South Carolina Department of Corrections
Implementation Panel Report of Compliance
July 2018

Executive Summary

The South Carolina Department of Corrections (SCDC) has continued to have substantial difficulties in meeting the requirements of the Settlement Agreement. This report of the Implementation Panel (IP) will provide our review and analysis of the status of compliance based on our review of documents provided, our onsite visits to SCDC facilities from July 12-16, 2018, and discussions and technical assistance to the SCDC since our last Implementation Panel visit from March 19-23, 2018.

There was a major and extremely serious incident, the riot at Lee Correctional Institution on April 15, 2018 in which seven inmates were killed and twenty two inmates were seriously injured by other inmates. The SCDC facilities went on statewide lockdown following the riot and the subsequent management of the facilities and inmates, as well as the debriefing and assistance to both inmates and staff, are continuing.

During this on site review and analysis the IP spent significant time and effort to review the responses to the riot and the impact on both staff and inmates. The lockdown has had substantial impact on the delivery of mental health services, and compliance with the requirements of the Settlement Agreement have been impacted; however there have been significant efforts by SCDC administration, operations and clinical staff at specific facilities to restore mental health services, despite the continuing staff and other resource deficiencies that existed before the riot.

While SCDC has not demonstrated compliance with the great majority of requirements, the efforts to restore those services that were being provided, the efforts specific to particular facilities and the continuing necessary contributions by mental health leadership and the Quality Improvement Risk Management (QIRM) components, as well as collaboration with Operations must be acknowledged by the IP. In those facilities in which the lockdown restrictions have been reduced or eliminated for mentally ill inmates, progress has been demonstrated; for those in which the lockdown has continued, the impact has contributed to fewer and inadequate services and noncompliance with the Settlement Agreement. The longer mentally ill inmates are on lockdown status, the lack of necessary treatment and more harm is highly likely.

There have been some facilities that have discontinued the lockdown of inmates, largely contributing to the health and welfare of mentally ill inmates. Specific events include the first graduation of inmates in the High Level Behavioral Management Unit (HLBMU), and mixed success with the mass transfer of approximately 180 female inmates from Camille Graham C.I. to Leath C.I., which appears to have been beneficial in reducing the population at CGCI (along with very necessary increases in psychiatric and nursing staffing) but adversely impacted an already short-staffed clinical and security staff at Leath C.I. Further, this mass movement of inmates on the mental health caseload did not include time and notice to provide transition/termination for at least 60 female inmates on the mental health caseload which is very necessary for inmates who were in active treatment with mental health staff and/or had long term relationships with staff and inmates. These issues are necessarily important and impacted mental health care and stability for inmates and staff during the earlier mass movement of Level 3-Area Mental Health/enhanced outpatient care from various institutions to Broad River C.I. which, while well intended, was not well coordinated between staff to facilitate transition/termination for inmates actively engaged in treatment and/or other programs including Character Dorms/Programs.

The entire SCDC system continues to be understaffed by security and mental health, medical and nursing staff. There are ongoing efforts for recruitment and retention of staff. The recent increases in salaries for

psychiatrists have had a very positive impact; the clarifications that the parties agreed on hiring and retaining licensed mental health professionals by a date certain must be understood and re-enforced by SCDC; and the acknowledged necessity for adequate numbers of qualified nursing staff and medical staff to support and supplement the mental health staff are non-negotiable in order to achieve compliance with the provisions of the Settlement Agreement. Concurrently, the acknowledged necessity for adequate numbers of trained and supervised operations/corrections staff is vitally required for management of the facilities for basic requirements and support of the clinical staff. The Implementation Panel has reported these ongoing concerns at every site visit and in every report.

The IP has consistently reported our grave concerns regarding the inadequate staffing at SCDC. This a longstanding problem, and as with many systems, it has adversely impacted mental health care and resulted in associated lockdowns/segregation and uses of force, including chemical and physical restraints. The more recent efforts to recruit and retain clinical staff has resulted in some improvement at specific facilities or programs. However the critical shortages in nursing staff and inconsistencies with coverage by agency nurses continues with unacceptable medication management practices which the IP has previously reported.

Despite efforts to recruit and retain security staff, the security staffing remains inadequate to support the basic policy and procedural requirements and further compromises the adequate delivery of mental health services, as well as compliance with the Settlement Agreement. The following information summarizes the security staffing concerns and deficiencies.

Concerns

- The SCDC increased dollars for Security Staffing has not been successful in reducing correctional officer vacancies:

Additional Dollars* for Security Staffing
Fiscal Years 2013 – 2018

FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	Total
$1,899,103	$1,295,537	$2,552,804	$3,722,509	$16,979,426	$22,331,031	$48,780,410

*Includes overtime, spot bonuses, raises and others.

Historical Correctional Officer Starting Salary

Fiscal Year	LEVEL 1 (Min. Security)	LEVEL 2 (Med. Security)	LEVEL 3 (Max. Security)	Weighted Average (All Levels)
2014	$25,060	$26,062	$27,897	$26,826
2015	$25,561	$26,583	$28,438	$27,377
2016	$25,561	$26,583	$28,438	$27,384
2017	$27,891	$28,913	$30,768	$29,560
2018	$31,263	$32,560	$34,596	$33,289
2019	$32,263	$33,560	$35,596	$34,311
FY14 - FY19 Increase (%)	$7,203 (28.7%)	$7,498 (28.8%)	$7,699 (27.6%)	$7,485 (27.9%)

Filled Frontline Security Positions*

January 1, 2017	January 1, 2018	July 1, 2018
1,732	1,805	1,795

*cadets, correctional officers and corporals.

The overall average starting salary for correctional officers in FY2018 was $33,289. With overtime, eligible correctional officers earned $41,964.

- On Duty Correctional Staff for Day and Night Shifts are routinely less than 50 percent of the authorized staffing-Shortages are at critical levels for a number of institutions;
- Even prior to the Agency System-Wide Lockdown most Level 2 and 3 Institutions are locked down from 7p to 7a daily;
- Correctional Officer Staff vacancies prevent SCDC from providing even the basic services in the Restrictive Housing Units and General Population;
- When food is served to inmates in their housing units, temperatures are not checked after the food leaves the food service department. Numerous inmates complained about the food being served cold and frequently meals were not served at the scheduled times;
- Correctional Staff continue to deny showers, recreation and other privileges for minor violations without due process;
- The RHU Policy for Behavior Levels and Step Down Programs Policy has not been fully implemented and the programs have been revised without policy changes;
- The Agency has a Lockdown Lift Plan; however, the plan has not prioritized releasing inmates in designated mental health housing units from the lockdown where possible.

Improvement or Potential for Improvement:

- SCDC is making progress ensuring RHUs have televisions and each inmate in RHU receives a crank radio;
- Crank Radios are not taken from RHU inmates unless the inmate commits a rule violation;
- SCDC is preparing RFP to purchase tablets for use by inmates ;
- Perry CI has begun providing RHU inmates outside recreation 1 to 2 times per week;
- Lieber CI Leadership has demonstrated inmate medication can be properly distributed even with critical staffing shortages;
- SCDC was receptive to developing a strategy that in the near future would remove all inmates from RHU on Security Detention with a Mental Health Designation Level 1, 2, or 3.

SCDC is highly unlikely, if not completely unable, to achieve substantial compliance with the Settlement Agreement and the provision of constitutionally adequate and required mental health care without major and consistent increases in staffing and resources and/or major reductions in the numbers of inmates housed in SCDC facilities. In calendar year 2018 there have been six completed suicides in SCDC facilities including one in the Crisis Intervention Program at Broad River C.I., which is specifically designed to treat and mange inmates who are at increased risk for self-harm and/or suicide.

Despite these challenges and deficiencies, the SCDC administration has reduced or removed the lockdown restrictions at several facilities and the IP has encouraged all facilities visited to provide proposals to the administration for the transition of mentally ill inmates to receive required services and for all inmates to be provided education and community/town hall meetings to keep them and staff informed. Several wardens and their staff, supported by regional directors and central administration, are clearly trying to provide the services they can, given the long term staff deficiencies and needs for policy/procedures revisions, training and supervision.

As Exhibit B illustrates, the Implementation Panel determined the following levels of compliance:

1. Substantial Compliance---18
2. Partial Compliance---34
3. Non-Compliance---8

The assessments, reviews and recommendations of the IP are detailed in this report. The IP is deeply concerned and has communicated its distress at the problematic progress of SCDC in meeting the requirements of the Settlement Agreement, while it also acknowledges the sincere and progressive efforts made in facilities by leadership staff to provide what they can despite these ongoing deficiencies. SCDC has over time begun to implement a number of programs including the Crisis Stabilization Unit (CSU), High and Low Level Behavioral Management Units (HLBMU, LLBMU), Step Down units and enhancements for the Gilliam Psychiatric Hospital (GPH) and Intermediate Care Services (ICS) with plans to open a "Choices" program at the ICS level, and has progressed in identification of inmates who require mental health services (currently 18-19% of the population). Unfortunately, all of these programs are maxing out/reaching or are past capacity and require resources to provide required services. The resource deficiencies in security, mental health, nursing, and medical services as well as space limitations and lockdowns preventing adequate service provision, including medication management, timely assessments and treatment and security support greatly impact the ability to provide adequate and required services and compliance with the provisions of the Settlement Agreement.

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 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
On June 2, 2018, one hundred eighty (180) women were transferred from Camille to Leath to allow Camille to clear R&E within acceptable time frames. Leath's nursing hours of operation have been extended from 7:00 AM to 10:00 PM daily. Health Services leaders are currently considering extending hours to 24/7 to relieve the backlog at Camille's R&E.

While SCDC inmates with mental health issues are not identified at as high a rate as nationwide averages, SCDC has made steady progress at identifying mentally ill inmates as they enter the Reception and Evaluation program areas. Both Camille Graham R&E and Kirkland R&E have shown notable improvement with administering mental health screenings in a timely fashion. Camille Graham's R&E has made continual efforts at identification with its steadily increasing rate of QMHPs evaluating Routine referrals in a timely manner, as well as its overall change over time in evaluating Urgent referrals by QMHPs. Kirkland R&E has also demonstrated improvement with identifying Routine referrals; however, more progression is required to adequately assess and evaluate inmates who are referred on an Urgent basis. Efforts have been made to better code and track Emergent referrals since the March IP visit. Graham R&E faces difficulties in completing psychiatric follow-ups within the required timeframes for its Routine referrals, since most of the second follow-up evaluations tend to be Routine to the psychiatrist. Kirkland continues to demonstrate major improvement in assessing routine referrals to the QMHP within the required timeframe for the months and assessing Routine referrals to the psychiatrist. There is room for growth for both institutions to better manage and/or track Emergent referrals.

A new psychiatrist joined the Camille R&E staff June 11, 2018 to aid in the psychiatric services provided to inmates in R&E.

Planned Actions

1. Kirkland R&E staff and Graham R&E manager and Lead QMHP have begun implementing a new method of tracking and logging Emergent referrals. Additionally, monthly monitoring will continue to occur by the Division's Quality Assurance department.

The tables below provide information in regard to R&E timeframes for Camille R&E and Kirkland R&E for the months of February through May. Attention was given to average length of stay, median length of stay, average number of days from intake to screening, and mental health screenings, routine referrals, urgent referrals, and emergent referrals completed within mandated timeframes. For the complete study, refer to Appendix A.

Graham R&E	February	March	April	May
Average Length of Stay (days)	53.5	45.8	44.2	43.3
Median Length of Stay (days)	56	41	47.5	39
Average # of days from intake to screening	2.3	2.6	2.8	1.3
MH screening completed within mandated timeframe (=m), (n = total; m/n *100 = %)	(n =28; m=26) 92.9%	(n =29; m=25) 86.2%	(n =12; m=11) 91.7%	(n =33; m=33) 100.0%
Routine referrals completed within mandated timeframe	(n =17; m=15) QMHP = 88.2% (n =28; m=14) Psychiatry = 50.0%	(n =14; m =14) QMHP = 100% (n =29; m=2) Psychiatry = 6.9%	(n =5; m =5) QMHP = 100% (n =12; m=2) Psychiatry = 16.7%	(n =13; m =13) QMHP = 100% (n =33; m=23) Psychiatry = 69.7%
Urgent referrals completed within mandated timeframe	(n =9; m=5) QMHP = 55.6% (n =0) Psychiatry	(n =10; m=6) QMHP = 60.0% (n =0) Psychiatry	(n =5; m=2) QMHP = 40.0% (n =0) Psychiatry	(n =11; m =5) QMHP = 45.5% (n =0) Psychiatry
Emergent referrals* completed within mandated timeframe	(n =2; m=1) QMHP = 50.0% (n =0) Psychiatry	(n = 0) QMHP (n =0) Psychiatry	(n = 2; m=0) QMHP = 0% (n =0) Psychiatry	(n = 9; m=4) QMHP = 44.4% (n =0) Psychiatry

Kirkland R&E	February	March	April	May
Average Length of Stay (days)	61.2	63.7	56.2	66.2
Median Length of Stay (days)	62	59	55	64
Average # of days from intake to screening	3.2	3.3	3.2	3.6
MH screening completed within mandated timeframe (=m), (n = total; m/n *100 = %)	(n =40; m=32) 80.0%	(n =42; m=35) 83.3%	(n =61; m=57) 93.4%	(n =53; m=45) 84.9%
Routine referrals completed within mandated timeframe	(n =37; m=23) QMHP = 62.2% (n =39; m=20) Psychiatry = 51.3%	(n = 39; m=35) QMHP = 89.7% (n = 42; m=34) Psychiatry = 81.0%	(n=52; m= 51) QMHP = 98.1% (n = 58; m=54) Psychiatry = 93.1%	(n=41; m= 41) QMHP = 100.0% (n = 51; m=46) Psychiatry = 90.2%
Urgent referrals completed within mandated timeframe	(n =3; m =2) QMHP = 66.7% (n=1; m =1) Psychiatry =100%	(n = 2; m=0) QMHP= 0% (n = 0) Psychiatry	(n=6; m=3) QMHP = 50.0% (n =3; m = 3) Psychiatry = 100%	(n=7; m=6) QMHP = 85.7% (n =2; m = 1) Psychiatry = 50.0%
Emergent referrals* completed within mandated timeframe	(n = 0) QMHP (n =0) Psychiatry	(n = 0) QMHP (n =0) Psychiatry	(n=2; m=2) QMHP = 100% (n =0) Psychiatry	(n = 0) QMHP (n =0) Psychiatry

July 2018 Implementation Panel findings: As per status update section. Problems in meeting relevant timelines were related to mental health and correctional staffing allocations/vacancies. Tracking response times to emergent referrals continues to be problematic.

July 2018 Implementation Panel Recommendations: Our December 2017 recommendations essentially remain unchanged and are as follows:

1. Continue to QI the relevant timeframes.
2. Adequately address the mental health and correctional staffing vacancies.

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

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

Tracking

To track the percentage of mentally ill inmates, the Division of Resources and Information Management (RIM) generates a report entitled *Mental Health Classifications for the Mentally Ill Institutional Population*. This report includes:

- the numbers of mentally ill inmates by classification,
- the percentage of mentally ill by classification as a percent of the mentally ill population, and the percent of mentally ill inmates as a percentage of the total population.

The most recent reports, shows that of SCDC's 19,111 inmates, 3,722 or 19.5% are classified as mentally ill.

Mental Health Classifications for Mentally Ill Institutional and Female GEO Care Population on June 18, 2018

SCDC Institutional and Female GEO Care Population = 19,111
SCDC Mentally Ill Population = 3,722

Mental Health Classification	Female	Male	Total	Percent of Mentally Ill Population	Percent of Total Population
Missing	21	377	398	N/A	2.08%
BL	0	17	17	.457%	.089%
BU	0	18	18	.484%	.094%
L1	3	79	82	2.20%	.429%
L2	15	161	176	4.73%	.921%
L3	71	232	303	8.14%	1.59%
L4	578	2,370	2,948	79.2%	15.4%
L5	46	113	159	4.27%	.832%
MR	2	17	19	.510%	.099%

The screenshots above were created from the **June 18, 2018** RIM reports. The full reports are attached as Appendices B (Word) and C (Excel).

Identifying Inmates in the Population

An analysis of data was done to compare the percentage of mentally ill inmates who transferred out of SCDC's two R&E centers to the percentage of the total population that is classified as mentally ill to the total number of inmates who ended up on the MH caseload. The theory is that if there is a higher percent of the total population that is mentally ill than what transfers from R&E, then it follows that inmates whose diagnoses were missed at R&E or who develop mental illness after leaving R&E are indeed being picked up through the current processes and added into the mental health caseload.

Historically, if an inmate in the general population and inmates in segregation needed mental health care, they could be self-referred through sick call or referred by medical or other SCDC staff members, as well as by family or other outside sources. However, it was noted that this was sometimes a cumbersome process, as inmates were being told to sign up on sick call, and at times, it was weeks or months before they were evaluated by the QMHP. An effort has been made by the Div. Behavioral and Mental Health Services to ensure inmates referred for evaluation are seen more timely, even if they do not go through sick call. The Division has also initiated routine mental health rounding in the segregation units over the past two years, which not only helps to pick up on decompensating inmates, but it is felt that this type of interaction may help avert an inmate from decompensating into mental illness. Furthermore, in February 2017, the Division began doing annual screening of inmates who were not on the caseload to determine if mental health services were indicated.

This latest practice (annual screening) has not resulted in any significant increase in the caseload and was therefore discontinued after a year's trial. This review will show the overall effectiveness of SCDC's existing methods, even though the data will not identify exactly how/why each case was added to the caseload.

Overall findings for October 2017 – March 2018 are that between 25-50% (mean 37.2%) of the inmates transferring out of Camille Graham R&E were on the caseload, while 49-53% (mean 51.0%) of the agency's total female population was on the caseload, a difference of 13.8%.

Regarding the male inmates, findings for October 2017 – March 2018 are that between 10-12% (mean 11.7%) of the inmates transferring out of Kirkland R&E were on the caseload, while 15-16% (mean 15.6%) of the agency's total male population was on the caseload, a difference of 3.9%.

Overall findings are that inmates who leave R&E with no mental health classification but who later need mental health services are indeed being identified through the existing processes. From October through March, the female inmates have been identified at a higher rate (average 13.8%) than the males (average 3.9%). This data has been forwarded to the Division Director for his analysis to help determine if the current processes are adequate or if some other means of identifying inmates in the non-R&E population who need services should be considered.

July 2018 Implementation Panel findings: As per status update section. Significant improvement is noted.

July 2018 Implementation Panel Recommendations:

1. Continue to track the statistics relevant to this Settlement Agreement provision.
2. Perform a QI study to assess whether inmates admitted during past 12 twelve months, who were not placed on the mental health caseload in R&E but were currently on the mental health caseload, should have been placed on the mental health caseload while in R&E.

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 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

The Division of Behavioral/Mental Health & Substance Abuse Services (BMHSAS) has implemented a review process of the Mental Health R&E Counselors to determine the appropriateness of cases being triaged as outlined in policy. This review entails a detailed overview of two cases (at a minimum) from each counselor conducting evaluations during the reporting period. The findings from the review are outlined as follows:

Follow-up findings from R&E Audit (Camille Graham & Kirkland)

- Sixteen total cases reviewed.
- 9/16 cases reviewed did not present any documentation or clinical issues.
- One case reviewed (375551) documentation was limited and did not included on C-SSRS findings.
- One case reviewed (375641) MEDCLASS was entered incorrectly as NMH instead of L4.
- One case reviewed (359772) inmate was not med-classed as NMH; however, documentation supports inmate should be included as a L5.
- One case reviewed (323759) notated disruption between prescribed medication for inmate between admission to CSU and return back to R&E.
- One case reviewed (1981470) inmate was med- classed as L3 but documentation supported needing a higher level of care.
- Although emergent referrals are being notated by QMHP at both Kirkland and Camille Graham, documentation is not clear regarding the referral process to the Psychiatrist or if the referral type has changed from emergent to urgent or routine.

Findings was forwarded to R&E MH Managers at Camille Graham and Kirkland for appropriate follow-up. R&E staff were required to sign receipt, review and when applicable correction of findings.

A detailed analysis of the institutional audits is included as Appendix D.

July 2018 Implementation Panel findings: As per status update section. Partial compliance is assessed due to the absence of data relevant to follow-up and effectiveness of corrective action.

July 2018 Implementation Panel Recommendations: Continue to monitor via a QI process. Refer to the previous provision's recommendation.

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 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

It is intended that the inmates who arrive at the Reception & Evaluation center (R&E) of the South Carolina Department of Corrections (SCDC) will be transferred to their assigned institutions no more than 30 days after their admission. For inmates who are identified as mentally ill (MI) through the R&E screening processes and who remain over 30 days in R&E, it is the goal of SCDC to ensure that those inmates are receiving adequate and appropriate mental health services to meet their needs. The study seeks to identify whether MI inmates – as identified from mental health screenings and evaluations – who do not transfer from R&E to their institutions in a timely manner, are still afforded the following services while at the R&E Centers:

- receive continual and consistent mental health care;
- have access to QMHP and psychiatrist follow-ups as clinically indicated;
- receive their psychotropic medications prescribed by the psychiatrist;
- have a treatment plan developed; and
- attend group therapy.

Methodology used in the Study

The sample size for this study consisted of all the inmates classified as mentally ill who remained at Camille Griffin Graham Correctional Institution's R&E and Kirkland Correctional Institution's R&E for more than 30 days. Information was gathered on those inmates who ended up on the caseload after their initial mental health screenings and evaluations for February, March, April, and May. Information was pulled from RIM generated reports for all R&E removals each month, excluding those who were released within 90 days, to determine which inmates remained in R&E over 30 days before transferring to another institution. Also, clinical chart reviews were conducted to obtain the required data regarding services received by inmates.

Results:

Graham R&E	February	March	April	May
Total MI Inmates Removed from R&E	28	29	12	33
Total # MI Inmates in R&E > 30 days | %	25| 89%	28| 97%	10| 83%	29| 88%
# I/M with a Tx Plan Developed| %	0 | 0%	0 | 0%	0 | 0%	0 | 0%
# I/M with a QMHP F/u Due| %	4| 16%	2| 7%	2| 20%	2| 7%
# I/M with a QMHP F/u Completed| %	0 | 0%	0 | 0%	1 | 50%	2 | 100%
# I/M with a Psychiatrist F/u Due| %	0 | 0%	2| 7%	1 | 10%	1 | 3%
# I/M with a Psychiatrist F/u Completed| %	N/A	0 | 0%	0 | 0%	1 | 100%
# I/M with Psychotropic Meds Prescribed & Received| %	25 | 100%	28 | 100%	7 | 70%	29 | 100%
# I/M who Attended Group Therapy| %	25 | 100%	28 | 100%	10 | 100%	29 | 100%

Source: RIM R&E Removals Report

Kirkland R&E	February	March	April	May
Total MI Inmates Removed from R&E	40	52	61	53
Total # MI Inmates in R&E > 30 days| %	34| 85%	46| 88%	54| 89%	53| 100%
# I/M with a Tx Plan Developed| %	0 | 0%	0 | 0%	0 | 0%	0 | 0%
# I/M with a QMHP F/u Due| %	8 | 24%	10| 22%	8| 15%	8| 15%
# I/M with a QMHP F/u Completed| %	4 | 50%	3| 30%	5| 63%	1| 13%
# I/M with a Psychiatrist F/u Due| %	3 | 9%	5| 11%	4| 7%	6| 11%
# I/M with a Psychiatrist F/u Completed| %	2 | 67%	3| 60%	2| 50%	1| 17%
# I/M with Psychotropic Meds Prescribed & Received| %	23 | 68%	38| 83%	48| 89%	34| 64%
# I/M who Attended Group Therapy| %	0 | 0%	0 | 0%	0 | 0%	0 | 0%

Source: RIM R&E Removals Report

Assessment

As evidenced by the results, the majority of inmates who received a mentally ill classification at R&E remain in R&E for more than 30 days. In May at Kirkland R&E, 100% of all inmates who ended up on the mental health caseload remained in R&E over 30 days. At Graham R&E in May, 88% of all inmates who ended up on the mental health caseload remained in R&E over 30 days. For the months of February through May 2018 at both Graham's and Kirkland's R&E center, between 82% and 100% of all inmates who were classified as mentally ill remained in R&E over 30 days.

The MI inmates who remained at Graham R&E over 30 days received group therapy sessions at a rate of 100% for the months of February through May; however, none had treatment plans developed. No inmates remaining over 30 days at Kirkland R&E received group therapy sessions or had a treatment plan developed during the reviewed time period.

There were very few inmates who required a follow-up session with a QMHP or psychiatrist during their extended stay at R&E, based on their levels of care. Of those inmates who had follow-up evaluations due during that timeframe, 0% to 25% actually received a follow-up QMHP or psychiatric evaluation.

The study reviewed, with regards to psychotropic medications, whether or not the inmates were prescribed or were receiving medications. At Kirkland R&E, from February to May 2018, 64% - 89% of all mentally ill inmates who remained in R&E over 30 days were prescribed medications. At Graham R&E, from February to May 2018, 70% - 100% of all inmates who remained in R&E over 30

days were prescribed medications. The remaining inmates were not prescribed psychotropic medications by the psychiatrist or they refused medication as part of their treatment.

Both programs' results indicate room for improvement in providing services to inmates who are not transferred from R&E in a timely manner, particularly group therapy sessions, treatment planning, and appropriate follow-up evaluations as clinically indicated. SCDC continues to work towards compliance and transferring mentally ill inmates to their placed institutions within a reasonable time frame so that they can receive adequate and consistent care.

Planned Actions

1. Graham R&E staff and Kirkland R&E staff will begin completing treatment plans for inmates who remain at R&E for more than 30 days after being classified as mentally ill.

July 2018 Implementation Panel findings: As per status update section. Improvement is noted. Issues at Kirkland are more problematic related to staffing vacancies and physical plant limitations.

