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

Executive Summary

This Sixth Report of the Implementation Panel (IP) is provided and stipulated in the Settlement Agreement in the above referenced matter, and it is based on the most recent Site Visit to the South Carolina Department of Corrections' (SCDC) facilities and on our review and analysis of SCDC's compliance with the Settlement Agreement criteria. The IP has conducted site visits to SCDC on May 2-5, 2016; October 31-November 4, 2016; February 27- March 3, 2017; July 10-14, 2017; December 4-8, 2017; and March 19-23, 2018. SCDC has continued to struggle with providing the requested pre-site documents and information that have been consistently requested to be provided to the IP no less than two weeks prior to the scheduled site visit. Although there has been some improvement, the IP continues to receive documents up to and during the actual site visits. The IP had a meeting with SCDC administrative, clinical and operations leadership including the Quality Improvement Risk Management (QIRM) and Research and Information Management (RIM) components to attempt to facilitate having a better process for obtaining documents as well as providing technical assistance to SCDC regarding the need for there being essentially a single point of contact identified by SCDC for the provision of these documents. The documents include those that are clinically focused and are traditionally provided by QIRM with necessary documents provided by the Division of Behavioral Health and Substance Abuse Services (DBHSAS) to QIRM prior to the provision to the IP. Similarly, on the operations side, the provision of documents in a timely manner as requested has also not been as consistent as requested. During the meeting, the participants went over the document request list and several items were eliminated or modified to help facilitate more consistency and timeliness in the provisions of documents by SCDC. The IP has considered the documents provided, including those that were provided during the site visit, however must re-emphasize that several of the documents provided to the IP should have already been provided to QIRM for clinical matters and reviewed, and provided by Operations for security management issues. It is our hope that the provision of documents for our next visit scheduled in July 2018 will be more reliable, consistent and timely. Between the site visits, the IP continues to provide technical assistance to SCDC with conference calls by the monitors and SCDC administrative staff as well as plaintiff's counsel.

During this site visit, as with past site visits, the Regional Directors have assisted with the process of review of items and information relevant to the Settlement Agreement and the Wardens and their administrative staff have provided access and consistent support for the IP touring the requested areas. Dr. Sally Johnson, consultant to SCDC, accompanied the IP to the facilities during this visit and Ms. [redacted] the newly appointed Deputy Director of Healthcare Services, also was very helpful in her participation in the on-site visits. On March 23, 2018, the IP held our traditional exit briefing, attended by Director Sterling and SCDC administrative and clinical staff as well as attorney Roy Laney who represents SCDC. Plaintiffs' counsel, Daniel Westbrook, and Judge William Howard were not able to attend but were apprised of the IP's preliminary findings.

As with past reports, this Executive Summary is intended to present an overview of the SCDC analysis and the Implementation Panel's findings regarding SCDC's compliance with the Settlement Agreement. The IP has continued to provide onsite technical assistance, presented its findings, and have attempted to acknowledge the positive efforts and findings demonstrated by specific programs and/or facilities, as well as continuing concerns regarding service delivery and compliance, and specific concerns that may have presented since the last site visit.

In that regard since the last site visit there has been a Use of Force event involving a mentally ill inmate at Lee Correctional Institution, which is under investigation by SCDC because of concerns with regard to the adherence to policies and procedures and the impact on the inmate and staff. [redacted]

As in past reports, the IP has defined and reported the compliance levels as "non-compliance", "partial compliance", or "substantial compliance" in each of the elements as well as providing specific findings and recommendations onsite in the individual facility exit briefings as well as at the comprehensive exit briefing on 3/23/18.

The IP visits included the following institutions during the week of March 19-23, 2018:

Kirkland Correctional Institution
Broad River Correctional Institution
Camille Graham Correctional Institution
Allendale Correctional Institution

Included in this report are Exhibit B and Appendices A-Z and Attachments 1-7. Exhibit B is the summary of the IP's assessment of compliance with the remedial guidelines. The preliminary "Master Plan" for mental health services which was reviewed during the last site visit has been updated by [redacted] and SCDC staff and we look forward to progression of that Master Plan. Exhibit B illustrates the Implementation Panel's findings regarding the levels of compliance as follows: 1) Substantial compliance - 15 components; 2) Partial compliance - 38 components; 3) Non- compliance - 5 components.

The Implementation Panel has made consistent attempts to acknowledge the sincere efforts by SCDC to improve mental health care, however SCDC continues to struggle in their attempts to achieve compliance with the necessary requirements of the Settlement Agreement in various programs and facilities. SCDC has moved forward with its plans to "centralize" several of their mental health services by programmatic levels, including: 1) High level BMU at Kirkland Correctional Institution; 2) Low level BMU at Allendale Correctional Institution; 3) Crisis Stabilization Unit at Broad River Correctional Institution; 4) Enhanced outpatient/area mental health (Level Three) at Broad River Correctional Institution; and 5) Multiple programs at Camille

Graham Correctional Institution for Women including Crisis Stabilization Unit (CSU), Intermediate Care Services (ICS), and Outpatient Services. There has been discussion of the potential need for a Behavioral Management Unit at Camille Graham which has not yet been proposed or developed. In addition, with regard to the contractual agreement with Columbia Regional Care Center (CRCC) for inpatient hospital beds for male and female inmates in need, the availability of hospital beds at CRCC has not yet been achieved as SCDC staff report that the provider has had construction and other issues which have delayed or impeded immediate access to the 10 beds that were agreed upon by contract. The IP strongly encouraged the appropriate components of SCDC, including clinical, operations and legal to pursue assuring availability of these beds for SCDC inmates when necessary.

In the Fifth Report of the Implementation Panel, the IP identified 10 areas of serious concern from past site visits and noted in previous reports including the following:

1. Staffing - including clinical (mental health, medical and nursing), operations, administrative and support staff. The IP cannot overemphasize the vital importance of having adequate numbers of appropriately qualified and trained staff. There has been some progression on the operations side of the house and limited progression on the clinical side of the house in hiring additional staff and providing as much "coverage" as possible by clinical staff. However, the allocated staffing positions for SCDC do not appear to be adequate for the provision of necessary services across this system. SCDC has engaged outside consultants to provide their estimates of the actual allocations needed for appropriate implementation of mental health services but also of basic provisions from a correctional/operations perspective. We have reported in the past and observed during this and past visits a lack of adequate numbers of operations staff to provide basic services and requirements as per policy including inmates in general population being subjected to lockdowns because of a lack of adequate staffing. This has led to further complications involving medication administration (see below) as well as out of cell time for inmates that is required by policies and procedure. In addition, while there have been efforts to increase the mental health staffing component by implementing tele-medicine and other coverage efforts, these are at best stop gap measures that need to be replaced by onsite staff to provide consistent mental health care to inmates identified by SCDC as in need of such care. In that regard, SCDC has made very good progress in identifying the actual mental health "caseload" which is estimated at over 18% based on the SCDC calculations. The IP has made recommendations regarding addressing these needs as well as the need to provide consistency of mental health staff and multidisciplinary participation in treatment planning including inmates to facilitate the most appropriate treatment services and outcomes. The nursing staffing issues are at such critical levels that medication management has fallen below acceptable clinical standards of care (see below).

2. Conditions of Confinement - including restrictive housing units (RHU) and segregation of any type. During our last site visit the IP was made aware that SCDC administrative staff "reinterpreted" the policy on Suicide Prevention Management to allow for up to 120 hours in "safety cells" in outlying facilities before required transfer to the CSU. Although a

correction has been made that inmates cannot remain in outlying facilities in safety cells for longer than 60 hours, this condition or situation has been complicated even further because the occupancy of the CSU at Broad River has been at or near capacity and there exists a "waiting list." The Settlement Agreement essentially prohibits there being a "waiting list" and the required 60-hour timeframe during which inmates must be transferred must be adhered to. During the course of our site visit to BRCI, it was clear that the 31 available CSU cells were occupied and the additional 32 CSU cells on the second tier were being occupied by "inmate watchers." The IP advised early in this process our views with regard to inmate watchers as well as the provision of individual (single cell) housing for inmate watchers within the CSU unit. One of the options being considered by SCDC was to bring in the "boats" which are plastic objects which are intended to substitute for beds and have been used in other facilities. This is an unacceptable option in providing inmate health care when there are potentially available beds within the CSU itself, which would hopefully alleviate the need for inmates sleeping in "boats" on the floor without mattresses. The IP also discovered that mattresses are not being used in the CSU at Camille Graham because of the interpretation that a one piece suicide resistant blanket/mattress/pillow was adequate. The IP apprised the staff at Camille Graham that these substitutions were not adequate for beds or mattresses. The concerns regarding the safety cells at Gilliam Psychiatric Hospital at KCI which were found to have inadequate suicide resistance on the last visit have been corrected as of this visit.

3. Prolonged Stays in Reception and Evaluation at both Kirkland CI and Graham CI. At Graham CI there have been increased efforts to identify inmates who are in need of mental health services and efforts to try to provide group therapies and other contacts with mental health staff for female inmates who remain in the R&E at Graham for greater than 30 days. While the clinical staff at Graham CI reported an increased number of group therapies for women in R&E as well as women in RHU, the women in those programs reported less time out of cell than what was reported by clinical staff due to cancellations of groups and "competing" activities that were being run at the same time as groups. A study that will be reflected later in this report indicated that the referral process from the R&E`s at Kirkland and Graham has been monitored more closely and revealed that there has been some documentation of urgent referrals to a qualified mental health professional but essentially no documentation of emergency referrals for psychiatric providers. The collective experience of the IP challenges the concept that no one coming into the SCDC as an inmate with mental health needs is in need of emergency and/or urgent referral services to a psychiatric provider. We have made this clear on multiple visits.

