South Carolina Department of Corrections
Implementation Panel Report of Compliance
July 2017

Executive Summary

This fourth report of the Implementation Panel (IP) is provided as stipulated in the Settlement Agreement in the above-referenced matter, and it is based on the fourth site visit to the South Carolina Department of Corrections facilities and our review and analysis of SCDC's compliance with the Settlement Agreement criteria. The first site visit by the Implementation Panel was May 2 thru May 5, 2016, the second site visit was October 31 thru November 4, 2016, the third site visit was February 27 thru March 3, 2017, and this site visit was July 10 thru July 14, 2017. As has been the process before each site visit, the Implementation Panel requested and received a plethora of documents, including policies and procedures and additional reports as noted in this report. However several documents were received during the week prior to the fourth site visit. We requested that documents be provided to the IP at least two weeks prior to the site visits and SCDC has not provided the requested documents on time. In addition, we have had conference calls with the plaintiffs and defendants as well as discussions with SCDC staff, inmates, and plaintiffs, and we reviewed additional documents during the onsite visits. We conducted an Exit Conference on July 14, 2017, which was attended by Director Bryan Stirling and members of the administrative, operations, and clinical staff of SCDC; plaintiffs' counsel Daniel Westbrook; defendant's counsel Roy Laney; and the mediator, Judge William Howard. During the Exit Conference we provided our preliminary findings based on the current site visits and addressed questions and concerns offered by any of the participants.

Consistent with our past reports, this Executive Summary is a brief overview of the SCDC analysis and the Implementation Panel's findings regarding SCDC's compliance with the Settlement Agreement. The specific Settlement Agreement criteria (with the exception of Policies and Procedures) are described in detail in this report, and the compliance levels, i.e., noncompliance, partial compliance, or substantial compliance in each of the elements along with the basis for those findings and recommendations of the Implementation Panel are also included. Appended to this report is Exhibit B to the settlement agreement, which is a summary of the Implementation Panel's assessment of compliance with the remedial guidelines. Exhibit B does not include a separate component for the development of overall policies and procedures that will address implementation of the components set forth in Exhibit B, but the Implementation Panel wants to acknowledge the work that has gone into development of the policies while acknowledging that training and implementation have yet to be fully accomplished and will be monitored closely. We commend SCDC on their efforts to fully implement the required training and have made recommendations for revisions in the training process and curricula. As Exhibit B reflects, the Implementation Panel determined the following levels of compliance:

1. Substantial Compliance – 11 components
2. Partial Compliance – 44 components
3. Noncompliance – 4 components

As discussed during this site visit and during our Opening and Exit Conferences with the parties. the Implementation Panel's primary concerns regarding SCDC's failure to demonstrate substantial compliance with the Settlement Agreement have been reported in detail in previous reports and, regrettably, will be repeated in this report, albeit with some notations of individual staff components or facilities that are positive and significant areas with minimal improvement and/or regression. The specific areas impacting the failures to achieve substantial compliance have to do with the following issues: (1) staffing, including clinical, operations, administrative, and support staff; (2) conditions of confinement including specifically the Restrictive Housing Units (RHU), segregation of any type; (3) prolonged stays in Reception and Evaluation and the quality and appropriateness of evaluation, referral and treatment components; (4) lack of timely assessments and adequate treatment at the mental health programmatic levels; (5) operations practices and adherence to policies and procedures; (6) access to all higher levels of care, particularly timely hospital level care for male and female inmates; and (7) future planning for adequate numbers of beds and staffing for mental health higher levels of care as the hospital and male CSU and ICS programs will be in need of additional resources. Since the last site visits and report, the IP members have had conference calls with the parties to provide technical assistance and consultation regarding the need for a Master Plan for mental health services to include all levels of care based on a realistic needs assessment to meet the requirements of the inmate population and the Settlement Agreement. However an adequate plan with integrated components for a comprehensive system has not been provided.

A great deal of time and effort by the parties and their experts was dedicated to the development of policies and procedures prior to implementation of the Settlement Agreement, and most of the policies and procedures have been completed while others continue to be revised and/or developed. The other necessary components including training staff regarding the policies and procedures, implementation, supervision regarding those policies and procedures, and quality management review via the quality assurance/improvement mechanisms within SCDC are currently incomplete and inadequate and should be of primary focus going forward.

In our last report we recognized the major achievement of the development of the Quality Assurance Risk Management (QARM). Since the last visit, this vital and essential component of the SCDC management structure has changed their name to Quality Improvement Risk Management (QIRM). The Implementation Panel continues to be very positively impressed by the efforts of the QIRM component, which in addition to conducting audits of facility mental health services and operations, presented very informative booklets describing important data and analysis for several facilities during this site visit. We strongly recommend this process should be expanded to include all facilities scheduled for inspections for each upcoming visit. We have also reported our positive impressions of the staff providing IT and web based information data collection and analysis components, and strongly encourage the continuation and expansion of their efforts at the central levels. The pilot program for implementation of the Electronic Health Record (EHR) NextGen, including the planned implementation of eZmar, the electronic medication administration records, was reviewed on site and a number of concerns were discussed, including the breakdown of communication between systems resulting in medication errors at Camille Graham C.I. and Leath C.I. These breakdowns have resulted in reports by inmates and staff of inmates missing medications as prescribed, which represents a crisis in the provision of health care. While on site, plans to address these issues were being developed.

During our past site visits the IP emphasized during our discussions and on-site reviews, the data collection and analysis component of the quality management program must be accomplished at the facility level and relate to policies and procedures, and specific facility parameters and mental health programs, operations, support, and ultimately inmate mental health needs. Since the last site visit SCDC Division of Behavioral Health has hired Health Services Office Assistants (HSOA's) to facilitate the data collection and analysis component at the facility level, which is an important improvement; however the training of the HSOA's has not been coordinated with QIRM and the actual reporting during this site visit was inconsistent and inadequate. As previously reported, the dire need for staffing and active on-site and central support for instituting, developing, and/or maintaining adequate services and support functions at the facility level has not been fully achieved.

The Low Intensity Behavioral Management Unit at Allendale C.I. became operational in 2016, and was visited during the last site visit and by the Implementation Panel coordinator in July after the full IP visit. The Low Intensity BMU continues to develop and has demonstrated some progress. During the last site visit the IP was informed the High Intensity Behavioral Management Unit had begun although not scheduled to open until March 2017. We were informed during this visit the High Intensity BMU did not open in April 2017, and is not scheduled to open until January, 2018. Further, the former Self Injurious Behavior Program was closed, and a temporary High Level BMU was opened in the building (D Dorm) with 24 available beds. The IP had conference calls with SCDC to discuss development of a realistic, needs assessment-based Master Plan to include all levels of mental health care, including BMU's, as the previous draft plan presented by SCDC was not comprehensive and included a target number of beds for the High Level BMU of 112 beds that did not appear to be based on a needs assessment. The Crisis Stabilization Unit at Camille Graham C.I. was completed and opened since the last visit, as were four suicide resistant cells at Leath C.I.

As noted in our previous reports, the Implementation Panel has continued to provide technical assistance and suggestions regarding how obtaining compliance with the Settlement Agreement criteria and its requirements could be accomplished, and reemphasized that these processes should be developed within SCDC by the appropriate staff within the SCDC and consultants, if necessary, who are responsible for their implementation, training, and supervision of staff on the actual requirements. SCDC must continue to develop and implement an internal process that supports and assures effective quality management so that the process will be developed and sustained beginning with the Settlement Agreement monitoring process and continuing after the settlement agreement has been satisfied and/or otherwise resolved. The timely development and implementation will also facilitate transition to the anticipated Electronic Health Record (EHR). The information gleaned from the pilot program at Camille Graham C.I. and Leath C.I. for implementation of the EHR is compelling and SCDC has committed to review and refinement of the EHR, eZmar and pharmacy systems (CIPS) to assure continuation and improvement of mental health services.

Accordingly, the following description and appendices are reflective of our overviews of the specific facilities that were inspected during this site visit, namely Camille Graham Correctional Institution, Leath Correctional Institution, Kirkland Correctional Institution, Broad River

Correctional Institution, McCormick Correctional Institution, and Perry Correctional Institution. As reported during our Exit Conference, the Implementation Panel considers the conditions at Camille Graham Correctional Institution and Perry Correctional Institution to be at a severe crisis level that requires immediate correction. Not only are the staffing levels for clinicians, as well as operations staff, unacceptably low, preventing the implementation of effective treatment measures, but also based on the operations staffing Perry C.I. has experienced frequent and continuing lockdowns since at least February 2016 and has been unable to provide adequate recreation or showers. Similar problems with providing services at male facilities have been reported and during this site visit McCormick C. I. was on lockdown and inmates were not receiving adequate services. The Implementation Panel monitors use of force across all facilities and during this site visit observed a use of force incident in the RHU that was subsequently referred for investigation. The IP will review that investigation when completed. The problems reported at Camille Graham C.I. regarding medication management constitute serious medication errors resulting in inmates not receiving medications as prescribed. These conditions must be corrected immediately, and plans to address the multiple factors contributing to the crises at Perry, Leiber and Graham must be developed and implemented. . The operations and mental health vacancies continue to adversely contribute to inadequate treatment and unsafe conditions of confinement at other institutions (as reported based on previous site visits) and must be corrected.

The Implementation panel also noted and reported on several positive achievements demonstrated at several facilities including:

1) Excellent efforts at Camille Graham by management and staff to address deficiencies reported by the IP from prior visits, as well as establishment of the CSU for women;
2) Excellent efforts by management and mental health staff at Broad River C.I. to identify and assess inmates on the mental health caseload that had not been assessed or seen within required timeframes;
3) Efforts by management and mental health and operations staff to develop the High Intensity BMU at Kirkland; this program is not yet functioning as a BMU;
4) Efforts by management staff at Perry to implement inmate mentors to assist with monitoring inmates in RHU or lockdown status and other innovative measures to mitigate the dire conditions in the RHU; this facility remains in crisis;
5) Efforts by management and central offices to complete suicide resistant cells at Leath C.I.;
6) Excellent efforts by management operations and the program director for the development and implementation of the Step Down Program at McCormick.

Below are the specific findings followed by the appendices that provide overview information on the system as a whole as well as the individual facilities within the system. As noted, Policies and Procedures remain in Partial Compliance and are likely to be impacted by the eventual development of a Master Plan for the Mental Health Services Delivery System.

1. The development of a systematic program for screening and evaluating inmates to more accurately identify those in need of mental health care:

1.a. Develop and implement screening parameters and modalities that will more accurately diagnose serious mental illness among incoming inmates at R&E with the stated goal of referring inmates to the appropriate treatment programs.

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update: See R&E Report in APPENDIX 1

[I]t is clear that from October 2016-February 2017, in nearly all measures, SCDC was not compliant with nearly all timeframe measures defined by policy and the R & E process. With the data reported at this point, it is anticipated that staff can better evaluate where the delays are occurring identify solutions to reduce number of days taken at each step, in order to achieve the 30-day of our & E processing goal.

July 2017 Implementation Panel findings: As per SCDC status update section. Based on discussion with staff, it appeared that the partial compliance was related to inadequate mental health and custodial staffing allocations, which are exacerbated by lockdowns and staff being pulled elsewhere.

The average length of stay in the Camille Graham R&E remained >40 days. Staff reported that R&E inmates are now receiving about 3 hours per day of of out of cell recreational time. However, inmates reported receiving only about one hour per day of out of cell recreational time.

July 2017 Recommendations: As per our March 2017 recommendations, which stated the following:

1. Continue to QI the relevant timeframes.
2. Adequately address the mental health and correctional staffing vacancies.
3. Accurately track the out of cell time offered to R&R inmates on a weekly basis.

Accurately determine and track the percentage of the SCDC population that is mentally ill.

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update:

The Division of Resources and Information Management (RIM) generates a weekly report of Mental Health Classifications for the Mentally Ill Institutional Population. As of May 2, 2016, the rate of mentally ill inmates as a percent of the total institutional population is 16.6%.

SCDC has demonstrated an increase of 6.4% since March 2016.

Routine Reassessment *(click here to return to 1d)*

As part of SCDC's endeavor to accurately determine the mentally ill population within SCDC, the Division of Behavioral Health and Substance Abuse Services has implemented monthly mental health screeners (wellness checks) that are completed annually based on the inmate's anniversary incarcerated date. Orders to Report (OTRs) are distributed to inmates in their housing units. Inmates report to a central location and QMHPs administer the Mental Health Short Screening Form (MHSSF) in a group format. If inmates do not show, staff are requested to schedule a second group session. Continued no shows result in follow-up discussion with security staff in the housing units for verification that inmates received the OTRs and consciously elected not to show up for the session. The QMHP, with the assistance of security staff, work collaboratively to ensure that inmates refusing to show up for annual wellness checks are not presenting current acute symptoms warranting an immediate mental health intervention.

Those needing referral to a QMHP based on the screening will be assessed within the same time frames required by the R&E mental health process. This rescreening was implemented in February 2017 at Camille, March at Lee, April at Perry, and at McCormick in May. To date, the four institutions have reported that 10 inmates have been added to the mental health caseload as a result of the routine reassessments.

The data below reflect the impact of screenings.

	Number Eligible	Number refused (documented)	Number not screened	Screened	MH Referrals	Added to MH Caseload	Updated MH Classification	
							L4	L5
Camille	104		18	81	42	3	3	0
Lee	297	24	113	160	24	3	2	1
Perry	86	23	1	62	16	4	4	0
McCormick	99	0	0	53	14	Not reported	0	0

Anniversary Mental Health Screening Schedule

Month	Institution(s)
February	Camille Graham
March	Lee
April	Perry
May	McCormick
June	Lieber
July	Broad River
August	Trenton/Manning/Wateree River
September	MacDougall
October	Allendale /Evans
November	Tuberville/Kershaw
December	Leath/Tyger River
January 2018	Ridgeland/Kirkland
February 2018	Livesay/Catwaba
March 2018	Palmer/Goodman

July 2017 Implementation Panel findings: We expressed our concern regarding the number of inmates who have not been screened for reasons that were not clear based on the study. We also are concerned about the lack of a protocol for inmates refusing to be screened that should include a record review and discussion with custody staff concerning these inmates.

We were told that at CGCI the inmates listed as not screened are inmates who have refused screening. We were not clear whether this was the case at the other institutions.

July 2017 Recommendations:

1. Need to address and correct the large number of inmates who have not been screened.
2. Need to develop a written protocol for assessing inmates who have refused screening.

1.b. The implementation of a formal quality management program under which mental health screening practices are reviewed and deficiencies identified and corrected in ongoing SCDC audits of R&E counselors;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update:

The Mental Health Division began an audit of R& E counselors in May 2017. Four records for each of the four R&E counselors were audited. All records reviewed included routine referrals. The auditor assessed the following items during the audit:

- Types of referrals:

- Open mental health clinic notes;
- MEDCLASS entry into the AMR;
- Documentation of the mental health screening outcome in the AMR;
- Timeliness of psychiatric evaluation;
- Inmate referral to psych clinic after initial mental health evaluation;
- Documentation of inmates' refusal of mental health services; and,
- Compliance.

R&E Counselors' Audit Results	n	%
Counselors audited	4	
Number of records reviewed	16	
# Routine referrals	16	100%
# urgent referrals	0	0%
# emergent referrals	0	0%
Inmates were referred to the psychiatrist after receiving the initial mental health evaluation.	11	69%
Of the 11 inmates referred to the psychiatrist, those seen within the 14 days of the initial mental health evaluation.	5	45%
MH Notes found open	0	0%
MEDCLASS entered in EMR	1	6%
MH Outcomes documented	15	94%
Of the 11 inmate referred to the Psychiatrist, those refusing mental health services.	2	18%
Of the 2 inmates refusing service, the number signing a Refusal of Medication (M-53)	0	0%

MH is planning to discuss deficiencies with R&E Manager Mr. Goodson. The following areas were noted as major findings during this review:

- Routine inmates not seeing the Psychiatrist within the fourteen day timeline as outlined in policy
- Refusal medication paperwork (M-53) documentation was not available
- Medclass entries not being entered timely after clearance by QMHP and/or Psychiatrist.