Many R&E inmates at Camille Graham CI reported significant delays in being prescribed psychotropic medications. However, the scheduled medication administration times were now much more reasonable. These inmates reported generally receiving 45-60 minutes of out of cell recreational time on a daily (Monday -Friday) basis.

July 2018 Implementation Panel Recommendations:

1. Continue to monitor via a QI process.
2. Accurately track the out of cell time offered to R&E inmates on a weekly basis.
3. Continue to provide the average and median LOS data in the future for inmates in the R&E upon transfer from the R&E.
4. R&E inmates need reasonable access to mental health services for both medication purposes and crisis intervention.
5. Remedy the staffing issues.

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 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

The annual mental health screenings were not proving to be helpful based on the numbers of inmates being added to the mental health caseload. Therefore, per the recommendation of the Implementation Panel during their March visit, the Division discontinued this practice.

See response in 1.a.i.

Appendix E indicates inmates who added to the caseload from the period of February- May 2018 post their R&E placement (N= 194).

July 2018 Implementation Panel findings: As per status update section.

July 2018 Implementation Panel Recommendations: As per 1.a.i.

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 2018 Assessment: noncompliance

June 2018 SCDC Status Update:
In May, 2018, [redacted] from QIRM was hired by the Office of Operations to serve as Deputy Warden for Compliance (DWC) for Broad River Correctional Institution. The DWC works closely with the Warden and Regional Director to develop, implement, evaluate and provide oversight of a comprehensive system to track and measure institutional compliance, coordinate the institution's data collection, tracking and reporting system and develop corrective action plans to facilitate compliance.

[redacted] is being reassigned as SOTP Program Coordinator on July 1, 2018. [redacted] MH Administrator, is moving from HQ to BRCI to manage the MH Program.

Caseload Management
The Murray dorm hosted a Mental Health Day on June 14, 2018, which brought the unit into 100% compliance with QMHP sessions. All inmates who were past due or due for the month of June were seen or had the opportunity to be seen. Several QMHPs from various institutions set up confidential stations in BRCI's visitation room. A total of sixty-six (66) inmates were either past due or needed to be seen before the end of June. Staff report that 21 of the 66 (32%) of eligible inmates refused the session. Twelve inmates requested to be added to groups. QMHP session with Area MH inmates at BRCI in 100% compliance.

Staffing in Murray Dorm
BRCI staff housed within the Murray Dorm include:

1 Deputy Warden of Compliance
1 Unit Manager
1 Unit Counselor
2 Security staff (one on each wing)
1 Qualified Mental Health Professional
2 Mental Health Techs
1 Classifications Staff

Two QMHPs joined the staff at BRCI in June. With that addition, three QMHPs are now assigned to the Murray dorm. Planned caseload ratio for the Murray dorm QMHPs will be 1:48. The regional supervisor will no longer maintain a caseload once all QMHPs have started. One Psychiatric Nurse Practitioner has been dedicated to Area Mental Health.

Provision of Services
Staff report that since the statewide lockdown, provision of groups was limited. During the lockdown, staff report that 5-6 inmates were allowed to participate in groups. Due to the limitation, all inmates were allowed to participate in each group with the exception of the Coping & Living Mindfully (CALM) group. Staff reported that six groups were provided during the statewide lockdown:

On June 6, 2018, Sexual Trauma Services of the Midlands (STSM) began offering the CALM groups. Due to the lockdown, only 11 inmates were allowed to participate in the two weekly groups. From these group participants, 5 inmates requested and will begin up to eight individual counseling sessions. Due to the sensitive nature of the sessions, the inmates will be given OTR's to report to the conference room in the front of the institution to have the individual sessions.

Access To Management

Access to Management meetings were held on January 19 & 22 and February 23, 2018. The March 29, 2018, Access to Management Meeting was canceled due to security concerns in the unit. Because of the statewide lockdown, no Access to Management meetings have been held since February. Broad River CI plans to continue the meeting with the Murray dorm once the lockdown has been lifted and expand to the yard to give all inmates the opportunity to address issues/concerns.

Expanding this process within one month from the Murray Unit to the BRCI compound was discussed at the June 20, 2018 Wardens' meeting.

Crank Radios

An incentive-based program to promote good behavior in the unit. This program provides an opportunity for inmates to maintain the use of a crank radio. All inmates were provided a radio on May 11, 2018. New residents receive radios on Fridays. Refer to Appendix F for the BRCI Murray Dorm Update.

L3 Inmates not at BRCI

Although the Murray Dorm has been centralized for L3 inmates, as of the June 18, 2018, RIM-generated report of MH classifications for mentally ill inmates, 87 or 37% of the 303 L3 male inmates are housed in other institutions.

Structured time for this report was analyzed using daily activity rosters received from the institution and the structured-time database. Below is a summary of the structured time Area inmates received by week for each month in the reporting period.

High Intensity Outpatient/Area MH	February			March				
	9-Feb	16-Feb	23-Feb	2-Mar	9-Mar	16-Mar	23-Mar	30-Mar
n=	180	184	184	230	228	226	223	222
Percentage inmates getting 0 min	92%	74%	90%	86%	76%	82%	78%	70%
Percentage inmates getting 15-59 mins	0.0%	2.2%	4.3%	6.1%	8.8%	8.0%	10.8%	11.7%
Percentage inmates getting 60-359 mins	7.8%	15.8%	4.9%	4.8%	10.1%	4.9%	8.5%	14.0%
Percentage inmates getting 360-599 mins	0.0%	0.0%	0.0%	0.0%	1.3%	0.0%	0.4%	0.5%
Percentage inmates getting 10 hours	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.5%

High Intensity Outpatient/Area MH	April				May			
	6-Apr	13-Apr	20-Apr	27-Apr	4-May	11-May	18-May	25-May
n=	223	233	232	237	240	236	232	232
Percentage inmates getting 0 min	76%	67%	69%	68%	79%	78%	82%	91%
Percentage inmates getting 15-59 mins	9.9%	14.6%	16.8%	16.9%	7.9%	11.4%	10.3%	3.4%
Percentage inmates getting 60-359 mins	9.0%	14.2%	0.9%	3.8%	6.3%	7.2%	5.2%	2.6%
Percentage inmates getting 360-599 mins	0.4%	0.0%	0.0%	0.4%	0.4%	0.0%	0.0%	0.0%
Percentage inmates getting 10 hours	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

The chart below demonstrates SCDC's ability to track the percentage of L3 inmates in comparison to the mentally ill population and the percentage of the overall population and shows an increase in the numbers and percentages of inmates receiving services. Since May of 2017, this population has 1.16% to 1.58% of the overall SCDC population.

Month	Female L3 inmates	Male L3 inmates	Total Population	Percent of Mentally Ill Population	Percent of Total Population
May-17	47	190	237	6.93%	1.16%
Jun-17	48	183	231	6.79%	1.14%
Jul-17	50	215	265	7.63%	1.32%
Aug-17	52	222	274	7.99%	1.38%
Sep-17	61	227	288	8.17%	1.43%
October-17	69	246	315	8.89%	1.57%
November-17	72	237	309	8.63%	1.55%
December-17	80	220	300	8.37%	1.51%
January-18	85	218	303	8.45%	1.55%
February-18	78	222	300	8.23%	1.54%
March-18	78	218	296	8.10%	1.54%
April-18	76	235	311	8.40%	1.60%
May-18	75	231	306	8.24%	1.58%

Data source: RIM: Weekly Mentally Ill Report for Institutional and Female GEO Care Population

July 2018 Implementation Panel findings: As per status update section.

Prior to the April 15, 2018 systemwide lockdown, compliance with the Settlement Agreement was difficult to achieve related primarily to custody and mental health staffing shortages, physical plant limitations and institutional cultural issues, especially in high security housing units that were essentially locked down. We had consistently recommended that staff attempt to mitigate the harm associated with such limitations by increasing out of cell time, providing crank radios/ tablets, etc. Unfortunately, the current lockdown has resulted in the problems found in the high security housing units likely being spread to most of the housing units that remain on locked down status. Specifically, inmates on the mental health caseload are at significant risk of their mental illness symptoms being exacerbated by the conditions of confinement associated with their lockdown status, which increases with the duration of being locked down. Ironically, attempts to mitigate the harm associated with lack of compliance with the Settlement Agreement are now outweighed by the harm associated with the prolonged locked down status.

Broad River Correctional Institution

Related to the lockdown status, previous improvements in access to care have generally not been maintained. Improvement is noted relevant to staffing allocations/vacancies as summarized in the status update section. The June 14, 2018 mental health day was a very helpful temporary remedy to problems related, in part, to the lockdown status following the riot at the Lee Correctional Institution.

During the afternoon of July 17, 2018, the Implementation Panel (IP) met with a group of about 10 Murray dormitory inmates in a group setting. These inmates complained about poor access to mental health services since the systemwide lockdown. Other complaints included the timing of the morning medication administration process, the manner of the medication administration (i.e., under the cell door) and conditions of confinement related to lockdown status. They confirmed that they were being offered showers on a three time per week basis. They stated that the interventions by Deputy Warden [redacted] have been very helpful to many of them.

Staff reported that the mental health technicians were making daily rounds within the Murray dormitory.

Related to custody staff shortages and the current prolonged lockdown, it was clear that mental health services offered to inmates in the Murray dormitory were severely limited and compromised.

Lee Correctional Institution

During the afternoon of July 18, 2018, the IP met with about thirty inmates in a community meeting-like setting in the Better Living Incentive Community (BLIC) housing unit at the Lee CI. These inmates clearly verbalized their distress re: their conditions of confinement since the system-wide lockdown that began following the April 15, 2018 riot at Lee CI. Issues included poor access to mental health services, lack of access to cleaning supplies, sparse information re: when the lockdown will end, medications being administered to them under the cell doors, and increasing stress and frustration due to their locked down status. Inmates did have access to showers on a three times per week basis and visitation privileges.

July 2018 Implementation Panel Recommendations:

The prolonged lockdown for all inmates, especially those on the mental health caseload, is very stressful and is likely to exacerbate the symptoms of many inmates on the mental health caseload. More efforts need to be implemented to mitigate such negative effects that should include a plan to facilitate a transition to ending the lockdown soon (e.g., begin allowing inmates out of cell time on a daily basis, which will be the most effective approach). Providing inmates with reading materials, music, crank radios, etc. are examples of other interventions that can help to mitigate the harmful effects of the lockdown. Community meetings should be held to facilitate successful implementation of such a transition.

Leath Correctional Institution

During the afternoon of July 19, 2018, the IP site visited the Leath CI. About 180 inmates from Camille Graham CI had been transferred to Leath CI beginning during June 2018. During June 5, 2018, about 112 inmates were transferred with 65 of the inmates reportedly being on the mental health caseload. These inmates were given no advanced notice of the transfer. Since the transfer, ~ 10 of these inmates have had one or more of the 19 CSU admissions of Leath CI inmates.

We subsequently interviewed most of the inmates in the Phoenix housing unit in a community-like setting. These inmates had numerous complaints which included the following issues:

1. poor access to the psychiatrist;
2. poor access to the mental health counselors;
3. very limited access to group therapies;
4. medication discontinuity issues (i.e., medications running out resulting in significant lapses of receiving medications;
5. receiving disciplinary reports with subsequent restrictions and punitive segregation time due to charges of self-mutilation (when the self-mutilation is self-harming behaviors in contrast to tattoos);
6. disrespectful and provocative behaviors by correctional officers directed at inmates in the housing unit;
7. limited access to jobs;
8. their housing unit having more restrictions than most other housing units at Leath related to custody staff shortages, which includes a "rotation" process;
9. not being permitted to talk while in the dining hall; and
10. inmates recently transferred from Camille Graham CI had numerous complaints re: the transfer process and their current placement as compared to Camille Graham CI.

We subsequently discussed these complaints with key clinical and custodial staff. There was agreement that the following would occur:

1. QI the medication discontinuity issue, which appeared to be related both to training issues and apparent flaws with the NextGen EMR.
2. Discontinue writing disciplinary reports for self-cutting behaviors related to an inmate's mental health problems.
3. Improve communication among custody staff involved with job assignments.
4. Consider changing the rules re: talking in the dining hall.

We recommend that the issues re: disrespectful behaviors by some of the correctional officers be addressed.

We discussed at length with staff issues related to caseload inmates who were recently transferred from CGCI and were experiencing significant problems related to the transfer. Specifically, we recommended that their continued placement at Leath CI be reconsidered via a staffing with the treatment team and discussing with them other housing placement options at Leath CI.

We also discussed with staff issues related to disciplinary infractions issued to inmates who were reportedly cheeking medications and charged with trafficking medications based on cheeking the medications. We discussed other possible reasons for cheeking medications such as not wanting to take H.S. meds at 4 pm. We recommended that this issue be further addressed. We have no disagreement in issuing DRs when trafficking medications is proven.

July 2018 Implementation Panel Recommendations: As above.

2.a.ii. Significantly increase the number of male and female inmates receiving intermediate care

services and provide sufficient facilities therefore;

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

Dr. [redacted] Chief Psychiatrist, and [redacted], Division Director of BMHSAS, have developed a program draft and goals for Behavioral residential treatment in Kirkland's F1 unit. The F1 unit will continue to be considered a residential mental health unit; however, the scope of services provided will target inmates who repeatedly re-cycled back and forth to Broad River's Crisis Stabilization Unit and outpatient MH services (including intensive outpatient). The cohort of inmates who will be admitted in this program are too disruptive to have combined programming with the current offenders in ICS, specifically those diagnosed with a serious mental illness. The F1 and F2 populations will be separated to establish F1 being behavioral and higher functioning and F2 as SMI and lower functioning. This separation will also address the number of inmates that are currently denied admission into the presently structured ICS. The program will be managed separately from F2 which also addresses the current administrative structure of not being able to achieve 10 structured hours in both F2 and F1 units.

A reclassification of positions was submitted to HR for processing on June 22, 2018, to include three MH Techs, four QMHPs and one Program Manager. The nursing vacancies will be replaced/requested in FY20 Budget Year). Preparations are underway to prepare nursing to return to the unit on July 15, 2018. While the telephone and computer for medication room is currently pending, an iron door was installed. The treatment room will be used by nursing in F1 to prevent movement of behavioral ICS inmates. The need for eight additional correctional officers has been identified to fully operate the F1 unit.

The chart below demonstrates SCDC's ability to track the percentage of L2 inmates in comparison to the mentally ill population and the percentage of the overall population and shows an increase in the numbers and percentages of inmates receiving residential treatment services. These numbers include HLBMU, LLBMU and Male and Female ICS (L2) inmates.

Residential Level of Care*							
Month	**Male Residential**	**Female Residential**	**Total Residential Pop**	**MI Population**	**% MI Pop**	**Total Pop**	**% of Total Pop**
May-17	165	27	192	3,420	5.61%	20,373	0.94%
Jun-17	170	28	198	3,371	5.87%	20,015	0.99%
Jul-17	182	27	209	3,473	6.02%	20,141	1.04%
Aug-17	186	26	212	3,458	6.13%	20,035	1.06%
Sep-17	181	27	208	3,524	5.90%	20,109	1.03%
Oct-17	176	25	201	3,543	5.67%	20,056	1.00%
Nov-17	187	25	212	3,582	5.92%	19,929	1.06%
Dec-17	186	20	206	3,585	5.75%	19,811	1.04%
Jan-18	180	16	196	3,602	5.44%	19,580	1.00%
Feb-18	183	17	200	3,647	5.48%	19,458	1.03%
Mar-18	187	18	205	3,656	5.61%	19,281	1.06%
Apr-18	190	16	206	3,704	5.56%	19,410	1.06%
May-18	193	15	208	3,713	5.60%	19,313	1.08%

Provision of Services Camille Graham ICS Structured Out-of-Cell Time

Limitations to Structured Time Reporting at Camille

There are no automated reports generated from NextGen that demonstrate structured time received by inmates whose records are maintained in that system. Currently, structured time is analyzed by manual audits in NextGen and/or using daily activity logs which is a very time consuming process and increases the potential for inaccuracies due to human error when manually entering structured time into an Excel database.

Structured time for this report was analyzed using daily activity rosters received from the institution and the structured-time database. All of the ICS inmates were included in the sample. Below is a summary of the structured time inmates received by week for each month in the reporting period. The total number of structured activities scheduled and corresponding number of hours shown are approximations. The data was taken from the QIA databases for Structured/Unstructured Time. SCDC Policy 19.12, *Intermediate Care Services (ICS)*, section 3.4 states: "ICS inmates are provided ten (10) hours of structured out-of-cell activities weekly, which take place Monday through Friday."

According to schedules provided to QIRM by the Institution, there were approximately 9-10 groups specifically scheduled per week for the ICS inmates, for an average of approximately 14 hours per week. These inmates also have access to the groups scheduled for the general population, of which there are typically about 23 groups per week, for an average of approximately 28 hours per week. (Note that there are of some instances of ICS groups and general populations groups that are scheduled at the same time, which would reduce the opportunity slightly for ICS inmates.) An analysis of the number of groups scheduled indicate that there were enough group sessions scheduled by the institution to allow ICS inmates to participate in the required 10 hours of structured out of cell time.

For the months in the reporting period, with the exception of one week, zero percent (0%) of inmates received the required 10 hours of structured out-of-cell unstructured time; however, most inmates received some level of structured services throughout the month as reported in the charts below. In the third week of May, 1 inmate (6% of the ICS population) received the required 10 hours. The charts below provide the percentages of inmates who received structured services based on the breakdown below:

- ☐ 0 min
- ☐ 15-59 mins
- ☐ 60-359 mins
- ☐ 360-599 mins
- ☐ 10 hours

To see the numbers of inmates receiving the reported hours captured by the percentages below, see Appendix G.

Camille ICS Inmates Structured Time (minutes)

	February				March			
	9-Feb	16-Feb	23-Feb	2-Mar	9-Mar	16-Mar	23-Mar	30-Mar
n	15	16	16	17	16	15	14	14
% inmates getting 0 min	13%	0%	25%	12%	19%	20%	21%	21%
% inmates getting 15-59 mins	0%	0%	38%	0%	13%	7%	14%	14%
% inmates getting 60-359 mins	80%	81%	25%	76%	63%	47%	50%	57%
% inmates getting 360-599 mins	7%	19%	13%	12%	6%	27%	14%	7%
% inmates getting 10 hours	0%	0%	0%	0%	0%	0%	0%	0%

*February 2 fell at the end of the last week of January and would have been included week 4 of January's report

	April				May			
	6-Apr	13-Apr	20-Apr	27-Apr	4-May	11-May	18-May	25-May
n	14	15	15	14	13	12	16	14
% inmates getting 0 min	29%	7%	100%	0%	8%	8%	19%	0%
% inmates getting 15-59 mins	29%	20%	0%	7%	0%	0%	6%	7%
% inmates getting 60-359 mins	36%	60%	0%	36%	77%	92%	38%	43%
% inmates getting 360-599 mins	0%	13%	0%	57%	15%	0%	31%	43%
% inmates getting 10 hours	0%	0%	0%	0%	0%	0%	6%	0%

Kirkland ICS Structured Out of Cell Time

Structured time for this report was analyzed using data from the RIM reports (groups and individual sessions with the QMHP and Psychiatrist) and the structured time database with information entered by the QIAs. Below is a summary of the structured time inmates received by the week for each month in the reporting period.

For the months in the reporting period, with the exception of two weeks, (0%) of inmates received the required 10 hours of out-of-cell structured time; however, most inmates received some level of structured services throughout the month as reported in the charts below. During weeks four and five in March, one inmate (2% of the sample) received the required 10 hours of structured out-of-cell time. The charts below provide the percentages of inmates who received structured services based on the breakdown below. To see the numbers of inmates receiving the reported hours captured by the percentages below, see Appendix AAA.

Kirkland ICS Inmates Structured Time (minutes)

	February*			March				
	9-Feb	16-Feb	23-Feb	2-Mar	9-Mar	16-Mar	23-Mar	30-Mar
n=	40	40	41	37	43	42	42	45
% inmates getting 0 mins	40%	38%	27%	16%	30%	29%	36%	31%
% inmates getting 15-59 mins	13%	20%	24%	30%	14%	17%	26%	22%
% inmates getting 60-359 mins	48%	40%	49%	51%	51%	45%	31%	38%
% inmates getting 360-599 mins	0%	0%	0%	0%	0%	0%	0%	0%
% inmates getting 10 hours	0%	0%	0%	0%	0%	0%	2%	2%

*February 2 fell at the end of the last week of January and would have been included week 4 of January's report

	April				May			
	6-Apr	13-Apr	20-Apr	27-Apr	4-May	11-May	18-May	25-May
n=	45	48	50	47	45	45	45	45
% inmates getting 0 mins	33%	40%	76%	28%	42%	33%	33%	36%
% inmates getting 15-59 mins	18%	4%	24%	19%	29%	13%	18%	16%
% inmates getting 60-359 mins	44%	48%	0%	47%	20%	51%	36%	42%
% inmates getting 360-599 mins	2%	0%	0%	0%	0%	2%	0%	0%
% inmates getting 10 hours	2%	0%	0%	0%	0%	0%	0%	0%

The first graduation set for HLBMU for four or five inmates with aftercare plans is scheduled for July 18, 2018 during the IP's site visit. The HLBMU and LLBMU are each expected to be at full capacity by July 15, 2018.

Plans to expand the BMU and aftercare has begun. Moultrie Dorm side B, which is identical to the B-side of the CSU dorm is being considered for the BMU expansion. This expansion would allow one tier to have single cells and one tier to include both single and double cells to allow for phase 3 inmates to begin double celling prior to graduation. The plans include fencing on the second tier and gated showers for added security. The drawings for these changes are currently underway;

A meeting will be scheduled with Columbia International University (CIU) leadership to discuss recruitment of additional inmate watchers for CSU Broad River. SCDC is considering an expansion of the watcher program outside of CIU. Specific criteria, training and expectations will be developed with specific program goals and will focus on statewide character dorms as the program "feeder" for inmate watchers.

July 2018 Implementation Panel findings: As per status update section. Our previous report included the following:

We discussed with staff issues related to the current number of inmates determined to be in need of an ICS level of care. For purposes of this provision, inmates in any type of mental health residential level care (e.g., a BMU) should be included in the statistics relevant to receiving an ICS level of care. It has been our experience that 10% to 15% of the total mental health caseload population is usually in need of an ICS level of care at any given time, which is significantly more than the current percentage of caseload inmates receiving an ICS level of care.

Our opinion re: the above remains unchanged.

Kirkland Correctional Institution

During the morning of July 17, 2018, we attended an ICS treatment team meeting/staffing and interviewed most of the F1 ICS inmates in the community meeting setting. The process observed during the treatment team staffing meeting was problematic from the perspective of minimal treatment planning occurring with the interviews being predominantly a check in.

The F1 ICS inmates were generally very complementary of the treatment being provided although most inmates were being offered only 3-4 groups per week. They described the group treatment as being helpful as was individual treatment. In addition, good access to the psychiatrists was reported by these inmates.

We were very encouraged that the ICS program is no longer on a locked down status.

Nursing staff are again housed within the male ICS unit.

Clinical Staffing for the ICS was reported as follows:

1.13 FTE psychiatrists (# Hours/week on-site = 42.50)
9.0 FTE Mental Health Counselor (3.0 FTE vacancies)
4.0 FTE MHTs (1.0 FTE vacancy)
16.0 FTE RNs (12.0 FTE vacancies)
13.0 FTE LPNs (13.0 FTE vacancies)
4.0 FTE paramedics/tech

July 2018 Implementation Panel Recommendations: Previous recommendations included the following and remain unchanged as follows:

1. 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.
2. The lack of medication administration on an HS basis needs to be remedied.
3. Staffing vacancies/allocation issues need to be adequately addressed in order to meet adequate programming guidelines.

Camille Griffin Graham Correctional Institution

The inmate count during July 20, 2018 was 608 inmates. During July 20, 2018 there were 267 mental health caseload inmates (-~44% of the population), which included 18 L2, 59 L3, 160 L4, and 24 L5 mental health caseload inmates.

The RHU count during March 21, 2018 was 23 inmates, which included 15 mental health caseload inmates.

There were 12 CSU beds and 2 safety cells in RHU. The census during July 20, 2018 was zero.

Staffing data included the following:

Psychiatric coverage is provided by 1.0 FTE psychiatrist.

7.0 FTE QMHP positions are allocated with 5.0 FTE positions filled.
3.0 FTE MHT positions are allocated with 3.0 FTE positions filled.
16.0 FTE nursing staff positions were allocated
3.0 FTE RN FTE positions filled and 3.0 FTE RN vacancies.
2.0 FTE LPN positions were filled with 8.0 FTE LPN vacancies.

We observed a treatment team meeting during the afternoon of July 20, 2018, which was also attended by the psychiatrist. Very little treatment planning was discussed during this meeting.

We interviewed about 12 inmates on the D wing within the Blue Ridge housing unit. These ICS inmates reported increased access to mental health groups and generally had favorable comments regarding the program.

We also interviewed in a community setting the majority of inmates residing in C Wing within the Blue Ridge housing unit. Most of these inmates were mental health level 3 inmates with many also classified as mental health level 4. Medication management issues (e.g., medications expiring without being renewed in a timely manner, missed medication dosages, etc.) continued to be a common complaint. Medications were now administered by the nursing staff in the housing unit, generally around 7 a.m. and 7 p.m. Inmates reported improvement in the mental health services, especially as compared to one year ago. Most inmates reported attending at least one mental health group therapy per week, in addition to weekly community meetings and access to programs run by the Chaplain's office.

July 2018 Implementation Panel Recommendations: The most pressing need is to fill the nursing staff vacancies and adequately address the medication management issues.

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 2018 Assessment. partial compliance

June 2018 SCDC Status Update:
SCDC has established a regular Compliance Initiatives meeting to discuss plans and priorities to address and monitor progress in programs and services relative to the Mental Health Settlement Agreement. On March 29, 2018 a multidisciplinary meeting including staff from Health Services, Operations, Health Services Compliance and Mental Health convened to identify priorities from the Settlement Agreement. A follow-up meeting was convened by the Chief Legal & Compliance Officer where committees were assigned by each of the pretty areas identified at the March meeting.