4. The Lack of Timely Assessments by Multidisciplinary Treatment Teams at the Mental Health Programmatic Levels. This continues to be a concern particularly with regard to the availability of psychiatrists and nurse practitioners to provide input into the multidisciplinary treatment team process. There has been improvement at the CSU BRCI in that there is participation by psychiatrists via tele-medicine at the treatment team meetings. However, based on our onsite review, the actual participation of the psychiatrist was more along the line of a psychiatric assessment rather than actual participation by a

psychiatrist and other team members in the discussion of the inmate's required needs. Assessments by mental health professionals should be completed prior to the multidisciplinary treatment plan meeting which is intended to have all of those assessments reviewed with the inmate to determine the best course of action.

5. Operations and Clinical Staff Adherence to Policies and Procedures and Lack of Appropriate Supervision.

6. Access to All Higher Levels of Care for Male and Female Inmates - Our previous concerns with regard to access to all higher levels of care for male and female inmates focused largely on the role of the CSU's in the Continuum of Mental Health Services. The role of the male CSU at BRCI appears to be expanding and the need for not only multidisciplinary clinical staff participation but also classification staff in addition to current operational staff participation appears to be a vital component to the IP which has not yet been implemented. The CSU at CGCI continues to be developed and the need for participation of multidisciplinary, clinical and classification staff appears to be very necessary. There have been improvements in the BMU's in that they have increased their levels of programmatic participation. The low level BMU at Allendale CI was visited and inmates were interviewed. In addition the IP attended a graduation ceremony for four inmates who were graduating from the low level BMU. These are all very positive achievements, however they reflect that the actual provision of staff is inadequate for this program which has only two QMHP's and no regular psychiatric participation at treatment team meetings. In addition, because of the staffing issues, as well as space issues at Allendale CI, the program is capped at 24 beds. Similarly at the high level BMU at Kirkland CI, the program has also been capped at 20 inmates because of a lack of staffing and space resources. These are deficiencies that are affecting the overall programs as well as the availability of programs to other inmates who may have been appropriate for admission to these programs but are placed on a waiting list because of inadequate resources.

7. Future Planning for a Comprehensive Mental Health Services Delivery System including Staffing Beds and Programs. The Master Plan which was reviewed at the last site visit was largely a plan to develop a plan. There has been some progression in developing this plan, but it is highly dependent on resource allocation. Even if the current staffing allocations are satisfied for clinical and operations staff, it is the IP's opinion that the full staffing at the allocated measures would be inadequate to provide for the actual inmate needs. SCDC has sought consultation from classification and operations experts and has continued consultation with their psychiatric expert, Dr. Sally Johnson.

8. Medication Management, particularly at Graham CI and Leath CI. The IP has expressed our grave concerns with regard to medication management (not limited to the women's facilities) and the interface between the electronic medical record, the eZmar System and the RIM, as well as the very dire staffing needs for nurses at these facilities. There are similar needs for nursing staff at the male facilities, which includes the need for filling allocated positions with on board staff, as much of the coverage in SCDC facilities is being

done by an agency of pool nurses who have no consistent involvement with specific inmates and therefore the potential for medication errors and other problems with medication administration have been evident and continue. The practice of providing inmates with medications "under the door" in small manilla envelope packages even when administered via the "putter" (described as a golf club like item onto which the package of medication is placed and then slid under the door for the inmate to retrieve, which we observed while on site) is well below the standard of care and requires immediate correction. The implications of providing medications in this way to the general population inmates (with plans to reconfigure their doors to include food slots to place medications through) as well as segregation inmates who by and large have doors with food slots in them, is simply unacceptable and the actual monitoring and evaluation of medication administration, medication errors, and inmate adherence to prescribed medications are all very problematic and may contribute not only to medication contraband being distributed by inmates who are not taking their medications but also the potential of hoarding of medications by inmates that may be used subsequently for self-harm and/or suicide. The clinical and security risks of these practices cannot be overemphasized.

9. Substantial Progress in the Quality Management Program has been noted in the efforts by the Quality Improvement Risk Management Program (QIRM), which has been a major asset to the SCDC system, as well as the documentation of compliance with the Settlement Agreement requirements. The Behavioral Health Division also has a quality management component and the interface between Behavioral Health, QIRM and RIM are essential for actual demonstration of compliance in adequate mental health care. The concerns regarding collaboration, methodology, reliability and timeliness of reporting information has been reported in the IP's past reports as well as onsite and again must be reinforced in this report.

10. Implementation of the EHR including eZmar and the Interface with the Pharmacy System, which has been piloted at Graham CI and Leath CI, has been an important learning curve for SCDC. Based on some of the problematic areas identified as in need of revision and/or improvement, the rollout to the male facilities has been delayed. The IP agrees with this delay to facilitate that when the rollout is implemented it has the most likely chances for success.

11. The IP remains extremely concerned about UOF issues at certain SCDC correctional facilities. The monthly reviews by the responsible IP member continue to identify UOF incidents where a threat does not exist to justify the UOF or the UOF was not within SCDC guidelines. An extreme example is the planned UOF incident that occurred at Lee Correctional Institution where an inmate was seriously injured. SCDC officials and the IP Team reviewed the UOF video together during the March 2018 site visit and were alarmed at the magnitude of the UOF violations in conjunction with flagrant participant disregard for inmate safety and welfare. It is encouraging that SCDC management took immediate action terminating an employee and initiating a criminal investigation. SCDC management must become more proactive in identifying and addressing UOF issues. The

IP is encouraged that the Operations Division has created an Administrative Regional Director to review UOF incidents with the purpose of implementing strategies to address individual and systemic UOF deficiencies. The Mental Health Division has also created a position to review and provide input regarding UOF incidents involving inmates with a mental health designation. It is imperative that SCDC Operations and Mental Health Staff collaboratively work together on preventing UOF incidents. Further, it is essential and necessary that Operations and Mental Health staff address the unacceptably low percentage (29% in January 2018) of notifying clinical counselors (QMHPs) before planned uses of force to request assistance in avoiding the necessity of force and managing the conduct of inmates with mental illness.

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 March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
The Division of Behavioral Health and Substance Abuse Services completed CQI study to determine if the timeframes for the initial screening and follow up evaluations outlined by policy were being met, to identify root causes of any deficiencies, and to provide action plans to correct any identified deficiencies.

The complete study is included as Appendix A. Results were as follows:

During the course of this study, Camille Graham showed improvement with identification (n= 51 urgent & n= 20 emergent). Kirkland R&E demonstrated an improvement with identifying urgent referrals (n= 40); and reported that emergent referrals are triage as crisis cases and not reflected in their percentages. Compliance percentage averages from both programs based on mandated timelines in policy were as follows:

	Camille Graham	Kirkland
Screening	51.3%	47.3%
Routine Referrals (QMHP)	67%	71.1%
Routine Referrals (Psych)	57.4%	43.1%
Urgent Referrals (QMHP)	19.1%	72.8%
Urgent Referrals (Psych)	8.3%	62.5%
Emergent Referrals(QMHP)	51.1%	0%
Emergent Referrals (Psych)	0%	0%

In comparison to the last reporting period, Mental Health screening practices timeliness decreased for both programs averaging 5.47 days. Both programs have received an increase of Psychiatry time since last reporting period, which is reflected in Kirkland's routine and urgent referrals to Psychiatry for the month of January. The identification of emergent referrals appear to be problematic for Kirkland; however, they report those cases are managed on crisis intervention and not coded properly to be counted in this report.

Planned Actions

1. Assess and determine the reason why screening practices for both programs decreased this reporting period.
2. Assist Kirkland R&E staff with coding and documenting emergent referrals that are being processed through crisis intervention in order to be counted in the data.

March 2018 Implementation Panel findings: As per SCDC status update section. Improvement in meeting required timeframes since the last monitoring is noted although partial compliance remains due primarily to both custody and mental health staffing vacancies.

Staff informed us that the zero percentages related to emergency referrals to psychiatrists were due to such referrals being tracked as crisis stabilization unit referrals. They will begin to track these referrals as emergent referrals and also track what percentage of such referrals result in referrals to the crisis stabilization unit.

The partial compliance on urgent referrals is very concerning and needs to be adequately addressed.

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

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

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:

To track the percentage of mentally ill inmates, the Division of Resources and Information Management (RIM) generates s 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.

Mental Health Classifications for Mentally Ill Institutional and Female GEO Care Population on February 26, 2018

SCDC Institutional and Female GEO Care Population = 19,458
SCDC Mentally Ill Population = 3,647

Mental Health Classification	Female	Male	Total	Percent of Mentally Ill Population	Percent of Total Population
Missing	32	222	254	N/A	1.31%
BL		22	22	0.60%	0.11%
BU		20	20	0.55%	0.10%
L1	1	71	72	1.97%	0.37%
L2	17	141	158	4.33%	0.81%
L3	78	222	300	8.23%	1.54%
L4	601	2,302	2,903	79.60%	14.90%
L5	40	112	152	4.17%	0.78%
MR	2	18	20	0.55%	0.10%

The most recent reports, dated February 26, 2018 are attached as Appendices B1 and B2.