July 2017 Implementation Panel findings: As per SCDC update.

July 2017 Recommendations: The above QI study is a good start in implementing this provision. As we have stated during prior site visits, quality improvement reports including this one, should be "stand-alone" documents that include the following subsections:

- Description of the issue being reviewed;
- Methodology used in the study;
- Results;
- Assessment of the results; and
- Planned actions, if any.

Please use the above format for QI studies and other audits.

1.c. Enforcement of SCDC policies relating to the timeliness of assessment and treatment once an incoming inmate at R&E is determined to be mentally ill;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update:

The R&E Committee Internal Committee established in November, 2016 reviews and discusses R&E data for Kirkland and Camille. The March report indicated by Quantity Improvement and Risk Management (QIRM), formally QARM, indicated lengths of times for inmates to gain access to service and to be classified were outside of SCDC policy. Specifically, Both Kirkland and Camille Graham were outside of the fourteen days for inmates seeing the QMHP and Psychiatrist for routine referrals. In addition, there were very limited referrals being of an emergent or urgent nature. Since the previous site visit, the Division of Resource and Information Management (RIM) has requested that RIM add additional features to the AMR system to better capture types of encounters such as emergent, urgent, and routine referrals. Unique clinical services, such as individual, group, and crisis management services are also now identifiable.

The R&E Committee held its first meeting 11/18/16 and has had five subsequent meetings. The committee has spent most of the first six months establishing processes for the medical and mental health areas to have front hand knowledge regarding how many inmates are being backed up at R&E for medical and mental health reasons. The committee also discussed the small number of referrals being processed as emergent/urgent and explained criteria for both categories. Through this process, it was identified that weekly reporting needed to occur from medical and mental health, identifying how many referrals were pending MH/Medical assessments. Copies of the committee agenda and minutes are in APPENDIX 2.

SCDC currently has one Psychiatrist covering Kirkland R&E who works an average of 18 hours a week. Camille Graham R&E has two part time psychiatrist providing coverage, working a combined total of 4 hours a week, which averages 14 hours a month. SCDC's staffing plan does include increase psychiatry coverage at both facilities once vacant psychiatrist positions are filled. Therefore in the interim, cases requiring an urgent response are referred to the Chief Psychiatrist for assistance. Dr. [redacted] comes twice monthly (every other Thursday) average 5 hours each visit. Dr. [redacted] provides coverage to R/E twice monthly after the treatment team, which averages 2 hours each visit.

July 2017 Implementation Panel findings: As per SCDC status update.

July 2017 Recommendations:

1. Implement the processes summarized in the SCDC status update section
2. Continue to monitor the relevant timeframes.

3. QI the reasons for the small number of urgent/emergent referrals.
4. Address staffing needs for prompt psychiatric and medical assessments.

1.d. Development of a program that regularly assesses inmates within the general population for evidence of developing mental illness and provides timely access to mental health care.

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update:

*Please see report in 1A…Routine Assessment (**click here** to access the response)*

July 2017 Implementation Panel findings: As per 1A.

July 2017 Recommendations: As per 1A.

2. The development of a comprehensive mental health treatment program that prohibits inappropriate segregation of inmates in mental health crisis, generally requires improved treatment of mentally ill inmates, and substantially improves/increases mental health care facilities within SCDC.

2.a. Access to Higher Levels of Care

2.a.i. Significantly increase the number of Area Mental Health inmates vis-a-vis outpatient mental health inmates and provide sufficient facilities therefore;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update: NONE

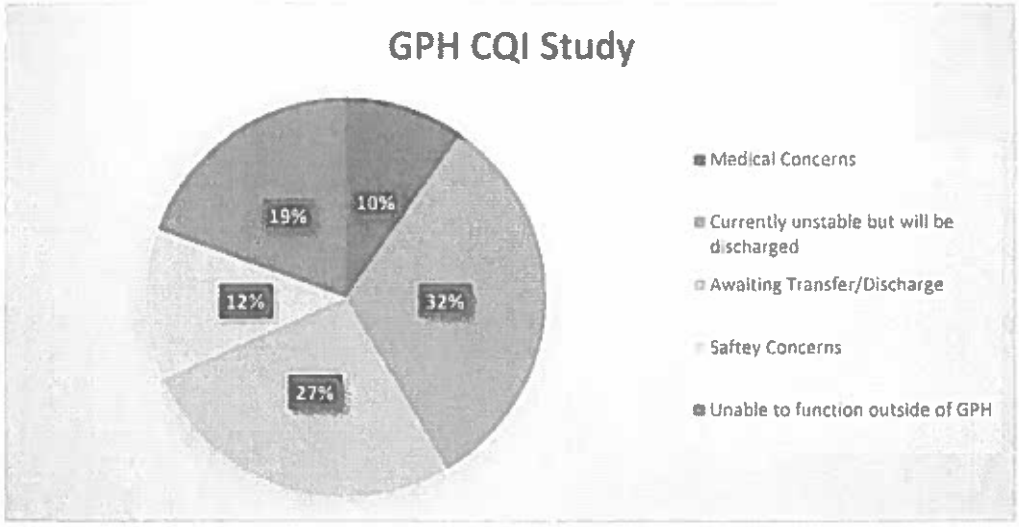
During the November 2016 site visit, the Implementation Panel recommended CQI studies. The studies should be conducted by MH program staff, in conjunction with QIRM, to include narratives of their process, analysis, and improvement plan. QI studies will serve as mechanisms to assure that SCDC Mental Health Services are operating optimally based on settlement agreement requirements and current allocated resources. The purpose of this particular QI study was to assess inmates residing at GPH more than 90 days, contributing to the hospital having an ongoing waiting list. The preliminary question asked prior to the study was how many of the extended stay inmates are in need of a BMU/Residential Care level of placement? The QI study was completed by staff from GPH and the Mental Health Division Director.

The full report is available as APPENDIX 3.

Assessment of the Results

The results from the QI study indicate 10% of inmates are being held at the hospital for chronic medical concerns and 12% are being held for safety concerns. The largest percentages of inmates at the hospital over 90 days are awaiting placement to a step-down level of care (59%). However, it appeared of the 59%, 27% are ready for discharge and waiting for placement. The breakdown of how many inmates are waiting placement at Intermediate Care Services (ICS) versus Behavioral Management Unit (BMU) are as follows:

Step-down Placement	Number of Inmates
Intermediate Care Placement (ICS)	14
Behavior Management Unit (BMU)	3
Total	17



Planned Actions

(1)- Appoint a risk manager at GPH to assist with ensuring cases are staffed and referred to a step-down program in a timely manner. The risk manager will also be responsible for working with the appropriate security and medical staff to determine best placement options for inmates with chronic medical needs and security concerns.

(2)- The Division Director will work with the management at ICS ensuring program is properly operating as a step-down program for the hospital. For the 14 cases waiting for ICS, they will be referred to the program.

(3)- Properly staff ICS to receive cases that formerly would have been assigned to the Self-Injurious Behavior (SIB) unit which is now disbanded as of April 30, 2017.

The plan for females receiving L3 services is outlined in 2.a.ii below.

July 2017 Implementation Panel findings: Although the above study is not specific to provision 2.a.1., it is a useful study relevant to provision 2.a. (Access to Higher Levels of Care). It appears that the delay in discharging inmates from GPH, who are ready for discharge from a clinical

perspective, is related to a shortage of ICS beds that are adequately staffed from custody and mental health perspectives.

July 2017 Recommendations: A staffing needs analysis for all aspects of the mental health system throughout the SCDC, which should include both mental health and custodial staff, is needed. This analysis should be completed in a timeframe that would permit the Director to request additional FTE positions, if needed, for the next fiscal year.

In addition, a salary analysis should be completed specific to mental health staff positions to determine the level of salary that is needed to be competitive for hiring purposes.

2.a.ii. Significantly increase the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefore;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

The ICS population for males and females, as of May 29, 2017, continues to be less than 5%. This is below the 10%-15% desirable threshold for all residential programing. The capacity for ICS beds for both males and females is as follows:

Program	Bed Capacity	Location
ICS (Males)	F1 (64) & F2 (200)= 264 beds	Kirkland F1 and F2 Buildings
ICS (Females)	Blue Ridge D Wing (16 single rooms) & Blue Ridge C Wing (75 open pods) = 91 beds	Blue Ridge

If all ICS beds were utilized to capacity, the ICS inmates would account for 10% of the total mental health population, with the understanding that the average MH Caseload maintains at 3400 (16.5%). However, it should be noted that Blue Ridge Wing C also houses 30 High Intensity Outpatient (L3, formerly known as Area Mental Health Inmates). As a result, the overall ICS population will peak at 9%. To accomplish the 10-15% threshold, the remaining residential beds will be occupied by GPH, BMU and HAB programming (see below).

Program	Bed Capacity	Percentage (average population of 3400).
GPH	87	2.5%
Private Provider (Guaranteed Beds	10	.2%
ICS Males & Females	355- 30 (High Intensity Outpatient inmates)= 325	9.5%
BMU Beds (*see explanation below in segregation section).*	112	3.2%
HAB Beds	25	.7%
		Total =16.1%

ICS Structured time for men has only tracked groups that averaged one hour for each inmate. The ICS Program Manager operates 20 groups with attendance averaging 8-10 inmates. Because ICS at Kirkland averages 150 residents, structured time that only counts group time will not accomplish the goal of 10 hours of structured out of cell activity. To address this concern ICS has developed a plan that includes:

- Offering at least ten additional groups
- Counting other structured services such as community meetings, seeing the QMHP/ Psychiatrist, and structured recreation activities with the Recreational Therapist.

ICS men are offered Recreation twice a day, weather permitting, at 9:30 and 1:30. Recreation takes place for one hour.

Treatment team participation/report Kirkland ICS
Treatment team is held weekly with 100% participation from the Psychiatrist, Dr. [redacted] QMHP's. and Security (Unit Manager). Treatment team was canceled one week in May due to institution being on lock-down and one week in April after four inmates in the program were murdered. Medical participation at Treatment Teams is averaging 50%.

Medication
Kirkland Pill line is three times days- 7:00, noon and 4:00. The pills are carried from Operations and distributed in an assigned pill room in the unit.

Plan for females receiving L2 services at Camille Graham.
The following lists address the deficiencies identified in the March IP site visit at CGCI. (The Blue Ridge building houses female Area, ICS, and CSU inmates, so all these will be addressed in this section.) The current number of structured therapeutic groups at CGCI Blue Ridge per week is 12.

CAMILLE Group Calendar JUNE 2017

All Groups in ICS unless otherwise noted.

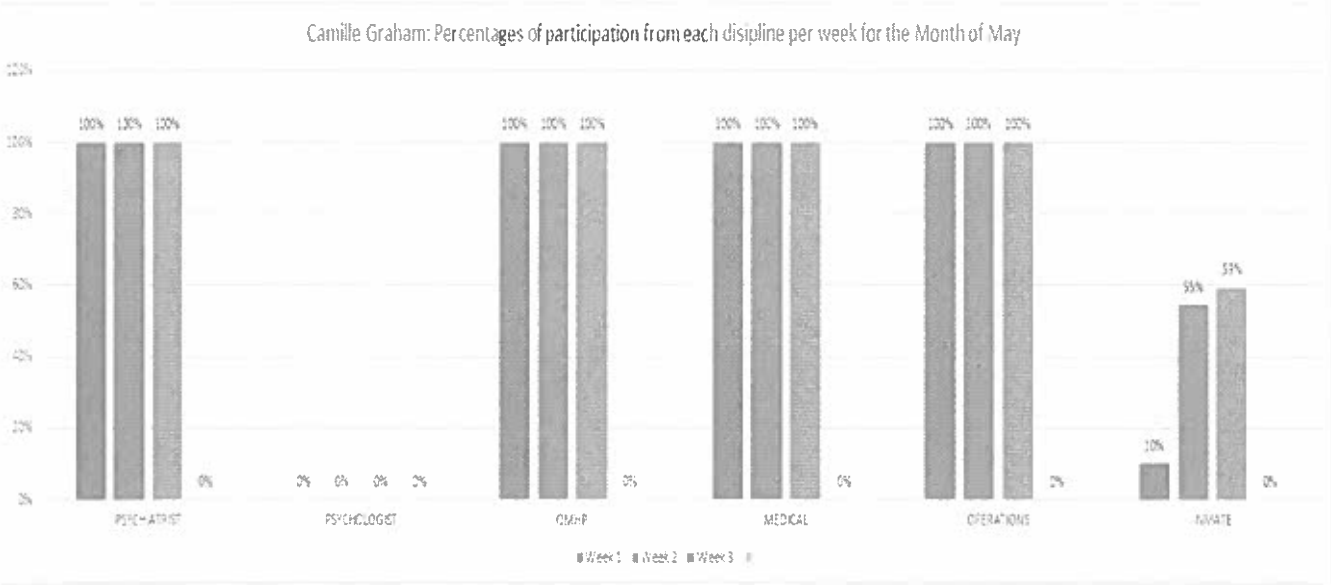
Structured therapeutic groups per week and inmate participation are outlined below:
The inmate participation and average out of cell hours by recent weeks (women housed in Blue Ridge)

Dates	Ave. out of cell time	Highest	Groups Offered	Participation Rate
May 1-5	1 hour 10 mins	3.4	8	63%
May 8-12	1 hour 8 mins	2.41	8	68%
May 15-19	1 hour 39 minutes	4.3	7	73%
May 22-26	1 hour 50 minutes	4	7	65%
May 29-31*	1 hour 10 minutes	2	4	not reported
June 5-9	2 hours 47 minutes	9	9	63%

*activity therapy and one group was canceled this week

Treatment Team Participation CGCI

May 2017- 100% participation from all disciplines except Psychologist and inmate participation



July 2017 Implementation Panel findings: From a literal perspective, the SCDC status update did not adequately address this provision, which states the following: "Significantly increase the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefore." GPH beds should not be counted as residential beds because they are hospital beds. However, it is likely that SCDC will have enough ICS beds if the current bed capacity is adequately staffed with correctional and mental health staff. The staffing needs analysis previously referenced should help determine whether the current understaffing is related to allocations, vacancies or both issues.

KCI ICS

The data relevant to the number of hours of out of cell structured therapeutic activities actually received by individual ICS inmates, on average on a weekly basis was very low, and reportedly inaccurate.

Data was presented relevant to ICS Inmates seen for individual sessions with the QMHP. However, the methodology relevant to this data and the assessment of results were very unclear.

The lack of medication administration at KCI not being available on a HS basis (i.e., at night) is very problematic. In addition liquid oral medications and long acting injectable medications are not available or limited because nursing staff have been removed from ICS, which is also very problematic.

During the morning of July 11, 2017 we observed a treatment team meeting in the male ICS at KCI. The appropriate staff were present, inmates were interviewed by the team and a reasonable multidisciplinary discussion occurred during the meeting.

We also discussed with staff issues related to the trauma experienced by the team and other inmates related to the four homicides within the ICS during this year.

CGCI

We assessed the female ICS services at Camille Graham CI during July 13, 2017

Significant improvement was noted regarding inmate access to out of cell structured therapeutic activities since the March 2017 site assessment. Staff reported offering ICS inmates 15 hours per week of out of cell therapeutic activities with about 5-7 hours actually being used by the inmates.

We interviewed inmates in Section C in a community-like setting. These inmates were either L-2, L-3 or L-4. Most inmates reported receiving one to two groups per week with some inmates indicating participation in three groups per week. The main reason for not participating in groups was reported to be related to scheduling conflicts with school, work, etc. Inmates uniformly describesd the groups as being very helpful. They also described most mental health staff as being very helpful to them.

In general, there were not many complaints verbalized by inmates regarding correctional staff although one CO was clearly identified by many inmates as being very problematic due to being inappropriately provocative toward inmates. Inmates described continuity of medication issues related to both untimely medication renewals and other medications not being available. These issues appeared to be due to eZmar software issues and psychiatrists' vacancies.

Community meetings have been held on a weekly basis and were described by staff and inmates as being very helpful.