GPH's subcommittee focused on completing the nurses station including furnishings, computer & phone lines, locks on doors, pill window pass-through; and reclassified a third shift QMHP from vacant position for GPH.

The nursing station will be complete when outlets are installed and locks have been put in place. Pending completion, DHEC will conduct a final inspection as soon as the pill window is ready. On June 12, 2018, the Deputy Director of Health Services (DDHS) and Warden held a meeting with nursing to discuss the function of nursing station. The QMHPs working with inpatient and residential inmates were informed that day-shift hours will be until 7 pm on weekdays, and that they would also be responsible to ensure on-site clinical coverage each weekend day shift.
Church services are now authorized. Staffing has improved to include a full-time onsite Psychiatrist [redacted] and the addition of (Dr. [redacted] who is scheduled to begin in July. The following changes/additions have improved the GPH custody staffing:

- One additional Escort officer 8AM-4PM (February)
- Unit Counselor schedule changed from 8AM-4PM to 6AM-2PM to assist with showers and recreation.
- One additional Unit Counselor (custody) 10AM- 6PM (April)

Staffing analysis has identified the need for 37 additional CO's, and additional Sergeants and Lieutenants.

The chart below demonstrates SCDC's ability to track the percentage of L1 inmates in comparison to the mentally ill population and the percentage of the overall population the numbers and percentages of inmates receiving services.

L1 Population

Month	Female L1	Male L1	Total Pop.	% L1 MI Pop.	% of Total Pop.
May-17	1	78	79	2.31%	0.388%
Jun-17	0	74	74	2.20%	0.373%
Jul-17	0	77	77	2.22%	0.382%
Aug-17	0	81	81	2.34%	0.404%
Sep-17	0	81	81	2.30%	0.403%
October-17	0	73	73	2.06%	0.364%
November-17	0	73	73	2.04%	0.366%
December-17	0	80	80	2.23%	0.404%
January-18	0	75	75	2.08%	0.383%
February-18	1	71	72	1.97%	0.370%
March-18	0	80	80	2.19%	0.415%
April-18	1	80	81	2.19%	0.417%
May-18	2	74	76	2.05%	0.394%

Structured Out-of-Cell Time

Structured Therapeutic Activity for Gilliam Psychiatric Hospital (GPH)
The entire GPH population was analyzed to determine structured out of cell time scheduled, offered, and received by inmates. The data represented in this report is inclusive of RIM reports from the AMR for February 2018 through May 2018. Activity therapy and community meetings are inclusive from

February 1, 2018 through April 8, 2018. The data for Activity Therapy and Community meetings after April 9, 2018 have not been entered nor calculated in the weekly/monthly totals for GPH. Below is a summary of the structured time inmates received by the week for each month in the reporting period.

Gilliam Psychiatric Hospital	February			March				
	9-Feb	16-Feb	23-Feb	2-Mar	9-Mar	16-Mar	23-Mar	30-Mar
n=	78	81	79	77	81	82	87	89
% inmates getting 0 mins	15%	14%	24%	16%	16%	27%	20%	28%
% inmates getting 15-59 mins	9%	6%	13%	14%	12%	23%	24%	26%
% inmates getting 60-359 mins	40%	40%	56%	43%	44%	38%	51%	45%
% inmates getting 360-599 mins	23%	32%	6%	23%	19%	9%	6%	1%
% inmates getting 10 hours	13%	7%	0%	3%	6%	0%	0%	0%

Gilliam Psychiatric Hospital	April				May			
	6-Apr	13-Apr	20-Apr	27-Apr	4-May	11-May	18-May	25-May
n=	88	87	85	92	89	88	89	88
% inmates getting 0 mins	22%	39%	66%	60%	45%	41%	26%	20%
% inmates getting 15-59 mins	10%	39%	25%	27%	40%	43%	30%	39%
% inmates getting 60-359 mins	36%	21%	5%	5%	10%	11%	39%	41%
% inmates getting 360-599 mins	25%	0%	0%	0%	0%	0%	0%	0%
% inmates getting 10 hours	3%	0%	0%	0%	0%	0%	0%	0%

CRCC CONTRACT UPDATE

CRCC continues to undergo construction modifications, which has impeded full implementation of the 10 bed unit devoted solely to SCDC. However, CRCC has made accommodations to accept SCDC inmates during their construction period. CRCC has provided treatment to a total of twelve mental health patients from the period of March-May 2018.

Currently, there are eleven SCDC inmates admitted to CRCC; eight males and two females.

July 2018 Implementation Panel findings: As per status update section.

Clinical staffing for GPH was reported as follows:

	Total FTE as of July 2018	Staffing Plan FTE
Psychiatrists:	1.68 (67.25 hrs/week)	4.0
Psychologists:	.56 (22.50 hrs/week)	.5
QMHP's:	8.00 (1.0 FTE vacancy)	8.00
MHT's:	7 (1.0 FTE vacancy))	16 .0
Recreational therapists	3.0 FTEs	3.0

Nursing:	RN/LPN	Staffing Plan FTE

	GPH Allotted FTE		
RN:	16 (12.0 vacancies)		19.00
LPN:	13		15.00
Paramedic /tech:	4 (4.0 FTE vacancies)		5.00

The amount of out of cell time, both structured and unstructured, actually used by GPH inmates remains alarmingly small. This issue is predominantly related to inadequate staffing allocations (both correctional and mental health staff) although institutional cultural issues likely contribute.

Renovations at GPH are not yet completed with specific reference to the nursing stations, which appears to be primarily related to a recent inspection that identified issues with the nursing station door's lock.

Significant progress is noted from the perspective of hiring 2 psychiatrists for providing psychiatric services to GPH inmates/patients.

Staffing analysis has identified the need for 37 additional CO's, and additional Sergeants and Lieutenants.

We met with about 40 inmate GPH inmate/patients in GPH via a community-like meeting on both sides of the housing unit. B unit inmate/patients, who generally had a higher acuity level than the A side of the housing unit, reported limited access to group therapies on a weekly basis as well as limited out of cell structured time. It was not unusual for inmates to have to choose between attending a group therapy or unstructured out of cell time due to scheduling issues.

Unit A inmates generally described more satisfaction with the GPH program as compared to B side inmates.

Lockdown status in GPH ended about 4-6 weeks prior to the site assessment.

July 2018 Implementation Panel Recommendations: Continue to monitor via a QI process.

The following December 2017 recommendations are unchanged:

1. Focus on providing more out of cell structured therapeutic and unstructured time to inmates in GPH. We strongly recommend at least several community meetings be conducted per week with both mental health and correctional staff in attendance and actively participating.
2. Complete the renovations.

The significant custody staffing allocations should be a high priority to remedy. These officers should be regularly assigned to GPH and receive enhanced mental health training relevant to working in an inpatient setting.

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

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

Additional Staff

[redacted] and [redacted] completed interviews for chief and staff psychologist positions, and they have selected a Chief and two psychologists. The Chief Psychologist will start on August 1, 2018, but has agreed to be onsite for the July 16, 2018, visit. Offers for 2 psychologists are pending position reclassification.

All positions for psychiatry will be filled by end of August with psychiatrists or psychiatric NP (15+ positions. (15+ positions= SCDC full-time, part-time, dual with DMH, contract: in-person and tele psych)

A position for Assistant Deputy Director of Behavioral Health is currently posted. NextGen Program Manager, [redacted] left employment with SCDC; however, the position was filled by [redacted] Staff anticipate that HCA and Head Nurse positions (except McCormick) will be filled by 9/1/18.

New Recruitment Initiatives

A director of recruiting has been hired from the private sector with significant Linkedin experience, and extensive contacts in the military community. SCDC is also piloting an expanded telehealth program with the University of South Carolina and the Medical University of South Carolina to provide greater, geographic telehealth coverage. SCDC is also in discussions with a private company to provide additional telehealth services. Further, SCDC is seeking an amendment to the settlement agreement provision identifying its subject matter experts in order to seek innovative, cutting edge, data driven recruitment initiatives. Lastly, SCDC revamped its billboard recruitment efforts by mapping the locations of the homes of current employees to target those communities for billboard advertisement.

Critical Incident Stress Management Program

The Critical Incident Stress Management Program (CISM) has continued to develop since the initial report July 2017. The CISM Program has been established to provide support services to staff who have been assaulted and/or otherwise experienced trauma. There are several levels of support that are being implemented within the CISM Program. While not all of these services are yet available, they continue to be established at this time and are in varying states of implementation projected over the coming months and years.

- Peer Support (one-on-one support)
- Group Intervention (diffusing, debriefing, demobilization, crisis management briefing)
- Post Critical Incident Seminar (PCIS) (3-day event for staff experiencing long-term challenges resulting from traumatic experience(s)) PCIS's will eventually be implemented and occurring on a periodic basis throughout each year)
- Desert Waters (addresses challenging environment we work in – entire SCDC workforce would participate in this, once implemented)

Since that time, the following accomplishments/activities have been achieved:

1) Four SCDC staff trained in ICISF (International Critical Incident Stress Foundation) Model for CISM (Fall 2017)
2) Strategic Plan developed for the Division of Victim Services, which includes the CISM Program
3) Three positions dedicated to CISM Program (hired February 2018)
   a. [redacted] – CISM Program Administrator
   b. [redacted] – CISM Program Manager
   c. [redacted] – Administrative Assistant
4) Memorial Service coordinated at Headquarters for staff person who had passed away (April 2018)
5) Peer Support has been provided for staff who have been assaulted over the past year on an ongoing basis throughout the agency. These services complement the work being done by the SITCON Team, adding another layer of support for SCDC employees to have in the aftermath of any traumatic experience.
6) Peer Support provided for staff involved in Lee Correctional Riot (April 2018 and ongoing since)
7) Trauma/Crisis Intervention Dog was obtained through a partnership with PAALS (Palmetto Animal Assisted Life Services). Flossy has already responded to several situations, providing support in both group and individual situations. Additionally, she has participated in several trainings not only in South Carolina for staff, but also in Ohio and Idaho!
8) Formal Debriefings conducted June 21st & 22nd, 2018. 232 first responders to Lee Correctional Riot participated (Including Police Services, RRT, SORT, SITCON, Operations, Lee staff, Lee County Sheriff's Department, Lee County Fire/Rescue staff, etc…). Facilitators for the debriefings came from the North Carolina Department of Corrections, Georgia Department of Community Services (parole/probation), SC-LEAP (Law Enforcement Assistance Program), Columbia Police Department, Horry County Sheriff's Department and SCDC to support all participants.

It is important to note that the CISM Program is being developed with research in mind to eventually be able to evaluate the difference the services are making in the lives of SCDC staff. We are in the process of developing an initial survey about the current climate of staff attitudes/feelings. This will serve as the baseline for future surveys/research to compare the difference CISM support services is having on the agency in the areas of morale, retention, well-being, etc.

MH Vacancy Rates

Based on the current staffing chart below, BMHSAS reports a vacancy rate of 17.67%, which is a decrease from last reporting period (< 5.56). The Division attributes the continued decrease to the recent salary enhancements for both Psychiatrists and Qualified Mental Health Professionals (QMHPs).

Title	Total # of Positions	Full-Time		Pink Slip		Dual		Contract		Total % Filled Position
		Filled	Vacant	Filled	Vacant	Filled	Vacant	Filled	Vacant	
Division Administration										
Division Director - QMHP	**1**	1	0	0	0	0	0	0	0	100.00%
Quality Assurance	**4**	3	1	0	0	0	0	0	0	75.00%
Training Coordinator	**1**	1	0	0	0	0	0	0	0	100.00%
PREA Coordinator/ Grievance/ Special Projects QMHP (Non-Licensed)	**1**	1	0	0	0	0	0	0	0	100.00%
Support Staff	**2**	2	0	0	0	0	0	0	0	100.00%
Institutional Administration	**2**	4	0	0	0	0	0	0	0	200.00%
Institutional Admin Support Staff	**8**	7	1	0	0	0	0	0	0	87.50%
Bay Area Totals - (only at GPH)	**9**	9	0	0	0	0	0	0	0	100.00%
Activity Therapy Totals	**3.53**	3	0	0	0.53	0	0	0	0	84.99%
Mental Health Tech Totals	**43**	36	7	0	0	0	0	0	0	83.72%
QMHP Totals (includes MH Supervisors	**87.06**	70	16	0.53	0.53	0	0	0	0	81.01%
Psychology Totals	**4.14**	0	3	0.94	0	0	0	0.20	0	27.54%
Psychiatry/Nurse Practitioner Totals - (Based on 40 hours/week)	**14.62**	6	2	3.60	0.81	0.98	0	1.23	0	80.78%
Division Totals	**180.35**	**143**	**30**	**5.07**	**1.87**	**0.98**	**0**	**1.43**	**0**	**83.44%**

A MH vacancy report is included as Appendix H.

The Health Services Position Tracking Log is included as Appendix CCC
A report submitted from the Division of Administration reports the days from selection entry to hire date has decreased by 43% for non-security positions and 67% for security positions.

Position Type	Days from section entry to hire		Decrease in days	% decrease
	7/1/2017-12/31/2017	2/1/2018-4/30/2018		
Non-security	58.87	33.31	25.56	-43%
Security	66.55	22.22	44.33	-67%

These decreases in wait time are attributed to more streamlined processes and improved workflow.

As a result of the Governor's Executive Order on April 23, 2018, institutional Lieutenants are allowed to earn overtime pay for three months, effective May 22, 2018. Lieutenants will be eligible for overtime for time worked greater than 160 hours in a 28-day FLSA working week.

Each institution is responsible for monitoring and reporting their overtime usage. Meetings will be held with Operations, Human Resources and Finance at the end of each 28-day pay cycle. Meetings are scheduled as follows:

- June 11, 2018
- July 9, 2018
- July 30, 2018
- August 27, 2018

A copy of the memo sent to staff with this information is included as Appendix I. A copy of the Executive Order is included as Appendix J.

July 2018 Implementation Panel findings: As per status update section. We were very encouraged by the improvement in decreasing the staff vacancy rate as described in the status update section, which was clearly related to both improved salaries and more streamlined hiring practices.

July 2018 Implementation Panel Recommendations: Continue to monitor via a QI process.

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 2018 Assessment: compliance (July 2017)

June 2018 SCDC Status Update:

Intermediate Care Services (ICS)

There were a total of 27 cases that were denied entry into the ICS program for the period of October - December 2017 and February - April 2018. All 27 ICS denials were reviewed by the Committee. The committee did not concur with 5 of the decisions and indicated their "Reason for Overturn of Denial/Reconsideration." One of those cases has since been admitted to the ICS Program. The remaining 4 cases were scheduled to be re-staffed the week of June 11, 2018; however, as of this narrative no updated information has been received. The committee concurred with the remaining 22 denials.

Lower Level Behavioral Management Unit (LLBMU)

There were a total of 54 cases that were denied entry into the LLBMU program for the period of October - December 2017 and February - April 2018. Of those cases. All 54 LLBMU denials were reviewed by the Committee. They did not concur with 13 of the denial decisions and indicated their "Reason for Overturn of Denial/Reconsideration." All of the cases were re-staffed and per the Program Supervisor, the results are as follows: 3 = accepted and are awaiting transfer to LLBMU; 1 = already in a program; 2 = HLBMU referral recommended; 2 = not accepted due to pending disciplinary issues; 2 are already in other mental health programs; 2 cases were initially returned to LLBMU for reconsideration, as the Committee did not concur with the denial decision, and then they were denied a second time with a different reasoning and the Committee concurred with the denials, and; 1 case is pending LLBMU recommendation. The committee concurred with the other 41 denials.

* No January 2018 data was received for ICS or LLBMU.

GPH

Four cases were denied between the months of February-May. The review committee concurred with two of the recommendations and have not yet reviewed the remaining cases.

Denial Reviews			
	ICS	LLBMU	GPH
Total Program Denials	27	54	4
Denials Returned for Reconsideration	5	13	0
Percent of Denials Overturned	19%	24%	0%

July 2018 Implementation Panel findings: As per status update section.

July 2018 Implementation Panel Recommendations: Continue to monitor via a QI process.

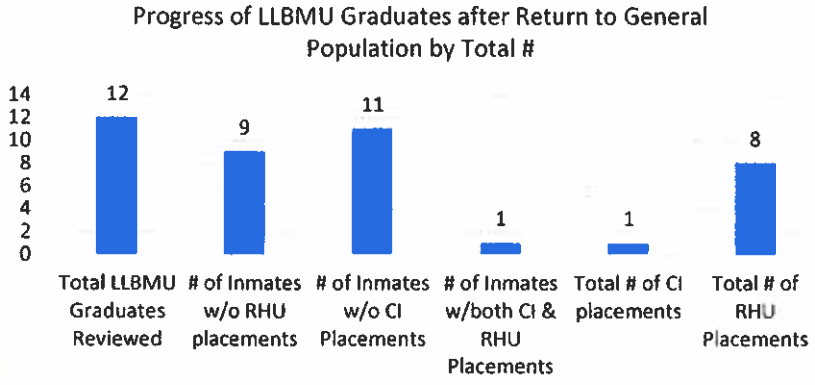
2b. Segregation:
2b.i. Provide access for segregated inmates to group and individual therapy services

Implementation Panel July 2018 Assessment: partial compliance

June 2018 Update

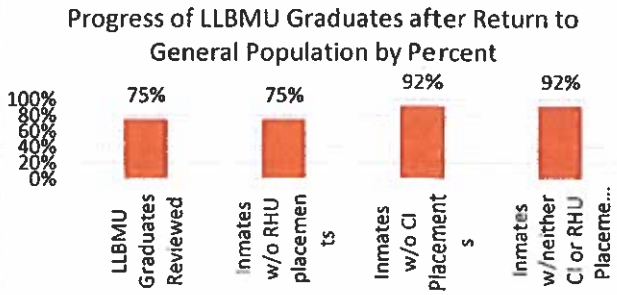
Although the LLBMU will not be toured during the June, 2018, IP visit, the following information provided details regarding the progress of inmates since graduating from the LLBMU.

Inmate Progress Since LLBMU Graduation		
	Total #	% of Total
# of LLBMU Graduates	16	-
Total LLBMU Graduates Reviewed	12	75%
# of Inmates w/o RHU placements	9	75%
# of Inmates w/o CI Placements	11	92%
# of Inmates w/both CI & RHU Placements	1	8%
Total # of CI placements	1	-
Total # of RHU Placements	8	-



*Progress at Transferring Institutions as of 5/29/18

Inmate Progress Since LLBMU Graduation		
	% of Total	Total #
LLBMU Graduates Reviewed	75%	12
Inmates w/o RHU placements	75%	9
Inmates w/o CI Placements	92%	11
Inmates w/neither CI or RHU Placements	92%	11



Progress at Transferring Institutions as of 5/29/18

Out-of-Cell Structured and Unstructured Time

HLBMU

Unstructured Time

Unstructured time is not captured in a RIM report. According to the QMHP for the program, Phase I inmates are allowed to be out of their cells for 2 hours/day from Monday-Friday. Phase II inmates are allowed to be out of their cells from 7:00am - 5:45pm daily. Phase III inmates are allowed to be out of their cells from 7:00am - 8:45pm daily. This schedule provides inmates in all three phases the opportunity to be out of their cells for at least 10 hours/week. Unstructured activity includes recreation, library time, and religious services.

Structured Time

This summary reports the percentage of inmates who received the required 10 hours of structured time as this is the requirement of the MH settlement agreement. Each institutional report includes the number and percentage of inmates who received at least 1 structured activity and the number and percentage of hours received. Although this summary may indicate in some weeks that 0% of inmates received 10 hours, the detailed report will reflect that most inmates received some structured time.

HLBMU

HLBMU Structured Out of Cell Time

Structured time for this report was analyzed using data from the RIM reports (groups and individual sessions with the QMHP and Psychiatrist) and the structured time database with information entered

by the QIAS (community meetings and activity therapy). Below is a summary of the structured time inmates received by the week for each month in the reporting period.

The following chart shows the number and percentage of inmates receiving structured time by minutes each week for the reporting period. In weeks four and five of March the percentage of inmates receiving 10 hours of structured time was at its highest at 94% and 83%, respectively.

HLBMU Inmates Summary	February			March				
	9-Feb	16-Feb	23-Feb	2-Mar	9-Mar	16-Mar	23-Mar	30-Mar
n=	17	17	17	17	17	17	18	18
% inmates getting 0 mins	12%	12%	18%	29%	6%	0%	6%	11%
% inmates getting 15-59 mins	0%	6%	0%	0%	0%	0%	0%	0%
% inmates getting 60-359 mins	41%	71%	47%	41%	12%	47%	0%	0%
% inmates getting 360-599 mins	41%	12%	35%	29%	24%	47%	0%	6%
% inmates getting 10 hours	6%	0%	0%	0%	59%	6%	94%	83%

HLBMU Inmates Summary	April				May				
	6-Apr	13-Apr	20-Apr	27-Apr	4-May	11-May	18-May	25-May	1-Jun
n=	18	18	18	19	17	17	17	16	16
% inmates getting 0 mins	6%	6%	6%	53%	24%	6%	18%	19%	6%
% inmates getting 15-59 mins	0%	0%	22%	16%	12%	0%	0%	0%	19%
% inmates getting 60-359 mins	17%	17%	67%	21%	47%	88%	71%	38%	63%
% inmates getting 360-599 mins	0%	28%	0%	0%	18%	0%	12%	38%	6%
% inmates getting 10 hours	78%	50%	0%	0%	0%	0%	0%	0%	0%

The following chart shows the number and percentage of inmates receiving structured time by minutes each week for the reporting period for the RHUs.

Restrictive Housing Units

Broad River RHU Inmates Summary	February				March				April				May				
	10-Feb	17-Feb	24-Feb	3-Mar	10-Mar	17-Mar	24-Mar	31-Mar	7-Apr	14-Apr	21-Apr	28-Apr	5-May	12-May	19-May	26-May	2-Jun
n=	31	32	33	33	31	30	34	35	37	39	40	43	44	42	43	44	43
Number inmates getting 0 min	55%	84%	85%	76%	84%	57%	79%	80%	78%	54%	80%	81%	82%	79%	88%	89%	100%
Number inmates getting 15-59 mins	19%	6%	3%	15%	0%	17%	3%	11%	11%	13%	13%	7%	14%	7%	0%	2%	0%
Number inmates getting 60-359 mins	19%	6%	3%	9%	16%	27%	18%	9%	5%	28%	0%	9%	5%	10%	7%	2%	0%
Number inmates getting 360-599 mins	6%	3%	0%	0%	0%	0%	0%	0%	3%	0%	0%	0%	0%	0%	0%	0%	0%
Number inmates getting 10 hours	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Kirkland RHU Inmates Summary	February				March				April				May				
	10-Feb	17-Feb	24-Feb	3-Mar	10-Mar	17-Mar	24-Mar	31-Mar	7-Apr	14-Apr	21-Apr	28-Apr	5-May	12-May	19-May	26-May	2-Jun
n=	6	7	8	9	8	7	6	7	7	7	10	9	9	12	14	16	16
Number inmates getting 0 min	83%	57%	75%	78%	13%	43%	83%	100%	43%	71%	100%	56%	89%	92%	93%	81%	75%
Number inmates getting 15-59 mins	0%	29%	13%	11%	25%	43%	0%	0%	29%	14%	0%	33%	0%	0%	7%	13%	25%
Number inmates getting 60-359 mins	0%	0%	0%	0%	38%	0%	0%	0%	0%	0%	0%	0%	11%	0%	0%	6%	0%
Number inmates getting 360-599 mins	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Number inmates getting 10 hours	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Perry RHU Inmates Summary	February				March				April					May			
	10-Feb	17-Feb	24-Feb	3-Mar	10-Mar	17-Mar	24-Mar	31-Mar	7-Apr	14-Apr	21-Apr	28-Apr	5-May	12-May	19-May	26-May	2-Jun
n=	41	45	51	44	37	35	38	47	38	36	35	33	35	40	35	39	37
Number inmates getting 0 min	85%	73%	78%	91%	81%	83%	97%	74%	87%	78%	97%	73%	100%	80%	97%	100%	100%
Number inmates getting 15-59 mins	10%	22%	16%	9%	16%	11%	3%	21%	13%	22%	3%	27%	0%	15%	3%	0%	0%
Number inmates getting 60-359 mins	2%	4%	0%	0%	3%	6%	0%	2%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Number inmates getting 360-599 mins	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Number inmates getting 10 hours	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Lee RHU Inmates Summary	February				March				April				May				
	10-Feb	17-Feb	24-Feb	3-Mar	10-Mar	17-Mar	24-Mar	31-Mar	7-Apr	14-Apr	21-Apr	28-Apr	5-May	12-May	19-May	26-May	2-Jun
n=	48	41	42	46	46	46	41	38	40	39	48	51	52	49	48	56	49
Number inmates getting 0 min	85%	88%	98%	96%	93%	91%	90%	95%	88%	95%	96%	98%	90%	94%	94%	100%	100%
Number inmates getting 15-59 mins	15%	10%	2%	4%	2%	7%	10%	5%	13%	5%	2%	2%	8%	4%	2%	0%	0%
Number inmates getting 60-359 mins	2%	0%	0%	0%	0%	0%	0%	0%	3%	0%	0%	0%	0%	2%	2%	0%	0%
Number inmates getting 360-599 mins	0%	0%	0%	0%	2%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Number inmates getting 10 hours	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Camille RHU Inmates Summary	February			March					April				May				
	10-Feb	17-Feb	24-Feb	3-Mar	10-Mar	17-Mar	24-Mar	31-Mar	7-Apr	14-Apr	21-Apr	28-Apr	5-May	12-May	19-May	26-May	2-Jun
n=	28	27	21	25	22	20	25	26	30	38	33	33	34	39	33	36	40
Number inmates getting 0 min	79%	74%	76%	80%	50%	60%	56%	73%	97%	95%	91%	76%	100%	87%	82%	22%	75%
Number inmates getting 15-59 mins	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Number inmates getting 60-359 mins	11%	22%	14%	16%	36%	25%	40%	19%	3%	5%	9%	24%	0%	13%	18%	33%	13%
Number inmates getting 360-599 mins	11%	4%	10%	4%	14%	15%	4%	4%	0%	0%	0%	0%	0%	0%	0%	44%	13%
Number inmates getting 10 hours	0%	0%	0%	0%	0%	0%	0%	4%	0%	0%	0%	0%	0%	0%	0%	0%	0%

July 2018 Implementation Panel findings: Problems remain in tracking out of cell time, which needs to be reconciled for future reporting purposes. All the programs were negatively impacted by the lockdown following the Lee CI riots. However, it was our understanding that both the HLBMU and LLBMU are no longer on a lockdown status. We did not assess either the HLBMU or LLBMU during this site assessment.

