessment of the facilities progress in addressing sexual abuse. The annual report will be made public by being placed on GFPRS, Inc's website with all personal identifiers removed.
Other documentation: 2018 annual report

Interviews and observations: The Director and PREA Coordinator state all data is kept electronically and in hard copy in his locked office for at least 10 years.

Findings: Based on the above policies, other documentation and interviews, the facility meets this standard.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard.*) ☐ Yes ☒ No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☐ Yes ☒ No ☐ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☒ Yes ☐ No ☐ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

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Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

2016 Audit posted and reviewed.

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 resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Dave Cotten 10/23/19

Auditor Signature **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.