We observed a treatment team meeting during the afternoon of July 13, 2017. We were again encouraged by the multidisciplinary discussion and the presence of a psychiatrist, Dr. [redacted]

July 2017 Recommendations:

1. Complete the staffing needs analysis.
2. Provide accurate information regarding the number of hours of out of cell structured therapeutic activities both offered and received by individual ICS inmates, on average, on a weekly basis.
3. Provide accurate and meaningful data relevant to the frequency that ICS inmates were being seen for individual sessions with a QMHP.
4. The lack of medication administration for HS, liquid, and long acting injectable medications needs to be remedied.
5. We met with Ph.D., Deputy Director of Health Services, [redacted] Assistant Deputy Director of Health Services and [redacted], Project Manager RIM re: the medication issues with a focus on developing an interim solution until the software issue has been resolved. We suggested that a pharmacist and nurse visit high-risk housing units on a regular basis until the software issue has been resolved and establish a similar process in a clinic setting for general population inmates.

2.a.iii. Significantly increase the number of male and female inmates receiving inpatient psychiatric services, requiring the substantial renovation and upgrade of Gilliam Psychiatric Hospital, or its demolition for construction of a new facility;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

Increase the number of male and female inmates receiving inpatient psychiatric services Reasons for low admission rate of female inmates to an inpatient psychiatric unit

Most of Camille Graham inmates who require inpatient hospitalization or become active psychotic are typically transferred to our contracted facility pending bed availability.

o Our goal is to provide higher acuity services to actively psychotic mentally ill inmates by ensuring psychiatric care, medication compliance and follow-up within a timely matter.

o Camille Graham/SCDC- has Probate Court Orders for Outpatient Patient mental health services for those inmates with a history of Inpatient Hospitalization; the Probate Order is part of the discharge plan transfer order.

o SCDC is exploring contracts with Correct Care to guarantee 10 beds for inmates needing inpatient hospital level of care. (*Target completion date- August 01, 2017*).

Female inpatient/hospital level care

Since the March IP visit, there was only one (1) referral to Geo Care, Inmate # [redacted]; Dates of admission: March 3, 2017 to June 2, 2017.

There have been no rejections based on bed availability/waiting list since the IP's March site visit.

GPH Staffing

Location	L1	L2	L3	L4	L5	LC	BL	BU	RT	MI	MR	Mentally Ill Inmates	Loc Total	Loc's Pop.	Total Mentally Ill Pop.	Total Pop.
GILLIAM PSY CENSUS	77	0	2	0	0	3	0	0	0	0	0	**82**	91	90.1%	2.40%	.402 %
Staffing	Psychiatry Coverage = 121.45 hours per week					QMHP = 7 MH Tech/Bay = 11 AT = 2 Psychologist= 20 hours a week				Vacancies = QMHP = 3 MH Tech/Bay = 9 Psychiatrist= 1 Psychologist= 1 (tele)			Needed/Additional Staffing QMHP=3 Activity Therapy= 1 MH Tech/Bay= 4			

Renovation and upgrades of Gilliam Psychiatric Hospital GPH Renovations

See APPENDIX 4, Section 3, Kirkland Correctional Institution -- Gilliam Psychiatric Hospital (GPH) for GPH update.

Male and female inmates receiving inpatient psychiatric services

Gilliam Psychiatric Hospital (GPH) Structured/Unstructured Data Analysis for week of 05/15/2017 to 05/21/2017			
Total Number of Inmates on GPH Roster	88	88	88
STRUCTURED ACTIVITY			
Total # of Structured Activities offered.	20	20	20
Total # of Structured Activities held.	7	4	1
% of Groups Held	35%	20%	5%
Total # of Hours of structured of activities offered.	46:24:17	66:22:30	0:00:00
Number of Inmates who participated in at least (1) Structured Activity	72	51	30
% Inmates who participated in at least (1) Structured Activity	82%	58%	34%
Number who did not participate in at least (1) Structured Activity	16	37	58
% of Inmates with no recorded sturctured activity	18%	42%	66%
Average time allotted for each structured activity	2:00:19	2:24:49	2:39:00
Average time out of cell time for sturctured activities	5:06:56	5:18:36	2:39:00
Number of Inmates participating in at least 10 Hours of structured out of cell time	2	0	0
UNSTRUCTURED ACTIVITY			
Total # of Untructured Activities offered.	9	7	
Number of Inmates who participated in at least (1) Unstructured Activity	27	21	3
% Inmates who participated in at least (1) Unstructured Activity	30.68%	23.86%	3.41%
Number who did not participate in at least (1) Untructured Activity	61	67	85
% of Inmates with no recorded Unsturctured activity	69.32%	76.14%	96.59%
Average time allotted for each Unstructured activity	N/A	N/A	N/A
Average time out of cell time for Unsturctured activities	4:48:53	2:20:00	2:41:40
Number of Inmates participating in at least 10 Hours of unstructured out of cell time	4	0	0

July 2017 Implementation Panel findings: Renovations at GPH, with specific reference to the nursing station, are not expected to be completed until December 2017.

As per SCDC status update.

The amount of out of cell time, both structured and unstructured, actually used by GPH inmates is alarmingly small. Based on information obtained from staff, it appears that this issue is predominantly related to inadequate staffing allocations (both correctional and mental health staff) since the correctional staff vacancy rate has generally been less than 12%.

July 2017 Recommendations:

1. Complete the previously referenced staffing needs analysis for GPH that should include both custody and mental health staffing positions.

2. Focus on providing more out of cell structured therapeutic and unstructured time to inmates in GPH.
3. Continue to monitor implementation of the scheduled GPH renovations, which continue to be on schedule..
4. Fix the "treatment chairs" as well as their configuration in GPH.
5. Further explore the reasons for the low admission rate of female inmates to an inpatient psychiatric unit.
6. Finalize options for inpatient psychiatric beds for females.
7. Provide training/supervision to mental health staff regarding court orders relevant to involuntary medications.

2.a.iv. Significantly increase clinical staffing at all levels to provide more mental health services at all levels of care;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

Mental Health
The current (6/21/17) vacancy rate for mental health is 37%.

Mental Health Staffing Summary								
	Full-Time		Pink Slip		Dual		Contract	
Job Category	Filled	Vacant	Filled	Vacant	Filled	Vacant	Filled	Vacant
Administrative Support Totals – (includes QA Director; HSOA Team Leads; HSOA's)	8	7	14	4	0	0	0	0
Bay Area Totals - (only at GPH)	3	4	0	0	0	0	0	0
Activity Therapy Totals	3	0	0	0	0	0	0	0
Mental Health Tech Totals - (includes HSC I/CCC III's)	28	14	0	0	0	0	0	0
Qualified Mental Health Professional Totals - (includes Division Director; Asst. Div. Director; CCC IV; CCC V; Regional Managers; Program Managers; Clinical Supervisors)	63	27	0	0	0	0	0	0
Psychology Totals	0	3	0.6	0	0	0	0.61	0
Psychiatry/Nurse Practitioner Totals	3	4	3.05	1.92	1.84	0	1.7	0
	108	59	17.65	5.92	1.84	0	2.31	0
	167		23.57		1.84		2.31	
			27.72					
DIVISION TOTALS	194.72							

Mental Health Staffing Summary

	Total	Full Time		Pink Slip		Dual		Contract		TOTAL (F Rate)
Job Category		F	V	F	V	F	V	F	V	
Administrative Support	33	8	7	14	4	0	0	0	0	66%
Bay Area	7	3	4	0	0	0	0	0	0	43%
Activity Therapy	3	3	0	0	0	0	0	0	0	100%
Mental Health Tech	42	28	14	0	0	0	0	0	0	66%
QMHP	90	63	27	0	0	0	0	0	0	70%
Psychology	4.21	0	3	0.6	0	0	0	0.61	0	29%
Psychiatry/NP	15.51	3	4	3.05	1.92	1.84	0	1.7	0	62%
POSITION TOTALS	194.72	108	59	17.65	5.92	1.84	0	2.31	0	37% Vac

(Position Summary – as of 06/20/2017)

The summary of current mental staffing allocations and vacancies was submitted in the document drop. See "Other Information" folder, #44a.

Medical staffing numbers
A report of the staffing plan for Health Services for RN, Paramedics, LPN, CNA-MED Techs and Program Staff is attached as APPENDIX 5. This report details the staffing needs by institutional levels, institutions, clinical service areas and disciplines.

Operations Staffing
Because a shortage of correctional officers may have an impact on clinical and mental health services, multiple initiatives have been initiated to increase recruitment and retention of staff.

To address the Operations staffing shortage, as of June 13, 2017 the following new agency budget items have been approved and are effective July 1, 2017:

H.3720 (2017-2018 Appropriations Bill)

- New Agency Budget items effective July 1, 2017
- $5,368,496 - C/O Rate Adjustment & Retention ($1,000 salary increase)
- $188,394 - Quality Assurance & Risk Management Personnel
- $468,911 - Medical Plan-Phase III of III

- $1,489,927- Mental Health Remedial Plan- Phase III of III
- $285,451- Re-entry Skills (CHANCES) Program
- Funds appropriated for special assignment pay at the Department of Corrections are for the purpose of addressing vacancies and turnover of staff by providing a pay differential for certain employees assigned to institutions with a Level II or Level III security designation. The funds are to be used for special assignment pay only and may not be transferred to any other program. If the employee leaves one of the qualifying job classes or leaves a Level II or Level III institution for a non-Level II or non-Level III facility, they shall no longer be eligible for this special assignment pay. Only employees in full-time equivalent positions are eligible for this special assignment pay. The special assignment pay is not a part of the employee's base salary and determined by the Director of the Department of Corrections at Level II and Level III institutions.

From July 1, 2013 (FY 2014) to September 18, 2017 (FY 18), officer hiring salaries shave increased by:

- 26% at Level 1 institutions from $25,060 to $31,763;
- 31% at Level 2 institutions, from $26,062 to $34,177; and,
- 34% at Level 3 institutions from$27,065 to $36,213.

Recruitment Efforts (Click here to return to 3d)

To continue to address the staffing shortages, the Division of Administration continues to implement recruitment efforts included in the March report in addition to the new efforts outlined below:

1. Truck and car wrap on SCDC vehicles advertising positions and opportunities completed and being updated to include new purchases.
2. Beginning October 2016, SCDC placed 13 billboards statewide to advertise SCDC positions and opportunities. Medical /MH specific billboards are currently being bid.
3. Converted SCDC application process to the state website NEO.GOV to allow for streamlined, easier application and notice of positions at SCDC. Full and part-time positions will be posted for medical and mental health staffing
4. Hosted a booth at the South Carolina State Fair manned by employees. Spoke with 682 potential applicants. Booked 4 spots at 2017 Fair to double our exposure.
5. Hired retention lieutenants to work with and train new officer staff.
6. Decreasing the time for step incentives from a five – step program to a two – step program with a higher salary in a shorter period of time (from 2 years to 6 months).
7. Scheduled Overtime for officers being offered in all institutions.
8. Hired Paramedics and offered shift diff to this pool.
9. Increased officer pay by $1,000 in FY18
10. Changed the rehire process to decrease the time to rehire.
11. Added promotion car to fleet to attract candidates.
12. Developing an internal training program based on an existing Character program.
13. Added full time recruiter in the upstate based out of Tyger River.
14. Advertising in quarterly nursing publications.

15. Offering management/supervisory training through Midlands Technical College
16. Increased referral bonus to $500 per referral.
17. Offering a sign on bonus to medical and mental staff that will beat local hospital competition.
18. Added promotion car to fleet to attract candidates.
19. Sponsoring/Advertising in Columbia with the Back to the Farm Music Festival
20. Sponsoring/Advertising with Greenville Drive for First Responders Day to benefit Livesay, Perry, and Tyger River.

A salary survey was conducted to compare SCDC average salaries, to the average state salaries and the averages for the disciplines from INDEED.com and the South Carolina Hospital Association.

Staffing plans for LLBMU and HLBMU (include CIT-trained staff)

Location	L1	L2	L3	L4	L5	LC	BL	BU	RT	MI	MR	Mentally Ill Inmates	Loc Total	Loc's Pop.	Total Mentally Ill Pop.	Total Pop.
ALLENDALE	0	0	1	143	6	0	13	0	0	0	0	**163**	1,032	15.8%	4.77%	.800%
Staffing (Includes LBMU)	Psychiatry Coverage = 21.5 hours per week					QMPH = 2 MH Tech = 1				Vacancies = QMHP = 3 MH Tech = 2			Needed/Additional Staffing QMHP=1 MH Tech=2			

Location	L1	L2	L3	L4	L5	LC	BL	BU	RT	MI	MR	Mentally Ill Inmates	Loc Total	Loc's Pop.	Total Mentally Ill Pop.	Total Pop.
KIRKLAND	0	138	2	102	0	0	0	0	0	0	0	**242**	1,779	14.4%	5.53%	.928%
KIRKLAND INFIRMARY	0	2	0	6	0	0	0	0	0	0	0	**7**	21	33.3%	.205%	.034%
KIRKLAND MAX	0	0	1	4	0	4	0	10	0	0	0	**19**	21	90.5%	.556%	.093%
Staffing (Includes ICS, SIB, R&E, and HLMBU)	Psychiatry Coverage = 77.80 hours per week					QMPHs = 11 MH Tech = 2						Vacancies = QMHP = 5 MH Tech = 3 Psychiatrist= 1 Psychologist= 1		Needed/Additional Staffing = QMHP=5 MH Tech=4, Activity Therapist= 1		

As an additional retention effort, the Division of Victim Services is developing a program to serve as support for staff members at SCDC. The proposed program is summarized below.

As an agency, SCDC is in the process of implementing a CISM (Critical Incident Stress Management) Program for staff. CISM is an umbrella term that includes a variety of possible services to support staff who have experienced trauma. Within the framework of CISM, there will be a more structured response activated to "debrief" and "diffuse" groups of staff directly involved in situations as well as providing one-on-one peer support for all staff requesting assistance for work-related and/or personal issues they are facing. These CISM processes are nationally (and even internationally) recognized in many correctional agencies, law enforcement as well as fire departments. More recently, the National Institute for Corrections has begun supporting and conducting research in how corrections as a profession "changes" people over time (the cumulative impact of working in the field of corrections) and how to most effectively improve the well-being of these employees.

We know that correctional employees who are exposed to traumatic events in the workplace (assaults, urine/feces thrown, hostage situations, etc....) have reported at times that they do not feel supported and may resign at a much higher rate, causing extraordinary turnover rates. Traditionally, employees have been told after being involved in a critical event to "write an incident report and get back to their post as soon as possible". Until recently, there has been little regard for the emotional impact critical events can have on staff and how to best work with them in the aftermath of such trauma. Through CISM, employees will be able to discuss their reactions and identify needs to most effectively continue working within a correctional environment.

PROPOSED
CRITICAL INCIDENT STRESS MANAGEMENT (CISM)
WITHIN SCDC

GROUP INTERVENTION IMMEDIATE EVENT RELATED	ONE-ON-ONE SUPPORT	GROUP INTERVENTION LONG-TERM EVENT RELATED	CUMULATIVE "CORRECTIONS FATIGUE"
Responding to traumatic events that occur in the course of work. (Staff assaults, death of employee at work, riot, suicide, etc....) Group Processes Include: ✓ Debriefing ✓ Diffusing ✓ Demobilization ✓ Crisis Management Briefing	Peer Support by trained team member for issues related to personal and/or professional (health diagnosis, divorce, bankruptcy, staff assaults, work related stress, etc....)	Some experiences just never go away...and can created ongoing issues. Periodic opportunities to address effects of traumatic events can help reduce the symptoms and help with employee retention and morale	Educational program and group process that addresses ongoing, cumulative effective of working within correctional environment. *Desert Waters* is well-known program that can start to build resiliency for correctional employees

July 2017 Implementation Panel findings: The 40% mental health staffing vacancy rate noted during the November 2016 site assessment is little changed from the current 37% vacancy rate or the 38% vacancy rate during March 2017. The department implemented an aggressive recruiting campaign as reported in our March 2017 report and the current SCDC status update section relevant to hiring of both correctional and mental health staff. We previously opined that the salary for psychiatrists is likely not competitive to psychiatrists' salaries in the community in contrast to other state institutions, which continues to be our opinion. The SCDC overall correctional officer staffing vacancy rate for institutions was 29.5 % as of July 2017. The vacancy rate for Level III institutions (highest security) at Lee Correctional Institution, Lieber Correctional Institution McCormick Correctional Institution, Perry Correctional Institution and the female Camille Graham Correctional Institution exceeded 40 %.