During the morning of July 17, 2018, we attended a graduation ceremony for five HLBMU inmates that was very impressive and meaningful for the inmates and family members who were able to attend.

July 2018 Implementation Panel Recommendations: SCDC should identify strategies that could potentially immediately remove all inmates in RHU on Security Detention status with the Mental Health Designation Levels 1, 2, 3. A QI Study should be conducted to assess why a high number of inmates that graduated from the LLBMU in March 2018 have been placed in RHU.

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

Implementation Panel July 2018 Assessment: noncompliance

June 2018 SCDC Status Update:

To mitigate conditions of confinement within the RHUs, crank radios have been distributed in some of the RHUs. It is unclear how many radios were designated specifically for the RHUs. QIRM staff conducted an assessment of the distribution of radios issued to inmates in the RHUs based on contracts and/or tracking logs received from the institutions. The table below illustrates the number of radios issued at institutions from which documentation was received.

Institution	# of radios issued
Broad River	61
Lee	95
Perry	22
Camille	89

In early assessments QIRM staff determined a lack of uniformity in guidelines directing the distribution of radios from one institution to another. Another concern identified was the stipulation that inmates had to be disciplinary-free for up to 90 days to qualify for the receipt of a radio. It was felt that this was counterproductive, as disciplinary infractions were factors for the RHU placement.

Several institutions developed contracts to track and outline provisions for inmates to receive and maintain radios. QIRM reported the lack of consistency across the agency. If an inmate qualified in one institution based on one institution's rules he/she may not qualify at another based on their different set of rules. This was brought to the attention of the Operations staff, and one set of guidelines has been developed to increase continuity and consistency across the system. This information was discussed at the June 20 Warden's meeting, and followed up with a memo outlining the official procedure and for distributing the crank radio. See Appendix K for copy of the memo and accompanying inmate contract.

Televisions

The chart below shows the status of the addition of televisions to the RHUs as reported by the Office of Operations. One hundred seventy one (171) televisions were purchased for installation in RHU's and 56 are installed and functioning to date.

Institution	# of TV's needed	TVs delivered To Institution
Allendale	8	8
Broad River	8	4
Evans	24	24
Camille	16	16
Kershaw	16	16
Kirkland	0	
Leath	5	5
Lee	10	10
Lieber	4	4
MacDougall	6	6
McCormick	8	8
McCormick (Step-down)	5	5
It was uncle and number of televisions that have been delivered to the institution of actually been set up. ArRidgeland	5	5
Trenton	4	4
Turbeville	10	10
Tyger River	40	0
Wateree	2	2
Total	171	127

July 2018 Implementation Panel findings: As per status update section. The uncertainty and apparent inconsistency re: the distribution of crank radios needs to be remedied. In addition, it was unclear the number of televisions, which had been delivered to various institutions, that were actually installed.

Previous efforts to mitigate the harmful effects of not being able to comply with many aspects of the Settlement Agreement have essentially ended at the present time related to the systemwide lockdown.

Broad River Correctional Institution

July 2018 Implementation Panel findings: Conditions of Confinement continue to be impacted by correctional staff shortages. The system-wide lockdown has further exacerbated BRCI being able to provide basic services. There did not appear to be any progress in improving RHU conditions of confinement since the March 2018 IP Site Visit. Also a significant number of inmates were transferred from Lee CI increasing the number of inmates in RHU. Out of Cell recreation did not occur in April 2018 and May 2018 due to the system-wide lockdown. Prior to the system-wide lockdown, BRCI had begun affording RHU inmates out of cell recreation. QIRM QI studies identified that 60-80 percent of the randomly selected RHU inmates in February 2018 and March 2018 were offered out of cell recreation 5 times per week. BRCI Management reported RHU inmates are receiving showers 3 times per week. QIRM QI studies conducted for randomly selected BRCI RHU inmates for the month of May 2018 indicated 0

percent received showers 3 times per week. SCDC records indicate that correctional staff are consistently failing to perform 30 minute inmate welfare checks at irregular times.

RHU inmates complained they are not receiving clothing exchange, opportunity to clean their cells and sick call access. Maintenance personnel were in RHU performing electrical repairs when the designated IP member visited RHU.

July 2018 Implementation Panel Recommendations: Remedy the identified deficiencies and begin providing basic RHU services. Continue QI studies monitoring BRCI efforts to improve RHU conditions of confinement.

Lee Correctional Institution

July 2018 Implementation Panel findings: During the morning of July 18, 2018, we observed the mental health rounding process in the RHU, which was performed in a competent manner but was significantly hampered by the noise level within the housing unit. Due to the lockdown status systemwide, inmates in the RHU have not had any recreational time since April 15, 2018.

During the rounding process, one inmate was identified as being actively psychotic, who was subsequently transferred to GPH following the cell front assessment. Another inmate, who was on suicide watch in a crisis cell within the RHU, only had a blanket. It was unclear why the institution did not have mattresses available for inmates on suicide watch.

The April 15, 2018 riot had a major impact on Lee CI RHU Operations. For a period of time after April 15, 2018, the second RHU had to be re-opened and operated without additional staff. Fortunately, SCDC has been able to transfer a number of inmates and again closed the 2nd RHU. However, the Lee CI lockdown continues to impact RHU operations. The IP identified that correctional staff are not making 30 minute inmate welfare checks at irregular times and the times between inmate welfare checks routinely exceeded one hour. RHU inmates complained they are not receiving clothing exchange or the opportunity to clean their cells. General RHU maintenance and sanitation was observed to be at an unacceptable level. Upon the IP receiving complaints from several RHU inmates that their cell lights were broken, Lee CI Management completed an inspection and reported 8 of 92 cells had lights that were broken and not working on the day of the site visit. SCDC QIRM QI studies indicate 20 percent of the RHU inmates are receiving showers 3 times a week.

July 2018 Implementation Panel Recommendations: Remedy the identified deficiencies and begin providing basic RHU services. Continue QI studies monitoring Lee CI efforts to improve RHU conditions of confinement. Obtain essential property, such as mattresses, for inmates on suicide watch.

Perry Correctional Institution

July 2018 Implementation Panel findings: During the morning of July 19, 2018, the IP observed the mental health rounding process in the RHU, which was done in a competent manner by the mental health tech. In general, this RHU was reasonably quiet and clean. Showers were being offered to inmates on a three times per week basis. Recreational time began to be offered to a limited number of inmates during the past two weeks. Medication administration occurred through the food slot. 57 of the 107 RHU inmates were on the mental health caseload.

July 2018 Implementation Panel Recommendations: Continue to implement access to out of cell time for all inmates in the RHU.

Leath Correctional Institution

July 2018 Implementation Panel findings: The RHU was clean and quiet. Inmates were receiving adequate access to showers but not adequate access to out of cell recreational time due to custody staff shortages.

July 2018 Implementation Panel Recommendations: Remedy the above.

Camille Griffin Graham RHU

Fifteen of the 23 RHU inmates were on the mental health caseload.

Staff reported that RHU groups continue to be provided to mental health caseload inmates in the RHU. RHU inmates reported generally being offered one hour per weekday of outdoor recreation, showers three times per week and some of the inmates reported access to weekly group therapies/activities. Access issues to the psychiatrist were described. Medication management issues did not appear to be present.

The unit was clean and quiet.

Drs. Metzner and Johnson observed a group therapy that involved 4 inmates that was well run by the mental health clinician.

July 2018 Implementation Panel Recommendations: Address the access issues to the psychiatrist and counselors. The statewide lockdown resulted in fewer out of cell activities and treatment in RHU's and General Population units.

2b.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 2018 Assessment: noncompliance

June 2018 SCDC Status Update:
All mental health inmates should receive timely individual sessions with the QMHP and Psychiatrist, even when in the RHU. The frequency of individual sessions is based on the mental health classification or clinical need of the inmate. Below are the results of an analysis of the timeliness of QMHP and Psychiatrist sessions for HLBMU and RHU inmates with a mental health classification.

HLBMU
During the reporting period, while inmates in phase 1 and phase 2 did receive individual sessions with the QMHP, none of the inmates were seen weekly as required in policy. For phase 3 inmates, 75% received timely sessions with the QMHP. Sessions with the Psychiatrist were also reviewed for timeliness, and 77% of BMU inmates had timely sessions with the Psychiatrist. For the complete analysis of timeliness of sessions, refer to pages 30 -33 in Kirkland's Institutional Report, Appendix L.

RHU

During the reporting period, RIM caseload monitoring reports were used to review timeliness of sessions with the QMHP and Psychiatrist. The reports used were dated March 1st, April 1st, May 1st, and June 1st. Sample sizes were based on the number of inmates on each report with a RHU classification. For complete details, refer to each institutions' report under the Caseload Management Section.

Broad River RHU

- From the **March 1st** report, 47% of the inmates had timely sessions with the QMHP and 63% had timely sessions with the Psychiatrist.
- From the **April 1st** report, 57% of the inmates had timely sessions with the QMHP and 50% had timely sessions with the Psychiatrist.
- From the **May 1st** report, 67% of the inmates had timely sessions with the QMHP and 47% had timely sessions with the Psychiatrist.
- From the **June 1st** report, 57% of the inmates had timely sessions with the QMHP and 63% had timely sessions with the Psychiatrist.

Camille RHU

There are no reports generated from NextGen that demonstrate timeliness of sessions. Therefore, a manual audit of ten (10) L3 RHU inmates was conducted in NextGen to analyze timeliness of sessions for the month of May. Of the 10 inmates reviewed, 40% had timely sessions with the QMHP and 0% had a timely sessions with the Psychiatrist. There was 1 inmate with a documented session with the Psychiatrist in May; however, the last session held prior to that one was in January, which makes the May session overdue.

Kirkland RHU

- From the **March 1st** report, 62% of the inmates had timely sessions with the QMHP and 62% had timely sessions with the Psychiatrist.
- From the **April 1st** report, 50% of the inmates had timely sessions with the QMHP and 100% had timely sessions with the Psychiatrist. (The sample size was 2 RHU inmates).
- From the **May 1st** report, 75% of the inmates had timely sessions with the QMHP and 75% had timely sessions with the Psychiatrist.
- From the **June 1st** report, 85% of the inmates had timely sessions with the QMHP and 77% had timely sessions with the Psychiatrist.

Lee RHU

- From the **March 1st** report, 60% of the inmates had timely sessions with the QMHP and 57% had timely sessions with the Psychiatrist.
- From the **April 1st** report, 69% of the inmates had timely sessions with the QMHP and 62% had timely sessions with the Psychiatrist.
- From the **May 1st** report, 60% of the inmates had timely sessions with the QMHP and 70% had timely sessions with the Psychiatrist.
- From the **June 1st** report, 57% of the inmates had timely sessions with the QMHP and 43% had timely sessions with the Psychiatrist.

Perry RHU

- From the **March 1st** report, 83% of the inmates had timely sessions with the QMHP and 90% had timely sessions with the Psychiatrist.

- From the **April 1st** report, 87% of the inmates had timely sessions with the QMHP and 93% had timely sessions with the Psychiatrist.
- From the **May 1st** report, 92% of the inmates had timely sessions with the QMHP and 80% had timely sessions with the Psychiatrist.
- From the **June 1st** report, 96% of the inmates had timely sessions with the QMHP and 93% had timely sessions with the Psychiatrist.

July 2018 Implementation Panel findings: As per status update section.

July 2018 Implementation Panel Recommendations: Need to determine the reasons for noncompliance and remedy the underlying causes.

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

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

Between June 19- June 21, 2018, forty-eight inmates of significant concern to SCDC were transferred to an out-of-state private prison in Mississippi, which will potentially relieve some RHU tensions. Lee CI RHU inmates on medications are being swapped with inmates NOT on medications due to the continuing challenges within the Lee RHU and to decrease the nursing workload. As of June 19, the RHU inmates on medication were being cohorted for to make it easier for nurses to dispense medication. Several facilities, including Lee and BRCI, have had a "mental health day" with consolidated efforts to catch up on backlogs of visits for inmates. Turbeville is being targeted to become a specialized RHU for mental health inmates, with additional programming.

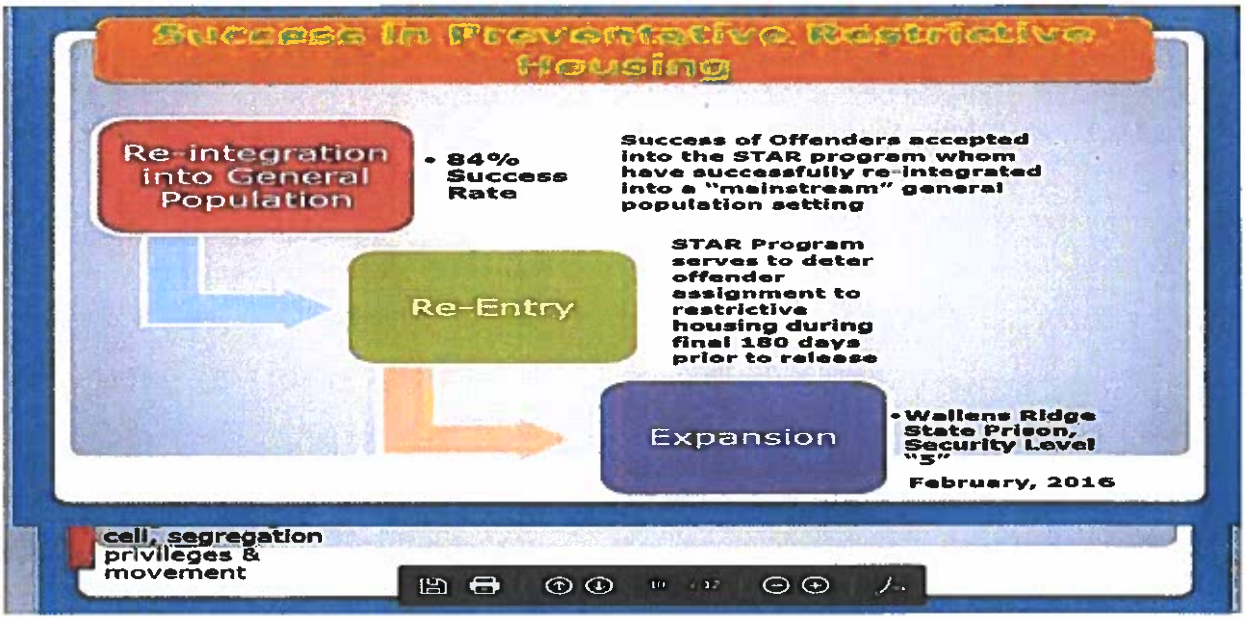
One thousand, nine hundred fifty (1950) crank Radios have been purchased this fiscal year and distributed to the mentally ill and non-mentally ill RHU inmates with priority first to SD (long-term), then SP (protective concerns), then to all in RHU inmates.

One hundred sixty-three (163) televisions were purchased for installation in RHUs, and 56 are installed and functioning to date.

Class 16 of CIT staff completed training on June 15, 2018. NIC has approved offer of Mental Health first Aid for SCDC with training scheduled for 60 staff from September 26-27, 2018.

To address segregation and the cycle of fear that impacts readmissions to CSU, Evans CI has been designated for a Specialty Concerns Unit. This Unit will house inmates who refuse to leave the RHU due to fear and it will eventually be used to house the inmates who are threatening suicide and going to CSU to escape fearful situations.
Evans is awaiting the appointment of an AW of Programs. The former AW Programs retired but returned as a QMHP. The position for AW of programs has been posted.

Key staff including the Warden from Evans traveled to Virginia to see its STAR program in action, considering it as a program model. Additional programming will be identified. A position for a QMHP was offered but was declined due to salary. The position has since been reposted. Currently there are two Mental Health Techs.



Character dorm inmates from Kershaw and Ridgeland (50 each) have been identified to transfer to Evans when programming is available. Seventeen Allendale Character Inmates have transferred to Evans CI at this point with over 200 "protective concerns" inmates in RHUs across SCDC awaiting potential movement to Evans when programming is available.

July 2018 Implementation Panel findings: As per status update section. It is concerning that the trip to Virginia resulted in apparent enthusiasm by custody staff to add canines as part of the security detail.

We look forward to receiving more information re: the proposed Specialty Concerns Unit.

During the morning of July 19, 2018, the IP interviewed about 40 inmates in the stepdown unit at the Perry CI in a community meeting setting. Twenty-four (24) of the 43 inmates in this unit were on the mental health caseload. Medication management issues were not present. Caseload inmates generally met with their QMHPs about every 90 days. A very structured program for all transition unit inmates was described by the inmates, which were generally reported to be very positive.

July 2018 Implementation Panel Recommendations: Please send additional information re: the Specialty Concerns Unit.

2b.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 2018 Assessment: compliance (November 2016)

June 2018 SCDC Status Update:

The "Mental Health Classifications for Mentally Ill Institutional and Female GEO Care Population" Report produced by RIM each Tuesday identifies the percentage of mentally ill and non-mentally ill inmates for each institution. Utilizing this report along with the "Inmates in Lockup by Institution and Mentally Ill vs. Non-Mentally Ill Population" Report QIRM was able to compare populations as charted below. For the months of February through May 2018, about 41% of the Segregation Population was Mentally Ill inmates. That remains disproportionate to the approximately 16% of the total population that were mentally ill.

	Week	Tot. MI	Tot. Pop.
Feb	1	**3,585**	**19,323**
	2	**3,602**	**19,333**
	3	**3,614**	**19,406**
	4	**3,647**	**19,458**
March	1	**3,613**	**19,208**
	2	**3,610**	**19,160**
	3	**3,640**	**19,204**
	4	**3,656**	**19,281**
April	1	**3,603**	**19,064**
	2	**3,623**	**19,089**
	3	**3,640**	**19,137**
	4	**3,674**	**19,286**
	5	**3,704**	**19,410**
May	1	**3,648**	**19,088**
	2	**3,662**	**19,130**
	3	**3,682**	**19,169**
	4	**3,713**	**19,313**
Quarter Tot.		**61,916**	**327,059**

Percentages of Mentally Ill & Non Mentally Ill Inmates in Segregation vs Total Population

	Segregation			Tot. Population		
	Mentally Ill	Non Mentally Ill	Total	Mentally Ill	Non Mentally Ill	Total
	6,033	8,736	14,769	61,916	327,059	388,975
% of Total	**40.85 %**	**59.15 %**	100%	**15.92 %**	**84.08 %**	100%

July 2018 Implementation Panel findings: As per status update section. We remain concerned regarding the overrepresentation of mentally ill inmates in RHUs.

July 2018 Implementation Panel Recommendations: Assess the underlying reasons that mentally ill inmates are so overrepresented in RHU and remedy the situation.

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

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

A review of temperature and cell check logs was completed to evaluate the temperature and cleanliness of segregation cells as self-reported by the officers in Broad River CSU and RHU; Camille CSU and RHU; and Kirkland's D-Unit, F-1, and GPH; Evans RHU; and Perry RHU (B, C, and D Dorms). Officers are required to check temperature and cleanliness in segregation units twice daily in a total of 8 randomly chosen cells daily. The documentation from these checks (SCDC Form 19-163) is to be uploaded into the S:/Operations folder or, if done through the newly developed electronic OATS system, it is uploaded by RIM into the Secure Login App. Therefore, the data source for this review was taken from this shared folder or the App. If the documentation had not been uploaded, it was considered not done. The full review, attached as Appendix M.

Random, Daily Cell Checks

Each institution is required to check random cells in each segregation unit twice daily for temperature and cleanliness, document the check, and upload the documentation to the shared Operations folder. Some institutions had significant deficiency in checking the number of cells required every day. Some deficiencies came because no documentation was uploaded; others were because only one shift would document the daily temperature and cleanliness checks.

The review showed that only BRCI CSU (80%), BRCI RHU (72%) and CGCI CSU (82%) did not upload data daily with at least a 90% compliance. BRCI's RHU had low compliance at 72%; however, this is a tremendous improvement over the 3% they had showed in the October 2017 – January 2018 period. It appears the OATS system which they started in April, has helped to increase their compliance significantly.

Temperature Checks

Of all the cell checks that were documented, across the board, 100% of the cells did have temperature checks documented.

Temperature Range

Some institutions maintained most of their temperatures within the acceptable range while others had significant problems. Broad River RHU (97%), Camille CSU (97%), KCI GPH (93%), and Perry RHU (B-Dorm 96%, C-Dorm 96%, D-Dorm 98%) all had substantial compliance keeping their temperatures within the accepted range (68°-78°). Kirkland's F-1 had 89% and the D-Unit 86% compliance with temperature ranges, and BRCI CSU (76%) and Evans RHU (77%) had the lowest compliance.

There were two segregated areas where some temperatures were significantly (> 8 degrees) outside the accepted range. Evans RHU and Perry's C-dorm had 10% and 13% of their out-of-range temperatures respectively that were significantly out of range.

Correcting Temperature Deficiencies

When temperatures were out of range, there was seldom documentation that anything was done to correct the problem. In previous months, CGCI had piloted using a revision to Form 19-163 in which a field was required if the temperature was outside the accepted range of 68°-78°. In the first study, Camille documented taking action in 43% of the cases where the temperature was out of range; in this study, CGCI RHU reported 82% compliance and CGCI CSU reported 38% compliance, compared to 2% at BRCI CSU, and 0% elsewhere. This was in spite of the fact that several of the units began using the revised form during the time period covered in this audit. As noted in the previous study, no documentation has been provided to show if the work orders have been acted upon or if the facility

temperatures have improved. It appears that the OATS app format does not require any specific action if the temperature is out of range, so the officers are not documenting anything, if they are doing anything.

Cleanliness and Sanitation Checked
All institutions were consistent (~97 - 100% compliance) in documenting cell cleanliness when they checked a cell.

Cleanliness and Sanitation Deficiencies Corrected
Of those cells that were checked for cleanliness, no institution showed a substantial compliance in documenting the correction of problems with cell cleanliness, though Evans scored the highest (82%). Camille CSU was second at 50%. Officers at KCI's GPH occasionally documented if a deficiency was addressed (18%).

July 2018 Implementation Panel findings: As per status update section. There was significant improvement in institutions performing and uploading temperature checks and cell inspection forms. Institutions failing to address and/or correct identified temperature and sanitation deficiencies remains an issue.

July 2018 Implementation Panel Recommendations:

1. Operations Management ensure all prisons are performing daily inspections for cleanliness and taking temperatures of random cells;
2. 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;
3. SCDC QIRM continue to perform QI Studies regarding Correctional Staff performing daily, random cell temperatures and cleanliness inspections.

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

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
QIRM continues to identify processes to improve data collection and reporting to accurately and effectively reflect improvement work and compliance with the components of the Mental Health Settlement Agreement.

After a policy review, it has been identified that policy–driven processes have not been fully implemented which may be a contributing factor in concerns regarding data and reporting. A conceptual model was generated based on the criteria for reporting as outlined in policies HS 19.07, Mental Health Services - Continuous Quality Management (CQM), and GA 06.06, Continuous Quality Improvement Review.

A Quality Management Master plan, Appendix N, has been developed that outlines how both policies, when fully implemented as written, will result in improved data reporting and monitoring throughout all levels of the agency. The plan will compel institutional and program staff to identify areas for

improvement and allow them to self-monitor progress towards compliance. The plan incorporates reporting from the program and institutional level through the Senior Management Board.

During the last reporting period, the following ICQMC Meetings were held at various institutions as outlined in SCDC Policy GA 06.06. Meeting minutes and agenda are included in Appendix O

Camille Graham Correctional Institution
An Institutional Continuous Quality Management Committee (IQCMC) meeting for Camille Graham was conducted on Thursday, May 31, 2018 at 1:00pm. Based on information provided and discussed, the institution identified the following Process Improvement Plans to address deficiencies:

During this meeting, areas identified for a PIP (Process Improvement Plan) focused on creating a protocol for CSU and improving NextGen documentation. Improper documentation in NextGen has been identified by staff as a possible reason for low compliance ratings in different areas. For example, treatment plans are sometimes entered in places other than the treatment plan tab, individual sessions with the QMHP are sometimes coded as contact notes, and RHU rounds are coded as group notes. The completed PIP which outlines the institution's plan to address these areas has not been received.

Agenda, minutes and submitted PIP updates for each institution are included Appendix O

Lee Correctional Institution
An Institutional Continuous Quality Management Committee (IQCMC) meeting for Lee was conducted on Tuesday, March 27, 2018 @ 10:30am. Based on information provided and discussed, the institution identified the following Process Improvement Plans to address deficiencies RHU out of cell group activity

- Lack of Mental Health staffing
- Update M-120 to reflect increased shower for inmates on CI/SP status.

MacDougall Correctional Institution
An Institutional Continuous Quality Management Committee (IQCMC) meeting for MacDougall was conducted on Wednesday, March 28, 2018, at 10:00am. Based on information provided and discussed, the institution identified the following Process Improvement Plans to address deficiencies:

- Weekly Treatment Teams Participation and MUSC Contract Review
- Staffing of CIT members (2 each Shift)
- Internal Audit process

Broad River Correctional Institution
An Institutional Continuous Quality Management Committee (IQCMC) meeting for Broad River was conducted on Wednesday, June 6, 2018, at 9:00am. Broad River has not identified any PIPS.