As of February 26, 2018, the following institutions have implemented this annual screening process:

During the Implementation Panel's last visit, in December 2017, SCDC submitted a quality improvement study that indicated that ten inmates out of 671 included in the study had been added to the mental health caseload as a result of this anniversary screening process. This reporting period, the quality improvement study on this topic, Appendix B3, indicates only four inmates out of 661 included in the study have been added to the caseload as a result of this anniversary screening process. However, please note that these studies examined different institutions for different lengths of time. The study submitted in December examined Camille, Lee, MacDougall, McCormick, and Perry over a three month time period (July through September of 2017) while the current study examined Camille, Broad River, and Allendale over a four month time period (October of 2017 through January of 2018). Despite the fact that the two studies examined different institutions over differing lengths of time, the number of inmates eligible for anniversary screenings in each study were very similar: 671 and 661, respectively. Thus it appears that the anniversary screening process was less effective in the most recent study than it was in the previous study. Protocol changes were implemented in October of 2017 with

the goal of increasing the efficacy of these anniversary screenings. At this point, SCDC plans to continue to implement this new protocol and monitor its efficacy while simultaneously exploring other options so that we will be prepared to replace the anniversary screening process should it ultimately prove unsuccessful. Please see the Planned Actions section of the quality improvement study attached as Appendix B3 for more information.

Assessment of the results from the above referenced study was as follows:

Only one of the three studied institutions, Camille, is completing the majority of their anniversary screenings with any consistency. Camille was the first SCDC institution to begin anniversary screenings. They did so in February of 2017. AS such they have more experience with the process than the other studied institutions. Additionally, the numbers of inmates eligible to be screened are low at Camille in comparison to the other studied institutions. Both of these factors likely contributed to Camille's success in completing these screenings. However, even at Camille where screenings are being completed, QMHP follow ups were completed at only 60% at best and no psychiatric follow ups were completed in a timely manner. Most importantly, Camille added only four inmates to the mental health caseload during the studied time period and the other studied institutions added none. Overall, it appears that the current anniversary screening procedure is not an effective way to reach the agency's goal of accurately identifying inmates with mental illness who were not classified as mentally ill prior to the screening in order to bring the identified rates of mental illness within SCDC's inmate population closer to national average rates.

Planned actions, if any:
On October 2, 2017, The Division of BMHSAS implemented a new statewide protocol (see attachment). This protocol requires that the QMHPs or Mental Health Techs account for all inmates eligible for anniversary screenings in any given month. In order to accomplish this, mental health staff will seek out inmates who fail to report for their appointments for face to face contact. Additionally, mental health staff will follow up on inmates who refuse to attend their appointment by completing a records review (AMR and medical chart) and talking with security staff. No inmate will be noted to have "refused services" until all of this has been done. The data in this study begins at the same time that this new protocol was implemented. It takes time for a new protocol or procedure to be learned at put into practice; particularly in as large and complex a system as SCDC. Thus, the Division of BMHSAS will continue under this protocol through April of 2018 and then will reassess its efficacy. The Division of BMHSAS will also explore alternatives to the anniversary screening system so that if rates of completion and additions to the mental health caseload have not improved at that time. SCDC will be prepared to move method of achieving this goal.

March 2018 Implementation Panel findings: As per the current status section, which indicates that 18.74% of the total inmate population is on the mental health caseload. It also appears clear that the annual mental health assessment from an epidemiological screening perspective is not very helpful for such purposes. These statistics, when viewed in context of the percentage of inmates being identified as requiring mental health services during the R&E process, indicate that inmates

not initially identified as requiring mental health services during the R&E process are later identified via a variety of different processes such as self-referral and staff referral, based on the increasing percentage of the inmate population receiving mental health services.

March 2018 Implementation Panel Recommendations: Continue to track the statistics relevant to this Settlement Agreement provision.

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 March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
The Division of BMHSAS does not have a standard protocol or established practice that requires MH supervisors to review those inmates determined to be NMH by QMHP to assess for agreement/disagreement; however, complexed cases are staffed with MH Supervisor, who is licensed as an independent mental health practitioner to provide guidance to subordinates. The psychiatrist is also available for consultation. The Division does review cases from each QMHP caseload, during their quarterly audits, to include cases determined to be NMH. If issues are noted, these concerns are shared with the R&E Mental Health staff.

A CQI study was done to help the administrators in the SCDC Behavioral/Mental Health and Substance Abuse Services (BMH&SAS) evaluate KCI R&E counselors. The study did not include CGCI R&E, since they already have a reasonable number of inmates identified at R&E and placed on the mental health caseload.

The results of the study were as follows:

Kirkland R&E	Total # of removals from KCI R&E	Special Removals with referral to counselor that left R&E with "MH" classification.	# of Special Removals that reclassified to mentally ill within 6 months.	% of Special Removals that were reclassified.
June 2017 Removals	433	56	5	8.9%
July 2017 Removals	447	53	2	3.8%
August 2017 Removals	542	79	6	7.6%
September 2017 Removals	428	48	0	0.0%
Totals	1850	236	13	5.5% average

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

March 2018 Implementation Panel Recommendations: Repeat this study during the next monitoring period.

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 March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
Health Services identified that a temporary pink slip position was needed to ensure the mental health MEDCLASS data was entered timely. A Medical Assistant position was identified for Kirkland R& E and processed for hiring.

Additional CNAs have been processed for hiring or brought in through agency staffing. Consistent staffing of CNAs for Kirkland and Camille have been problematic due to initial background issues or frequent turnover in these positions.

March 2018 Implementation Panel findings: As per status section. Staff reported that R&E inmates are receiving prescribed psychotropic medications, when clinically indicated, on a timely basis within the R&E units. We discussed with them the need to ensure that a clinician is identified as essentially being a mental health caseload inmate's primary mental health clinician during his or her time within the R&E unit. In addition, inmates with length of stay greater than 30 days within the R&E unit need to have additional mental health services provided to them as compared to those with length of stay less than 30 days, which include increased out of cell time.

The Implementation Panel interviewed CGCI R&E inmates in group settings on March 23, 2018, and received information regarding conditions of confinement in R&E. Out of cell recreation is normally only one (1) hour per day. For a brief period, additional evening recreation time was permitted; however, the evening sessions were discontinued. Access to the correctional facility gymnasium is provided three (3) times per week weather permitting. Showers are afforded three days per week. Meals for R&E inmates are served in the CGCI cafeteria unless the correctional facility is on lockdown. R&E inmates are not permitted to utilize the canteen until they are classified, limiting their access to personal care items while confined in R&E. Inmates complained they are not issued sufficient hygiene items to meet their personal needs. Groups were instituted approximately four (4) weeks ago with approximately three (3) groups held per week offering topics in social skills, coping and character development. Inmates are not allowed visitation while they are assigned to R&E.

March 2018 Implementation Panel Recommendations:

1. Remedy the above identified staffing issue.

2. Perform a QI study to determine whether R&E inmates are being referred to a psychiatrist, when clinically indicated, in a timely fashion as well as receiving any prescribed medications in a timely manner.

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 March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
As per 1.a.i.

March 2018 Implementation Panel findings: As per 1.a.i.

March 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 March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
See report at Attachment 3

March 2018 Implementation Panel findings: During the afternoon of March 20, 2018, we interviewed inmates in a community-like setting in Murray housing unit at the Broad River Correctional Institution that was occupied primarily by inmates with an L3 mental health classification with other inmates having an L4 classification. These inmates were significantly less distressed about their housing as compared to our December 2017 interviews with them. The change was largely related to the various interventions by custody and mental health staff that are summarized elsewhere in this report. However, significant issues remain that included the following:

1. Problematic access to the psychiatrist and continued problematic access to a QMHP were described, which was confirmed by QI studies.
2. Lack of access to educational activities.
3. Very poor access to medical services.
4. Morning pill line occurring at 4 AM even though breakfast was generally not served until after 6 AM.

5. Evening pill call line generally occurred at 4 PM.
6. Very limited access to group therapies.

The Access to Management meetings have allowed executive and institutional staff members from various disciplines to address and handle inmate's concerns/issues on the spot. Associate Warden Peoples has been very responsive to inmate concerns.

Significant improvement relevant to inmates housed in the Murray housing unit has occurred since the last site assessment. AW Peoples' leadership was impressive.

March 2018 Implementation Panel Recommendations: The access to management meetings should serve as a model throughout the system for how to improve conditions of confinement even when resources are very limited.

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

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
The following chart shows the number of male and female inmates receiving intermediate care services between January 2017-January 2018. The number of inmates classified as L2 has decreased monthly since July 2017.

QIRM staff completed a CQI study to review and assess if inmates placed in ICS receive 10 hours of structured out-of-cell time as directed by the Individualized Treatment Plans per week.

The study examined the total amount of structured time received per month for each inmate in the sample.

The complete CQI study is attached as Appendix D.