Key administrative staff thought that it was too early to assess the effectiveness of the recruitment campaign. We emphasizedthat it was important to have an assessment regarding the salary structure by December 2017 since psychiatrists completing their residency training during July 2018 will be making job decisions often by January 2018.

As referenced in the prior section, a staffing needs analysis for all aspects of the mental health system throughout the SCDC, which should include both mental health and custodial staff, is needed. This analysis should be completed in a timeframe that would permit the Director to request additional FTE positions, if needed, for the next fiscal year.

July 2017 Recommendations: As above.

2.a.v. The implementation of a formal quality management program under which denial of access to higher levels of mental health care is reviewed.

Implementation Panel July 2017 Assessment: **compliance (07/17)**

June 2017 SCDC Status Update

1. This committee has met three times (20 Apr 17, 17 May 17, 21 Jun 17). There are four members: [redacted] meets w/us via VTC.
2. Prior to each meeting, Dr. [redacted] receives reports from the six (five as of June) residential/inpatient programs (SIB, ICS, HAB, LLBMU, HLBMU, GPH) which reflect the number of requests for admission, the number of inmates accepted, the number wait-listed, the number removed by the referral source before they were admitted/denied and the number denied. These reports also contain a section in which all inmates who are denied admission/acceptance are identified along with the date they were denied and an explanation of why they were denied.
3. During the meeting, all inmates denied are reviewed. Their AMR and their relevant OMS data is reviewed. The committee decides to either concur or not concur with the denial. The names of

those inmates whom we believe were denied inappropriately, along with the reasons we believe the denial was inappropriate, are forwarded to Mr. [redacted] for further action.
4. Mr. [redacted] replies to Dr. [redacted] regarding his decision to agree or disagree with our not concur finding.
5. The results of these meetings are reflected in the table below:

Month/Yr	Program	# referrals	# accepted	# wait list	# removed	# denied	# not concur	# overturned	# to be revisited
Feb 17	GPH								
	ICS								
	HAB	0	0	0		0	0	0	
	HLBMU								
	LLBMU					19	10	4	4
	SIB								

Month/Yr	Program	# referrals	# accepted	# wait list	# removed	# denied	# not concur	# overturned	# to be revisited
Mar 17	GPH	27	20	1	0	6	0	0	0
	ICS	22	14	0	0	8	0	0	0
	HAB	0	0	0	0	0	0	0	0
	HLBMU	0	0	0	0	0	0	0	0
	LLBMU	25	10	3	0	10	3	0	2
	SIB	1	1	0	0	0	0	0	0

Month/Yr	Program	# referrals	# accepted	# wait list	# removed	# denied	# not concur	# overturned	# to be revisite
Apr 17	GPH	19	9	1	8	1	0	0	
	ICS	5	2	2	0	1	0	0	
	HAB	0	0	0	0	0	0	0	
	HLBMU	0	0	0	0	0	0	0	
	LLBMU	4	0	0	0	4	2	0	
	SIB	0	0	0	0	0	0	0	

Month/Yr	Program	# referrals	# accepted	# wait list	# removed	# denied	# not concur	# overturned	# to be revisited
May 17	GPH	22	12	5	5	0	0	0	0
	ICS	10	4	0	0	6	1		
	HAB	1	1	0	0	0	0	0	0
	HLBMU	0	0	0	0	0	0	0	0
	LLBMU	59	2	19	0	38	17		
	SIB	0	0	0	0	0	0	0	0

A formal review process was initiated in March 2017, chaired by Dr. [redacted] (psychologist) and Dr. [redacted] (chief psychiatrist. The May report includes a review of 10 inmates. Four were admitted and six denied admission to ICS. There was an average number of 2.7 mental health hospitalizations.

July 2017 Implementation Panel findings: As per SCDC status update section. There appear to be issues, at times, between the Warden and mental health staff relevant to continued placement of a small number of inmates in the HLBMU.

July 2017 Recommendations:

1. Continue with this process.
2. Resolve the placement issue for relevant inmates in the HLBMU referenced above.
3. Re-educate mental health staff on the criteria for referral to the BMUs as including inmates with personality disorders rather than exclusively SMI.

2.b. Segregation:

2.b.i. Provide access for segregated inmates to group and individual therapy services

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

The chairs at Allendale that were uncomfortable have been adjusted. KCI's high level BMU has moved from the former SSR building to D-dorm on June 5, 2017. At this point, the therapy chairs are not being used in that unit. The inmates are kept in handcuffs and belly chains in the group room, five at a time.

Data re: the LLBMU provided was as follows:

Allendale LLBMU Structured/Unstructured Data Analysis for 04/17/2017 to 04/21/2017	
Total Number of Inmates on Allendale LLBMU Roster	15
STRUCTURED ACTIVITY	
Total # of Structured Activities offered this week (uncertain)	N/A
Total # of Structured Activities held this week	8
Total # of Hours of structured of activities offered this week.	27:30:00
Number of Inmates who participated in at least (1) Structured Activity	15
% Inmates who participated in at least (1) Structured Activity	100%
Number who did not participate in at least (1) Structured Activity	0
% of Inmates with no recorded sturctured activity	0%
Average time allotted **for each** structured activity	1:15:00
Average time out of cell time for sturctured activities for the week (per	39:12:00
Number of Inmates participating in 10 hours of structured out of cell time this week	11
% of Inmates participating in 10 hours of structured out of cell time this week (out of the total roster)	73%
% of Inmates participating in 10 hours of structured out of cell time this week (out of inmates who participated in at least 1 structured activity)	73%

Allendale LLBMU Structured/Unstructured Data Analysis for 05/01/2017 to 05/05/2017	
Total Number of Inmates on Allendale LLBMU Roster	15
STRUCTURED ACTIVITY	
Total # of Structured Activities offered this week (uncertain)	N/A
Total # of Structured Activities held this week	4
Total # of Hours of structured of activities offered this week.	14:45:00
Number of Inmates who participated in at least (1) Structured Activity	11
% Inmates who participated in at least (1) Structured Activity	73%
Number who did not participate in at least (1) Structured Activity	4

At KCI's HLBMU, the structured hours started out about 11 hours/week for 14 inmates (currently 11 inmates). However, due to a security incident, most of the security staff was pulled, and currently the number of structured hours at HL BMU has been reduced.

July 2017 Implementation Panel findings: During the morning of July 11, 2017, we interviewed HLBMU inmates in the HLBMU at the KCI. The inmate census in this unit was 21 with a current capacity of 24. This unit, which was initially started within the SSR building was moved to D-dorm on June 5, 2017. The previous program at D- dorm, which was the self-injurious behavioral unit, was closed with some of the inmates remaining in the HLBMU and other inmates being transferred to the intermediate care unit (ICS).The HLBMU at KCI will eventually be expanded (112 beds) and moved to the Broad River CI around December 2017.

Related to a disturbance at another prison, many inmates were subsequently transferred to the SSR at the KCI, which resulted in correctional officers assigned to the HLBMU being pulled to provide coverage at the SSR. As a result, the HLBMU program has essentially never been appropriately implemented due to the custody staffing shortages (average about two officers per day with only one officer assigned at times) and inadequate mental health staffing (1.0 FTE QMHP and 1.0 FTE mental health technician, both of whom provide coverage to the SSR) within the unit. Related to the fiscal year cycle, supplies have been extremely limited for this program which means that they have not had access to group therapy materials and do not have enough tables or chairs. In addition, at least one of the televisions was not working in addition to a microwave in need of repair.

Related to the custody staffing pattern, inmates had extremely limited access to the outdoor recreation yard. Inmates were also very upset that their visitations did not include weekend visits Inmates had numerous complaints regarding the program which included the following:

1. Several inmates claimed that they had no idea why they had been transferred to this program.
2. Lack of structured programming within the program.
3. Lack of access to outdoor recreation.
4. Lack of access to medications being administered at night.
5. Lack of access to weekend visitation.
6. Concerns about being shackled while being escorted out of the unit.
7. Lack of access to mental health treatment.

The HLBMU is currently not a treatment program although the physical plant is certainly better than what was available within the SSR and, at least, some RHUs. It is clear that many of the problems are related to inadequate mental health and custody staffing. Unfortunately, inmates are not being provided with many privileges that could at least mitigate the lack of programming such as reasonable access to the yard, increased out of cell time within the dayroom's, at least intermittent visitation during weekends, and/or permission to have pictures of their families within their cells.

Based on short interviews with these inmates, it appears likely that at least several of them would be capable of transitioning to a general population yard without going through the HLBMU program.

The LLBMU appears to be very successful based on data presented by SCDC staff.

During the morning of July 12, 2017, we site visited the McCormick CI, where we gathered information re: the Step-Down program ("SDP"). Fifty-three inmates have successfully graduated from this program during the past three years with five inmates having been returned to an RHU with three of the five RHU returnees eventually returning to the SDP.

Eligibility for the SDP includes having a security detention (SD) custody classification and being disciplinary free for at least six months.

SDPs are also located at Lee CI and Leiber CI. The Lee SDP had a total of forty-seven graduates and the Leiber SDP had thirty-three graduates. Other statistics relevant to these programs were consistent with these programs being very successful. These programs have been successful related to a very competent and conscientious program director and numerous community volunteers who provide classes to the SDP inmates.

Issues for the SDP continue to involve custody institutional cultural issues that need to be addressed.

The RHU Behavior Level System for inmates on Security Detention Status has not been implemented. The stand alone Step Down Program Policy for inmates that are released from Security Detention and require heightened supervision remains in the development phase.

July 2017 Recommendations:

1. Provide privileges to inmates in the HLBMU that would at least partially mitigate the lack of programming within this unit.
2. Reassess which inmates, if any, in the HLBMU are not in need of a BMU but could transition to a general population yard.
3. The program director of the Step Down Program ("SDP") should be actively involved in the hiring of the correctional staff for this unit and should have significant input in removing COs who turn out to not be a good fit for the program.
4. Implement the RHU Behavior Level System for inmates on Security Detention status prior to the next IP Site visit;
5. Finalize the SDP Policy for inmates that are released from Security Detention and require heightened supervision and move forward with implementation prior to the next IP Site Visit.
6. There are many lessons to be learned for the implementation of the BMUs from the experience of the SDP, which include the optimal size of the program, number of

admissions in a specific period of time and selction of correctional officers working in such programs.

2.b.ii. Provide more out-of-cell time for segregated mentally ill inmates;

Implementation Panel July 2017 Assessment: **noncompliance**

June 2017 SCDC Status Update

Crank Radios
About 200 have been distributed to both mentally ill and non-mentally in inmates in PCI RHU, LL and HL BMU's. and GPH.

- About 500 arrived in late June and are will to be distributed in other RHU's.

RHU Rounds are done consistently across the agency to help mitigate where we are unable to provide the 10/10. The following chart of RHU rounds is reported by the HSOAs.

- RHU Rounds

Institution	Compliance Rate	Staff Conducting Rounds
Allendale	100%	QMHP
Broad River	100%	QMHP
Camille Graham	100%	QMHP
Evans	100%	QMHP
Kershaw	100%	MH Tech
Kirkland	100%	QMHP
Ridgeland	50%	QMPH
Leath	100%	QMHP
Lee	100%	MH Tech
Lieber	100%	MH Tech
McCormick	100%	QMHP
Perry	100%	MH Tech
Tuberville	Unable to confirm at time of report	
Tyger River	100%	QMHP

July 2017 Implementation Panel findings: Mr. [redacted] reported that mental health staff have received training relevant to the mental health rounding process. When possible from a staffing perspective, the same mental health clinicians are performing rounds on the same inmates for at least six months at a time. The rounding process reportedly no longer includes, on a routine basis, a mini-mental status examination unless clinically indicated..

During the afternoon of July 11, 2017 we observed the mental health rounding process in the RHU at Broad River CI, which was done in a competent manner. However, the RHU environment was

chaotic and very noisy, which appeared to be related to the presence of the implementation panel members and a large contingent of correctional officers and upper management staff coming onto the unit. Due to the extreme noise level, it was very difficult to interview inmates during the rounding process.

During the morning of July 12, 2017, we observed the mental health rounding process in the RHU at the McCormick CI. There were 36 inmates in the RHU with 10 of these inmates being on the mental health caseload. The institution was on lockdown status during the site visit.

The RHU was filthy at the time of the site visit related, in part, to inmates flooding the unit the evening before in response to a cell search process having been completed. The unit had not been cleaned following the flood due to a statewide lockdown. Inmates reported access to showers on a three times per week basis. They indicated very little access to the outdoor recreational areas.

During the rounding process, we observed a use of force incident that was very problematic from a variety of perspectives including inadequate de-escalation techniques being implemented.

During the afternoon of July 12, 2017, we observed the mental health rounding process at the Leath CI RHU, which was done in a competent manner. The covering for the outer door window was opened during the rounds process, at our request, which required the presence of two correctional officers. This allowed the clinician to hear the inmate much more clearly and resulted in a much more humane interaction.

The unit was very clean and quiet. Inmates generally described reasonable access to the outdoor recreational yard although it was not uncommon for an inmate to lose yard privileges due to not standing during count. This latter issue is a systemwide practice.

During the morning of July 13, 2017 we observed the mental health rounding process in the RHU at the Camille Graham Correctional Institution, which was done in a competent manner. The RHU was clean and the housing unit was reasonably quiet. Staff reported that inmates have access to up to three hours per day of outdoor recreational time. However, similar to other SCDC institutions, inmates can lose access to the recreational time for disciplinary reasons that include not standing for counts. Issues related to such a process are described later in this report by Mr. Sparkman.

Significant issues relevant to medication management were present in the RHU that are similar to those described in a a prior section that summarized the ICS program at CGCI.

We observed the mental health rounding process in one of the tiers during the morning of July 14, 2017 at the Perry CI. Although the tier was reasonably clean, the conditions of confinement were terrible. Inmtes do not get any out of cell time for recreational purposes, very limited access to showers and very limited laundry exchange. Mattresses were frequently dirty and torn. Inmates also complained of very limited access to cleaning materials for purposes of cleaning their cells.

The Perry Correctional Institution correctional officer staffing for the RHU is at a crisis stage. A review of cell check logs revealed due to staffing shortages correctional officers are unable to make thirty-minute checks and frequently the time between the checks exceeded one hour. There are occasions when the time between cell checks was three to four hours. At times, RHU Correctional Officer Staffing is one correctional officer in each control room of the three RHU buildings and one correctional officer to float between the three buildings. Clearly, this is unsafe for staff and inmates and makes it impossible for essential services to be provided for RHU inmates. The lack of correctional supervision has provided inmates the opportunity to cause significant damage to the physical plant. Two recent incidents occurred where inmates knocked holes in their cell walls. In one of the incidents, the inmates were able to exit their cell and cause significant damage to the RHU physical plant. In the other incident, an inmate alleges the inmate in an adjacent cell knocked a hole in the cell wall and was able to assault him with bodily fluids. The Perry Correctional Institution RHU Supervisor reported an attempt is made to provide inmate showers two times a week (scheduling calls for three showers per week). A review of inmate cell activity cards revealed inmates received no more than one shower per week and some inmate cards indicated no showers. A review of May 2017 shower records for one of the RHU buildings was conducted. Based on the documentation, none of the inmates assigned to the building received a shower during the month.

An incentive program has been initiated that included crank radios and special visits as rewards. Siginficant problems at PCI existed re: access to a psychiatrist and medication management issues.

Inmates on the mental health caseload in the segregation units at the Broad River CI, McCormick CI, Leath CI, CGCI and Perry CI were overrepresented, which was consistent with systemwide statisitics.

July 2017 Recommendations:

1. We remain very concerned about the conditions of confinement within the RHU at the Broad River Correctional Institution and at the McCormick CI. We were unable to adequately assess inmate access to yards at both prisons and showers at the McCormick CI. Such data should be gathered and reported prior to our next site assessment.
2. Consider revising the practice of losing yard privileges due to not standing for counts and other minor violations. SCDC should at a minimum provide an inmate due process before arbitarily restricting out of cell recreation.
3. Consider establishing a privilege level that would allow for the window covering in the outer door at the Leath CI RHUto remain open.
4. Consider eliminating the Perry CI RHUs from housing SD inmates due to crisis correctional officer staffing.