Kirkland Correctional Institution
An Institutional Continuous Quality Management Committee (IQCMC) meeting for Kirkland was conducted on Monday, Feb.12, 2018, at 9:00am. The agenda outlined discussion topics to include the following:

The second Institutional Continuous Quality Management Committee (IQCMC) meeting for Kirkland was conducted on Thursday, June 14, 2018, at 9:00am

July 2018 Implementation Panel findings: As per status update section. It is our understanding that the current plan is for the individual institutions to be responsible for the relevant continuous quality improvement process, which will be monitored by QIRM.

July 2018 Implementation Panel Recommendations: As above.

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 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
In efforts to bring the agency into compliance with the stipulations set forth in the SCDC Mental Health Lawsuit settlement, the Implementation Panel has been particularly focused on certain areas of SCDC policies and practices. One area of focus for the Implementation Panel is Use of Force as it applies to inmates on the Mental Health Caseload. The frequency and severity of force that is used with this population is a major concern. For this reason, a Use of Force Coordinator for the Division of Mental/Behavioral Health and Substance Abuse Services was hired on March 19, 2018. The Coordinator reviews medical records and Offender Management System for recent psychiatry visits, Treatment Team reviews, individual counseling sessions, group counseling sessions, uses of force on client, and disciplinary history to assess whether a possible change to level of care, medications, etc., may be indicated. In this role the Coordinator determines if protocols were followed relative to contacting QMHP prior to a planned use of force and determines if the response was timely and effective in mitigating a use of force.

In a review of uses of force involving mentally ill and non-mentally ill inmates, the data continues to demonstrate that although the mentally ill population makes up the smaller percentage of inmates, the uses of force continues to be used at a higher rate among this population. Although they only make up 19% of the population, the data shows that they 54% of the uses of force involved inmates with a mental health classification for these reporting months.

	Mental Health Inmates (MH)	UOF MH	Non-mental Health NMH	UOF NMH	Total Pop	Total UOF
February	3585	44	15738	52	19323	96
March	3613	68	15592	38	19205	106
April	3603	46	15461	43	19064	89
	10801	158	46791	133	57592	291
% of uses of Force		54%		46%		
% of the Total Population	19%		81%			

July 2018 Implementation Panel findings: As per status update section. The Use of Force Coordinator for the Division of Mental/Behavioral Health and Substance Abuse Services is formalizing procedures to review use of force incidents involving inmates with a mental health designation. A study is currently underway to review and assess inmates with a mental health designation that are frequently involved in use of force incidents. The Use of Force Coordinator for the Division of Mental/Behavioral Health and Substance Abuse Services and Operations Administrative Regional Director (ARD) have begun collaborating on use of force incidents involving inmates with a mental health designation. Data reveals a

slight percentage decrease in the number of inmates with a mental health designation being involved in use of force incidents from 49 percent to 46 percent since the March 2018 Assessment while the SCDC inmate population with a mental health designation increased from 18.7 percent to 19 percent.

July 2018 Implementation Panel Recommendations:

1. SCDC continue to monitor all Use of Force incidents to identify and address the reasons for disproportionate Use of Force involving inmates with mental illness;
2. SCDC formalize and implement procedures to review inmates with a mental health designation that are involved in use of force incidents.
3. Identify strategies to reduce use of force against inmates with mental illness and non-mentally ill inmates;
4. The Division of Operations Administrative Regional Director and Division of Mental Health UOF Coordinator collaboratively work together to address issues and concerns that contribute to disproportionate UOF involving mentally ill inmates;
5. All required SCDC staff complete Use of Force Training in Calendar Year 2018.

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 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

A report of Employee Corrective Actions was provided for July 2017 through April 2018. During this timeframe there were nineteen reported corrective actions imposed at eight institutions. The imposed sanctions ranged from verbal warnings to termination for the following offenses:

1. Excessive Use of Chemical Munitions
2. Gross Misconduct
3. Unnecessary/ Excessive Use of Force
4. Negligence in Carrying Out Job Duties
5. Policy Violation
6. Violation of Rules/ Regulation

Institution	Incident Date	Date of CA	Reason for CA	Corrective Action	Additional Corrective Action
Evans CI	1/15/2018	5/4/2018	Policy Violation	Memo/ Letter of Understanding (LOU) or Discussion	Attended Training 4/18/18
Evans CI	2/22/2018	5/1/2018	Policy Violation	Memo/ LOU or Discussion	Training 4/18/18
Evans CI	3/6/2018	5/11/2018	Policy Violation	Memo/ LOU or Discussion	
Evans CI	3/26/2018	4/16/2018	Policy Violation	Memo/ LOU or Discussion	Training 4/18/18
Leath CI	1/26/2018	3/28/2018	Negligence Carrying Out Job Duties	Memo/ LOU or Discussion	

Leath CI	1/26/2018	3/28/2018	Negligence Carrying Out Job Duties	Memo/ LOU or Discussion	
Lee CI	1/27/2018	2/2/2018	Unnecessary and/or Excessive Force	Verbal Warning	
Lee CI	3/12/2018	3/14/2018	Gross Misconduct & Unnecessary / Excessive Force	Termination	
Perry CI	11/4/2017	2/15/2018	Violation Rules/ Regulations	Written Warning	
Perry CI	1/4/2018	2/15/2018	Unprofessional Conduct	Suspension	
Perry CI	1/14/2018	4/9/2018	Excessive Use of Chem Munitions	Verbal Warning	
Ridgeland CI	1/6/2018	6/6/2018	Policy Violation	Memo/ LOU or Discussion	
Ridgeland CI	2/27/2018	2/28/2018	Excessive Use of Chem Munitions	Letter of Discussion	Attended Training 5/31/18
Trenton CI	11/23/2017	2/15/2018	Excessive Use of Chem Munitions	Memo/ LOU or Discussion	
Trenton CI	2/10/2018	2/24/2018	Excessive Use of Chem Munitions	Memo/ LOU or Discussion	
Trenton CI	4/3/2018	5/8/2018	Negligence Carrying Out Job Duties	Suspension	
Turbeville CI	12/15/2017	1/22/2018	Negligence Carrying Out Job Duties	Written Warning	
Turbeville CI	12/27/2017	3/1/2018	Negligence Carrying Out Job Duties	Suspension	
Tyger River CI	7/12/2017	7/22/2017	Unnecessary/ Excessive Force	Suspension	

July 2018 Implementation Panel findings:
SCDC continues implementation of the revised OP 22.01 Use of Force Policy requiring instruments of force to be employed in a manner consistent with manufacturer's instructions. SCDC has not provided documentation the Housing Unit Post Orders as it applies to *Cover Teams* has been revised to achieve compliance that MK-9 use is consistent with manufacturer's instructions. The SCDC Division of Security provided a list of SCDC approved Use of Force Equipment in April 2018.

SCDC continues efforts to ensure all instruments of force, (e.g., chemical agents and restraint chairs) are employed in a manner fully consistent with manufacturer's instructions, and are tracked to enforce compliance. Reports are compiled and distributed weekly and monthly containing the summaries for types of force utilized as well as the MINs summaries. Findings are verbally reported and discussed in a weekly meeting with QIRM and Operations Staff.

SCDC had two incidents during the relevant period that required restraint chair use. UOF Reports identified that hard restraints were utilized a total of 6 times: February (2), March (1), April (3), and May (0). The IP was not provided data on the amount of time the inmates remained in hard restraints nor was information provided regarding whether an assessment was conducted to determine if SCDC guidelines for hard restraint use were followed.

SCDC reported no incidents where canines or batons were used in a UOF.

SCDC data continues to identify a high percentage of incidents where MK 9 was not employed in a manner fully consistent with manufacturer's instructions. As identified in the status update section, there is more accountability for employees committing UOF violations.

July 2018 Implementation Panel Recommendations:

1. Operations and QIRM continue to review use of force incidents through the automated system to ensure instruments of force are fully consistent with the manufacturer's instructions;
2. QIRM continue to meet weekly with Operations leadership to discuss UOF and other relevant issues;
3. SCDC revise the UOF Report to include Canines;
4. All required staff complete Use of Force Training in Calendar Year 2018.

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 2018 Assessment: compliance (July 2017)

June 2018 SCDC Status Update:

Operations and QIRM staff continue to review and monitor use of force incidents through the automated systems and in a daily review of MINS. There have been no documented reports from February- May 2018 of inmates being placed the crucifix or other positions that do not conform to generally accepted correctional standards.

July 2018 Implementation Panel findings: As per status update section. SCDC remains in compliance. Neither SCDC nor the IP identified any incident where an inmate was placed in the crucifix or other position that did not conform to generally accepted correctional standards.

July 2018 Implementation Panel 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 2018 Assessment: **compliance (March 2018)**

June 2018 SCDC Status Update:
During the months of February – April 2018 there were two documented incidents involving the use of the restraint chair. Both incidents involved inmates with a mental health classification, one occurring at Broad River CSU and the other at Perry RHU. This information is provided in the Automated Use of Force System and cross reference with the inmate's Automated Medical Record and the RIM report, which is produced on the 22nd of each month, therefore the month of May 2018 was not available. The restraint chair report is included in the Regional Monthly Reports. The most recent report is included as Appendix P.

July 2018 Implementation Panel findings: As per status update sections. From February through April 2018 there were two (2) reported uses of the restraint chair. Both incidents occurred in April 2018 and involved inmates with a mental health designation. IP document reviews found the required restraint chair guidelines were followed. SCDC continues to rarely use the restraint chair and is commended on their success in limiting its use. UOF Reports identified that hard restraints were utilized a total of 6 times during the relevant period: February (2), March (1), April (3), and May (0). The IP was not provided data on the amount of time the inmate remained in hard restraints and whether SCDC guidelines for hard restraint use were followed.

July 2018 Implementation Panel Recommendations: QIRM continue to track and monitor compliance with use of the restraint chairs. Inmates placed in hard restraints should be monitored and tracked by QIRM in addition to restraint chairs to include: compliance with guidelines and the amount of time in hard 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 2018 Assessment: compliance (December 2017)

June 2018 SCDC Status Update:
The QIRM Use of Force Reviewer was able to substantiate the length of time for both inmates placed in the restraint chair during this reporting period. The inmate at BRCI CSU was in the restraint chair for 47 minutes (7:05pm – 7:52pm). The inmate in Perry RHU was in the restraint chair for 120 minutes (2:20pm – 4:20pm). The videos for both inmates were reviewed and the Automated Medical Records were utilized to verify this information. The restraint chair report is included in the Regional Monthly Reports. The most recent report is included as Appendix P.

July 2018 Implementation Panel findings: Per SCDC update. QIRM collects data and issues quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs. For the 2 restraint chair uses in the relevant period (both occurred in April 2018): one was for 47 minutes and the other 2 hours.

July 2018 Implementation Panel Recommendations: QIRM continue to prepare a Restraint Chair Report for each monitoring period.

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

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

During the June 20, 2018, Wardens meeting, ADDO [redacted] discussed the use of chemical munitions in the RHUs. He later followed up with an email, Appendix R that reinforced the need for monitoring how force is applied, with a focus on only using force only when necessary and appropriate. The email provided the policy statement and sections of SCDC Policy, OP 22.01 *Use of Force,* relative to the variables in determining if force should be used and when force should be planned versus unplanned. Wardens, Associate Wardens and Majors were provided with a list of the use of force components with the directive to focus on the highlighted sections below:

Use of Force

- 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;
- Prohibit the use of force in the absence of a reasonably perceived immediate threat; 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;

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
OFFICER OF THE DEPUTY DIRECTOR FOR OPERATIONS

MEMORANDUM

The following has been implemented by the Division of Operations to ensure that Use of Force (UOF) are conducted only when necessary and appropriate, in accordance with SCDC Policy OP-22.01, Use of Force.

1. **The Division of Operations, will discuss UOF issues, with emphasis placed on UOF violations, at all monthly Wardens meetings, Quarterly A/W meetings and Captains/Majors Meetings.**
2. **Wardens will administer employee corrective action when UOF violations are observed by the Regional Director Reviewer.**
3. **All employee corrective action is required to be documented, including Letters of Understanding and Verbal Counseling, with a copy send to the Division of Operations ARD.**
4. **The Administrative Regional Director (ARD) is conducting refresher training at institutions to address specific policy violations that occur in the institution. Refresher training has been conducted at the following institutions: Evans Correctional Institution on April 18, 2018, Trenton Correctional Institution on May 17, 2018, Ridgeland Correctional Institution on May 31, 2018 and Kershaw Correctional Institution on June 14, 2018.**
5. **The ARD is tracking trends of the number of UOF an employee is involved in on a monthly basis. Employees with high numbers of UOF will be assessed and interviewed to determine whether the UOF was necessary and appropriate.**
6. **Quality Improvement Risk Management have identify the following institutions as having the high number of UOF, (Broad River, Lieber, and Perry.) The Regional Directors will met with each Warden and his staff to determine if the resolutions to the incidents were appropriate or could they have been resolved differently.**

Glenn Stone, Admin. Regional Director

Institutional leaders were required to discuss with and provide a copy of the email and attachment to executive staff and RHU employees; and by July 1, provide documentation that the information was received by and discussed with staff.

The memo below was sent to institutional staff outlining steps implemented by the Division of Operations to ensure that Use of Force (UOF) are conducted only when necessary and appropriate, in accordance with SCDC Policy OP-22.01, Use of Force.

UOF Referrals to Police Services

SCDC Police Services maintains the complete records for Use of Force referrals to their Office for cases that are opened for investigation. A newly implemented function within the AUOF system will now allow approved positions, such as Wardens and Regional Directors, to make referrals to Police Services. For February – April 2018, the following case information was provided:

Investigations opened in Police Services Case Management System (PCM)

Case #	Status	Incident Date	Incident Location	Open Date	Closed Date	Primary	Classification Codes
31-2018-017	Administratively closed	3/14/2018	(0442) Ridgeland	3/22/2018	5/9/2018	UOF	Personnel investigations
32-2018-042	Active	3/12/2018	(0551) lee	3/13/2018		UOF	Assistance to institutions or other
34-2018-028	Administratively closed	3/4/2018	(0191) Perry	3/8/2018	3/19/2018	UOF	Personnel investigations
31-2018-011	Administratively closed	2/8/2018	(0442) Ridgeland	2/8/2018	5/25/2018	UOF	None

18-02-0421-0024 – incident date 2/13/18 - no case warranted

Excessive UOF Grievance Study

It is required by policy, GA-01.12, Inmate Grievance System, number 11, that in most instances, grievances will be processed from initial to final disposition within 171 days, except when an extension is requested by the authorized person (Grievance Branch Chief). As part of SCDC's ongoing efforts to ensure this requirement is met, a CQI study was completed to evaluate the timeliness of the processing of excessive use of force, unprofessional conduct, and physical abuse grievances and to determine if an appropriate response was provided to the inmates who filed such grievances. In this study, grievances coded as excessive use of force, unprofessional conduct, and physical abuse were reviewed for the months of February 2018, March 2018, and April 2018. The grievances were included in the study if the narrative of the grievances described excessive use of force or if an alleged action by the officer lead to a physical injury to an inmate.

During the month of February, there were a total of 20 grievances filed that met the criteria outlined in the detailed report in Appendix R. Of those 20 grievances filed, 10 of them were unprocessed and returned to the inmates. The remaining 10 were processed per policy.

During the month of March, there were a total of 10 grievances filed that met the criteria for inclusion. Of those 10 grievances filed, four of them were unprocessed and immediately returned to the inmates. The remaining 6 were processed, but not all were processed per policy.

During the month of April, there were a total of 15 grievances filed that met the criteria for inclusion. Of those 15 grievances filed, 11 were unprocessed and immediately returned to the inmates. The remaining four were processed per policy.

Issues Identified:

- Several of the unprofessional conduct grievances should have been coded as excessive use of force based on the narrative in the grievance summary.
- Some grievances were returned to inmates citing the inmate's failure to attempt a sufficient informal resolution; however, Policy GA 01.12, section 13.2 states in certain cases informal resolution may not be appropriate or possible when the matter involves allegations of criminal activity.
- Inmates were not always served with the warden's response within the required timeframe.

July 2018 Implementation Panel findings:
The IP continues to monitor SCDC Use of Force MINS Narratives monthly and identify incidents where there did not appear to be a reasonably perceived immediate threat that required a use of force. Headquarters Operations Leadership has begun holding meetings with Institution Management staff where high numbers of problematic UOF incidents are identified to develop strategies to address inappropriate UOF. The IP Use of Force Reviewer and SCDC Operations Leadership also continue to jointly review Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of force.

SCDC Use of Force MINS for February 2018 through May 2018:

February 2018	110
March 2018	120
April 2018	100
May 2018	156

As indicated, the number of UOF incidents have remained steady except May 2018 when there was an approximate 33 percent increase in UOF incidents. A likely contributing factor to the dramatic increase in UOF incidents is the Agency system-wide lockdown. The IP is not aware of SCDC performing a formal analysis to determine why there was a dramatic increase in UOF incidents for May 2018.

SCDC had 18 Inmate Grievances alleging excessive UOF from March 2018 to May 2018. QIRM conducted a CQI Study to assess whether grievances for excessive UOF are processed timely and inmates receive an appropriate response with a final disposition rendered. The Agency Inmate Grievance Program Administrator was interviewed by an IP member. He had serious concerns with how the QI Study was conducted and believed the study had serious flaws. The Grievance Administrator identified the Agency does not clearly identify the department responsible for investigating grievances related to excessive UOF.

SCDC Police Services provided data regarding their involvement in Use of Force investigations as follows for the relevant period March 2018 through June 2018:

Referrals Received	5*
Investigations Opened	4
Investigations Pending	1
Investigations Closed	3**
Investigation Unwarranted	1

* The number of Police Services UOF investigations opened and conducted based on the number of incidents occurring each month in the system (averaging over 100 UOF incidents per month) is very low.
** Administratively Closed.

SCDC continues to enhance the UOF Policy accountability component to appropriately address Use of Force violations. SCDC provided documentation verifying corrective action is being taken for employees identified committing UOF violations. The Agency still does not have a written

procedure to track employees referred for UOF violations from when they are identified to final disposition.

SCDC continues to pilot the Canine Policy and Training prior to full implementation. The responsible IP Member has not been forwarded any UOF incidents involving canines during the relevant period to assess if there are any issues or concerns.

The IP remains concerned about inappropriate and excessive use of force by SCDC employees as determined by reviewing UOF MINS Narratives for the relevant period. The main concerns are: 1) employees utilizing immediate UOF when the circumstances appear to meet the criteria for a planned UOF; 2) failure to contact a QMHP prior to planned UOF when time permits; 3) inappropriate MK9 use in volumes that is excessive without justification; and 4) failure to follow required SCDC decontamination procedures after chemical agent use.

July 2018 Implementation Panel 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. IP continue to review SCDC Use of Force reports and monthly Use of Force MINS Narratives and provide SCDC feedback;
4. The IP Use of Force Reviewer and SCDC Operations Leadership continue to jointly review Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of force;
5. QIRM and the Agency Grievance Coordinator develop a research design to conduct a CQI Study that properly assesses if grievances for excessive UOF are processed and inmates receive an appropriate response with a final disposition rendered in a timely fashion;
6. Police Services continue to provide the number of investigations: substantiated, unsubstantiated or unfounded;
7. Develop and implement a written procedure to track employees recommended and/or referred for UOF violations;
8. All required staff complete Use of Force Training in the Calendar Year 2018; and
9. Require meaningful corrective action for employees found who have committed use of force violations;
10. Provide the IP with an update on the Canine UOF and Training Pilot and include canines on the UOF Report.

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;

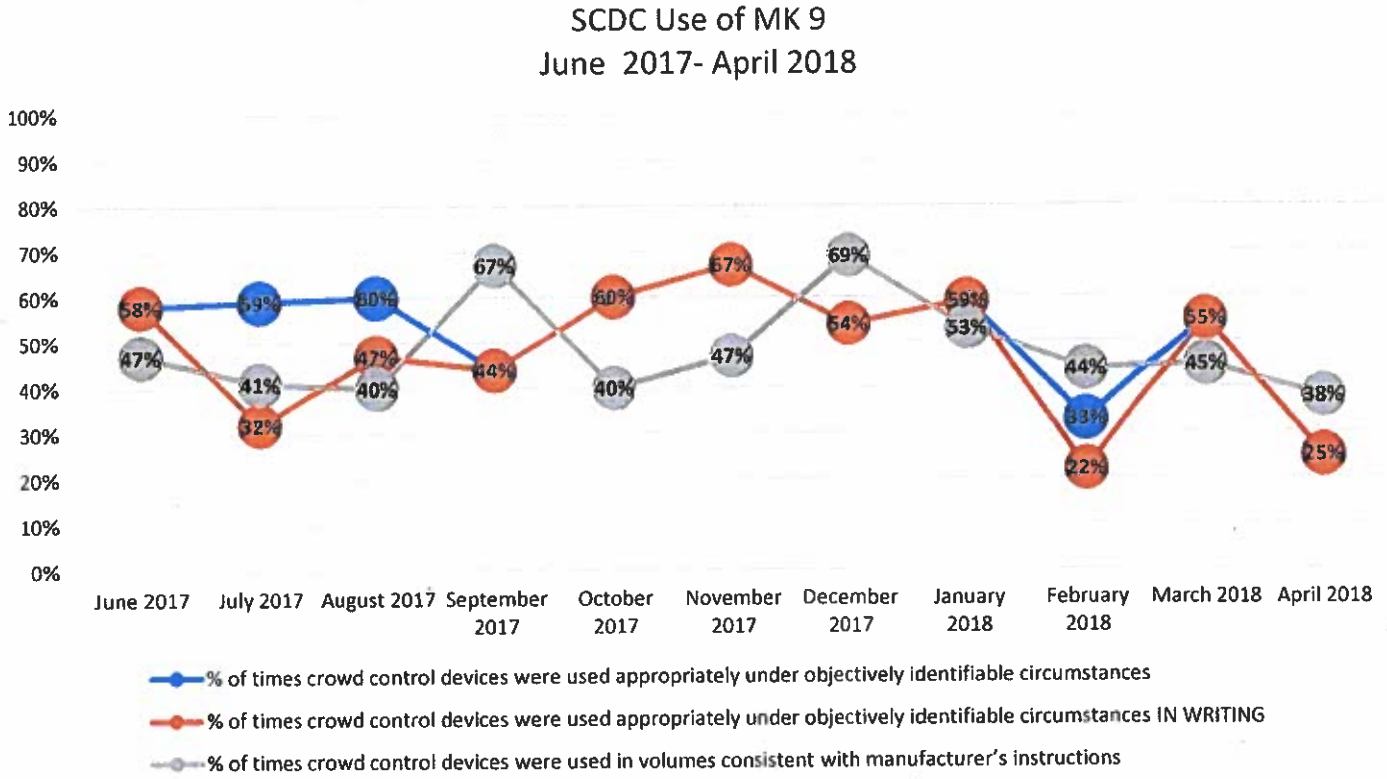
Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

The chart below provides information comparing uses of crowd control canisters during this reporting period but includes data since June 2017 to show changes over time. A QIRM UOF Reviewer began looking at the number of times crowd control devices were used appropriately under identifiable circumstances, the number of times crowd control devices were used appropriately under objectively

identifiable circumstances in writing, and the number of times crowd control devices were used in volumes consistent with manufacture's instruction in June of 2017. Based on this information, June 2017 is the baseline for tracking data received from RIM reports and the Automated Used of Force System. The QIRM Use of Force staff reviewed **145** use-of- force incidents in which MK-9 was used between June 1, 2017, and April 30, 2018.

- There were 78 (54%) uses 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 69 (48%) incidents where the crowd control devices were used appropriately under objectively identifiable circumstances in writing.
- There were 69 (48%) incidents where the crowd control devices were used in a manner consistent with manufacturer's instructions.



July 2018 Implementation Panel findings: SCDC continues to have a high percentage of incidents where MK9 is used in individual cells without objectively identifiable circumstances set forth in writing and with volumes that exceed SCDC and manufacturer's guidelines. For the relevant period MK9 non-compliance was:

% of time MK9 identified as not being used within SCDC guidelines: February 18 (78%), March 18(45%) and April 18 (75%);
% of time MK9 volumes exceeded SCDC guidelines: February 18 (56%), March 18 (55%), and April 18 (62%);

July 2018 Implementation Panel Recommendations: A finding of lack of improvement for the next relevant period will require strong consideration for a rating of non-compliance. Recommendations:

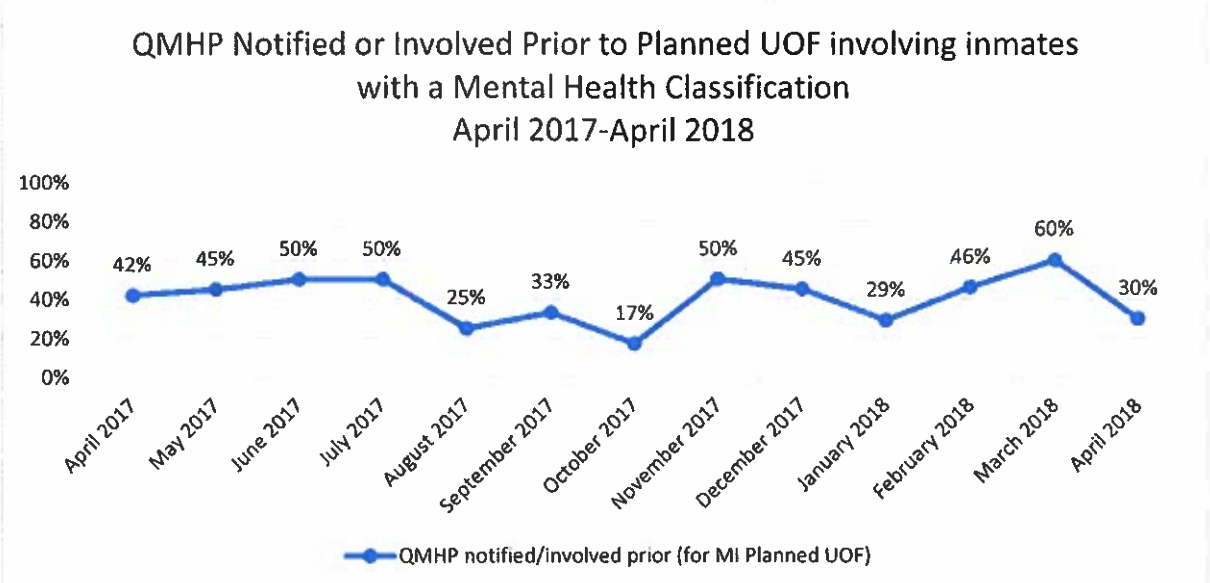
1. Operations and QIRM continue to review use of force incidents utilizing the automated system to identify use of force violations;
2. QIRM Use of Force Reviewers continue to generate reports involving crowd control canisters including MK-9;
3. QIRM and Operations leadership continue weekly meetings to discuss UOF and other relevant issues;
4. IP continue to review SCDC Use of Force reports and monthly Use of Force MINS Narratives and provide SCDC feedback;
5. The IP Use of Force Reviewer and SCDC Operations Leadership continue jointly reviewing Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of crowd control canisters including MK-9;
6. Revise Housing Unit Post Orders as they pertain to *Cover Teams* to qualify that MK-9 use will be consistent with manufacturer's instructions; and
7. All required staff complete Use of Force Training in the Calendar Year 2018.