Assessment of the results included the following:

Camille Graham
Data analysis in this study revealed that most treatment plans are not individualized and do not specify the structured time inmates will participate in based on their needs. At Camille Graham, most treatment plans do not refer to groups at all and the few that due state something such as "will refer to groups or inmate will attend groups". Only two of the treatment plans referred to individual counseling and/or sessions using that specific wording. Other treatment plans implied individual sessions would be held by stating something such as the following: "CCC will help inmate come up with different coping skills". A few of the treatment plans did not refer to or imply individual sessions at all. With that in mind, credit for structured time was given if the treatment plan referred to groups and/or individual sessions/implied individual sessions.

Kirkland
Data analysis in this study revealed that most treatment plans are not individualized and do not specify the structured time inmates will participate in. There were a few treatment plans that listed specific groups the inmates would participate in. However, for most of the treatment plans, when groups were mentioned, the following statements were used to include but not limited, "attend groups that aid in behavior modification", "attend assigned groups", and "attend group tailored to his identified problems and/or behavioral patterns". There were a few treatment plans that did not refer to groups at all. With that in mind, credit for structured time was given if the treatment plan referred to groups and/or individual sessions.

Planned actions:

It is unclear which groups/activities an inmate should participate in based on the wording on the treatment plans, specifically the lack of individualization for which groups would have been most appropriate for the inmates based on their mental health diagnosis. As a result, a discussion was held with ICS managers, Division Director for Behavioral/Mental Health, and the Deputy Director of Health Services in regard to placing all groups offered as structured time into categories. With categories, the treatment plan could reference any category of a group that an inmate may be referred to, based on his or her individual needs. This would ensure the individuality of treatment plans for each inmate versus a general reference to groups. Therefore, it is recommended that categories are created for groups to ensure ICS staff and inmates are receiving credit and the benefit of all of the treatment plan driven structured services that are offered and received.

March 2018 Implementation Panel findings: 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.

Kirkland Correctional Institution

Nursing staff continues to not be housed within the male ICS unit related to safety and space issues. Our December 2017 report included the following:

> Very little has changed from a custody staffing perspective in the male ICS since the April 2017 homicides other than assigning a unit manager and correctional counselor to the male ICS unit. Following the homicides, the male ICS unit was reorganized as follows: Unit F1, which is a 64 bed ICS housing unit, was established for ICS inmates who were considered a high risk of harming vulnerable inmates from the perspective of their functioning level. Unit F2,

> which is a 128-room ICS housing unit with a capacity of 256 inmates, was designated to treat inmates with a lower level of functioning as compared to F1 inmates. The count during the site visit of unit F2 was 97 inmates as compared to the count of 40 inmates in Unit F1.
>
> The lack of medication administration at KCI being available on an HS basis (i.e., at night) continues to be very problematic. Long acting injectable medications are available but are administered off the housing unit because nursing staff have been removed from ICS related to perceived safety issues.

Except for the inmate count during the March 2018 site visit, little has changed in the context of the above description. At the time of the site visit the total male ICS count was 156 inmates with nine of these inmates being at Gilliam Psychiatric Hospital and one inmate in the RHU.

During the morning of March 20, 2018, we observed a treatment team meeting in the male ICS at KCI. The appropriate staff was present and inmates were interviewed by the team. However, the first inmate reviewed by the treatment team resulted in a very problematic staffing process that was characterized by the inmate escalating in a very agitated manner, which continued until the unit housing manager made an appropriate intervention.

ICS inmates were reported to be offered two structured therapeutic activities (i.e., group therapies) per week as well as a variety of recreational activities each week. Structured therapeutic activities were not discussed during the treatment team meeting but were based on the inmate's primary clinician's assessment.

Clinical Staffing for the ICS was reported as follows:

1.06 FTE psychiatrist (# Hours/week on-site = 42.50)
0.00 FTE psychologist
7.0 FTE Mental Health Counselor (3.0 FTE vacancies)
3.0 FTE MHTs
16.99 FTE RNs (13.99 FTE vacancies)
12.85 FTE LPNs (9.85 FTE vacancies)

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

1. A plan needs to be developed and implemented specific to a custody staffing analysis specific to the male ICS as soon as possible due to obvious safety concerns.
2. Provide accurate information regarding the number of hours of out of cell structured therapeutic activities both offered and received by individual ICS inmates, on average, on a weekly basis.
3. The lack of medication administration on an HS basis needs to be remedied.
4. Safety [and space] issues related to the absence of nursing staff having offices within the ICS need to be resolved

Additional recommendations include the following:

1. Review the problematic treatment staffing referenced above in order to learn from the process.
2. 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 March 5, 2018 was 707 inmates. During March 5, 2018 there were 356 mental health caseload inmates (~50% of the population), which included 18 L2, 78 L3, 223 L4, and 34 L5 mental health caseload inmates.

The RHU count during March 21, 2018 was 40 inmates, which included 30 mental health caseload inmates.

There were 12 CSU beds and 2 safety cells in RHU (which were not suicide resistant). The number of inmates on CI status generally ranged from 0-4 per day with a census of five patients during our site visit.
Staffing data included the following:

> Psychiatric coverage is provided by three psychiatrists that involves 17.4 hours per week, which included the use of telepsychiatry. Additional psychiatric coverage provided two hours per week by psychiatric nurse practitioner.
>
> 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
> 1.0 FTE RN FTE positions filled and 5.0 FTE RN vacancies.
> 3.0 FTE LPN positions were filled with 7.0 FTE LPN vacancies.

We observed a treatment team meeting during the afternoon of March 21, 2018. A psychiatric nurse practitioner was present during this meeting. 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 daily mental health groups since the December 2017 site visit and generally had favorable comments regarding the program. Staff reported that ICS inmates received 3 to 20 hours per month of out of cell structured therapeutic activities in addition to having access to about four hours per week of activity therapies.

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. Not surprisingly, medication management issues (e.g., medications expiring without being renewed in a timely manner, missed medication dosages, etc.) were common related to the significant nursing vacancies. Complaints about the 4 AM pill call line were also voiced, which included not being awakened in time for the pill call line. Access issues were described relevant to the psychiatrist and QMHPs. Many inmates voiced dissatisfaction with the psychiatrist related to the medications prescribed and/or not prescribed to them.

March 2018 Implementation Panel Recommendations:

1. The most pressing need is to fill the nursing staff vacancies as well as the psychiatrists' vacancies.
2. Remedy the lack of suicide resistant safety cells.

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 March 2018 Assessment. **partial compliance**

February 2018 SCDC Status Update:
SCDC was advised by Correct Care that the 10-bed unit dedicated to SCDC has again been delayed due to issues with contractors. However, Correct Care is admitting SCDC patients without the unit being completed. SCDC patients will be prioritized above other patients so that Correct Care can fulfill the 10-bed agreement.

QIRM staff have identified problems with the databases used by the QIAs for calculating the provision of out of cell time to inmates. The available data on out of cell time is not reliable because of these issues. These problems are being analyzed and addressed by QIRM staff so that reliable data can be produced and provided in future reports.

Because of the database issues, data to accurately represent GPH's increased provision of structured activities is not yet available to include in this report. However, GPH staff report and document the provision of out-of-cell structured and unstructured activities in addition to the documentation done by the QIAs. Initial review of that documentation demonstrates that the provision of out-of- cell structured activities and community groups being provided to the inmates has increased since the last reporting period. An increase in group activities with the Activity Therapist has also been noted.

This data will be made available for review during the March 2017 site visit. Hard copies of documentation are available in the interim, if needed. To demonstrated GPH's ongoing work and efforts to comply with this provision, QIRM staff will have detailed reports available for review.

March 2018 Implementation Panel findings: The amount of out of cell structured therapeutic activities offered to inmates was reported by staff to be 6-10 hours per day. However, during the past two weeks the amount of out of cell structured therapeutic activities has been very minimal

due to painting and renovations occurring on the unit in preparation for the site visit. Since December 2017, inmates were reported to be offered 3 to 4 hours per day of out of cell unstructured time. The limited out of cell structured therapeutic activities was reported to be due to a combination of both correctional and mental health staffing vacancies and/or allocations.

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 waiting for various equipment to be delivered that were ordered months ago. Licensure inspection cannot occur until the equipment is in place.

Clinical staffing for GPH was reported as follows:

	Total FTE as of 3/20/18	**Staffing Plan FTE**
Psychiatrists:	2.18	4.0
Psychologists:	.60	1.50
QMHP's:	6.00 (1 starts 3/26)	9.00
MHT's:	16.00 (1 starts 3/26)	16.00
Activity Therapists	.80	1.00

MEDICAL/NURSING FTE
GPH/ICS/DEATH ROW

	Total FTE as of 3/20/18	Allotted FTE	Staffing Plan FTE
Nursing:			
RN:	3	16.99	19.00
LPN:	3	12.85	15.00
Paratech:	2	0	5.00
Other:			
NP	2		

During the morning of March 20, 2018, we interviewed GPH inmates in a community setting. These inmates complained about the limited out of cell time and limited access to out of cell structured therapeutic activities although the groups attended were described as being helpful.

As per the status update section, access for female inmates to inpatient psychiatric care remains very limited.