2.b.iii. Document timeliness of sessions for segregated inmates with psychiatrists, psychiatric nurse practitioners, and mental health counselors and timely review of such documentation;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

The following charts outline Caseload Monitoring Compliance Percentages for four, three two, and one month timeframes for seeing the QMHP and Psychiatrist.

Percentages of Levels of Care that have 4 previous QMHP Dates

	L1	L2	L3	L4	L5
Broad River		0%	0%	10%	0%
Camille		0%	0%	0%	0%
Kershaw		0%	0%	0%	0%
Kirkland		0%	0%	0%	0%
Leath		0%	0%	0%	0%
Lee			30%	5%	0%
Lieber		0%	44%	18%	0%
MacDougall		0%	0%	0%	0%
McCormick		0%	0%	0%	0%
Perry		0%	84%	14%	20%
Turbeville		0%	0%	23%	0%
Tyger River		0%	0%	0%	0%

Percentages of Levels of Care that have 3 previous QMHP Dates

	L1	L2	L3	L4	L5
Broad River				11%	0%
Camille		0%	0%	0%	
Kershaw				0%	
Kirkland					
Leath				0%	
Lee			75%	28%	0%
Lieber			77%	13%	0%
MacDougall				0%	0%
McCormick				0%	0%
Perry			90%	15%	20%
Turbeville		0%		73%	67%
Tyger River				35%	

Percentages of Levels of Care that have 2 previous QMHP Dates

	L1	L2	L3	L4	L5
Broad River				11%	0%
Camille		0%	0%	0%	
Kershaw			0%	0%	
Kirkland					
Leath			0%	4%	
Lee			77%	31%	0%
Lieber			80%	14%	0%
MacDougall			0%	0%	0%
McCormick			0%	0%	0%
Perry			97%	15%	40%
Turbeville			0%	81%	100%
Tyger River			0%	56%	

Percentages of Levels of Care that have a previous QMHP Date

	L1	L2	L3	L4	L5
Broad River			0%	98%	0%
Camille		100%	96%	91%	
Kershaw				83%	
Kirkland					
Leath				15%	
Lee			85%	31%	0%
Lieber			80%	15%	0%
MacDougall				13%	
McCormick				0%	0%
Perry			100%	15%	40%
Turbeville			0%	89%	100%
Tyger River				73%	

Percentages of Levels of Care that have 4 previous Psych Dates

	L1	L2	L3	L4	L5
Broad River		0%	0%	10%	0%
Camille		0%	0%	0%	0%
Kershaw		0%	0%	23%	0%
Kirkland		0%	0%	0%	0%
Leath		0%	0%	0%	0%
Lee			0%	0%	0%
Lieber		0%	32%	16%	0%
MacDougall		0%	0%	0%	0%
McCormick		0%	0%	2%	0%
Perry		0%	100%	50%	0%
Turbeville			0%	9%	0%
Tyger River		0%	0%	0%	0%

Percentages of Levels of Care that have 3 previous Psych Dates

	L1	L2	L3	L4	L5
Broad River		0%		10%	0%
Camille		0%	0%	0%	
Kershaw		0%	0%	0%	
Kirkland					
Leath			0%	0%	
Lee			79%	25%	0%
Lieber			61%	12%	0%
MacDougall			0%	0%	0%
McCormick			0%	67%	0%
Perry			94%	73%	0%
Turbeville			0%	63%	100%
Tyger River				69%	

Percentages of Levels of Care that have 2 previous Psych Dates					
	L1	L2	L3	L4	L5
Broad River				11%	0%
Camille		0%	0%	0%	
Kershaw			0%	61%	
Kirkland					
Leath			0%	6%	
Lee			85%	27%	0%
Lieber		0%	75%	14%	0%
MacDougall			0%	0%	0%
McCormick			0%	85%	0%
Perry			94%	87%	0%
Turbeville			83%	100%	
Tyger River			0%	75%	

Percentages of Levels of Care that have a previous Psych Dates					
	L1	L2	L3	L4	L5
Broad River				98%	0%
Camille		100%	98%	89%	
Kershaw			0%	75%	
Kirkland					
Leath			0%	31%	
Lee			91%	86%	0%
Lieber		0%	76%	16%	0%
MacDougall			0%	66%	0%
McCormick			0%	89%	0%
Perry			97%	93%	0%
Turbeville				88%	100%
Tyger River				84%	

July 2017 Implementation Panel findings: The above data is very difficult to interpret because the methodology is not explained and an assessment relevant to the results is absent. However, staff were in agreement that mental health caseload inmates in segregation housing units were frequently not being seen in a timely manner as required by policies and procedures.

July 2017 Recommendations: Provide relevant data in the format previously referenced relevant to QI reports.

2.b.iv. Provide access for segregated inmates to higher levels of mental health services when needed;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

The schedules for LLBMU and HLBMU [were provided] but deleted from this report.

July 2017 Implementation Panel findings: See 2.b.i. (Provide access for segregated inmates to group and individual therapy services).

July 2017 Recommendations: As per our March 2017 recommendations, which included the following:

1. Implement the LLBMU and HLBMU as planned.
2. Consider options for developing a female BMU.

2.b.v. The collection of data and issuance of quarterly reports identifying the percentage of mentally ill and non-mentally ill inmates in segregation compared to the percentage of each

group in the total prison population with the stated goal of substantially decreasing segregation of mentally ill inmates and substantially decreasing the average length of stay in segregation for mentally ill inmates;

Implementation Panel July 2017 Assessment: **compliance (11/2016)**

June 2017 SCDC Update

QARM continues to track and report to the Wardens and Headquarters leaders, the number of inmates in security detention, disciplinary detention, maximum security, and short term lock up by inmates with and without a mental health classification.

The charts below show the percentage of mentally ill and non-mentally ill inmates in RHU, with each number compared to the same group in the total SCDC population. The most recent report was emailed to institutional leadership on June 21, 2017.

Summary of SCDC Mentally Ill & Mentally Healthy Inmates as a Percent of RHU and Total Institutional Population March 2017 - June 2017

Month	% of RHU Pop Mentally Ill	% of Total Pop Mentally Ill	% of RHU Pop Non-Mentally Ill	% of Total Pop Non-Mentally Ill
Mar-17	34.44%	16.60%	65.56%	83.40%
Apr-17	35.30%	16.50%	64.70%	83.50%
May-17	35.45%	16.60%	64.55%	83.40%
Jun-17	33.55%	16.80%	66.45%	83.20%

SCDC Mentally Ill Inmates as a Percent of RHU and Total Institutional Population on June 2017

Institution	% of RHU Pop Mentally Ill	% of Total Pop Mentally Ill	% of RHU Pop Non-Mentally Ill	% of Total Pop Non-Mentally Ill
BROAD RIVER	30.77%	22.10%	69.23%	77.90%
GILLIAM PSY	0.0%	92.40%	0.0%	7.60%
GRAHAM	66.67%	45.70%	33.33%	54.30%
GRAHAM R&E	51.85%	29.60%	48.15%	70.40%
KIRKLAND	20.00%	12.90%	80.00%	87.10%
KIRKLAND INFRM	0.00%	35.00%	0.00%	65.00%
KIRKLAND MAX	11.63%	90.50	88.37%	9.50%
LEATH	64.29%	58.50%	35.71%	41.50%
MCCORMICK	30.23%	14.90%	69.77%	85.10%
PERRY	61.06%	34.80%	38.94%	65.20%

ALLENDALE	20.27%	16.30%	79.73%	83.70%
EVANS	24.27%	11.20%	75.73%	88.80%
KERSHAW	36.00%	14.10%	64.00%	85.90%
LEE	47.89%	20.90%	52.11%	79.10%
LIEBER	52.46%	22.90%	47.54%	77.10%
MANNING	0.00%	1.04%	100.00%	98.96%
RIDGELAND	11.11%	11.90%	88.89%	88.10%
TRENTON	0.00%	.90%	100.00%	99.10%
TURBEVILLE	16.00%	10.40%	84.00%	89.60%
TYGER RIVER	15.63%	14.40%	84.37%	85.60%

** Percentages are subjected to change daily**

July 2017 Implementation Panel findings: As per SCDC status update. Our March 2017 findings included the following:

> Inmates with L4 MH classification have an average length of stay in segregation of about 507 days compared to 94 days for non-mental health caseload inmates.

July 2017 Recommendations: Our March 2017 recommendation that SCDC attempt to understand the reasons for the significant differences in the context of the length of stays in the RHU as previously referenced remains.

2.b.vi. Undertake significant, documented improvement in the cleanliness and temperature of segregation cells; and

Implementation Panel July 2017 Assessment: **partial compliance**

Total Number of Cells Checked	68
# of RHU Cells Checked	58
# of CI Cells Checked	10
# of Clean RHU Cells	41
# of Clean CI Cells	7
% of Clean RHU Cells	70.69%
% of Clean CI Cells	70.00%
# of Approved CI Cells Checked	10

% of **Approved** CI Cells Checked (if Applicable)	100%		
% of Checked RHU cells within the approved temp range	52%		
% of Checked CI cells within the approved temp range	80%		
Average Temperature for All RHU and CI Cells	73.35	Approved Temperature Range (in Degrees Fahrenheit)	68 °F to 78 °F

June 2017 SCDC Status Update

Documentations of cell temperature and cleanliness in CSU A spot check of the folders where these documents are uploaded showed that most institutions are uploading documents, but not daily. The percent compliance has not been established at this point.

Documentation that all RHU cells are inspected daily for cleanliness. A spot check of the folders where these documents are uploaded showed that most institutions are uploading documents, but not daily. The percent compliance has not been established at this point.

July 2017 Implementation Panel findings: SCDC provided Cell Temperature and Cleanliness Logs for all institutions except Ridgeland and Turbeville. A review of the documents revealed when temperatures and cleaniness logs had deficiencies there were no comments to identify the corrective action taken to address the issue(s). The provided logs had missing dates as well as incomplete and blank forms. Most troubling were facility logs that identified cell temperatures below 60 degrees and no information measures were taken to address the unacceptable low temperatures.

July 2017 Recommendations:

1. Operations Management ensure all prisons are performing daily inspections for cleanliness and taking temperatures of random cells;
2. Provide additional training to correctional officers on the proper procedure to perform daily cell inspections for cleanliness and temperature checks including documenting forms accuratedly and completely;
3. Ensure deficiencies identified in the cell inspections for cleanliness and temperature checks are followed up on and the action taken is documented on the Cell Temperature and Cleanliness Logs;
4. SCDC QIRM continue to perform QI Studies regarding Correctional Staff taking daily, random cell temperatures and cleanliness inspections.

2.b.vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Update

Policy GA-06.06 Continuous Quality Improvement Review has been finalized and approved by the director. The following plan outlines the training timeline:

Training Institutional Staff on CQI Policy

A lesson plan is being developed to provide training on the policy for institutional staff. The training will be rolled out in four stages:

1. QIRM Division Director will attend each institution's Warden's meeting to introduce the CQI policy, explain its purpose, identify staff for training and set a training date for the policy. This will occur as the lesson plan is being developed. (July 2017 – December 2017)
   - All Institutional Warden's Meetings are held on Mondays; however, efforts will be made to host a policy overview at times external to these meetings. This preliminary plan is based on the current Wardens' meeting schedules and will only include Level 2 and Level 3 Institutions, initially. An overview will be presented at the statewide Wardens and Associates Wardens' meetings to include the Level 1 institutions.
2. Upon completion of the lesson plan, it will be pilot-tested at up to three institutions. (October –November 2017)
3. Revision and updates will be made to the lesson plan for the CQI policy as applicable. (November- December 2017)
4. Formal training will be held onsite for each institution. (December 2017– May 2018)
5. The lesson plan will be converted into an e-training module and made mandatory for identified staff. The module will be assigned a class code to track staff who have completed the training. (August 2018)

July 2017 Implementation Panel findings: As per SCDC status update section.

July 2017 Recommendations: We discussed with staff having the IP members review a draft of the proposed training for comment purposes and to pilot the training before rolling it out systemwide.

2.c. Use of Force:

2.c.i. Development and implementation of a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Update

1. Police services will investigate all major incidents
2. Currently there is a warden's referral selected from the narrative section and a warden's advisement that are used to notify the warden that something has been found.
3. RIM is creating drop down tabs to select the employee involved in the UOF based on the reports submitted and information entered into the Mainframe. Once the employee is selected, the warden will be able to select from a box indicating "action taken" and the date. Utilizing specified drop down menus, RIM will be able to produce reports based on this information. This will document if employees are receiving multiple corrective actions for excessive use of force or other concerns and identify training needs.
4. RIM is working on how the informal corrective actions will be captured.
5. There are drop down boxes being created for reviewers (at any level) to select either completed review with appropriate actions or completed review with policy violations. This will allow staff to create reports that will determine if violations are being identified at the appropriate level(s).
6. The diagram for the use of force process is attached as APPENDIX 6.

RIM generated a report showing Employee Corrective Action (CA) taken in February 2017 - May 2017 for Use of Force incidents. This document was placed in the UOF document drop (#6). UOF staff have generated a restraint chair report and disseminated to Mental Health and Operations Leaders. The report is attached in APPENDIX 7.

A UOF report was disseminated to Wardens and Operations Leadership to included

- Types of force used:
  - Defensive Tactics (DT)
  - MK-4
  - MK-9
  - MK-4 Foam
  - MK-9 Form
  - Forced Cell Movement Teams (FCMT)
  - Restraint Chair
  - Hard Restraints
  - ISPRA
- Planned versus unplanned uses of force
- Use of force by shift and time of day
- Use of force by mental health classifications
- Use of Force by location within the institutions

July 2017 Implementation Panel findings: SCDC continues disproportionate use of force against inmates with mental illness. Approximately 17 percent of the SCDC inmate population is on the mental health caseload; however, use of force against inmates with a mental illness accounts for 40 percent of total incidents for the time period of June 3, 2016 through March 2017. SCDC has revised the OP 22.01 Use of Force Policy in March 2017 and the Use of Force Training Curriculum in June 2017. Use of Force Train for Trainer has been provided to 162 SCDC Officers and 62 Non-Uniform Staff. As of June 23, 2017, 1,266 SCDC employees have completed the Use of Force training. This includes 1,000 certified staff and 266 noncertified staff.

SCDC plans to have all staff trained on the revised Use of Force Policy by December 31, 2017. QIRM generates Use of Force Reports to monitor the Use of Force against mentally ill and non-mentally ill inmates. The revised Use of Force Policy has an identified accountability component with Use of Force violations being tracked and requiring Police Services to investigate major incidents. Implementation has not been fully accomplished.

July 2017 Recommendations:

1. SCDC continue to monitor all Use of Force to identify and address the reasons for disproporinate Use of Force against inmates with mental illness;
2. Develop strategies to reduce use of force against inmates with mental illness and non-mentally ill inmates;
3. All staff complete the revised March 2017 Use of Force Training by December 31, 2017.

2.c.ii. The plan will further require that all instruments of force, (e.g., chemical agents and restraint chairs) be employed in a manner fully consistent with manufacturer's instructions, and track such use in a way to enforce such compliance;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

1. The manufacturer's instructions are included in the document drop.
2. Operations and QIRM continue to review use of force incidents utilizing through the automated system and QIRM meets weekly with Operations leadership to discuss UOF and other relevant issues.
3. The Safety Data Sheets for all chemical munitions are available at all institutions where chemical munitions are located.
4. Instructions for proper use of Restraint Chairs are in our agency's lesson plan and available at each institution through the training lieutenant.

July 2017 Implementation Panel findings: As per SCDC status update and SCDC has revised the OP 22.01 Use of Force Policy requiring instruments of force are employed in a manner consistent with manufacturer's instructions. The policy includes a grid identifying the amount of chemical

agents that can be deployed for each application in accordance with manufacturer recommendations. The Use of Force Training Curriculum for all Staff was revised in March 2017. Use of Force Train for Trainer was provided to 162 SCDC Officers and 62 Non-Uniform Staff. SCDC plans to have all staff trained on the revised Use of Force Policy by December 31, 2017. Implementation remains in progress as SCDC has post orders that conflict with using MK 9 in a manner consistent with manufacturers's instructions.