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 December• 2017 Assessment: partial compliance

June 2018 SCDC Status Update:

The chart below shows the rates at which QMHPs are contacted prior to a planned UOF. The data shows that this continues to be an inconsistent process; however, the UOF Coordinator for MH has been charged with working to increase awareness among security personnel of Use of Force policies and procedures when dealing with Mental Health caseload clients, specifically ensuring that a QMHP is contacted prior to planned uses of force and "cool down" periods are utilized.



Because staff identified that there is inconsistency in either the process or with tracking and reporting, on May 30, 2018, the ADDO created and distributed codes for reporting and tracking averted uses of

force. The email shared with Wardens, Associate Wardens. Majors, and Headquarters staff acknowledged that although use of forces incidents were being tracked, a process was not in place to track the potential planned UOF incidents that were averted due to the skills of trained SCDC staff to include. Mental Health staff, Crisis Intervention Team (CIT) and the Situation Controllers Members (SITCON).

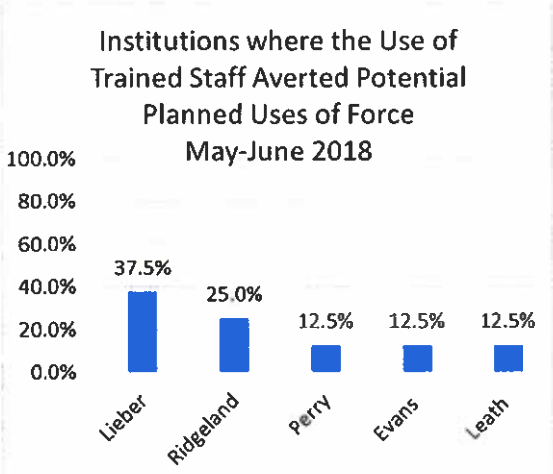
The following MIN codes were created with instructions to use them when potential planned UOF became unnecessary due to the intervention of staff noted above.

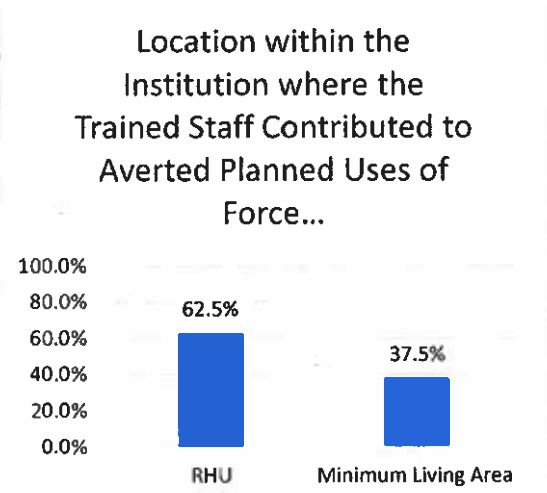
MIN Code
1070 - Diverted Use of Force (Mental Health)
1071 – Diverted Use of Force (C.I.T.)
1072 – Diverted Use of Force (SITCON)

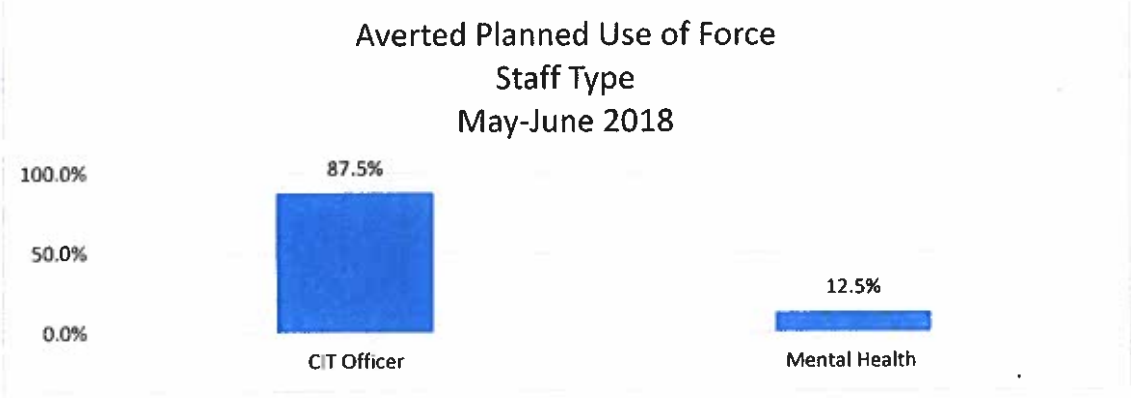
If one of the above noted MIN codes are used: 1) no Use of Force MIN Code would be entered on the same MIN; and, 2) no Automated Use of Force Report would be needed.

During the reporting period, eight MINS were generated using the three new codes for tracking uses of force averted due to the Intervening of trained staff.

Of the eight MINS, Evans, Perry and Leath each reported one incident averted in the RHU. Lieber reported three; two in the minimum living area and one in the RHU. Ridgeland reported two: one in the minimum living area and one in the RHU.







July 2018 Implementation Panel findings: Per the update Section. SCDC has been unsuccessful in making any progress. SCDC data identifies continued issues with notifying clinical counselors (QMHPs) to request their assistance prior to a planned use of force involving mentally ill inmates. The data for the period of May 2017 through April 2018, provides a historical perspective of the percentage of time QMHPs were contacted prior to a planned use of force involving mentally ill inmates:

May 2017-	45%
June 2017-	50%
July 2017-	50%
August 2017-	25%
September 2017	33%
October 2017	17%
November 2017	50%
December 2017	45%
January 2018	29%
February 2018	46%
March 2018	60%
April 2018	30%

Quite disturbing in April 2018 (the last month SCDC reported data for the relevant period), data indicated prior to a planned UOF QMHPs were only contacted in 30 percent of the incidents. This is the second lowest monthly percentage out of 12 months.

A positive development is the Agency beginning to track incidents where UOF is avoided or diverted. SCDC has revised the Agency MINS (Management Information Note) Reports to include incidents where a UOF was averted.

July 2018 Implementation Panel Recommendations: Remedy the above. A finding of lack of improvement for the next relevant period will require strong consideration for a rating of non-compliance. As identified in previous reports, additional training to Operations Supervisory and Mental Health Staff on their duties and responsibilities in a planned use of force is needed. Employees must be held accountable when the required assistance from QMHPs is not requested prior to a planned UOF incident involving mentally ill inmates. When operations employees notify mental health staff of a planned UOF, the mental health staff must complete a face to face interaction to assist or document reasons the interaction was not completed.

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

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

The following report shows that between 99% and 100% of all institutions report partial completion of the required training. From January 1- May 31, 2018, 0.4% of security staff have completed required General Provisions Training for calendar year 2018.

Security Staff Required to take Managing Mentally Ill Offenders Training in CY 2018 by Institution and Training Completion January 1 - May 31, 2018

Level		Institution	# Required to take Training	Partial Completion #	Partial Completion %	Fully Completed #	Fully Completed %	Did NOT Complete Training
1	252	GOODMAN	72	72	100.0%	3	4.2%	69
1	179	LIVESAY	58	58	100.0%	0	0.0%	58
1	251	MANNING	96	96	100.0%	0	0.0%	96
1	563	PALMER	26	26	100.0%	0	0.0%	26
		Minimum Security	252	252	100.0%	3	1.2%	249
2	411	ALLENDALE	130	130	100.0%	1	0.8%	129
2	551	EVANS	93	93	100.0%	2	2.2%	91
2	541	KERSHAW	126	126	100.0%	0	0.0%	126
2	422	MACDOUGALL	110	110	100.0%	1	0.9%	109
2	442	RIDGELAND	98	98	100.0%	0	0.0%	98
2	222	TRENTON	92	92	100.0%	1	1.1%	91
2	571	TURBEVILLE	133	133	100.0%	0	0.0%	133
2	161	TYGER RIVER	122	122	100.0%	0	0.0%	122
2	582	WATEREE RIVER	117	117	100.0%	1	0.9%	116
		Medium Security	1,021	1,021	100.0%	6	0.6%	1,015
3	211	BROAD RIVER	164	164	100.0%	0	0.0%	164
3	241	KIRKLAND	287	287	100.0%	1	0.3%	286
3	551	LEE	140	140	100.0%	0	0.0%	140
3	421	LIEBER	123	123	100.0%	0	0.0%	123
3	181	MCCORMICK	97	96	99.0%	0	0.0%	97
3	191	PERRY	130	130	100.0%	0	0.0%	130
		Maximum Security	941	940	99.9%	1	0.1%	940
	551	GRAHAM	115	115	100.0%	0	0.0%	115
	171	LEATH	70	70	100.0%	0	0.0%	70
		Female Institutions	185	185	100.0%	0	0.0%	185
	129	CATAWBA	1	1	100.0%	0	0.0%	1
	40	CORRECTIONAL INDUSTRIES	1	1	100.0%	0	0.0%	1
	1	HEADQUARTERS	1	1	100.0%	0	0.0%	1
	26	HQ ANNEX #2	40	40	100.0%	0	0.0%	40
	45	INMATE TRANSPORTATION TER	15	15	100.0%	1	6.7%	14
	22	RECRUITING & EMPLOYMENT	61	61	100.0%	0	0.0%	61
	90	SUPPORT SERVICES	1	1	100.0%	0	0.0%	1
	28	TRAINING ACADEMY	31	31	100.0%	0	0.0%	31
		Non-Institutional	151	151	100.0%	1	0.7%	150
		Agency Total	2,550	2,549	100.0%	11	0.4%	2,539

July 2018 Implementation Panel findings: We requested from SCDC the plan for implementing the required training but did not receive such a plan.

The SCDC mandatory courses for correctional officers concerning appropriate methods of managing mentally ill inmates for the Calendar Year 2018 are as follows:

2018 MH Training Schedule

Course Title	Hours	Program
Mental Health Services Overview	2.0 hours	Orientation
Suicide Prevention	2.0 hours	Orientation
Mental Health	2.0 hours	Basic
Pre-Crisis Communication	3.0 hours	Basic
Suicide Prevention	2.0 hours	In-Service (Instructor Led)
Suicide Prevention Video (Part 1)	1.0 hours	In-Service
Suicide Prevention Video (Part 2)	1.0 hours	In-Service
Working With the MI Population (USC Modules)	1.5-2.0 hours	In-Service
Total	14.5 -15.0 hours	

July 2018 Implementation Panel Recommendations: Develop and implement a plan for completing the required training. Also SCDC:

- Document and track the number of required employees completing the mandatory training for appropriate methods of managing mentally ill in Calendar Year 2018; and
- For each relevant period, report the progress being made with required employees attending the training.

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 2018 Assessment: compliance (March 2017)

June 2018 SCDC Status Update:
QIRM's Use-of-Force Reviewers continue to produce and disseminate monthly and quarterly UOF Reports. The most recent reports are attached as attached as Appendix S.
This report is sent to the IP UOF expert, Wardens, and Agency leadership. This report also details:

- Total use of force incidents that occurred in institution involving ALL inmates
- Types of force used involving chemical munitions, defensive tactics and the Restraint Chair
- Use of Control Cell
- Use of the Restraint Chair planned use of force and immediate use of force at each institution.
- Percentage of use of force incidents of Mentally Ill vs Not Mentally Ill type of force used on inmates classified as mentally ill
- Reports for the current reporting period are included in the QIRM document drop # 19

July 2018 Implementation Panel findings: SCDC continues to generate a monthly UOF Report Mentally Ill vs. Non-Mentally Ill. No issues were identified with the use of force data utilized to produce the report.

July 2018 Implementation Panel 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 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
The UOF Coordinator for Behavioral Health reports no uses of force averted as a result of QMHP intervention prior to a planned use of force that can be substantiated by MIN, AMR, NextGen, or Incident reports for the current reporting period.

July 2018 Implementation Panel findings: The UOF Coordinator for Behavior Health reported to the IP he is reviewing UOF incidents involving inmates with a mental health designation and following up with the assigned QMHP. There are written procedures for the review; however, the procedures have not been formalized in policies and procedures delineating review responsibilities and the action to be taken when an inmate with a mental health designation is involved in a UOF. SCDC has revised the Agency MINS (Management Information Note) Reports to include incidents where a UOF was averted. The Department

of Behavioral Health is currently conducting a study reviewing inmates with a mental health designation that are frequently involved in UOF incidents.

July 2018 Implementation Panel Recommendations: The Department of Behavioral Health should formalize the procedures for reviewing UOF incidents involving inmates with a mental health designation. Once the policies and procedures are approved responsible Behavioral Health staff should receive training on the policy. QIRM should begin performing QI studies assessing the Department of Behavioral Health review of UOF incidents involving inmates with a mental health designation.

3. 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 2018 Assessment: noncompliance

June 2018 SCDC Status Update:
The inpatient ratio was based on 1 psychiatrist per 25 Mentally Ill inmates for care which includes the following areas: GPH, CSU (BRCI), and CSU (Camille). Using the maximum amount of inmates at each of these locations, the following results are based on a full time equivalent of 37.50 hours for a professional provider. The ratio goal at GPH is currently below by -.85 percent or 31.88 hours is needed to reach the ratio standard. However, in July 2018, after hiring one full time equivalent (FTE) of 37.5 hours, SCDC will exceed the expected ratio. Both CSU's are within limits of the required ratio. All of the in-patient care will require additional FTE's based on time requirements for new admissions and the length of time for initial assessments. In addition, there will be a need for additional FTEs for a professional provider to be available for Treatment Team.

Residential treatment was based on 1 psychiatrist per 100 mentally ill inmates which includes ICS (Intermediate Care Unit – chronic care), HLBMU (High Level Behavior Management Unit), and LLBMU (Lower Level Behavior Management Unit). Based on this staffing pattern, ICS is in need of additional FTE's of 9.37 hours; however, additional coverage will be needed if ICS is expanded to take more inmates.

The outpatient ratio was 1 psychiatrist for every 500 mentally ill inmates. This covers 19 institutions housing inmates on the MH caseload. SCDC will be within a range of compliance after the hiring of one full time equivalent in July, which will provide additional coverage for ICS, R&E and CSU, and 15 additional FTE hours for BRCI. Appendix T shows the institutional staffing for psychiatric coverage for June and July 2018.

QMHP Staffing Ratios
Appendix U shows the staff to inmate ratio for each program and institution by Levels. The number of mentally ill inmates in each mental health classification (L1, L2, L3, L4 or L5) are shown in each program (GPH, BRCI/CSU, KR&E/HLBMU, KR&E/ICS, ACI/LLBMU, and CRCC). The number of mentally ill inmates that are L3, L4 and L5 are shown (by level) in each institution.

Staffing is shown for current and allocated QMHP's. Where indicated, Mental Health Managers are assisting with the caseload until the institution becomes fully staffed.

July 2018 Implementation Panel findings: The outpatient ratio of 1 psychiatrist for every 500 mentally ill inmates is not acceptable. An acceptable ratio would be between 1:200 to 1:250 caseload inmates who are receiving psychotropic medications.

July 2018 Implementation Panel Recommendations: As above.

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

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

Treatment team participation rates at the Crisis Stabilization Unit (CSU) and Gilliam Psychiatric Hospital (GPH) for the months of February through May 2018 are included below. The full report for CSU can be found in the Broad River Correctional Institution's Data Summary in Appendix M. The full report for GPH can be found in the Kirkland Correctional Institution's Data Summary in Appendix M.

CSU

- During the month of February 2018, Psychiatry participated 67% of the time, 0% for Psychology, 98% for QMHP, 74% for medical, 98% for Operations, 42% for classification, and 98% for inmates.
- During the month of March 2018, Psychiatry participated 62% of the time, 0% for Psychology, 100% for QMHP, 100% for medical, 89% for Operations, 100% for classification, and 100% for inmates.
- During the month of April 2018, Psychiatry participated 72% of the time with 7% from tele-psychiatry and 65% from face-to-face, 0% for Psychology, 100% for QMHP, 72% for medical, 100% for Operations, 100% for classification, and 100% for inmates.
- During the month of May 2018, Psychiatry participated 48% of the time, 100% for Psychology, 100% for QMHP, 27% for medical, 100% for Operations, 100% for classification, and 100% for inmates.

Significant improvement has occurred relative to the participation of psychiatrists, classification, operations, and inmates.

GPH

- During the month of **February 2018**, Psychiatry participated 89% of the time with 60.19% from tele-psychiatry and 28.7% from face-to-face, 100% for Psychology, 100% for QMHP, 66% for medical, 47% for Operations, 0% for classification, and 13% for inmates with 35 or 32% who were either not required or inappropriate for treatment team.
- During the month of **March 2018**, Psychiatry participated 95% of the time with 47.69% from tele-psychiatry and 47.69% from face-to-face, 100% for Psychology, 100% for QMHP, 85% for medical, 84% for Operations, 18% for classification, and 39% for inmates with 51 or 39% who were either not required or inappropriate for treatment team.
- During the month of **April 2018**, Psychiatry participated 36% of the time with 36% from tele-psychiatry and 0% from face-to-face, 100% for Psychology, 100% for QMHP, 90% for medical, 100% for Operations, 26% for classification, and 35% for inmates with 23 or 19% who were either not required or inappropriate for treatment team.

- During the month of **May 2018**, Psychiatry participated 89% of the time with 68.42% from tele-psychiatry and 23.18% from face-to-face, 100% for Psychology, 100% for QMHP, 100% for medical, 80% for Operations, 45% for classification, and 54% for inmates with 40 or 28% who were either not required or inappropriate for treatment team.

July 2018 Implementation Panel findings: As per status update section. Provide statistics relevant to attendance about inmates' lack of attendance due to either refusal or being "inappropriate" to attend the treatment team.

We observed a treatment team meeting at BRCI during the morning of July 18, 2018. The treatment planning that occurred during this meeting was excellent.

We also observed a treatment team meeting at Lee CI during the morning of July 19, 2018, which was conducted in a competent manner.

July 2018 Implementation Panel Recommendations: As above.

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 2018 Assessment: compliance (March 2018)

June 2018 SCDC Status Update:

The Mental Health General Provisions training is required for all employees hired in the division of Mental Health. This training provides an overview of all aspects of the SCDC mental health system, including but not limited to levels of care, mental health classifications, classifications, and assurance for the care and management for all inmates in need of Mental Health Services at SCDC. At time of report, 55% of employees who have started with the agency since January 01, 2018 have completed the training.

New Mental Health Staff (Hires and Transfers) in CY 2018 and Mental Health General Provisions Training taken in CY 2018 by Location and Training Completion January 1 - June 26, 2018

Level	Budget Unit	Institution	# Required to take Training	Completed		Not Completed	
				#	%	#	%
1	123	CATAWBA	0	0	N/A	0	N/A
1	232	GOODMAN	0	0	N/A	0	N/A
1	173	LIVESAY	0	0	N/A	0	N/A
1	251	MANNING	0	0	N/A	0	N/A
1	563	PALMER	0	0	N/A	0	N/A
Minimum Security			**0**	**0**	**N/A**	**0**	**N/A**
2	411	ALLENDALE	3	2	66.7%	1	33.3%
2	531	EVANS	2	2	100.0%	0	0.0%
2	541	KERSHAW	1	1	100.0%	0	0.0%
2	422	MACDOUGALL	0	0	N/A	0	N/A

2	442	RIDGELAND	1	0	0.0%	1	100.0%
2	222	TRENTON	0	0	N/A	0	N/A
2	571	TURBEVILLE	0	0	N/A	0	N/A
2	161	TYGER RIVER	1	1	100.0%	0	0.0%
2	582	WATEREE RIVER	0	0	N/A	0	N/A
Medium Security			**8**	**6**	**75.0%**	**2**	**25.0%**
3	211	BROAD RIVER	5	2	40.0%	3	60.0%
3	242	GILLIAM PSY	14	5	35.7%	9	64.3%
3	241	KIRKLAND	2	1	50.0%	1	50.0%
3	551	LEE	2	0	0.0%	2	100.0%
3	421	LIEBER	2	1	50.0%	1	50.0%
3	181	MCCORMICK	0	0	N/A	0	N/A
3	191	PERRY	2	2	100.0%	0	0.0%
Maximum Security			**27**	**11**	**40.7%**	**16**	**59.3%**
	331	GRAHAM	1	0	0.0%	1	100.0%
	171	LEATH	0	0	N/A	0	N/A
Female Institutions			**1**	**0**	**0.0%**	**1**	**100.0%**
	1	HEADQUARTERS	2	0	0.0%	2	100.0%
	26	HQ ANNEX #2	0	0	N/A	0	N/A
Non-Institutional Locations			**2**	**0**	**0.0%**	**2**	**100.0%**
All Institutions			**38**	**17**	**44.7%**	**21**	**55.3%**

July 2018 Implementation Panel findings: As per status update section. Newly hired health staff have 45 days from the date of hire to receive the required training.

July 2018 Implementation Panel Recommendations: Continue to monitor.

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 2018 Assessment: compliance (December 2017)

June 2018 SCDC Status Update:
See 2.a.iv

July 2018 Implementation Panel findings: See 2.a.iv.

July 2018 Implementation Panel Recommendations: See 2.a.iv.

3.e Require appropriate credentialing of mental health counselors;

Implementation Panel July 2018 Assessment: compliance (March 2017)

June 2018 SCDC Status Update:
On June 13, 2018, the DDHS and Division Director for BMHSAS met with HR leaders, Legal, and Employee Relations regarding a letter to 19 unlicensed MH staff to inform of licensure requirement

and need to: 1) identify requirements to obtain licensure, or 2) determine alternative to QMHP position. Staff were required to provide a reply within 30 days, by August 1, to acknowledge receipt.

The discussion further focused on: 1) determining how long staff would be allowed to pursue licensure for those willing to obtain QMHP and increase salary; and 2) pursuing alternative positions within SCDC for those unwilling to pursue licensure.

A formal letter from [redacted] Deputy Director for Health Services, and [redacted] Chief Counsel, was sent out to each of 19 (2 HQ staff) unlicensed QMHP staff on 6/22/18. Acknowledgement of receipt is due by August 1, 2018, to indicate how staff will pursue licensure and how long it would take to achieve licensure or not to pursue licensure and seek alternative employment.

Depending on licensure issues, it is likely that that licensure may take up to one year. Time frames will be established for alternative placement in alternative SCDC positions for those unwilling or unable to obtain licensure.

A procedure and form has been drafted to implement supervision by licensed clinician for all unlicensed QMHPs. The Director is willing to consider SCDC payment for licensure for those who pursue licensure.

In 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. The division is taking the necessary steps to require all employees serving in a QMHP role to become licensed within a defined period or be re-assigned in the agency to a more appropriate role based on their qualifications. 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.

Based on the provisions outlined in policy, 55/57 or 96% are appropriately licensed.

July 2018 Implementation Panel findings: As per status update section. We are encouraged that SCDC has established a process pertinent to licensure for non-licensed clinicians, which is consistent with the Settlement Agreement negotiation process.

July 2018 Implementation Panel Recommendations: Continue to self-monitor.

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

Implementation Panel July 2018 Assessment: compliance (July 2018)

June 2018 SCDC Status Update:
Initial Audit Reviews for all programs are consultative. Once the report is complete, it is forwarded to the BMHSAS Division Director for review. Afterwards, it is sent to the Warden, Associate Wardens' and Mental Health staff along with a scheduled date to meet with the Division Director and the QA Manager to discuss the audit findings. During the meeting, the Mental Health supervisor is notified to submit a written audit response outlining a plan of action addressing noncompliance issues to the QA

Manager by a designated deadline. It should be noted that when there are findings of significant noncompliance issues, it brought to the attention of the Mental Health Manager during the audit or via email so that immediate correction can be done. Continued noncompliance or regularly failed audits, will result in the implementation of Improvement Action Plans and/or corrective action as outlined in ADM-11.04 "Employee Corrective Action" policy. Since last reporting period, one QMHP resigned in lieu of termination due to repeated unsatisfactory audit reviews.

Formal CQM program to review clinical staff
Refer to the chart below for the audit review and scheduled discussion dates. Refer to Appendix X for complete audit reports for institutions listed below. Manager Responses are also included for those done prior to 5/3/18. BMHSAS audit dates are included as Appendix Y.