March 2018 Implementation Panel Recommendations: 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.
3. Fill the mental health staffing vacancies and perform a needs analysis for custody staffing in GPH.
4. Provide information relevant to the number of hours received, on average, to each GPH inmate on a weekly basis both in terms of out of cell structured therapeutic time and out of cell unstructured time. Please provide this data as part of the pre-site document requests prior to our March 2018 site assessment.

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

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
The following strategies outline SCDC's plan to decrease vacancy rates of clinical positions. This plan includes one-day hiring for nurses and mental health staff, spot bonuses, revised hiring practices in HR for medical and mental health – removed duplication of services in recruitment and HR to increase the speed of hiring; and the implementation of salary equity increases for all psychiatrist, QMHP and psychologist positions.

SCDC retained the expert services of [redacted] to conduct a security staffing study for SCDC. The study has been completed by [redacted]. The Director and pertinent SCDC leadership staff will meet with [redacted] on March 8, 2018, to receive the report outlining the results of the study and to receive explanations from [redacted] about his recommendations for SCDC and each institution.

An Executive Order was issued on February 27, 2018, by Governor Henry McMaster recognizing that SCDC does not enough officers to patrol the perimeter of correctional facilities to deter members of the public from throwing or dropping contraband over facility walls and fences and, in order to protect the public and prevent violence or threats of violence, proclaimed an emergency, and ordered the South Carolina State Guard to assist SCDC by staffing the exteriors and fence towers of correctional facilities and performing all other related activities to be memorialized in an agreement to be reached within 20 days. The Order is attached as Appendix E.

SCDC is awarding a bonus to eligible employees. The $500 bonuses will be awarded April 3, August 3, and December 4, totaling $1,500.

The eligibility requirements are included in a memorandum from Director Sterling as Appendix F.

SCDC hosted a "mass hiring event" on February28. 2018 where 70 scheduled applicants were slated to be hired in one day. 50 applicants of the near 70 participated in the event, of the participating candidates, 80% were hired. A list of candidates and hiring status is included as Appendix G.

This pilot event was designed to bring in a large group at one time to address staffing issues.

A comprehensive list of additional and ongoing hiring initiatives is included as Appendix H.

March 2018 Implementation Panel findings: The increased salary structure for psychiatrists and psychologists, which has recently been approved, is a very positive step. Efforts are being initiated to improve the salary structure for QMHPs as related to their working experience in the field.

We are encouraged by the various recruitment and retention strategies summarized in the current status section. However, the current hiring process remains very problematic due to the amount of time it takes to actually hire new staff, which has resulted in and will continue to result in potential new staff going elsewhere.

Attachment one provides data relevant to the health staffing plan and current staffing allocations/vacancies. The following chart summarizes current allocations and vacancies.

STAFF SUMMARY

	Total # of Positions	Full-Time		Pink Slip		Dual		Contract		Total % Filled Positions	Total % Vacant Positions
		Filled	Vacant	Filled	Vacant	Filled	Vacant	Filled	Vacant		
Administrative Support Totals (includes QA Manager and HSOA Team Lead)	11	10	1	0	0	0	0	0	0	90.91%	9.09%
Bay Area Totals - (only at GPH)	7	6	1	0	0	0	0	0	0	85.71%	14.29%
Activity Therapy Totals	3.53	3	0	0	0.53	0	0	0	0	84.99%	15.01%
Mental Health Tech Totals - (includes HSC I/CCC III's)	44	37	7	0	0	0	0	0	0	84.09%	15.91%
Qualified Mental Health Professional Totals - (includes CCC IV, CCC V, Regional Managers, Program Managers, Clinical Supervisors)	94	68	25	0.53	0	0	0	0	0	73.27%	26.73%
Psychology Totals	3.21	0	2	1	0	0	0	0.21	0	37.69%	62.31%
Psychiatry/Nurse Practitioner Totals	15.92	4	4	3.48	0.86	1.68	0	1.9	0	69.47%	30.53%
Division Totals	**178.19**	**128**	**40**	**5.01**	**1.39**	**1.68**	**0**	**2.11**	**0**	**76.77%**	**23.23%**

March 2018 Implementation Panel Recommendations: Adequately address the hiring process as referenced above.

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

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

February 2018 SCDC Status Update:
[redacted] Ph.D continue to review denials of referrals of inmates to higher levels of care. LLBMU has capacity for 24 inmates based on current staffing. The denial reports for LLBMU October 2017- January 2018 are attached as Appendix I. Per Dr. [redacted], GPH had no denials for the same review period.

The denial reports for ICS for October 2017- January 2018 are attached as Appendix J.

March 2018 Implementation Panel findings: As described in our December 2017 report, the QI review process included the following:

1. This committee has met three times (20 Apr 17, 17 May 17, 21 Jun 17). There are four members: [redacted] meets w/us via VTC.

2. Prior to each meeting, [redacted] receives reports from the six (five as of June) residential/inpatient programs (SIB, ICS, HAB, LLBMU, HLBMU, GPH) which reflect the number of requests for admission, the number of inmates accepted, the number wait-listed, the number removed by the referral source before they were admitted/denied and the number denied. These reports also contain a section in which all inmates who are denied admission/acceptance are identified along with the date they were denied and an explanation of why they were denied.

3. During the meeting, all inmates denied are reviewed. Their AMR and their relevant OMS data is reviewed. The committee decides to either concur or not concur with the denial. The names of those inmates whom we believe were denied inappropriately, along with the reasons we believe the denial was inappropriate, are forwarded to Mr. [redacted] for further action.

4. Mr. [redacted] replies to Dr. [redacted] regarding his decision to agree or disagree with or not concur in the finding.

We are concerned that the CSU staff at BRCI report that very few of their referrals to the ICS are accepted. Based on the SCDC status update section summary, either the CSU staff are making inappropriate referrals to ICS or the review process is flawed.

March 2018 Implementation Panel Recommendations: Re-evaluate the QI review process in the context of ICS referrals from the CSU. Implement corrective action if indicated.

2.b. Segregation:

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

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
QIRM has identified problems with data quality. As a result, an update to address this provision cannot be made with confidence.

Health Services Office Assistance were transferred to QIRM in January 2018. The process has begun to official change their titles to Quality Improvement Assistants, and redefining and streamlining their job duties. Since January, QIRM Analysts have been able to specifically identify problems data collection and reporting which has resulted in additional training. Since January four QIAs have resigned.

QIRM staff have identified the following issues with both the LLBMU and HLBMU.

Concerns with QIA's Documentation of LLBMU Data:

- Data from all three of the phases are recorded on separate spreadsheets, which makes the compilation of data very difficult (i.e. for 4 weeks in a month, there are 12 spreadsheets not 4). A new spreadsheet is being developed by the Lead QIA to consolidate reporting of for the unit.
- Certain activities have been recorded as structured time when they should be considered unstructured. For example, in Phase 1 10/09 – 10/13, medication administration was considered structured time.
- The formulas for performing calculations for total time out of cell were removed in several reports and some databases.
- The time allotted and time offered (which are necessary data) were excluded from the structured activity sheet in most of the reports from October and November.

Concerns with QIA's Documentation of HLBMU's data:

- The program's group reports list GROUPs, but does not define what those group are. This makes it difficult to document and report the structured time.
- Inmates' names and numbers are transposed in several placed making it difficult to correctly identify and report individual structured time

Concerns with QIA's Documentation ICS's data:

- In some ICS reports, the number of inmates listed as active vs. inactive included the wrong information which increases the probability there's a possibility that some inmates were listed as having recorded time when in fact they didn't and vice versa.

Planned Actions
The Division Director has established a meeting that includes all QIAs and QIRM Analysts on the first Wednesday of each month. A staff retreat was held on January 26 to explain the roles of

the QIAs with QIRM and to provide them with an overview of the Mental Health Lawsuit. Changes in roles and expectations were outlined at this meeting.

The next staff meeting is scheduled for March 4, 2018, where data quality issues will be addressed in detail and an additional training will be provided on collection and reporting structured and unstructured out-of-cell time.

The Lead QIA and lead Analyst for each institution will begin on-site technical assistance visits beginning the week of March 9 to ensure the proper collection of appropriate forms and operation of databases.

The QIRM Division Director is in the process of updating the job announcement to include data collection and reporting experience as a mandatory requirement.

March 2018 Implementation Panel findings: As per the current status section.

HLBMU

During the afternoon of March 19, 2018, we interviewed eight level I & II inmates in a community -like meeting setting as well as separately meeting with six level III HLBMU inmates in a group setting at the KCI. The HLBMU census was 20.
Since our December 2017 site visit, the mental health staffing of this unit consists of the following staff:

3.0 FTE QMHPs (2.0 FTE vacancies, which will be filled April 2, 2018)
1.0 FTE program manager
3.0 FTE mental health technicians

Privilege level III HLBMU inmates have had access to weekend visitation on a twice per month basis since our last site visit. These inmates confirmed improvements in the program since the last site visit, which included access to at least one group therapy per weekday, good access to one-to-one sessions as needed with a mental health clinician, access to limited recreational therapy, meals in the general population dining hall and access to walks outside of the housing unit when accompanied by custody and counseling staff.