July 2017 Recommendations:

1. SCDC review applicable policies and post orders to ensure all that references to instruments of force require their use is fully consistent with the manufacturer's instructions;
2. Operations and QIRM continue to review use of force incidents through the automated system;
3. QIRM continue to meet weekly with Operations leadership to discuss UOF and other relevant issues;
4. All staff complete the revised March 2017 Use of Force Training by December 31, 2017.

2.c.iii. Prohibit the use of restraints in the crucifix or other positions that do not conform to generally accepted correctional standards and enforce compliance;

Implementation Panel July 2017 Assessment: **compliance (3/2017)**

June 2017 SCDC Status Update

Operations and QARM staff continue to review and monitor use of force incidents through the automated system. There have been no documented reports of inmates being placed the crucifix or other positions that do not conform to generally accepted correctional standards.

July 2017 Implementation Panel findings: SCDC remains in compliance.

July 2017 Recommendations: Operations and QIRM staff continue to review and monitor use of force incidents through the automated system to ensure restraints are not used to place inmates in the crucifix or other positions that do not conform to generally accepted correctional standards. Pursue corrective action when violations and/or issues are identified.

2.c.iv. Prohibit use of restraints for pre-determined periods of time and for longer than necessary to gain control, and track such use to enforce compliance;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

UOF staff conducted a review of restraint chair use from February 1, 2017 - June 2017. The report was produced using data from the Automated Use of Force System and cross-referenced with the Automated Medical Record and Classification Bed Reports. Since February 1, 2017, the restraint chair was used in four incidents, all involving inmates with a mental health classification. All incidents involved self-injurious behavior and occurred at Broad River's CSU. Documentation indicated that the doctor ordered both inmates to remain in the restraint chair for two hours, as opposed to "up to two hours" as outlined in policy 22.01 section 13.5. *After the inmate is secured in the restraint chair, the inmate will be examined by a qualified medical staff member. In the event it is necessary that the inmate be secured in a restraint chair for up to two (2) hours, a qualified medical staff member will examine the inmate to assess his/her condition and approve continued placement which cannot exceed a total maximum of three (3) hours in the restraint chair.*

July 2017 Implementation Panel findings: As per SCDC status update and Appendix 7.

An issue remains that SCDC Physicians are ordering inmates to remain in the restraint chair for two hours as opposed to up to two hours. Restraint Chair use continues to occur infrequently. SCDC reported Restraint Chair use as follows: February 17-1, March 17-3, April 17-0, and May 17-0. A total of 4 incidents. There are continued issues with accurately documenting restraint chair use and strictly adhering to the required time frames.

July 2017 Recommendations:

1. SCDC Training Staff conduct additional training to applicable Operations and Medical Staff ensuring an understanding of restraint chair requirements and documentation. The training should emphasize that placement of an inmate in the restraint chair is "up to two hours".
2. QIRM continue to track and monitor compliance with use of the restraints.

2.c.v. The collection of data and issuance of quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs.

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

Same as in update for 2.c.iv.

July 2017 Implementation Panel findings: Collection of data and issuance of quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs is provided in the June 2017 SCDC Status Update and Appendix 7.

July 2017 Recommendations:

1. QIRM continue to prepare a Restraint Chair Report for each monitoring period.
2. The IP review SCDC Electronic Use of Force Reports involving the Restaint Chair during the next site visit.

2.c.vi. Prohibit the use of force in the absence of a reasonably perceived immediate threat

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

Use of Force Training Lesson plan and PowerPoint presentations were submitted with the document drop. Use-of-Force training on the revised OP-22.01 has been implemented. As of 6/23, 1,266 SCDC employees have completed the Use of Force training. This includes 1,000 (79%) certified staff and 266 noncertified staff.

Operation and QARM continue to monitor use of force incidents to ensure use of force is only when there is a reasonably perceived immediate threat.

July 2017 Implementation Panel findings: As per SCDC Update.

The IP monitors SCDC Use of Force MINS Narratives monthly and continues to identify incidents where there did not appear to be a reasonably perceived immediate threat that required a use of force. A use of force incident witnessed by the IP, the Assistant Deputy Director for Operations and the SCDC consulting psychiatrist during the site visit to the McCormick CI on July 12, 2017, clearly fell in this category. The IP has requested and received confirmation from SCDC officials the incident will be investigated by the SCDC Police Services Division with findings and conclusions provided to the IP. The revised OP 22.01 Use of Force has an accountability component. QIRM reviews Use of Force Reports and makes appropriate referrals to Operations and Police Services when violations are identified during their review. Police Services has the responsibility to investigate serious incidents. Appendix 6 the SCDC Use of Flow Chart identifies the process for addressing use of force violations.

July 2017 Recommendations:

1. Operations and QIRM continue to review use of force incidents utilizing the automated system to identify use of force violations;
2. QIRM and Operations leadership continue weekly meetings to discuss UOF and other relevant issues;
3. All staff complete the revised March 2017 Use of Force Training by December 31, 2017.
4. IP continue to review SCDC Use of Force reports and monthly Use of Force MINS Narratives and provide SCDC feedback;
5. SCDC implement the accountability component of OP 22.01 Use of Force and ensure

meaningful corrective action is taken for employees found to have committed use of force violations.

2.c.vii. Prohibit the use of crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

The QIRM Use of Force staff reviewed use of chemical munitions incidents involving crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances. Based on a RIM report, there were 85 use of force incidents in which MK-9 was used between Feb. 1, 2017 and May 31, 2017. There were 76 use of force incidents in which the officer's actions were justifiable based on circumstances set forth in agency policy. OP- 22. 01, Use of Force. There were nine use of force incidents in which the use of the MK-9 should not have been used. ***Five were in the Greenwood unit; one at BRCI, two at Lieber CI and one at Ridgeland CI.***

MIN [redacted] was also at BRCI. The inmate was sprayed for refusing to be cuffed in the holding cell. There was no conflict resolution attempted.

MIN [redacted] and MIN [redacted] occurred at Lieber CI. Both incidents were in reference to inmates refusing to be cuffed in the holding cell. There were no informal resolution attempts.

MIN [redacted] occurred at Ridgeland CI. In this incident the inmate refused to be cuffed in the holding cell. No conflict resolution.

July 2017 Implementation Panel findings: SCDC has revised the OP 22.01 Use of Force Policy requiring instruments of force are employed in a manner consistent with manufacturer's instructions. The policy includes a grid identifying the amount of chemical agents that can be deployed for each application in accordance with manufactuer recommendations. The Use of Force Training Curriculum for all Staff was revised in March 2017. Use of Force Train for Trainer was provided to 162 SCDC Officers and 62 Non-Uniform Staff. SCDC plans to have all staff trained on the revised Use of Force Policy by December 31, 2017. Since March 2017, SCDC Operations has revised procedures limiting the locations and staff that have access to MK 9. The revision has resulted in a reduction in the inappropriate use of MK 9. Implementation remains in progress as SCDC has post orders that conflict with using MK 9 in a manner consistent with manufacturers's instructions. Inappropriate MK 9 use continues to be identified by QIRM and the IP during their review of Use of Force incidents involving chemical agents.

July 2017 Recommendations:

1. SCDC review applicable policies and post orders to ensure all that reference MK 9 require that use is fully consistent with the manufacturer's instructions;
2. Operations and QIRM continue to monitor use of force incidents to ensure crowd control canisters, such as MK-9, are not utilized in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions.
3. QIRM continue to meet weekly with Operations leadership to discuss UOF and other relevant issues;
4. IP continue to monitor monthly Use of Force MINs to identify any inappropriate MK 9 use;
5. All staff complete the revised March 2017 Use of Force Training by December 31, 2017.

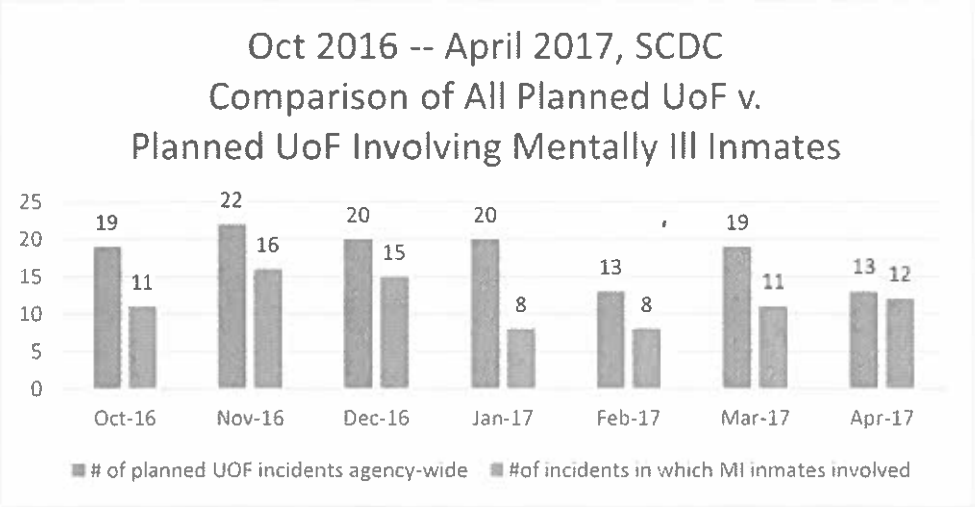
2.c.viii. Notification to clinical counselors prior to the planned use of force to request assistance in avoiding the necessity of such force and managing the conduct of inmates with mental illness;

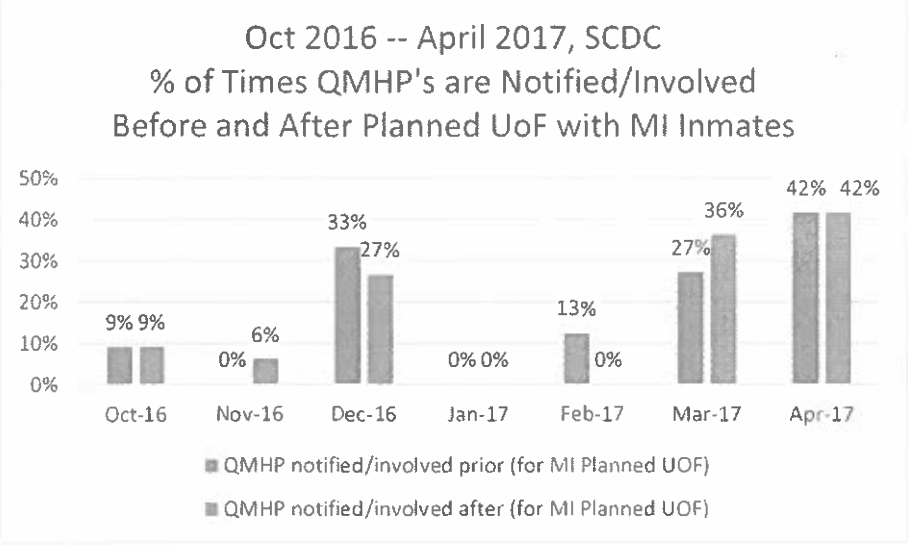
Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

A study was completed on the planned uses of force against SCDC inmates from October 2016 – April 2017. This was compared to a similar study used in SCDC's report to the IP for March 2017, and staff realized that some of the information had been misinterpreted in the earlier report. Therefore, the earlier report was not accurate. The results of the current report follows:

	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
# of planned UOF incidents agency-wide	19	22	20	20	13	19	13
#of incidents in which MI inmates involved	11	16	15	8	8	11	12
#of incidents in which QMHP notified/involved	1	1	4	0	1	4	6
QMHP notified/involved prior (for MI Planned UOF)	9%	0%	33%	0%	13%	27%	42%
QMHP notified/involved after (for MI Planned UOF)	9%	6%	27%	0%	0%	36%	42%





It is important to note, that the numbers reported by RIM are based on information put into the Automated UOF system by institution staff. Not every one of these incidents was *investigated fully* by QIRM staff, but:

- In at least two from the month of March 2017, the AUOF system reported that Medical/QMHP was notified prior to the use of force, but there was no correlating evidence of this in either the MIN or the medical record.
- The fields reported in the AUOF system are for medical/mental staff being "Present/Consulted Before" and "Present/Consulted After." This does not necessarily mean that the inmate was actually evaluated before or after the incident by the QMHP.
- Similarly, it has been seen that the medical record or MIN did document the presence of a QMHP, but the "Present/Consulted Before" and "Present/Consulted After" field in the AUOF

system was not properly completed, reflecting our compliance with the policy.

Therefore, it is evident that further training in proper documentation and enforcement of the same is necessary.

The UOF training includes specific notification of the clinical counselors prior to a planned UOF. This information is covered on page 32, section G, 2b of the lesson plan:

July 2017 Implementation Panel findings: SCDC data identifies continued issues with notifying clinical counselors (QMHPs) to request their assistance prior to a planned use of force. In February 2017, QMHPs were only contacted in 13 percent of the planned use of force incidents. There was an improvement in April 2017 with QMHPs contacted in 42 percent of planned use of force incidents. Although SCDC has demonstrated improvement in having QMHPs involved in planned use of force incidents, the percentage of their involvement remains at an unacceptable level.

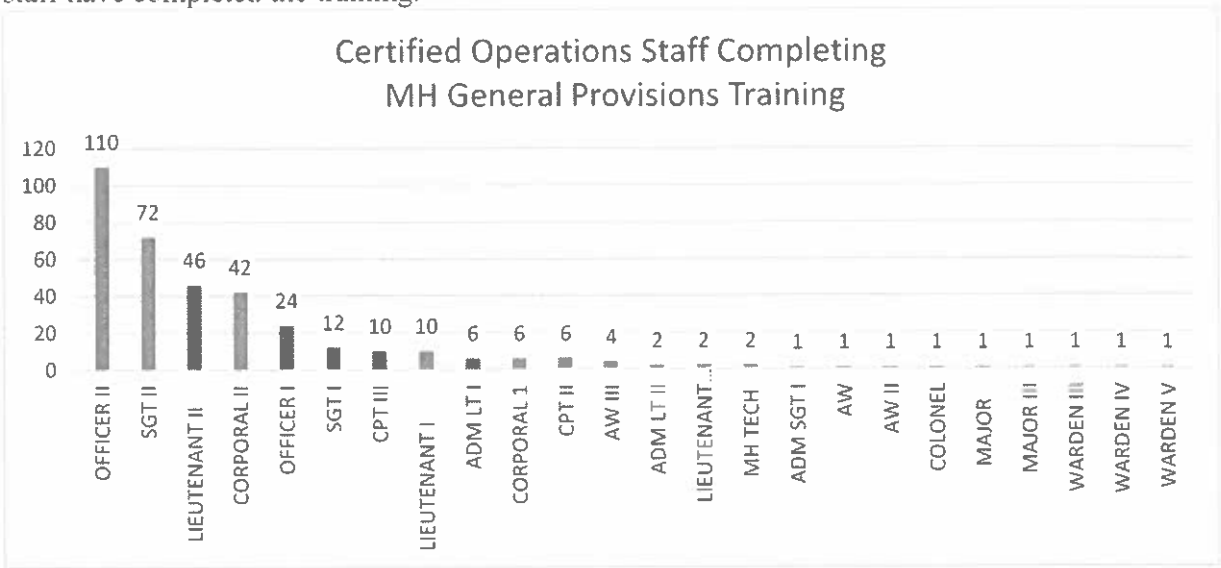
July 2017 Recommendations: Provide additional training to Operations Supervisory and Mental Health Staff on their duties and responsibilities in a planned use of force.

2.c.ix. Develop a mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

The training was initiated on June 1, 2017. As of June 23, 2017, the following certified operations staff have completed the training.



APPENDIX 8 provides a list of current mental health employees that took the Non-Security Basis Training (if they have already taken it). If a different class code was used historically, it will not show on this report. In the attached the second tab contains the codes used to pull the list of employees. If the employee is not a JD series employee (operations staff of all ranks - cadets through wardens,) AND had one of the highlighted program codes OR was in the highlighted budget unit OR had one of the highlighted Job Class codes, then they are on the list.