INSTITUTION	AUDIT REVIEW DATE	SCHEDULED DATE OF AUDIT DISCUSSION
Evans CI	January 23, 2018	April 3, 2018
Lee CI	January 17, 2018	April 4, 2018
Kershaw CI	January 22, 2018	April 4, 2018
Turbeville CI	February 6, 2018	April 13, 2018
BRCI – CSU	February 21, 2018	April 19, 2018
Camille	March 8, 2018	May 3, 2018
Kirkland - ICS	April 24, 2018	June 26, 2018
Kirkland – HLBMU	April 24, 2018	June 26, 2018
Perry	April 26, 2018	June 20, 2018
Kirkland – GPH	May 8, 2018	Pending

July 2018 Implementation Panel findings: As per status update section.

July 2018 Implementation Panel Recommendations: Continue to monitor.

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

Implementation Panel July 2018 Assessment: compliance (July 2018)

June 2018 SCDC Status Update:
See 3.f.

July 2018 Implementation Panel findings: See 3.f.

July 2018 Implementation Panel Recommendations: See 3.f.

4. 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 2018 Assessment: compliance (March 2017)

June 2018 SCDC Status Update:

RIM continues to produce and distribute a weekly "Medical Personnel Report." The following screenshot provides a snapshot of the detailed report. The most recent report was distributed on June 18, 2018. See screenshots below. The most recent report is included as Appendix Y.

Summary of Medical Positions as of COB Yesterday
run on June 18, 2018

Medical Job Classifications			FTE Positions			Temporary Positions			All Positions		
Job Class	State Title	SCDC Title	Filled	Vacant	Total	Filled	Vacant	Total	Filled	Vacant	Total
AA50	ADMIN SPECIALIST II	ADMIN SPEC	1	0	1	0	0	0	1	0	1
		ADMIN SPEC A	1	0	1	0	0	0	1	0	1
		ADMIN SPEC B	1	0	1	0	0	0	1	0	1
		ADMIN SPEC C	2	0	2	0	0	0	2	0	2
		ADMIN SPEC II	6	0	6	0	0	0	6	0	6
		ADMIN SPEC-PHARMACY TECH	1	0	1	0	0	0	1	0	1
		ADMIN SPECIALIST - INTERN	0	0	0	0	1	1	0	1	1
		PHARMACY TECH	1	0	1	0	0	0	1	0	1
AA50	ADMIN SPECIALIST II	Subtotal:	13	0	13	0	1	1	13	1	14
AA75	ADMINISTRATIVE ASSISTANT	ADMIN ASST	4	1	5	0	0	0	4	1	5
		ADMIN ASST - MENT HLTH	1	0	1	0	0	0	1	0	1
		ADMIN ASST I	1	0	1	0	0	0	1	0	1
		ADMIN ASST II	3	0	3	0	0	0	3	0	3
		ADMINISTRATIVE ASSISTANT	1	0	1	0	0	0	1	0	1
AA75	ADMINISTRATIVE ASSISTANT	Subtotal:	10	1	11	0	0	0	10	1	11

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

Implementation Panel July 2018 Assessment: substantial compliance (July 2017)

June 2018 SCDC Status Update:

RIM continues to develop, produce and maintain reports of inmates transferred to ICS or GPH or Correct Care beds. This continues to provide MH staff the ability to track the number and timeliness of inmates being transferred to GPH, contractual providers and ICS programs. The most recent report is included as Appendix Z.

Male ICS Admissions and Discharges
February 1, 2018 through May 31, 2018
Patients/Clients = 41
Admissions = 35
Discharges = 18

(Only Admission and Discharge dates between February 1, 2018 and May 31, 2018 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 8, 2018).)

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
[redacted]		L1	04/10/2018						
		L3	04/04/2018						
		L1	03/02/2018						
		L1	02/23/2018						
		L3		02/21/2018	L3	2151			
		L3	03/13/2018						
		L1	03/09/2018	04/19/2018	L1	41			
		RU	04/12/2018	05/02/2018	L1	20			
		L1	05/16/2018						
				02/21/2018	L4	4451			
		L3	03/15/2018						
			03/20/2018						
		L1	04/10/2018						
		L1	02/13/2018						
		L1	02/02/2018	03/05/2018	L1	31	0	03/05/2018	
		L3	02/15/2018						
		L1		02/07/2018	L1	133			
		L1	02/13/2018						
		L3	04/10/2018						
		L1		03/05/2018	L1	169			
		L1	05/21/2018						

July 2018 Implementation Panel findings: Compliance continues with regard to tracking referrals, however the IP is deeply concerned regarding the referrals from the CSUs at KCI and CGCI. We extend the rating of compliance based on SCDC assurances of appropriate referrals, but are not satisfied the responses to referrals address the needs of the inmate population; and waiting lists for services throughout the system for higher levels of care are not acceptable. The data produced by SCDC will be very closely reviewed.

July 2018 Implementation Panel Recommendations: Address the issues raised above.

4.a.iii. Segregation and crisis intervention logs;
Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
Policy 22.38, Restrictive Housing Units, section 3, number 14 says that correctional officers assigned to the RHU are to conduct security checks and to personally observe each inmate at least every 30 minutes on an irregular, unannounced schedule. A CQI study was conducted to evaluate if these cell checks were completed per policy at Broad River, Camille, Lee, and Perry. The results of the study is below. For the complete study, refer to Appendix AA.

Results:
Average time between checks should be less than 30 minutes—in fact, to accommodate the requirement of irregularity, this measure should be reasonably closer to 20 minutes. Perry came the closest to this measure in May; however, the cell checks still exceed 30 minutes.
Longest time between checks should be no more than 30 minutes. All institutions had longest times significantly greater than 30 minutes, but Broad River and Camille had the longest times for the month of May at 920 minutes each
The Percent Compliance with Keeping Cell Checks at Less than 30-Minute Intervals: Broad River and Lee have the lowest compliance in this measure, and their average time between checks supports this finding. Camille has the highest compliance average at 52%; however, their average time between checks still exceeds 30 minutes.
Irregularity of Cell Checks: All four institutions had fairly good compliance with this measure; however, the average time between checks indicates the checks are considerably exceeding 30 minutes, so the intent of the "irregular" requirement was frequently not met.
BRCI CSU
CSU began using the Offender Activity Tracking System (OATS) on December 4, 2017. (While the normal cell-check interval time is a maximum 30 minutes [irregular], in the CSU and for any inmate on CISP, the maximum interval is 15 minutes [irregular].) A review to determine if observation checks were being conducted at irregular intervals of no more than 15 minutes was completed on May 3, 2018. Inmates were randomly selected for review. To be included in the sample, inmates would have to have been in the CSU with information uploaded into the OATS reporting system on April 29 & 30 and May 2 & 3. Inmates were randomly selected until five met the dates' criteria. Although the percentage of overall scans in CSU has not yet reached full compliance, based on this review, of the cell checks that were conducted, all inmates in the sample had an increase in the percentage of cells checks that were completed within 15-minutes, as required by policy. The Unit has demonstrated an overall increase of 64.9%.

Any scan exceeding 15-minutes is noncompliant. The goal is to see a decrease in the number of scans non-compliant in this area. This was evident for each inmate in the sample with an overall decrease for the Unit of 77.8%.

July 2018 Implementation Panel findings: As per status update section.

July 2018 Implementation Panel Recommendations: Remedy the above.

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

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
EHR staff are developing a batch encounter extract process in NextGen that will allow staff to utilize the existing reporting logic currently used to report from the mainframe medical encounter data. This information will provide a means to monitor all medical and mental health encounters to review timelines and help document compliance. This process is close to being finalized which will ensure that the data integrity and quality is appropriate; however, it will need to be tested further to be certain. Additionally, the EHR Business Analyst position is currently vacant; when filled, this position will be able to run advanced reporting tools within the Nextgen and EZmar system that we are not able to currently utilize. Advertising through additional recruiting services will begin the week of 6/25/18.

July 2018 Implementation Panel findings: As per status update section.

July 2018 Implementation Panel Recommendations: Fill the vacant EHR business analyst position.

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

Implementation Panel July 2018 Assessment: compliance (March 2017)

June 2018 SCDC Status Update:
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 2018 Implementation Panel findings: As per SCDC update.

July 2018 Implementation Panel Recommendations: Operations and QIRM 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 2018 Assessment: compliance (March 2017)

June 2018 SCDC Status Update:
RIM continues to produce and disseminate a monthly, "UOF Report Mentally Ill vs. Non-Mentally Ill," report on the 22nd of each month for the previous month's information.
UOF Reviewers continue to track and report the number of UOF incidents involving mentally ill vs non-mentally ill inmates. This quarterly 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

The most recent report (March 2018) is included as Appendix BB.

A recent review of UOF for MI vs non-MI indicates that although they only make up 19% of the population, the data shows that they 54% of the uses of force involved inmates with a mental health classification for these reporting months. This data is included in *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.*

July 2018 Implementation Panel findings: As per SCDC update.

July 2018 Implementation Panel 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 2018 Assessment: compliance (March 2017)

June 2018 SCDC Status Update:
RIM continues to generate monthly report, CY 2018 CISP Entries. The most recent report for May was distributed on June 6, 2018. The following summarizes the average lengths of stay for inmates and *CY 2018 CISP Entries through May 31, 2018*See Appendix CC for the complete RIM report.

Entries in CISP Application = 977
Average Days on Crisis = 7
Average Time to CSU Placement = 50:25 (Hours:Minutes)
Average Days in CSU = 7
Average Days in Outlying Facility = 3
Active Cases = 53
RIM continues to produce and distribute a weekly spreadsheet that provides a list of inmates currently in SD, DD, MX ST, or AP custody by institution, MH classification, custody level and days in custody level. . The most recent report was disseminated on June 14, 2018. See screenshot below. The most recent report is included as Appendix.DD.

Institution	Days in DD SD MX ST AP Cust	SCDC #	Name	Current Custody	Begin Date in DD SD MX ST AP Custody	Dorm	Current Mental Classification
ALLENDALE	493	[redacted]		SD	02/06/17	MA 0206Z	MH

July 2018 Implementation Panel findings: As per status update section.

July 2018 Implementation Panel Recommendations: Continue to produce and disseminate 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

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 2018 Assessment: compliance (March 2017)

June 2018 SCDC Status Update:
QIRM Analysts had been providing a summarized report on inmates in segregation by institution, custody, and mental health classification to Operations staff. After meeting with Operations leaders, it was determined that the QIRM report is duplicative to the RIM report. RIM continues to produce and distribute the "Weekly Lockup by Custody and Mental Health Classification." This monthly report is shared with institutional and agency leaders. The most recent report was produced and distributed by RIM on June 20, 2018. The most recent reports (Excel and PDF) are included as Appendix EE.

July 2018 Implementation Panel findings: As per status update section.

July 2018 Implementation Panel Recommendations: Continue to produce and disseminate quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution.

4.a.ix. Quality management documents; and

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
Quality management documents, including reports, audit tools, audits, and other forms of documentation continue to be available in shared network folders. See examples below. 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.
Automated web-based systems include:

Temperature and Sanitation Log Entry

- Choose your Institution, Dorm, and Cell to enter a Temperature and Sanitation log.

Intake Education Assessment Report

- This report shows all inmates having an educational assessment during their intake within a date range.

Medical Transport Report

- This report shows all institutions with their transportation methods within a date range.

Mental Health Report

- This report shows inmates with a Mental Health classification housed in SMU.

Pending Disciplinary Dispositions

- This report shows inmates pending disciplinary disposition report.

OATS Report

- This report shows cell log activity from the Oat sOnlin eAppl dat ion.

July 2018 Implem entation Panel findings :As per status update section.

July 2018 Implementation Panel Recommendations: Continue to assess and validate quality management documents.

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

Implementation Panel July 2018 Assessment. partial compliance

June 2018 SCDC Status Update:

Task:	Start	End
Male Facility End User Training Week 1	4/30/18	5/4/18
Male Facility End User Training Week 2	5/15/18	5/18/18
Level 3 Institution Go Live (except Kirkland) – Broad River, Lee, Lieber, McCormick, Perry	5/21/18	5/25/18
Male Facility End User Training Week 3	6/5/18	6/8/18
Male Facility End User Training Week 4	6/19/18	6/22/18
Kirkland Go Live (EHR, EDR, Scheduling only)	6/26/18	6/28/18
Male Facility End User Training Week 5	7/10/18	7/13/18
Level 2 Institutions Go Live (partial) – Allendale, Evans, Ridgeland, Turbeville	7/24/18	7/27/18
Kirkland eZmar Go Live	8/14/18	8/16/18
Male Facility End User Training Week 6 (if needed)	8/28/18	8/30/18
All remaining Institutions Go Live – Catawba, Goodman, Kershaw, Livesay, MacDougall, Manning, Trenton, Tyger River	9/18/18	9/20/18
Specialty Clinics	10/2/18	10/4/18

SCDC has hired and trained 5 employees to help support the EHR. SCDC is still awaiting the hire of our business analyst position that will manage the reporting and analysis of NextGen data.

- 1 Help Desk staff member able to specifically address NextGen issues.
- 4 RIM staff members who will serve as statewide support staff for use of all aspects of the system: EHR, EDR, Scheduling, eZmar, interfaces, etc. These staff members will have

assigned territories and perform most of their duties onsite in the institutions alongside members of the Health Services staff.
- Position currently posted for hire—1 additional RIM staff member to conduct system configuration edits and produce reports and analysis of the NextGen data. Due to this staff absence, we are very limited
- A Project manager transition has occurred since the Implementation Panel's last visit; Daniel Mullins is now the project manager for the EHR implementation.

July 2018 Implementation Panel findings: As per status update section.

July 2018 Implementation Panel Recommendations: Continue to assess and validate documentation from EHR to support the Quality Management program. Perform a QI Study to assess SCDC Mental Health Disciplinary Treatment Team review of disciplinary sanctions received by inmates with a mental health designation.

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 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
See 4.a.iv

July 2018 Implementation Panel findings: See 4.a.iv.

July 2018 Implementation Panel Recommendations: Fill the vacant EHR business analyst position.

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

March 2018 Implementation Panel findings: noncompliance

June 2018 SCDC Status Update
The Health Services and BMHSAS administration are in preliminary stages of determining if some mental health medications can be given to inmates in KOP packaging. They are considering the possibility of piloting mental health medications as KOP versus dose by dose, and several facilities have been suggested for the pilot. The preference of the group was to utilize level 2 facilities initially and then consider and target level 3 facilities at a later date.

The suggested pilot facilities are Allendale, Evans, and Turbeville, but the Mental Health staffing at these institutions needs to be studied to ensure the pilot project is feasible. Inmates at these facilities would receive a 30-day supply of specified KOP meds. SCDC's Chief of Pharmacy is going to consolidate the list of medications which are appropriate for this process and forward for review.

Once the list of approved KOP medications and the institutions are agreed upon, the specific staff at the designated locations will be contacted and trained to ensure there is a consistent process in place for adequate monitoring.

July 2018 Implementation Panel findings: Our March 2018 findings included the following:

We discussed with staff in detail issues related to the "medication tool." This medication tool is being piloted due to current medication administration practices in RHUs systemwide as well as in general population units during lockdowns if food slots are not present in the cell doors. Attachment 2 provides SCDC's description of the medication tool. This medication tool is an attempt to provide medication administration in the context of grossly inadequate correctional officer allocations systemwide in addition to various significant correctional officer vacancies. It is not an acceptable alternative to medication administration for a number of reasons that include medication being administered in an unhygienic manner, inadequate observation regarding whether an inmate actually is swallowing the medication (i.e., does not permit acceptable direct observation therapy), and exposing nursing staff to unreasonable physical risks related to the need to bend down repetitively in order to administer inmate medications.

This below the standard of care medication administration system is exacerbated by the following:

1. Unacceptable nursing staff vacancies systemwide;
2. General lack of access to the electronic medical administration record when medication administration takes place in housing units;
3. Lack of medication carts due to both cost and inadequate nursing office space; and
4. Lack of a unit dose medication administration process due to inadequate nursing medication room space and inadequate funding.
5. Ironically, #s 2, 3 & 4 exacerbate the unacceptable nursing staff vacancies systemwide.

Staff reported that six institutions continue to have medications delivered under the cell door. Our opinion remains unchanged regarding this issue.

July 2018 Implementation Panel Recommendations: Our March 2018 recommendations included the following,

1. The salary structure for nurses is not competitive and results, in part, in the systemwide staffing vacancies;
2. Funding needs to be requested and obtained in order to remedy the above issues that contribute to the below the standard of care medication administration process; and
3. Correctional staff need to be recruited specifically for escorting nurses during the medication administration process in order for such a process to occur within the standard of care.

Our recommendations remain the same.

5.a. Improve the quality of MAR documentation;

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update

Access to proper equipment is addressed in detail above under MMCAP Contract Option and RHU/Medication Administration.

A QI study was done of the MARS documenting administration of medications ordered by psychiatrists for inmates at Perry, BRCI, Lee, and KCI, McCormick, and Lee. It looked at MARS from

February – April 2018. CGCI was not included in this study, since CGCI is using the EHR system, and the auditor did not yet have access to the system.
The measures studied were:

- Inmate compliance with taking the medications
- Nursing compliance with documentation

The auditor looked inmate medication compliance, nursing documentation, and if there were runs of 3 or more consecutive doses of medication missed, whether there was documentation of nursing or QMHP compliance counseling in these cases. The full methodology for the study and detailed results are found in the complete report, Appendix FF (Word and Excel spreadsheet). The report includes narratives of each institution as well as specific deficiencies noted when the medical records were reviewed to see if counseling was done.

But in general, an Excel spreadsheet was created to collect data Formula columns were inserted to calculate the following measures, as well as summaries for each institution.

- Inmate compliance with taking the medications (# doses taken / # doses possible)
- Nursing compliance with documentation (# completed MAR cells / # doses possible)

Findings
The following chart shows the number of MARs reviewed for each institution, the percent compliance of inmates in taking medications, compliance of nurses in documenting medication administration, the average number of days for inmates to receive new medications ordered, as well as the percent of inmates in whose chart reviews there were deficiencies noted. Note that it was not always clear which unit the MARs were taken from (such as RHU v. non-RHU), so it is possible that some of these measures should have been calculated on a different unit's spreadsheet.

MAR Summary Feb-April 2018						
	# MARs Reviewed	% Medication Compliance	% Nursing Documentation Compliance	Ave # of Days from New Medication order to 1st dose	# of Inmates in whose MARs Deficiencies Were Identified	% of Inmates in whose MARs Deficiencies Were Identified
Perry	9	94%	100%	N/A	1	11%
Broad River	50	54%	93%	5	33	66%
BRCI CSU	1	100%	100%	N/A	0	0%
Lee	6	53%	88%	N/A	2	33%
McCormick	9	89%	100%	1	1	11%
Lieber	5	98%	99%	N/A	0	0%
Kirkland	4	83%	88%	3	2	50%
KCI RHU and HLBMU	31	91%	95%	N/A	0	13%
KCI ICS	30	100%	100%	N/A	0	0%
GPH	24	100%	100%	2	4	0%

Summary:
The handwritten MARs from these institutions show:

- Inmate medication compliance is highest at the inpatient or ICS units. It was the lowest at Lee and BRCI, although Lee had many fewer MAR's audited. It is noted that most of BRCI's

MARs were from the Murray dorm immediately and up to 3 months after the L3 inmates were first moved to Murray Dorm.

- Although it appears that the nursing documentation compliance has improved since the time of the mental health lawsuit, there is still room for improvement.
- Although only a few MARs showed new medication orders, there were some that took more than 2 days for the inmate to receive the first dose.
- When the inmates were non-compliant with their medication, there was seldom any compliance counseling done.

This QI Study report was forwarded to the Health Services and Behavioral Health Administration for their review on June 27, 2018.

July 2018 Implementation Panel findings: As per status update section. Compliance with this provision should significantly improve as nursing staff vacancies decrease and the continued rollout and improvement of the electronic medical administration records system is implemented.

July 2018 Implementation Panel Recommendations: As above.

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

Implementation Panel July 2018 Assessment: noncompliance

June 2018 SCDC Status Update

The nursing shortage within the SCDC is only anticipated to worsen without significant relief from the legislature in the form of funding for raises to a competitive rate. Short of that, our efforts for recruitment continue but are not especially successful when compared to the community at large. We continue to propose a variety of recruitment initiatives that will be addressed separately. The lockdown situation created by the Lee CI disturbance in mid-April, 2018, has exacerbated our medication administration challenges significantly throughout the agency, especially at the Level 3 facilities.

Medication Assistance Device: The medication assistance device or "pill putter" was not found to be especially useful to the nursing staff in the medication process and has not taken form. As such, it has been essentially discontinued.

Food Flaps: The construction of the food flaps is contracted out to the State of Georgia and we have only one firm that is able to assist SCDC with the installation on a facility by facility basis for procurement reasons, so it is a slow process. But the installation of the food flaps by facility is progressing, which is improving the delivery of medications and is an improved alternative to "under-the-door" distribution.

Medication Windows: Some facilities, such as Level 2's, are off of lock down now and have returned to routine operations. They are conducting medication lines as they would routinely at pill windows in the Health Services units. However, the nurses continue to have to prepackage medications into coin envelopes and clear plastic envelopes into soufflé cups for the inmates, rather than this being carried out by the pharmacy staff.

Pharmacy continues to package medications in the ScriptPro vials for the Top 40 drugs and other medications and placed in labeled zip-lock bags, which are shipped to the facilities Monday through Friday. These vials and bags then require significant hours of nursing time to repackage into coin envelopes for inmates, alphabetically by dorm.

MMCAP Contract Option: There is an option through our MMCAP contract, but it is not available to us in SCDC, although it is an amendment available and utilized by other states such as VA and MT. It allows for not only the drug purchasing, which we currently utilizing, but the dispensing itself. Virginia made the transition and now utilizes the MMCAP pharmacy agreement for all pharmacy services, retaining two full-time pharmacists on staff, while all other pharmacy staff work through the contract pharmacy through MMCAP, Diamond Pharmaceuticals, out of Indiana, PA. Diamond then packages the medications to the specifications of the Commonwealth of VA DOC. A variety of packaging systems are available, including blister packs and unit of use, and Diamond then provides the medication carts as well and all storage mechanisms as needed, as well as software interface. The SCDC inquiry was specific to the use of the "pill pack" system that actually packages each inmate's dose of ALL medications for am and pm into each dose so the nurse is not repackaging at all. The problem appears to be the lack of availability of return of these drugs for credit so the loss of perhaps 15-18% in funding, despite the fact that the unit is sealed completely and labeled for each drug contained in the package. Diamond indicated their willingness to follow up with the South Carolina Pharmacy Board on this issue in greater detail, given that it is allowed for return in other jurisdictions. A provider changing drug orders frequently as is seen with our psychiatry staff could also be problematic with this system, but there are mechanisms to work around this.

Pharmacy Procurement: Procurement for SCDC went to State Procurement and identified that we could NOT amend our existing MMCAP agreement and had to put the pharmacy services out to bid, a process that can take up to two years in South Carolina. We continue to investigate this option.

Parata Pill PASS: This is one of a few systems that actually packages the medications into dose packs for inmates with all of the prescribed medications in one package, all labeled appropriately by inmate and time with all medications. This is a packaging system that our central pharmacy could actually utilize internally in lieu of the ScriptPro system now in use, and this would prevent the nurses from repackaging for hours on end into coin envelopes. All medications would be SEALED and LABELED from the pharmacy. In the worst case, even if a medication went under a door, which we will make every attempt to avoid, it would be labeled with all of the correct information for the specific inmate and would be SEALED in a plastic container, thus remaining hygienic. Of course, procurement indicates that this too must be advertised and bid, but perhaps there is only one other competitor; so we are investigating pricing for these two systems, Parata and TCG, as the two largest packaging competitors in this market.

RHU/Medication Administration: The RHU medication administration procedural guidelines have been developed/distributed/reviewed with all of the HCA's outlining the appropriate processes for medication administration in RHU. The process guidelines address proper inmate identification, medication administration/ documentation, and steps to be taken in the event of disruptions in the normal medication administration processes for RHU. Additional measures that are currently being reviewed to address the needs of the RHU population are: alternative medication delivery methods include the use of mobile medication carts, varied medication packaging systems, and revisions to medication administration schedules. (See guidelines in Appendix GG).

DISRUPTION IN THE RHU MEDICATION ADMINISTRATION PROCESS DUE TO DISTURBANCES OR OPERATIONS LOCK DOWN SITUATIONS:

If medical staff members are unable to conduct medication administration processes (pill lines or dorm delivery), the medical staff are to initiate the following process:

- Medical notifies the operations shift supervisor to verify the lock down status/obtain assistance. If the shift supervisor confirms they are unable to conduct medication pass, the medical staff is to notify the next operations member in the chain of command (Major, AW, Warden) on duty.
- When medication administration processes are unable to be completed, an incident report is to be completed by the medical staff with specific detailed information explaining the situation, who was notified, and steps that were taken to resolve the issue.
- The facility HCA/HN are to be notified by the medical staff of this occurrence.
- An email summary with a copy of the incident report should be scanned to the Deputy Director of Health Services, Assistant Deputy Director, Director of Nursing. Regional Nurse Manager, and the institutional Warden.

*July 2018 Implementation Panel findings: A*s per status update section. Our March 2018 findings included the following:

> Due to the very significant nursing vacancies and systemic deficiencies previously summarized that are not due to individual nursing staff, it is not reasonable to hold clinicians responsible for completing and monitoring MAR's under these conditions. It is reasonable to expect nursing staff to continually advocate for necessary staff, supplies and equipment.

Our opinion remains the same.

July 2018 Implementation Panel Recommendations: Decide which of the remedies described in the status update section will be implemented.

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

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update

Effective 06/20/2018, Camille Graham nursing has decided that all of Blue Ridge C and D medications will be passed in the dorm for AM and PM pill passes. The new pill line time change to 7am and 7pm. Staff are now required to notify the HCA immediately when inmates with court-ordered medications refuse. Staff were provided a list of all L2 inmates. If any identified L2 refuses their mental health medications, the HCA must be notified. Staff were notified that all pill passes must be signed off before their shifts end. If an inmate refuses a medication at the time of administration, the inmate is required to sign a refusal and forward to the ordering provider. Morning insulin is now done by the night shift nurses. Nursing coverage is now in place for CGI. An HCA, two LPNs, and one RN have been hired. An additional seven agency nurses have been also been hired.