Complaints voiced by these inmates included the following:

1. Security measures (e.g., being searched on multiple occasions) required when taken off the unit despite being constantly monitored by correctional staff.
2. Minimal, if any, ability to interact with general population inmates when off the unit. For example, when in the dining hall with general population inmates, they are not allowed to sit with them or interact with them.
3. Despite being told that level III privileges include access to jobs off the unit, none of these inmates have been offered or have had access to such jobs. However, staff

confirmed that level III privileges did not include off the unit jobs, which had been told to inmates on multiple occasions.

4. Lack of clarity concerning what they need to do and over what period of time it will be required, in order to be transferred to a general population housing unit.
5. These inmates perceived that upper custody management made decisions that directly impacted them without having an adequate knowledge of the current program and/or their progress within the program.
6. One of the inmates described problems with correctional officers on the unit from the perspective of attitudinal issues (i.e., "too much testosterone [being demonstrated]").
7. Medication management issues did not appear to be present.
8. Inmates complained of lack of incentives being offered within the program. We discussed with them the possibility of tablets (i.e., iPads) being part of an incentive program, which was received by them as being a very positive incentive.

Most of the HLBMU privilege level II inmates were unhappy with the program and demonstrated a fair amount of entitlement, which was significantly less than the entitlement demonstrated by the privilege level III inmates. They had similar complaints regarding access to general population privileges with minimal understanding regarding the current lack of access to such privileges. They did describe their daily group therapies as being helpful.

March 2018 Implementation Panel Recommendations:

1. We discussed with key custody and mental health staff the need for clear expectations and understandings relevant to the privilege levels to be communicated, on a repetitive basis, to the HLBMU inmates.
2. We strongly recommended that tablets (i.e., iPads) be implemented as part of an incentive program.
3. We also recommended periodic access to management meetings as currently being provided in the Murray housing unit.

LLBMU

During the morning of March 22, 2018, we interviewed nine level II & III BMU inmates, four of whom were graduating from the program during our site assessment. Eight other inmates have graduated from this program since its inception during 2016. These inmates described participation in daily group therapies/activities that were described as being very helpful. Suggestions for improvement in the program included implementing a more active transition program to the general population (e.g., actual participation/interaction with general population inmates and/or programs prior to actual completion of the LLBMU program).

We also attended a very well organized and meaningful graduation ceremony that was very impressive.

Mental health staffing for the Allendale CI , excluding the LLBMU, was 2.0 FTE QMHPs with

both positions being vacant. The mental health caseload during our site visit was 189 inmates. The regional manager, [redacted] has been providing coverage due to these vacancies. About 12 hours per week of psychiatric coverage is provided on site by three psychiatrists.

The LLBMU is staffed by 1.0 FTE QMHP and 2.0 FTE MHTs (1 FTE is currently vacant). The current functional capacity of the LLBMU was 24 with a current census of 18 inmates.

We remain very impressed with the LLBMU.

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

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
To mitigate conditions of confinement within the RHUs, hundreds of crank radios have been ordered and distributed to RHU inmates.

As of February 28, 2018, the Division of Operations reports that televisions for the RHUs have been ordered. According to a report from facilities management, the following information outlines the status on the televisions for the RHUs:

- The 1st 32 TVs are on site and waiting for the Lexan to be installed in the stands.
- The 2nd 32 TVs are at the electrical shop.
- The 3rd 32 TVs are at Trenton being modified to make them wireless.
- All the metal for the TV stands has been purchased, they are being fabricated at the sheet metal shop.
- All antennas have been purchased as well as all FM transmitters.

Responses to recommendations:
Per recommendation one, a tool (Medical Administration Aide) has been developed to better administer medication for the Restrictive Housing Unit inmates. The tool is being tested and modified to improve administration of medication.

Per recommendation two, Broad River Audit interviews of the Restrictive Housing Unit on February 14, 2018 results showed that recreation just resumed and that recreation was given the day before the audit.

Per recommendation six, the CSU cells are offline at Camille and a plan is in progress to ensure compliance with safety cell standards.

Per recommendation eight, cell check logs show how long the inmates were out of their cells, but will not show how long the inmate is in an activity. Based on the interviews from the audits for Kirkland, Allendale, Broad River, and Camille, inmates take showers Monday, Wednesday, and Friday of each week. Inmates at Kirkland and Allendale do not receive recreation. Inmates at

Camille and Broad River do receive recreation time, however, the times do vary based on their responses.

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

It is very unclear, and concerning, the reasons that the work orders for the previously referenced TVs continue to not be completed, especially in the context of conditions of confinement within the RHUs.

Broad River Correctional Institution

During the afternoon of Tuesday, March 20, 2018, we obtained information relevant to the RHU at the Broad River CI and interviewed inmates within this unit. Twenty-eight (28) of the 50 RHU inmates were on the mental health caseload. Although the physical plant appeared cleaner as compared to prior site visits, the conditions of confinement within the RHU continue to be very harsh although it appeared that inmates had increased out of cell time as compared to prior site visits. During the visit to RHU, two inmates in a cell complained their toilet was leaking and a large amount of water was observed on the walkway and inside the cell. The Unit Manager advised she did not have another cell for the inmates and she was allowing them to mop their cell every 3 to 4 hours. She provided further information, the cell plumbing would not be repaired for two days until Thursday, March 22, 2018 because of waiting for a plumbing part. After the Implementation Panel expressed their concerns, the Broad River Warden intervened and gave assurances the inmates would be moved to a cell with operational plumbing that did not leak. The next day, on Wednesday, March 21, 2018, the Warden reported the cell plumbing had been repaired the previous day and the problem had been rectified.

March 2018 Implementation Panel Recommendations:

Our December 2017 recommendations included the following, which are unchanged:

1. We understand that the major reason for the very limited out of cell recreational time offered to RHU inmates in most SCDC prisons is directly related to correctional officer shortages. We also understand that these shortages will not be corrected quickly. Much stronger efforts should be made to provide RHU inmates with increased privileges within their cells in order to mitigate not providing them with the out of cell time required by policy and procedures.

2. We remain very concerned about the conditions of confinement within the RHU at the Broad River Correctional Institution. The conditions of confinement should be changed to include at least one hour per day of out of cell recreational time in addition to access to showers on a three times per week basis.

3. Access to tablets (e.g. iPads) have been successfully implemented by other correctional systems in RHU environments. It was our understanding that crank radios will be increasingly available to RHU inmates as will TVs in the dayroom-like

areas. Ensuring that inmates receive timely laundry exchanges and that shower areas are kept clean are other common sense interventions.

4. The RHU must have established procedures that prohibit housing inmates in cells that have physical plant issues: i.e. plumbing, lighting.

Camille Griffin Graham RHU

Staff reported that 5 RHU groups per week were provided to mental health caseload inmates in the RHU. RHU inmates reported 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. Poor access to a psychiatrist was described. It is still problematic that staff take recreation periods without due process for minor rule violations, i.e. failing to stand for count. MH Staff rarely conduct face to face interviews with RHU inmates in an office setting. MH staff contact is primarily cell side. During the IP tours, inmates consistently report the need for access to mental health staff and others to address basic concerns for services.

March 2018 Implementation Panel Recommendations: Remedy the staffing vacancy issues.

Allendale Correctional Institution RHU

During the afternoon of March 22, 2018, we talked to almost all of the inmates in the RHU. Sixteen of the 60 RHU inmates were on the mental health caseload. Most of the inmates confirmed that they usually had access to the outdoor recreational cages for 45 to 60 minutes on a three times per week basis. Showers were offered on a three time per week basis. Medications were received on a timely basis although access to the psychiatrist was problematic as was access to the QMHP for out of cell sessions. Mental health rounds generally occurred on a weekly basis. RHU Cell Check Logs were reviewed and revealed correctional staff do not always make checks within 30 minutes at irregular intervals. Most cell checks occur between 30 to 45 minutes; however, a time span was identified when a cell check exceeded 3 hours. There were inmate complaints they were being inappropriately held in RHU because their circumstances had changed or they had been cleared for release but remained in RHU. These complaints are being investigated and will be followed up on by the responsible Implementation Panel Member.

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

Implementation Panel March 2018 Assessment: **noncompliance**

February 2018 SCDC Status Update:
See report at Attachment 1

Data on this topic is incomplete because some institutions failed to report their data far enough in advance of this report for it to be included. The institutional QMHPs are required to complete a

spreadsheet containing this data and send it to their institution's QIA. The QIAs are then to collate this data for their institution. The team lead then uses this collated data to create the summary below. Several QMHPs failed to provide their institution's QIA with this data for this reporting period either because the documentation has not been completed or the documentation is scattered and has not been gathered for production.

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

March 2018 Implementation Panel Recommendations: Remedy the above reporting issues.

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

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
See 2.b.i.

March 2018 Implementation Panel findings: See 2.b.i.

March 2018 Implementation Panel Recommendations:

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

2.b.v. The collection of data and issuance of quarterly reports identifying the percentage of mentally ill and non-mentally ill inmates in segregation compared to the percentage of each group in the total prison population with the stated goal of substantially decreasing segregation of mentally ill inmates and substantially decreasing the average length of stay in segregation for mentally ill inmates;

Implementation Panel March 2018 Assessment: **compliance (November 2016)**

February 2018 SCDC Status Update:
RIM continues to report and distribute the RHU Average Length of Stay report. The most recent reports are included as Appendix K. Examples of the report are captured below.