July 2017 Implementation Panel findings: SCDC remains in partial compliance. The mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates is as follows:

Introduction to Mental Health	1.5 hours	Orientation (all new employees)
Mental Health	2.0 hours	Basic Training
Pre-Crisis and Suicide Prevention	3.0 hours	Basic Training
Interpersonal Communications	10.0 hours	Basic Training
Communication Skills/Counseling	1.5 hours	Annual In-Service
Mental Health Lawsuit	4.2 hours	Annual In-Service
Suicide Prevention	4.0 hours	Annual In-Service

SCDC has not provided documentation that all correctional officers have received the training.

July 2017 Recommendations: QIRM provide documentation verifying all employees have completed the mandatory training for appropriate methods of managing mentally ill inmates developed by SCDC.

2.c.x. Collection of data and issuance of quarterly reports concerning the use-of-force incidents against mentally ill and non-mentally ill inmates;

Implementation Panel July 2017 Assessment: **compliance (3/2017)**

June 2017 SCDC Status Update

QIRM Use of Force staff continue to produce and disseminate the monthly UOF Mentally Ill vs. Non-Mentally Ill Report.

This report is sent to it IP UOF expert, Wardens, and Agency leadership. This report also details:

- Agency Use of Force by Type
- Video Review
- Grievances Related to Use of Force
- Grievances Filed by Inmates with a Mental Health Classification
- MINS: Mainframe vs Use of Force Application
- Exception Reports

July 2017 Implementation Panel findings: As identified in the SCDC Status Update a monthly UOF Report Mentally Ill vs. Non-Mentally Ill is generated. No issues were identified with the use of force data utilized to produce the report.

July 2017 Recommendations: Continue to produce and disseminate the monthly UOF Mentally Ill vs. Non-Mentally Ill Report.

2.c.xi. The development of a formal quality management program under which use-of-force incidents involving mentally ill inmates are reviewed.

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

An updated Use of Force flow chart is outlined in APPENDIX 6.

July 2017 Implementation Panel findings: As per the June 2017 SCDC Status Update and The Use of Force electronic monitoring and tracking system remains in place to monitor use of force incidents involving inmates including mentally ill inmates. Mental Health staff is electronically forwarded use of force incidents involving mentally ill inmates for review. SEE APPENDIX 6. Formalized procedures on how the use of force incidents involving mentally ill inmates are reviewed have not been completely developed by the Mental Health Department.

July 2017 Recommendations: As recommended in March 2017, formalize in writing the procedures for how the Mental Health Department staff will review use of force incidents involving mentally ill inmates;

1. Employment of enough trained mental health professionals:

3.a. Increase clinical staffing ratios at all levels to be more consistent with guidelines recommended by the American Psychiatric Association, the American Correctional Association, and/or the court-appointed monitor;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

See update at 2.a.iv. (Click here)

July 2017 Implementation Panel findings: See 2.a.iv.

July 2017 Recommendations: See 2.a.iv.

3.b. Increase the involvement of appropriate SCDC mental health clinicians in treatment planning and treatment teams

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

Report treatment team planning and participation by appropriate SCDC MH clinicians is attached as APPENDIX 9.

July 2017 Implementation Panel findings: As per our March 2017 findings, which stated the following:

> Significant improvement has occurred relative to the participation of psychiatrists in the treatment team process for the higher levels of mental healthcare. Issues clearly remain due to the significant psychiatrists vacancies (e.g., psychiatrists attending treatment team meetings and/or signing treatment team plans for inmates who are not under their direct care although such a practice is better than having no psychiatric involvement).

July 2017 Recommendations: Remedy the significant mental health staffing vacancies.

3.c. Develop a training plan to give SCDC mental health clinicians a thorough understanding of all aspects of the SCDC mental health system, including but not limited to levels of care, mental health classifications, and conditions of confinement for caseload inmates;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update:

APPENDIX 8 lists the MH staff who have completed the 4-week non-security basic training.

July 2017 Implementation Panel findings:

73.54% of SCDC mental health employees have taken either the basic training for the mental health provision course.

We had significant concerns, which we discussed with staff, regarding the two-hour training module that is completed online.

July 2017 Recommendations:

1. Consider using the IP members as consultants relevant to reviewing future draft training modules relevant to mental health services.

2. Continue monitoring completion of the training course for the remaining SCDC mental health employees.

3.d. Develop a plan to decrease vacancy rates of clinical staff positions, which may include the hiring of a recruiter, increase in pay grades to more competitive rates, and decreased workloads;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update:

Recruitment Efforts (Click here)

July 2017 Implementation Panel findings: As per SCDC status update section.

July 2017 Recommendations: As per SCDC status update section.

3.e. Require appropriate credentialing of mental health counselors;

Implementation Panel July 2017 Assessment: **compliance (3/2017)**

June 2017 SCDC Status Update

SCDC Policy 19.15, Mental Health Services - Mental Health Training, Section 3.4 stipulates that QMHPs will be required to maintain their professional licensure based on the requirements of their individual licensure board (Licensed Professional Counselor, Licensed Social Worker, etc.) and provide verification of continued licensure.

Those mental health counselors who are not licensed but were hired prior to above requirement are allowed to continue working under the supervision of a licensed counselor.

The following document outlines current licensure prior to 2013, new staff with licensure hired as of 2013, and existing staff with licensure obtained since 2015 and the percentage of licensed staff. Based on the provisions outlined in policy, 38/40 or 95% are appropriately licensed.

July 2017 Implementation Panel findings: Compliance continues.

July 2017 Recommendations: Continue to monitor.

3. f. Develop a remedial program with provisions for dismissal of clinical staff who repetitively fail audits; and

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

The CQI position job description has been reclassed and approved internally and sent to the State HR for approval. This was necessary due to the requested salary. Upon approval, Mental will post the position. The job description and approval forms submitted are attached as APPENDIX 10. The anticipated time-line to have the position on board no later than 09/01/17.

July 2017 Implementation Panel findings: See 3.g. Partial compliance is present due to the lack of a written plan specific to 3.g., which should include the use of supervision and/or counseling as part of a remedial program specific to this provision.

July 2017 Recommendations: Implement 3.g. and the counseling/supervision component of this provision.

3.g. Implement a formal quality management program under which clinical staff is reviewed.

Implementation Panel July 2017 Assessment: **partial compliance**

March 2017 Implementation Panel findings: We discussed with staff the use of a QI process other than peer review that needs to be established in order to meet the elements of this provision. Peer review likely (depending on South Carolina state law) would not allow the results to be used for supervision/managerial purposes in contrast to a QI process that was not a peer review process.

June 2017 SCDC Status Update

See response in 3f (click here)

July 2017 Implementation Panel findings: As per our March 2017 findings.

July 2017 Recommendations: See above.

Maintenance of accurate, complete, and confidential mental health treatment records:

4.a Develop a program that dramatically improves SCDC's ability to store and retrieve, on a reasonably expedited basis:

4.a.i. Names and numbers of FTE clinicians who provide mental health services;

Implementation Panel July 2017 Assessment: **compliance (3/2017)**

June 2017 SCDC Status Update

A "Medical Personnel Report" is produced and distributed weekly by RIM. The following screenshot provides a snapshot of the detailed report. The most recent report was distributed on June 12. 2017. [Screenshot] omitted from this report]

July 2017 Implementation Panel findings: Compliance continues.

July 2017 Recommendations: Continue internal monitoring via QIRM to demonstrate continued compliance.

4.a.ii. Inmates transferred for ICS and inpatient services;

Implementation Panel July 2017 Assessment: **compliance (7/2017)**

June 2017 SCDC Status Update

RIM is able to produce a report of inmates transferred to ICS or GPH or Correct Care beds at any time. This allows MH staff to track the number and timeliness of inmates being transferred to GPH, contractual providers and ICS programs.

Male ICS Admissions and Discharges
February 1, 2017 through May 31, 2017
Patients/Clients = 43
Admissions = 34
Discharges = 21

(Only Admission and Discharge dates between February 1, 2017 and May 31, 2017 are displayed. However, Days in ICS is displayed for all completed stays. Admissions and Discharges determined by M.H. Classification changes made in MEDCLASS. CISP admissions are through date report was run (June 26, 2017).)

Inmate #	Name	MH Class Prior to Admission	Admission Date	Discharge Date	New MH Class	Days in ICS	Days till First CISP Admission after Discharge	Date of First CISP Admission after Discharge	# of CISP Admissions Since this Discharge
		L1	05/30/2017						
		L1	05/31/2017						
		L1	03/08/2017	05/17/2017	L1	70			
		L1	05/31/2017						
		L1	04/06/2017						
		L1	05/17/2017						
		LC	05/16/2017						
		MR		03/08/2017	L4	209			
		L4	04/28/2017						
		L4		02/01/2017	L3	2431			
		L1		04/03/2017	L1	2244	7	04/10/2017	1
		L1		03/21/2017	L3	253	67	05/27/2017	1
		LC	05/16/2017						
		L3	03/16/2017	04/03/2017	L1	18			
		L1		05/11/2017	L3	295			
		L3	03/17/2017	05/11/2017	L3	55			
		L1	05/26/2017						
		L1	05/19/2017						
		L1		05/17/2017	L1	1700			
		LC	03/14/2017						
		L1	05/26/2017						
		L1	02/13/2017		L1	113			
		L1		02/09/2017	L1	43			
		L1	04/20/2017						
		L4	03/31/2017						
		L1	03/03/2017						
		L1		04/04/2017	L1	1428			
		L1	04/10/2017						
		MH		02/12/2017	L3	860			
		L1	04/19/2017	05/03/2017	L1	14			
		L1	05/05/2017		L1	32			
		LC		03/08/2017	L4	90	41	04/18/2017	2
		L1		05/16/2017	L3	434			
		L1		05/11/2017	L3	450	7	05/18/2017	2
		L1		02/02/2017	L1	316			
		L1	05/08/2017						
		L1	03/17/2017						
		MH		02/08/2017	MH	292			
		L1	04/19/2017						
		L1	04/03/2017						
		L1	05/31/2017						
		L1	03/17/2017						
		L1		05/16/2017	L3	522			
		L1	03/17/2017	04/03/2017	L3	17			
		L1		02/17/2017	L1	245			
		L1	02/24/2017						
		L1	03/17/2017						
		L1	05/26/2017						
		L1	05/17/2017						
		L1	04/19/2017						

GEO Female Admissions
February 2017 through May 2017

(Based on Movements to GEO (1018) by female inmates for any reason.
Review of medical record is needed to determine actual reason for transfer to GEO.)

Inmate #	Name	MH Class Prior to Admission	Admission Date	Admission Reason	Classified as L1 on	Discharge Date	Discharge Reason	Discharged To
		L2	03/03/2017	MEDICAL	03/04/2017	06/02/2017	ADMINISTRATIVE	GRAHAM

July 2017 Implementation Panel findings: As per SCDC status.

July 2017 Recommendations: Continue internal monitoring via QIRM to demonstrate continued compliance.

4.a.iii.Segregation and crisis intervention logs;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

The HSOAs hired by the Div. Behavioral Health have are collecting and transcribing the 30- and 15-minute cell check logs. In a recent review of 78 CI cell check logs none of the Fifteen-Minute Observation Logs provided to the HSOAs listed no inmates being placed in a holding cell or other alternative space. (Click here to return to 6b)

SUMMARY	
COUNT # cell checks	78
Minimum # allowed/day	96
Average time between checks	17
COUNT # Checks > 15 min	8
% cell checks >15 min	10%
% Compliance with <= 15min checks	90%
Average time between checks >15	32
Longest time between checks	45
# Cell checks not irregular	69
% Cell checks not irregular	88%
% Compliance with Irregular checks	12%

July 2017 Implementation Panel findings: On-site review by QIRM found various prisons that did not maintain any constant observation log sheets. In addition, as per the SCDC status update section, problems existed with compliance with the 15 minute checks.

July 2017 Recommendations: Remedy the above and perform a QI relevant to this issue.

4.a.iv. Records related to any mental health program or unit (including behavior management or self-injurious behavior programs);

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

- Clinical encounter data is available in the AMR (with additional information in the paper chart at GPH). New encounter types have been created that will better account for the type of care provided in each encounter. Staff have now received training on the new types of encounters.
- The new Electronic Medical Record (EMR) has been in use at both female institutions since 3/28/17. The current schedule to bring the male institutions online should be completed by the end of October, 2017.
- Activity and cell check logs remain on paper and are addressed in 4.a.iii., but RIM is working to create an automated system.

July 2017 Implementation Panel findings: As per the SCDC status update section.

July 2017 Recommendations: As per the rollout schedule for the EMR.

4.a.v. Use of force documentation and videotapes;

Implementation Panel July 2017 Assessment: **compliance (3/2017)**

June 2017 SCDC Status Update

- Use of Force web application:
- Retention policy for video and audio recordings is listed in policy OP 22.01; recordings must be retained for six years after the date of the incident, at that point, only the main report synopsis is forwarded to State Archives for permanent retention.

July 2017 Implementation Panel findings: Remains in compliance.

July 2017 Recommendations: Operations and QARM continue to monitor use of force documentation and videotapes through the SCDC automated use of force system

4.a.vi. Quarterly reports reflecting total use-of-force incidents against mentally ill and non-mentally ill inmates by institution;

Implementation Panel July 2017 Assessment: **compliance (3/2017)**

June 2017 SCDC Status Update

- RIM continues to produce and disseminate a monthly, "UOF Report Mentally Ill vs. Non-Mentally Ill," report.

- QARM UOF Reviewers continue to track and report, monthly, the number of UOF incidents involving mentally ill vs non-mentally ill inmates. This report is sent to it IP UOF expert, Wardens, and Agency leadership. This report also details:
    - Agency Use of Force by Type
    - Video Review
    - Grievances Related to Use of Force
    - Grievances Filed by Inmates with a Mental Health Classification
    - MINS: Mainframe vs Use of Force Application
    - Exception Reports

July 2017 Implementation Panel findings: As per SCDC update.

July 2017 Recommendations: Continue to produce and disseminate the monthly UOF Mentally Ill vs. Non-Mentally Ill Report.

4.a.vii. Quarterly reports reflecting total and average lengths of stay in segregation and CI for mentally ill and non-mentally ill inmates by segregation status and by institution;

Implementation Panel July 2017 Assessment: **compliance (3/2017)**

June 2017 SCDC Status Update:

A CY CISP Admissions" report is produced quarterly by RIM shows if an inmate stays in a CI cell in an outlying institution longer than the 60 hours allowed to have him transferred to CSU. RIM produces and distributes the weekly report, "Total length of stay in Segregation".

July 2017 Implementation Panel findings: Compliance continues.

July 2017 Recommendations: Continue internal monitoring via QIRM to demonstrate continued compliance.

4.a.viii. Quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution;

Implementation Panel July 2017 Assessment: **compliance (3/2017)**

June 2017 SCDC Status Update:

Weekly Lockup by Custody and Mental Health Classification" produced weekly by RIM QARM Analyst provide a detailed report on inmates in segregation by institution, custody and mental health classification. This monthly report is shared with institutional and agency leaders. The most recent report was sent to Wardens and Agency Leadership on June 20, 2017.

July 2017 Implementation Panel findings: Compliance continues.

July 2017 Recommendations: Continue internal monitoring via QIRM to demonstrate continued compliance.

4.a.ix. Quality management documents; and

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update:

- Quality management documents, including reports, audit tools, audits, and other forms of documentation are continue to be available in shared network folders. Access to each folder is managed by system administrators through the IT Access Request menu. This allows for central storage of documentation for access across divisions and institutions.
- The NextGen EHR has been implemented at the Camille Graham and Leath Correctional Institutions. It is scheduled for full implementation by late 2017.

July 2017 Implementation Panel findings: Improvement continues relevant to the implementation of this provision.

July 2017 Recommendations: Continue to develop the QI process.