July 2018 Implementation Panel findings: HS meds at the Kirkland ICS are administered during the late afternoon. Morning medications in the Murray dormitory at the BRCI were often administered between 3 and 4 AM.

July 2018 Implementation Panel Recommendations: Remedy the above.

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

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update
Food flap installation projects (multiple contracts - manufacture of flaps, installation of flaps) should be completed statewide SCDC by end of calendar year 2018. Inmates on meds at Lee CI RHU are being swapped out with non-medicated inmates from other RHU's to lighten nursing load on Lee nursing, given the number of nursing resignations since the major disturbance and lockdown. HCA's have been instructed how to document disruption of medication administration due to either: 1) lack of security escort, 2) lack of lockdown of the inmates for medication administration on the tiers, or 3) disruption of medication administration due to security issue/disturbance on the unit. Staff have been directed to complete an incident report with notice to the senior Operations management as well as Health Services management and to make attempts to make up the medication administration, with an emphasis on insulin-dependent diabetics.

Food Flap installation to improve safety within general population settings are now complete at McCormick and Evans and is now moving to Lieber.

Trial medication carts to improve medication administration are currently being tested. Nursing positions and salaries are a priority focus for the FY20 budget.

July 2018 Implementation Panel findings: See prior findings relevant to medication administration.

July 2018 Implementation Panel Recommendations: For reasons previously summarized, QI studies should address medication administration and medication management issues (e.g., level of compliance with policies and procedures specific to medication noncompliance, continuity of medications, etc.).

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 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
Plans for the BRCI CSU include renovating 32 rooms in Greenwood B on the lower tier to be suicide-resistant cells. The upper tier rooms will accommodate double-celled, character unit Inmate Watchers and the creation of therapeutic spaces for group and individual services. A nurses station will be located on the unit. A staffing assessment will be completed for an additional 32 beds expansion.

Boats with mattresses are being delivered for the male CSU; however, they will not be utilized until the CSU expansion process is underway and after a written process has been approved by the IP. The expansion will require the hiring of sixteen additional security staff for the current unit and twenty-three for the expanded unit. Positions have been allocated as a part of year 3 of the MH Lawsuit funding to support this expansion in addition of reclassification of other vacant positions in Health Services to support this expansion. Based on current Facilities Management's priorities, this project is anticipated to begin no later than January, 2019.

The Deputy Director of Health Services and Division Director for BMHSAS reevaluated CI cells for approval for use for CI purposes. Final inspection of safe cells in Kershaw and Lieber will be completed by July 1. All others have been completed and approved. Staff used a Safe Cells Inspection tool developed by the Ohio Department of Corrections and Rehabilitation as a guide. Refer to Appendix HH for the tool.

Safe cells for the CSU expansion were reviewed on June 19, 2018, with architect Steven Li. The following chart shows the location and status of safe cell that have been approved.

Safe Cells			
Institutions	**# or Cell**	**Location**	**Approved as Safe Cells**
Allendale Correctional Institution	4	RHU	Approved- KD/TM
Broad River Correctional Institution	4		Approved- KD/TM
	13	CSU	
Camille Graham Correctional Institution	4	RHU	
	12	Blue Ridge	Approved- KD/TM
Evans Correctional Institution	3	Infirmary & RHU	Approved- KD/TM
Kershaw Correctional Institution	4	RHU & Medical	
Kirkland Reception & Evaluation Center	8	F-1	Approved- KD/TM
	5	GPH	Approved- KD/TM
Leath Correctional Institution	4	Phoenix - A-Side	Approved- KD/TM
Lee Correctional Institution	4	RHU	Approved- KD/TM
Lieber Correctional Institution	4	RHU	
McCormick Correctional Institution	2	RHU - B-Wing	Approved- KD/TM
Perry Correctional Institution	6	RHU - B-Dorm, Z-Wing	Approved- KD/TM
Ridgeland Correctional Institution	2	RHU - South	Approved- KD/TM
Trenton Correctional Institution	1	RHU	Approved- KD/TM
Turbeville Correctional Institution	4	RHU - Murray	Approved- KD/TM
Tyger River Correctional Institution	2	RHU - East	Approved- KD/TM
TOTAL	**86**		

July 2018 Implementation Panel findings: As per status section update.

During the afternoon of July 17, 2018, we observed a staffing of an inmate in the BRCI CSU. This inmate's precipitating factor for the admission appeared to be primarily a safety concern. Staff reported that such concerns were frequently the precipitating factor for other inmates admitted to the CSU as well.

We were informed that CSU staff can no longer directly discharge to the Adjustment Unit, which has limited their discharge disposition options.

Our March 2018 findings included the following:

> It was very common that CSU patients had been admitted following a self-harming event or suicide attempt which was later assessed to have been directly related to safety and security concerns or other custodial issues. Interventions within the CSU frequently

involved a "therapeutic transfer" that was often only a temporary solution as evidenced by subsequent repeat CSU admissions within the next six months. Such interventions turned out to be temporary solutions due to resource issues at the receiving institution that resulted in recommended interventions not being implemented.

The CSU at BRCI has essentially been functioning as a clearing house for the entire system in the context of admitting many inmates who have security issues that were either not being adequately addressed or perceived by the inmates as not being adequately addressed. The CSU is hampered in adequately intervening for the following reasons:

1. The lack of a central office classification officer, who could implement appropriate interventions specific to safety concerns; and
2. Lack of timely access to specific treatment programs such as the LLBMU and the HLBMU due to waiting list issues.

It would be very helpful if the Adjustment Unit at Perry CI was moved to the BRCI, which would then serve as another resource for disposition purposes and facilitate communication with staff at the CSU.

The above findings and recommendations remain the same.

July 2018 Implementation Panel Recommendations: See above.

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 2018 Assessment: compliance (December 2017)

June 2018 SCDC Status Update:
Logs provided to the QIAs and observation during institutional audits did not identify inmates being placed in a holding cell or other alternative space. In a review of the cell check logs by QIRM staff, there was no documentation to indicate that shower stalls, rec cages, holding cells, and interview booths were being used for CI purposes. Any inmate assigned to a livable cell outside a designated safe cell is placed on one-to one and given immediate prioritization to CSU.

July 2018 Implementation Panel findings: As per status update section.

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

Implementation Panel July 2018 Assessment: noncompliance

June 2018 SCDC Status Update:
QIRM staff continue to be informed that the practice of continuous observation is being implemented in the institutions, and have witnessed the practice in action; however, The CSU is the only program where this is documented consistently based on the use of the 19-7C, *Constant Observation Log/INMATE WATCHER.*

- Staff reviewed documentation recorded on SCDC form 19-7C "Constant Observation log/Inmate Watcher" logs for three randomly selected inmates each month (February-May) to determine:

- rates for cell check completion
- Average time between checks
- Number of checks great than 15 minutes
- When greater than 15 minutes, the average time between checks
- Longest time between checks
- **Results**
- Average time between checks is between 13-15 minutes.
- Checks greater than 15 minutes ranged from 2-3 occurrences.
- The average time between checks that were >15 minutes ranged from 23-67 minutes.
- The longest time between checks range from 23-115 minutes.

The 115 minute gap was documented by the inmate watcher as the CISP inmate being out of his cell for either medical, treatment team, or recreation. There was no concurrent officer's documentation submitted to the auditor to show that the CISP inmate was still under constant observation.

July 2018 Implementation Panel findings: As per status update section. Further, a QI study indicated approximately 68% of inmates on suicide precautions received documented staggered q15 (every 15) minute checks/observation by assigned inmate watchers. A suicide occurred in the CSU by an inmate on suicide precautions.

July 2018 Implementation Panel Recommendations: Perform a QI study in other institutions where constant observation occurs; repeat study in CSU's at BRCI and CGCI.

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

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
SCDC is seeking a different vendor for suicide clothing/blankets based on current products being easily disassembled, which could cause a major liability issue for inmates who are on crisis watch. The new bid will go after 07/01/18 with the following specs:

Suicide Blanket Bid
- Size of suicide blankets are 56" x 80"
- Blankets must be made with 1000 denier nylon Cordura, lock-stitch quilted with 6 oz./yard polyester batting.
- Blankets must have a five-year guarantee.
- Blankets must be flame resistant and tear resistant (not easily disassembled, twisted into knots or nooses)
- Outer layers must be made where chafing or irritation won't occur to bare skin
- Blanket should not require any special laundering. Machine washing and drying are required so blankets can go back into cells quickly.

Five (5) institutions, Leath, Evans, Broad River, Camille, Kirkland and Perry, were included in a review of their provision of clean, suicide-resistant clothing, blankets, and mattresses. Broad River and Camille Graham use suicide-resistant supplies in both their Crisis Stabilization Units and in the crisis

cells located in the Restrictive Housing Units (RHU); however, Camille's safety cells in RHU have been taken "offline" and were not included in this study.

QIRM staff assessed the processes for issuing, cleaning and providing clean suicide-resistant clothing and equipment for inmates when placed on CI to determine if suicide resistant supplies were being cleaned each time they were returned from an inmate on Crisis Intervention (CI). Interviews with inmates and an assessment of supplies indicated that clean, suicide-resistant supplies were available and being supplied to inmates when placed on CI.

Tracking the issuing and cleaning of this equipment will enable SCDC to ensure that inmates are receiving clean, sanitary suicide prevention equipment when placed on CI.

Five (5) institutions (Evans, Broad River, Camille, Kirkland and Perry) participated in this study. Broad River and Camille Graham use suicide resistant supplies in both their Crisis Stabilization Units and Restrictive Housing Units (RHU). However, Camille's safety cells in RHU have been taken "offline" and are not included in this study.

The QIRM analyst completed a Suicide Resistant Supplies Review Form based on available equipment in the institutions. In addition inmate interviews were conducted and a qualitative analysis was done based on information provided from the interviews. The individual institutional reports are below.

Assessment of the results:
Overall, from the institutions included in this study, there were many suicide resistant supplies in disrepair. The number varies because of the 17 large bags in CSU at Broad River CI. All suicide resistant supplies were either in use by an inmate on CI/SP status or in a secured storage area. There were inmates on CI status at two institutions during the time of this audit and they were utilizing the appropriate suicide resistant supplies. All inmates who were interviewed indicated they received clean supplies (except one who responded he did not know). Due to the condition of many of the supplies and the large numbers of inmates on CI/SP status, it has been recommend that most institutions request additional supplies. A tracking system was established at some institutions to track their stock of suicide-resistant equipment, ensure items are cleaned regularly and are maintained in good repair; it is necessary that the other institutions begin using a written tracking system. Many institutions are allowing non-CISP inmates to use suicide resistant. Those institutions need to ensure that non-CISP inmates are not allowed to use the suicide-resistant equipment; they need to provide enough normal supplies for their non-CISP population. Lastly, at Kirkland, there are many areas at Kirkland where suicide resistant supplies are used (F1, GPH, SSR, and Infirmary). I recommended there be a refined method to track supplies at each unit.

The complete report is included as Appendix II.

July 2018 Implementation Panel findings: As per status update section. Mattresses were not available to inmates on suicide watch in the RHU at Lee Correctional Institution.

July 2018 Implementation Panel Recommendations: Remedy the above.

6.e Increase access to showers for CI inmates;

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

Protocol in the Crisis Stabilization Unit (CSU) dictates that inmates in the CSU will receive a shower daily, except when the inmate has a RHU (Restrictive Housing Unit) custody level when he or she is admitted into the CSU. Per Policy 19.03, Inmate Suicide Prevention and Crisis Intervention, ***"8.5 RHU inmates in CSU will be allowed daily showers if security staffing presence permits. Otherwise, RHU inmates with be allowed to shower a minimum of 3 times a week."*** As part of SCDC's ongoing efforts to ensure this protocol is followed, a CQI study was completed to evaluate the frequency of showers in the CSU.

A sample of 10 male inmates was selected for each of the months of February 2018, March 2018, April 2018, and May 2018 to review the number of showers the inmates received while they were in the CSU. For the month of May 2018, 10 female inmates were reviewed for the same.
Due to the variations in the length of stay in the CSU, the denominators were not always the same. For non-RHU inmates, the numerator is the number of showers an inmate received and the denominator is the number of days the inmate was in the CSU (which is the total number of showers the inmate should have received). For inmates who had a RHU custody level, the numerator is the number of showers the inmate received and the denominator is the number of showers the inmate should have received based on the length of stay in the CSU and the RHU policy requirement for showers. Inmates highlighted in yellow had a RHU custody level on their day of admittance into the CSU.

- For the month of February, the highest rate of compliance for showers for non-RHU inmates was 50%. The lowest rate of compliance was 15%. The compliance rate for showers for inmates with a RHU custody level was 100%, and one of the inmates received one additional shower.
- For the month of March, the highest rate of compliance for showers for non-RHU inmates was 36%. The lowest rate of compliance was 6%. There was one inmate with a RHU custody level, and the compliance rate for showers was 20%.
- For the month of April, the highest rate of compliance for showers for non-RHU inmates was 100%, with one inmate receiving all 10 of his possible showers. The next highest compliance rate for showers was 54%. The lowest compliance rate was 0% as there was one inmate who did not receive any of his eight possible showers. There was one inmate with a RHU custody level, and the compliance rate for showers was 40%.
- For the month of May
    - at the Broad River CSU, the highest rate of compliance for showers for non-RHU inmates was 100%, with one inmate receiving all 9 of his possible showers. The next highest compliance rate for showers was 50%. The lowest compliance rate was 19%. There were no inmates with a RHU custody level in the sample for the month of May.
    - at the Camille CSU, the highest rate of compliance for showers for non-RHU inmates was 100%, with one inmate receiving both of her possible showers. The next highest compliance rate was 50%. The lowest compliance rate was 25%. There was one inmate with a RHU custody level and the compliance rate for showers was 100%.

Overall Assessment

- Out of 35 non-RHU male inmates, only two (2), or 6%, received showers daily per protocol. This indicates staff are not providing showers daily per protocol for most non-RHU inmates or that scans are not properly completed for entry into the OATS report.
- At Broad River, in the month of February, the compliance rate for showers for inmates with a RHU custody level was 100%. This compliance rate dropped to 20% in the month of March and 40% in the month of April. This indicates staff are not providing showers three times per week per protocol and RHU policy or that scans are not properly completed for entry into the OATS report.

- At Camille, most non-RHU inmates received fewer than 50% of the recommended number of showers.

The study along with the methodology is included as Appendix JJ.

This study focused on CSU because tracking showers to CI inmates in the institutions continues to pose a challenge because are showers for inmates on CI/SP status are documented in the RHU logbook. General entries are made but there is no way to determine which specific inmate received a shower for the day, nor does the log entry indicate the timeframe in which the inmate received the shower. For example, the general entry will report, "7:15am - Showers conducted" or "10:15am – showers ended".

To incorporate a uniform system, it has been recommended that the back of SCDC form 19-7A, "30 Minute Cell check log", be added to the back of SCDC form 19-7B, "15 Minute cell check log" to accurately capture who and when a specific inmate received a shower. In addition to showers, this addition will show meals received and recreation. A snippet of the back of SCDC form 19-7A is shown below.

CELL CHECK LOG

Please answer in the spaces provided with (Yes) Y (No) N (Refuse) R or (Ineligible) I

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
BKFST ___	BKFST ___	BKFST ___	BKFST ___	BKFST ___	BKFST ___	BKFST ___
LUNCH ___	LUNCH ___	LUNCH ___	LUNCH ___	LUNCH ___	LUNCH ___	LUNCH ___
DINNER ___	DINNER ___	DINNER ___	DINNER ___	DINNER ___	DINNER ___	DINNER ___
SHOWER ___	SHOWER ___	SHOWER ___	SHOWER ___	SHOWER ___	SHOWER ___	SHOWER ___
REC ___	REC ___	REC ___	REC ___	REC ___	REC ___	REC ___

(Initial)

PRINT NAME: _____ /___

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(Initial)

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The M120 forms do not clearly identify if the inmates are allowed to shower. The M120 has been updated to indicate showers; however, it is included among a list of instructions as opposed to a distinct entry requiring an exclusive response. (Example: Treatment Plan (Include instructions for observation, shower, precautions, and property allowed). Plans to expand the OATS system to all RHU's are underway which will enable staff to document showers into this electronic system. A recommendation has been made to the Division of BMHSAS to revise the form again to highlight eligibility for showers.

July 2018 Implementation Panel findings: Per status update section. SCDC QI Studies have identified that CI inmates are not receiving the increased access to showers. Non-RHU CI inmates are to receive daily showers and CI inmates on RHU status are to receive showers 3 times per week. SCDC Mental Health Form M120 was revised to indicate showers; however, the form remains deficient in clearly identifying the CI inmate is authorized to shower.

July 2018 Implementation Panel Recommendations: Remedy the above. SCDC Operations and Mental Health Staff need to implement revised procedures to ensure inmates on CI status receive their required access to showers. An accurate electronic or manual system needs to be developed and implemented to record CI inmates are receiving showers in compliance with the established shower schedule.

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

Implementation Panel July 2018 Assessment: noncompliance

June 2018 SCDC Status Update:

As part of SCDC's ongoing efforts to ensure that inmates on Crisis Intervention/Suicide Prevention (CI/SP) have access to confidential sessions with mental health professionals, the Division of BMHSAS completed a CQI study to assess where SCDC is in reaching that goal and to identify barriers to success. The study, included as Appendix KK examined what types of mental health sessions were being provided to CI/SP inmates and the frequency of the various types of sessions. Confidential sessions made up a relatively small minority - between 15% and 21% - of the mental health sessions provided to CI/SP inmates in the months of February, March, April, and May 2018 in the facilities that were reviewed. "Other Locations" for sessions made up the largest category, between 39% and 48%, but sessions conducted cell front accounted for between 36% and 46% of all session locations. As stated previously, the "Other Locations" category is not abundantly clear if the session was confidential. While SCDC has not yet met the goal to provide confidential mental health sessions to all inmates on CI/SP status and in CSU, the results show that QMHPs and other Mental Health staff work to respect the mentally ill inmates by holding fewer sessions in front of the inmates' cells and other individuals when possible.

Location of Sessions for Inmates on CI/SP Status

Month	Cell Front	Confidential Setting	Other Locations
Feb-18	45.3%	15.3%	39.4%
Mar-18	36.7%	20.2%	42.0%
Apr-18	37.5%	16.1%	46.4%
May-18	37.4%	15.4%	47.2%

nth	# Cell Front Sessions	# Confidential Setting Sessions	# Sessions in Other Locations	# Sessions in All Locations
Feb-18	836	282	726	1844
Mar-18	676	372	772	1820
Apr-18	818	351	1012	2181
May-18	710	293	897	1900

Location of Sessions for Inmates on CI/SP Status

Moving forward, SCDC will continue its aggressive recruitment campaign in order to alleviate security staffing issues, as this is a major contributing factor to not being able to provide confidential QMHP sessions. Outside of CSU, Mental Health staff continue to face challenges having inmates removed from cells for individual counseling sessions based on security shortages. Mental Health staff will also be directed, until transitioning to EHR, that CI reporting and data coding should only consist of selecting from either cell front or confidential settings.

July 2018 Implementation Panel findings: As per status update section. Access to confidential spaces has worsened with the statewide lockdown.

July 2018 Implementation Panel Recommendations: Remedy the above.

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

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
See 2b.vi

July 2018 Implementation Panel findings: As per status update see 2 b.vi. Institutions have improved performing random cell temperatures and cleanliness inspections and uploading the information. There continues to be major issues with institutions correcting identified temperature and cell cleanliness deficiencies and reporting the corrective action as required.

July 2018 Implementation Panel Recommendations: Remedy the above. Continue to perform QI studies assessing compliance with correctional staff performing daily, random cell temperatures and cleanliness inspections and validate identified deficiencies are corrected in a timely manner.

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

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
The following chart outlines the process for monitoring SCDC policy, *19.03 Inmate Suicide Prevention and Crisis Intervention*

Component to be Monitored	Process for Monitoring
Monitor and track all suicides and suicide attempts statewide.	Agency Suicide Prevention Committee convenes a meeting after every completed suicide to identify root causes from an institution and systems perspective. A report is compiled listing findings and recommendations from every review. QIRM recently announced at the Agency Suicide Prevention Committee they will begin monitoring follow-up from recommendations made at the committee. Local Suicide Prevention Committee-meets every quarter and review all suicide attempts statewide.
Provide for the selection and dispatch of a mental health suicide reviewer (MHSR) after a suicide occurs.	Agency Suicide Prevention Committee – The Mental Health Suicide Reviewer (MHSR) dispatches 72 hours after a completed suicide. A roaster and summary report is included as part of the Agency Suicide Prevention Committee final report.
All staff with the responsibility for inmate supervision will receive 8 hours of training in mental health related content to include suicide prevention and intervention. New employees will receive the training during institutional orientation and/or during the Correctional Officer Certification Course.	Training Records kept on file regarding employees who have completed mandatory trainings. This information is available to QIRM.

SCDC certified correctional officers, and all medical and mental health staff (SCDC and contract) are required to maintain CPR certification every two (2) years. All other employees with direct inmate contact/supervision are strongly encouraged to become certified.	Training Records kept on file regarding employees who have completed mandatory trainings. This information is available to QIRM.
Suicide Risk Assessment - All inmates scoring a positive result for suicidality on the MHSF-III and receiving an emergent or urgent evaluation are administered the Columbia Suicide Severity Rating Scale (C-SSRS)-Lifetime/Recent form by a QMHP to identify modifiable or treatable acute, high-risk suicide factors, and available protective factors that inform of inmate's treatment and safety management requirements.	Information tracked through Divisional Audits performed by Q/A staff within the Division of Behavioral Health and results shared with QIRM. The Division of QIRM also conducts independent on site audits at institutions to collect information.
Upon referral, during normal working hours, the QMHP assigned to the institution will provide a confidential, face-to-face evaluation the same working day and the C-SSRS Lifetime/Recent form will be utilized. This evaluation will be documented in the Automated Medical Record (AMR or EHR). During off duty hours, the on-call Mental Health Professional will provide a telephone consultation within 30 minutes of being paged by Medical or Correctional staff. Continuous observation (face-to face, in person) will be provided while awaiting an assessment by a QMHP.	Information gathered from documentation completed by the QMPHs and audited by Behavioral Health Q/A and QIRM staff.
Inmates on CI/SP or Observation Status are re-assessed at a minimum every 24 hours to identify changes in condition that indicate a need for a change in supervision level and placement. The C-SSRS Daily/Shift Screen form is completed as a part of the re-assessment	Information gathered from documentation completed by the QMPHs and audited by Behavioral Health Q/A and QIRM staff.
Prior to an inmate's removal from CI, the inmate must be re-evaluated either face-to-face or via tele-psychiatry technology by a licensed psychologist or psychiatrist. The reason for removal shall be documented in the AMR	Information gathered from documentation completed by the QMPHs and audited by Behavioral Health Q/A and QIRM staff.
Inmates needing CSU level of care will be transferred to the CSU at Graham (females) or Broad River (males) within 60 hours of the initial referral. If the QMHP determines a CSU level of care is not needed, or is undecided, the QMHP will consult with a psychiatrist or licensed psychologist within 48 hours of the initial referral regarding disposition. When an inmate arrives at the CSU, he/she will be evaluated by the psychiatrist or licensed psychologist within 24 hours. A	Regarding the 60-hour threshold, information entered into Crisis Intervention/Suicide Precaution web based application by the QMHP is time stamped. Weekly reports are generated from the Division of Resource Information Management (RIM) system to the Division of Behavioral Health and QIRM for compliance monitoring. Documented sessions for inmates arriving at CSU are obtained from chart reviews conducted by Behavioral Health Q/A and QIRM staff.

preliminary treatment plan will be developed by a QMHP after conducting a clinical assessment.	
All safe cells must be kept clean and temperatures regularly monitored and documented to assure they are in an appropriate range.	Cell check reports submitted from each institution to QIRM.
All non-RHU CSU inmates, unless clinically contraindicated, shall have access to out-of-cell time for 10 hours of structured and 10 hours of unstructured activity in a seven day period. This includes access to the dayroom and outdoor recreation.	Structured time reports generated from EHR and unstructured time reports generated from the OATS automated system submitted from both CSU programs to the Division of BH and QIRM.
Training of Inmate Observers. Inmate Observers will receive at least four hours of initial training before being considered eligible for suicide watch duty. Additionally, each observer will also receive at least four hours of training semiannually	Bi-annual report submitted from CSU program staff to QIRM outlining training received from all Inmate Observers.

July 2018 Implementation Panel findings: As per status update section.

Significant improvement is noted in the most recent psychological autopsy report. We made specific suggestions to Dr. [redacted] re: the process.

July 2018 Implementation Panel Recommendations: Implement the above QI schedule.

Conclusions and Recommendations:

Consistent with its previous six reports, the Implementation Panel has provided recommendations in this report as well as onsite during this visit from July 16-20, 2018. This report includes the IP findings and recommendations thru the end of the site visit, July 20, 2018. We have also discussed with SCDC staff, inmates, and the parties the impact of the riot at Lee and subsequent statewide lockdown. While some facilities and programs have been removed from the lockdown and others have not, the impact of the riot and lockdown continue to impact the SCDC mental health services delivery. During the visit we strongly encouraged facilities and programs to provide proposals to SCDC leadership to restore mental health services including considerations of safety concerns of staff and inmates. The system was already understaffed and the IP cannot overemphasize the continuing need for adequate staffing, facilities and programs to achieve adequate mental health care and compliance with the Settlement Agreement.

As always, we hope this report has been informative and the technical assistance provided has been helpful. We appreciate the cooperation and assistance of all parties in the pursuit of these goals and look forward to the next visit in November, 2018.

Sincerely,

Raymond F. Patterson, MD
Implementation Panel Member

On behalf of himself and:

Emmitt Sparkman
Implementation Panel Member