Time Served (in days) for Removals from **Long Term RHU Custody (SD and MX)** during DECEMBER 2017

	Number of Removals from RHU	Minimum Days Spent in RHU	Maximum Days Spent in RHU	Average (Mean) Days Spent in RHU	Median Days Spent in RHU

All Removals from RHU	12	13	696	286	272
Non-Mentally Ill Removals from RHU	4	13	596	291	278
Mentally Ill Removals from RHU	8	15	696	284	235

Note: Numbers reflect removals from long term RHU custody (SD – security detention and MX - maximum lockup) during each month. Due to the small number of inmates being removed from long term RHU, averages can vary greatly. Inmates who were placed in RHU custody and removed from RHU custody on the same day were excluded. The mental health classification is based on the inmate's status at time of removal from RHU.

March 2018 Implementation Panel findings: Compliance continues. However, we have concerns regarding the accuracy of the data based on reviewing median and averages, which we discussed with staff.

March 2018 Implementation Panel Recommendations: Confirm and/or correct the accuracy of the data as referenced above.

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

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
A CQI study was done by QIRM Analysts to evaluate the temperature and cleanliness of segregation cells in Allendale RHU, Broad River CSU and RHU, Camille RHU, and Kirkland's D-Unit, F-1, and SSR.

The complete study is attached as Appendix L.

March 2018 Implementation Panel findings: Operations maintains a shared folder for institutions to upload daily cell inspections and temperature logs. SCDC QIRM conducted a CQI Study and the study can be found in Appendix L. All institutions are not uploading daily cell inspections and temperature logs. The information provided also identified correctional facilities failing to conduct the required daily inspections and temperature checks. Correctional facilities were identified not maintaining their temperatures within the acceptable range and there were correctional facilities with significant problems. Broad River Correctional Institution had the highest compliance with 89% in CSU and 100% in RHU although this was based on the fewest days recorded. Allendale CI had only 36% of their temperatures within the acceptable range. Allendale CI temperature issues are very concerning because cell temperatures were reported a problem by inmates on a previous site visit to the correctional facility approximately one year ago. Further, when Allendale

CI Maintenance was contacted by telephone during the March 18 Site Visit, they were unaware of a significant number of cells being outside the acceptable temperature range. Kirkland SSR had extreme deficiencies that should be an urgent priority. The revised SCDC Form 19-163 piloted at CGCI has the potential to improve staff documenting corrective action for cleanliness deficiencies. In the CQI Study, 4 of the 7 correctional facilities had zero percent of their deficiencies corrected. Two more facilities had 50 percent or less. Only Allendale CI had an acceptable correction action rate of 92%. A mechanism is needed to ensure work orders generated by correctional staff are addressed and the deficiencies are actually resolved. All institutions need improvement in documenting corrective measures when there are cleanliness and temperature deficiencies.

March 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.

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

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
The Division of Quality Improvement and Risk Management conducted ICQMC Meetings at various institutions based upon the information outlined in SCDC Policy GA 06.06. "Continuous Quality Improvement Review". The meetings were agenda driven and focused on the following (this list is not all inclusive):

A. Use of Force and grievances review
B. Monitoring and Evaluation of operations practices and conditions of confinement
C. Monitoring and Evaluation of special programs and services
D. Medication management
E. Staffing
F. Barriers to provision of services
G. Staff education and training
H. Overview of IP findings and specific recommendations
I. Recommendations for performance improvement plans

The meetings have been conducted according to the schedule with the exception of Lee Correctional Institution due to preparation for the IP visit. MacDougall had their initial meeting in October of 2017 and has continued to meet identifying opportunities for improvement and implementing the changes necessary. Camille Griffin Graham and Perry Correctional Institutions, both facilitated their initial ICQMC meetings in January on the 12th and 11th respectively. They are currently preparing responses to the Performance Improvement Plans prepared by their Lead

Analyst. Kirkland Correctional Institution completed held their initial meeting on February 12, 2018. They have received their Performance Improvement Plans and are in conversations with their Lead Analyst on the completion of these. The revised schedule is below to show the new date for Lee Correctional Institution.

March 2018	April 2018	May 2018	June 2018
Leath	McCormick	Evans	Tyger River
Lee	Allendale	Ridgeland	Lieber
Broad River	Evans	Ridgeland	

Although Lieber Correctional Institution is not scheduled to begin their meetings until June 2018 they did conduct an initial meeting on February 5, 2018. QIRM is working to obtain the information from this meeting and will assist them in identifying opportunities for improvement and the preparation of the Performance Improvement Plans.

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

March 2018 Implementation Panel Recommendations: Implement the above schedule.

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 March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
The Office of the Deputy Director of Operations (DDO) has assigned an Administrative Regional Director (ARD) to oversee the audit of the AUOF process for their office. The ARD responsibility is to review all AUOFs to determine if all procedures were followed and make contact with the correct institutional personnel to correct concerns noted. The ARD will attend meetings with Wardens, Associate Wardens, Majors and any other entity to discuss patterns noted in correctly and incorrectly performed UOF incidents. The ARD reports directly to the Assistant Deputy Director of Operations.

Institutional corrective action related to use of force are included as Appendix M.

Use of Force (UOF) data for Mental Health inmates and Non-Mental Health Inmates is complete through January 31, 2018. The data has been analyzed in P-charts to better see whether a change in UOF incidents has been observed in the two populations since the agency began institution-wide UOF training in May 2017 for specifically required mental health, medical and security staff. Additionally, a more robust module in UOF was added to the employee orientation and basic training core curriculum.

See Attachment 4 for the analysis.

March 2018 Implementation Panel findings: SCDC began institution wide UOF training in May 2017 for specifically required mental health, medical and security staff. A more robust module in UOF training was added to the employee orientation and basic training core curriculum. By the end of Calendar Year 2017, 84.2 percent of Medical Staff, 71.6 percent of Mental Health Staff, and 87.1 percent of Security Staff completed the required the UOF training. Overall in SCDC, 86 percent of the required SCDC staff completed the UOF training in Calendar Year 2017.

SCDC Operations has created an Administrative Regional Director (ARD) to oversee the audit of the AUOF process and to determine if all procedures are followed and make contact with the correctional institutional personnel to correct concerns. This is a positive move for SCDC.

SCDC has also employed a UOF Coordinator for the Quality Management Section in the Division of Mental Health. The Division of Mental Health UOF Coordinator will be responsible for:

- reviewing UOF incidents involving mentally ill inmates;
- providing training and technical assistance to Operations and Mental Health Staff on UOF policy and conflict resolution techniques;
- reviewing UOF video tapes to assess effectiveness of intervention and compliance with following "cool down period" guidelines;
- tracking inmates on the mental health caseload with repeated UOF incidents; and
- working closely with QIRM to report inappropriate UOF actions involving inmates on the mental health caseload.

The Division of Mental Health UOF Coordinator began employment on March 19, 2018.

SCDC UOF data reveals there continue to be disproportionate UOF incidents involving mentally ill inmates. The average SCDC institutional population receiving mental health treatment for the time frame September 2017 through February 2018 was 17.9 percent. UOF incidents involving mentally ill and non-mentally ill inmates for the months of November 2017, December 2017 and January 2018 was as follows:

Month	Mentally Ill Inmate Number of UOF Incidents	Non-Mentally Ill Inmate Number of UOF Incidents
November 2017	37	48
December 2017	49	61
January 2018	69	52
Monthly Total	155	161

The SCDC inmate population receiving mental health treatment for the time frame of September 2017 through February 2018 averaged 17.9 percent while 49 percent of the UOF incidents for the months of November 2017, December 2017, and January 2018 involved inmates receiving mental health treatment.

March 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. Identify strategies to reduce use of force against inmates with mental illness and non-mentally ill inmates;
3. 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;
4. 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 March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:

1. QIRM staff continues to meet weekly with Operations leadership to discuss UOF and other relevant issues. During the meeting UOF Reviewers report, by institution: the number of uses of force, type of use of force, plan or unplanned, type of chemicals used, use of force discrepancies that violate policy and procedure. An example of the weekly update is included as Appendix N.
2. QIRM's UOF Reviewers continue to monitor and review the Use of Force Incidents entered into the Automated Use of Force System as well as review the MINs for the institutions daily. Reports are compiled and distributed weekly and monthly containing the summaries for types of force utilized as well as the MINs summaries. These findings are also verbally reported and discussed in a weekly meeting with QIRM and Operations.
3. The list of SCDC approved Use of Force Equipment and Manufacturer specifications for each is available in the Sparkman Document Drop #3 section H, this information was provided by the Division of Security.
4. QIRM was not provided a revision to the Housing Unit Post Order to address the IP Recommendation of Cover Teams and their requirement to carry the MK-9 in accordance with the manufacturer's instructions.
5. As stated in this report section 2.c.vi SCDC was 86% compliant with the completion of Use of Force Training for CY 2017.

March 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 revised the Housing Unit Post Orders as it applies to *Cover Teams* to achieve compliance that MK-9 use is consistent with manufacturer's instructions. The information provided by the Division of Security did not include a list of SCDC approved Use of Force

Equipment. SCDC Operations and QIRM Staff are working to provide the list of Use of Force instruments approved and utilized by the Agency.

Appendix N identifies SCDC 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 no incidents during the relevant period that required restraint chair use. No restraint chair use for the relevant period indicates significant progress.