4.a.x. Medical, medication administration, and disciplinary records

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

SCDC's two female facilities, Camille Griffin Graham and Leath, began using the new system on 3/28/17. Additionally, they began use of eZmar on 5/16/17. Minimal complications were experienced with the NextGen go live, as expected with the use of any new system. Slightly more issues were experienced with the eZmar go live but those problems have been resolved. Preparation and planning for the rollout to all male institutions is currently underway. Please consult the project plan timeline summary below for more information.

Complete

Task:	Date(s) Completed
Project Plan approved	8/12/16
Configuration of secure VPN for encrypted network connection	7/29/16
Provisioning of hosted application and database server farms; All software installed	8/12/16
System Configuration Training	8/30/16-9/1/16
Site Visit Observations and Gap Analysis	8/23-25/16 and 9/20-21/16
Design of Training Plans and Preparing Database for Training	2/17/17
Pilot End User Training	3/17/17
Pilot NextGen Go Live	3/28/17
Pilot eZmar Go Live	5/16/17

Remaining Timeline

Task:	Start	End
Interface Build and Testing (Lab and PACS interfaces remaining)	8/26/16	8/31/17
Template and Report Design (ongoing)	10/3/16	--
Rollout Go Live	See details below	

Proposed Rollout to Men's Institutions (still being finalized with contractors)

Task:	Start	End
End User Training	7/18/17	8/25/17
Level 3 Institutions – Broad River, Lee, Lieber, McCormick, Perry	9/12/17	--
Kirkland	10/3/17	--
Level 2 Institutions (partial) – Allendale, Evans, Ridgeland, Turbeville	10/17/17	--
All remaining Institutions – Catawba, Goodman, Kershaw, Livesay, MacDougall, Manning, Palmer, Trenton, Tyger River, Wateree	10/31/17	--

July 2017 Implementation Panel findings: As per SCDC status update section.

Significant software issues and user errors have resulted in medication distribution and administration problems. We discussed with key administrative staff temporary work arounds, as previously sumarrized in this report, to implement until these issues have been resolved.

July 2017 Recommendations:

1. As above.
2. We strongly recommended that the eZmar needs to be used at the the time of medication administration regardless of location.

4.b. The development of a formal quality management program under which the mental health management information system is annually reviewed and upgraded as needed.

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

- Once the new EHR is in use, end users will be able to submit change requests electronically to RIM for review and implementation by the system administrator after consultation with subject matter experts. Necessary changes and improvements will be rolled out on a continual basis rather than annual.
- EHR software upgrades are published by the vendor on an intermittent basis. Adoption of each new release will be determined by weighing the degree of technical and end user functionality gained against the resources required to implement the upgrade.

July 2017 Implementation Panel findings: As per SCDC status update.

July 2017 Recommendations: Implement the EHR as planned.

Administration of psychotropic medication only with appropriate supervision and periodic evaluation:

5.a. Improve the quality of MAR documentation;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

The EHR system was implemented in the women's' facilities (Camille/Leath) March, 2017. These institutions and are currently using an electronic medication documentation/order process at this time. No paper audits conducted at those facilities pertaining to Item 5-a since March, 2017.

MAR audits are being conducted in SCDC facilities (excluding Camille/Leath). Medical audit reports/findings are provided to the HSOA's from the facility HCA/Head Nurses monthly. The HSOA's are currently compiling the audit reports/findings to provide to QIRM.

SCDC's two female facilities, Camille Griffin Graham and Leath, began using the new system on 3/28/17. They began use of eZmar on 5/16/17. Minimal complications were experienced with the NextGen go live, as expected with the use of any new system. Slightly more issues were experienced with the eZmar go live but those problems have been resolved. Preparation and planning for the rollout to all male institutions is currently underway.

Processes are still being developed to extract reports from the eZmar.

July 2017 Implementation Panel findings: As per the SCDC status update section. See sections 4.a.x. and 5.b.

July 2017 Recommendations: Resolve communications problems with eZmar and pharmacy electronic systems, and continue internal monitoring via RIM and QIRM.

5.b. Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

Medical audit reports/findings are provided to the HSOA's from the facility HCA/Head Nurses monthly. The HSOA's are currently compiling the audit reports/findings to provide information to QIRM.

July 2017 Implementation Panel findings: The QIRM audits have not included data specific to completion of documentation relevant to medication on a dose by dose basis. This data is being monitored by the Director of Nursing.

July 2017 Recommendations: The above referenced audits need to be included in the reports by QIRM relevant to this issue

5.c. Review the reasonableness of times scheduled for pill lines; and

Implementation Panel July 2017 Assessment: **noncompliance**

June 2017 SCDC Status Update

An HS pill line was initiated for the Kirkland ICS unit and specific medical staff members were implementing this plan effectively. There has been a disruption in the continuation of the ICS HS pill line due to staffing demands/inmate transfers from other institutions causing an additional unit to be open/require staffing. Plans are to resume the HS pill line as staffing conditions stabilize.

Health Services has have discussed the need for additional staffing for ICS /HS pill line. The following represents the ICS staffing needs at Kirkland:

4 nurses (minimum of 1 RN) 7 days/ weekly-0600-1830
4 Med techs (CNA) 7 days/weekly

This is based on a current patient census of approx. 160 beds with 200 inmates (some patients in single cells). Staffing needs could increase if patient census increases double bunked/cells instead of single cells.

July 2017 Implementation Panel findings: As per SCDC status update section.

July 2017 Recommendations: Implement the appropriate steps to resume HS, liquid, and long acting injectable medication administration as clinically indicated.

5.d. Develop a formal quality management program under which medication administration records are reviewed.

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

Standardized audit tools have been developed and incorporated into the medical audit processes. Instructions on the use of the standardized audit tools have been provided to the medical and mental health staff.

A template has been developed to capture the below information.

Inmate Name (Last)	Inmate Name (First)	SCDC#	MED Mars Orders Match	Drug Route Dosage	Start Date	Stop Date	Nurse Initial Properly	Allergies on Mar	Document Refusal Omitted	Three (3) Consecutive Missed doses- Action Taken	Month / Year Institution	Total

As explained earlier, the Health Services Office Assistant (HSOAs) collects the data from nursing staff for the generation of a compliance report. This report will be summarized monthly and submitted to QIRM and the Director of Nursing for review. Preliminary data pulled from a sample of five institutions indicate the following findings from the week of 05/29- June 02, 2017

Institution	Med Mars Match/Compliance Percentage	Drug Route Dosage	Nurse Initial Properly	Allergies on Mars	Refusal Documented Properly	Missed Medication Documented Properly	Proper Follow-up as a result of missed Rx
Broad River	100%	100%	90%	100%	80%	Unable to report	Unable to report
Kershaw	100%	100%	100%	100%	100%	100%	100%
Lee	100%	100%	100%	100%	100%	100%	Three requiring follow-up- no response from MH provider- 0%
Perry	100%	100%	86%	100%	100%	100%	100%
Tyger River	100%	100%	100%	100%	100%	100%- 1 case routed to MH	100%

July 2017 Implementation Panel findings: The QIRM audits have not included data specific to completion of documentation relevant to medication on a dose by dose basis. This data is being monitored by the Director of Nursing.

July 2017 Recommendations: The above referenced audits need to be included in the reports by QIRM relevant to this issue

6.A basic program to identify, treat, and supervise inmates at risk for suicide:

6.a. Locate all CI cells in a healthcare setting;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

The Division of Facilities Management has completed all renovations on designated CI cells. Mental Health is in the process of inspecting all cells with the plan of having them approved prior to the IP's July visit.

Categories	Average Time	Max Time	Min Time	Totals Numbers	Percentages
Time Elapsed From Beginning of Crisis to End of Crisis (OFF CI)	110:21:07	1218:55:00	68:23:00		
Time Elapsed From Beginning of Crisis to Arrival to CSU	43:28:00	51:13:00	29:41:00		
Number of Inmates Who Arrived to CSU				11	
Percentage of I Ms who Arrived to CSU Within 60:00:00				10	90.91%
Percentage of I Ms who Didn't Arrive to CSU Within 60:00:00 (If They DID Arrive to CSU)				1	9.09%
Percentage of I Ms Who Were off of CI Within 60:00:00 (If They *Didn't* Arrive to CSU)				42	85.71%
Number of Cell Front Sessions				10	
Percentage of Cell Front Sessions					58.82%
Number of Confidential Sessions				5	
Percentage of Confidential Sessions					29.41%
Number of Sessions in Other Locations				2	
Percentage of Sessions in Other Locations					11.76%
Total Number of Sessions				17	

July 2017 Implementation Panel findings: As per SCDC status update section. The inspection process is not yet been completed. Crisis intervention cells in F1 at the KCI and in the RHU at the McCormimcik CI were identified, which were still not suicide resistant. The four CI cells at the Leath CI, which were located in the Phoenix Housing unit, were sucide resistant.

The CGCI CSU is now open. The physical renovations were nicely done. Staffing remains an issue.

July 2017 Recommendations: Complete the process of inspecting all cells with the plan of having them approved prior to the IP's December visit.

6.b. Prohibit any use for CI purposes of alternative spaces such as shower stalls, rec cages, holding cells, and interview booths;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

Logs provided to the HSOAs listed no inmates being placed in a holding cell or other alternative space. Click here to see response at 4.a.iii. (Segregation and crisis intervention logs)

July 2017 Implementation Panel findings: Overflow "CI" cells are being usd in the RHU at PCI. which were not suicide resistant.

July 2017 Recommendations: Remedy the above.

6.c. Implement the practice of continuous observation of suicidal inmates;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

QIRM has been informed that the practice of continuous observation is has been implemented in the institutions, but the CSU is the only area where this is documented consistently.

July 2017 Implementation Panel findings: QIRM subsequently learned that the practice of continuous observation has not been fully implemented in all the institutions.

July 2017 Recommendations: Remedy the above.

6.d. Provide clean, suicide-resistant clothing, blankets, and mattresses to inmates in CI;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

During site visits to the institutions QIRM staff have started collecting data on the provision and maintenance of clean suicide-resistant clothing, blankets, and mattresses to inmates in CI. Staff are tasked with interviewing inmates using non-leading question to determine if they will confirm that clean supplies were provided throughout their visit. Data collection is ongoing and will be completed by June 27 and a final report provided to the implementation panel by June 30. The limited results outline below suggests that there is no established process on tracking and documentation of the cleaning smocks and blankets.

Institution	Number of suicide blankets	Number of Suicide Smocks	# of blankets in disrepair	# smocks in disrepair	How blankets/smocks and mattresses are cleaned after being used	How blankets/smocks and mattresses are stored after being cleaned	How is the cleaning documented	Documentation Provided	Inmates interviewed	Inmates stating provision of cleans smocks/ blankets	Notes
Kirkland (F1)	11	11	0	0	Each time an inmate takes a shower the blankets and smocks are changed and taken to laundry. The inmate gets a clean one after each shower	Folded up and placed inside of a large box in an office	None	None	Not documented	Confirmed by inmates interviewed	Supplies appeared clean to the observer
Broad River (RHU)	15	12	0	1 (Velcro doens't stic. Will not close properly)	After they are used they are put in a large laundry cart and taken to laundry on Tuesdays and Thursdays	They are rolled up and placed in a shelf in a storage room	None	None	None on CI	N/A	

In June, the Division of Behavioral Health ordered new suicide resistant mattresses for all CI safe-cells agency-wide.

July 2017 Implementation Panel findings: As per SCDC status update section. However, not all CI safe cells currently have suicide resistant mattresses.

July 2017 Recommendations: Obtain and distribute the ordered suicide resistant mattresses upon their arrival. QIRM perform QI studies to ensure institution staff are tracking and documenting the cleaning of smocks and blankets.

6.e. Increase access to showers for CI inmates;

Implementation Panel July 2017 Assessment: **noncompliance**

March 2017 Implementation Panel findings: A QI was performed that indicated significant compliance issues in both documenting showers offered daily as well as showers being offered in certain facilities during unreasonable times (e.g., 1:30 am).

March 2017 Recommendations: Correct the above.

June 2017 SCDC Status Update

No update provided

July 2017 Implementation Panel findings: No change since the March 2017 site visit.

July 2017 Recommendations: As per the March 2017 recommendation.

6.f. Provide access to confidential meetings with mental health counselors, psychiatrists, and psychiatric nurse practitioners for CI inmates;

Implementation Panel July 2017 Assessment: **noncompliance**

March 2017 Implementation Panel findings: Based on the email from Dr. [redacted] at CSU high security inmates are generally not seen in a confidential setting related to reported correctional officer shortages as well as mental health staff shortages.

March 2017 Recommendations: remedy the above.

June 2017 SCDC Status Update

All institutions

Categories	Totals Numbers	Percentages
Number of Cell Front Sessions	10	
Percentage of Cell Front Sessions		58.82%
Number of Confidential Sessions	5	
Percentage of Confidential Sessions		29.41%

July 2017 Implementation Panel findings: The above audit does not meet criteria for an adequate QI study for reasons previously discussed regarding the format of the order that should include following subsections:

- Description of the issue being reviewed;
- Methodology used in the study;
- Results;
- Assessment of the results; and
- Planned actions, if any.

In addition, the sample size is too small.

July 2017 Recommendations: Perform an adequate audit relevant to this issue.

6.g. Undertake significant, documented improvement in the cleanliness and temperature of CI cells;

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

HSOAs collected and analyzed compliance with cell and temperature checks for RHU and CI cells. Results are displayed in the table below.

Total Number of Cells Checked	68
# of RHU Cells Checked	58
# of CI Cells Checked	10
# of Clean RHU Cells	41
# of Clean CI Cells	7
% of Clean RHU Cells	70.69%
% of Clean CI Cells	70.00%
# of Approved CI Cells Checked	10
% of **Approved** CI Cells Checked (if Applicable)	100%
# of Checked RHU cells within the approved temp range	30
# of Checked CI cells within the approved temp range	8
% of Checked RHU cells within the approved temp range	52%
% of Checked CI cells within the approved temp range	80%
Average Temperature for All RHU and CI Cells	73.35

July 2017 Implementation Panel findings: As per SCDC status update.

July 2017 Recommendations: Remedy the identified issues.

6.h. Implement a formal quality management program under which crisis intervention practices are reviewed.

Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

Click here to see response at 2.b.vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.

July 2017 Implementation Panel findings: The SCDC status update section is only referring to the training relevant to a QI process. This provision requires actual QI studies relevant to crisis intervention practices.

July 2017 Recommendations: Begin performing QI studies as referenced above.

Conclusions and Recommendations:

The Implementation Panel has provided its assessments of compliance with the elements of the Settlement Agreement as well as recommendations in this and past reports and while on-site. As of the end of this site visit, July 14, 2017, 11 of the 58 elements (18.9%) were found to be in Substantial Compliance. The site visits began in May, 2016 and over the past two years SCDC has made progress in some areas in pursuit of the development and implementation of an adequate mental health services delivery system and internal processes to support the system, including QIRM and the EHR. We appreciate the particular efforts and activities by Director Stirling, central administrative staff, and staff at specific facilities to support the efforts to develop and provide adequate inmate healthcare. These efforts demonstrate attempts to improve services utilizing current resources. However, as stated in this and past reports major impediments to substantial compliance remain largely related to inadequate staffing, ineffective training and supervision, variable adherence to policies and procedures, and ingrained correctional cultural practices. The IP has provided technical assistance, suggestions, and recommendations and are hopeful our efforts and reports have been informative and helpful. The concerns identified as crises, both systemically and at specific facilities, are very problematic and require immediate and sustained corrective actions. We are deeply concerned about the continuing inadequate mental health care and harmful conditions of confinement. We look forward to further development of the mental health services delivery system in the South Carolina Department of Corrections and appreciate the cooperation of all parties in the pursuit of adequate mental health care for inmate residents living in SCDC.

Consistent with the Settlement Agreement and past reports, we are providing this report initially as a draft report to the parties for any comments and we will consider those comments when finalizing this report. The IP requests all comments regarding this report be provided within fifteen days of the date of this Draft Report.

Respectfully submitted,

Raymond F. Patterson, MD, Implementation Panel Member
On Behalf of Himself and
Emmitt Sparkman, Implementation Panel Member;
Jeffrey Metzner, MD, Subject Matter Expert; and
Tammie M. Pope, Implementation Panel Coordinator