SCDC continues to have UOF incidents where MK-9 chemical agents are not deployed in a manner consistent with manufacturer's instructions. Lee Correctional Institution (Lee CI) had several identified incidents during the relevant period where munitions were deployed from a 37 mm weapon and the use did not appear to be in accordance with manufacturer's specifications. In a March 2018 incident, an inmate sustained a leg injury that required hospital treatment and admittance to the Kirkland Infirmary. SCDC has initiated a criminal investigation for the March 2018 Lee CI incident and taken administrative action on three (3) employees. The Implementation Panel was advised by SCDC that further employee action for UOF violations is possible once an administrative investigation for the Lee CI March 2018 incident is completed.

SCDC began institution wide UOF training in May 2017 for specifically required mental health, medical and security staff. A more robust module in UOF training was added to the employee orientation and basic training core curriculum. By the end of Calendar Year 2017, 84.2 percent of Medical Staff, 71.6 percent of Mental Health Staff and 87.1 percent of Security Staff completed the required the UOF training. Overall 86 percent of the required SCDC staff completed the UOF training in Calendar Year 2017.

March 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. Revise Housing Unit Post Orders as they pertain to *Cover Teams* to require that MK-9 use will be consistent with manufacturer's instructions;
4. The SCDC Division of Security provide the Implementation Panel a list of UOF instruments approved and utilized by the Agency; and
5. 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 March 2018 Assessment: **compliance (July 2017)**

February 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 October 2017- January 2018 of inmates being placed the crucifix or other positions that do not conform to generally accepted correctional standards.

March 2018 Implementation Panel findings: 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.

March 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 March 2018 Assessment: **compliance (March 2018)**

February 2018 SCDC Status Update:
A review of the restraint chair usage was conducted for Nov 1, 2017 - Jan 31, 2018. The information provided in the Automated Use of Force System and RIM report(s) were cross referenced with the Automated Medical Records. During this reporting period there were zero (0) uses of the restraint chair.

March 2018 Implementation Panel findings: SCDC reported the Restraint Chair was not utilized during the relevant period; therefore demonstrating compliance with the provision.

March 2018 Implementation Panel Recommendations: QIRM continue to track and monitor compliance with use of the restraints.

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

Implementation Panel March 2018 Assessment: **compliance (December 2017)**

February 2018 SCDC Status Update:
A review of the restraint chair usage was conducted for Nov 1, 2017 - Jan 31, 2018. The information provided in the Automated Use of Force System and RIM report(s) were cross

referenced with the Automated Medical Records. During this reporting period there were zero (0) uses of the restraint chair.

March 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.

March 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 March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
Training
SCDC identified 2,488 employees, assigned to Mental Health, Medical or Security, who were required to take the Use of Force Training. The overall Agency compliance rate for the Use of Force Training for CY 2017 was 86%

Allendale Correctional Institution – The institution had 100% compliance for the 122 employees required to take the Use of Force Training for CY 2017.

Broad River Correctional Institution – There were 148 employees identified as required to take the Use of Force Training. The institution had an overall compliance of 45% for CY 2017, with Medical at 30.4%, Mental Health 33.3% and Security 47.5%.

Camille Griffin Graham Correctional Institution – The 124 employees required to take the Use of Force training achieved 98% compliance overall. The individual area compliance rates are as follows: Medical 92.3%, Mental Health 100% and Security 98%.

Kirkland Correctional Institution – The Gilliam Psychiatric Hospital is included in the numbers for the institution. Combining the GPH and institution employees required to take the Use of Force Training totaled 313. The combined overall compliance for Kirkland and GPH was 88% for CY 2017.

Gilliam Psychiatric Hospital			Kirkland Institution		
Area	# Req.	% of Compliance	Area	# Req.	% of Compliance
Medical	5	20%	Medical	30	53.3%
Mental Health	30	93.3%	Mental Health	3	66.7%
Security	N/A	N/A	Security	245	93.9%

Data Source: RIM Report *Required Staff to Take Use of Force Training*

Corrective Actions

Institutional corrective action related to use of force are included as Appendix M.

March 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.

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.

SCDC Use of Force MINS for November 17 through February 2018:

November 2017-	98
December 2017-	117
January 2017-	147
February 2017-	110

SCDC had 30 Inmate Grievances alleging excessive Use of Force from November 2017 to February 2018. The IP recommends QIRM conduct a CQI Study to assess whether grievances for excessive UOF are processed timely and inmates receive an appropriate response with a final disposition rendered.

SCDC QIRM produced an excel chart with106 incidents from June 2017 to October 2017 where potential UOF violations were identified from their reviews. There were fourteen (14) UOF incidents where there appeared to be violations and Operations had not conducted a review after receiving the QIRM referral. Operations responses for the majority of the UOF violations were to recommend additional training or concur a violation occurred. In conversations with Operations Leadership, a mechanism is not in place to track what happens once a determination is made an employee has committed a UOF violation. A review of Appendix M found that there were incidents where employees were found to have committed unnecessary and/or excessive force with no information about what occurred after the determination was made. SCDC officials acknowledged a system is not in place to track recommended corrective action for an employees.

SCDC Police Services provided data regarding their involvement in Use of Force investigations as follows:

	11/17	12/17	01/18	02/18
Referrals Received	*	*	*	*
Investigations Opened	2	0	2	1
Investigations Pending	0	0	2	1
Investigations Closed	1	2	1	0

*SCDC Police Services does not maintain data regarding incidents reviewed in which no investigation is conducted. The information Police Services provided regarding closed investigations did not identify for each investigation if it was: substantiated, unsubstantiated or

unfounded. 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.

SCDC had 86 percent of their required employees complete Use of Force training in the Calendar Year 2017.

The SCDC has enhanced the UOF Policy accountability component to appropriately address Use of Force violations. SCDC Operations has created an Administrative Regional Director (ARD) to oversee the audit of the AUOF process and to determine if all procedures are followed and make contact with the correctional institutional personnel to correct concerns. Additional improvements are needed. The Agency does not have a written procedure to track employees referred for UOF violations from when identified to final disposition.

SCDC has purchased Canines for tracking, search, and crowd control purposes. A Canine Policy and Training Curriculum have been developed and submitted to the IP and Plaintiffs' Counsel for review and approval. The responsible IP member provided feedback on the policy and training and revisions were made before both were submitted to other IP members and the Plaintiffs' Counsel. The Settlement Agreement requires review and approval by the IP and Plaintiffs' Counsel because canine use for crowd control constitutes UOF and is therefore a UOF policy. SCDC plans to pilot the Canine Policy and Training prior to full implementation. The responsible IP Member will participate in assessing canine use during the pilot to identify 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 Lee CI March 2018 incident where an inmate sustained an injury requiring hospital treatment and admission to the Kirkland CI Infirmary is a glaring example. The IP reviewed the handheld video for the incident with SCDC officials and identified numerous UOF violations and failure by employees to intervene and respond appropriately during the incident.

March 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 should conduct a CQI Study to assess if grievances for excessive UOF are processed and inmates receive an appropriate response with a final disposition rendered in a timely fashion;

6. SCDC Police Services should begin maintaining data on all incidents reviewed for UOF violations even if an investigation is not conducted;
7. Police Services needs to identify the number of investigations: substantiated, unsubstantiated or unfounded;
8. Develop and implement a written procedure to track employees recommended and/or referred for UOF violations;
9. All required staff complete Use of Force Training in the Calendar Year 2018; and
10. SCDC ensure the accountability component of OP 22.01 Use of Force is implemented and meaningful corrective action is taken for employees found to have committed use of force violations.

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

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
SCDC policy OP 22. 01, section 6.3 Chemical Munition, addresses the standard issued chemical for incident control. QIRM Use of Force Reviewers continue to review the use of chemical munitions incidents involving crowd control canisters.

QIRM UOF Reviewers 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 is the baseline for tracking data received from RIM reports and the Automated Used of Force System.

In an effort to determine that the MK-9 was used within the guidelines of policy OP- 22. 01 Use of Force. QIRM UOF Reviewers used the following parameters to determine that SCDC Staff members used the MK-9 in circumstances consistent with what is outlined within policy. Based on RIM reports. The QIRM Use of Force staff reviewed 115 use of force incidents in which MK-9 was used between June 1, 2017 and January 31, 2018.

In an effort to determine that the MK-9 was used within the guidelines of policy OP- 22. 01 Use of Force. QIRM UOF Reviewers used the following parameters to determine that SCDC Staff members used the MK-9 in circumstances consistent with what is outlined within policy.

Based on RIM reports, there were use of force incidents in which MK-9 was used between October 1, 2017 and January 31, 2018.

- During the reporting period there were 50 reported uses of crowd canister devices

- 34 (68%) in which the officer's actions were justifiable based on circumstances set forth in agency policy OP- 22. 01, Use of Force. This is up from 29 out of 51 (57%) from the last reporting period.

- There were 34 (68%) incidents where the crowd control devices were used appropriately under objectively identifiable circumstances in writing. This is up from 29 out of 51 (57%) from the last reporting
- There were 36 (72%) incidents where the crowd control devices were used in volumes consistent with manufacturer's instructions. This is up from 45% in the last reporting period.

The following charts provide additional information comparing uses of crowd control canisters during the reporting period.

	# times crowd control devices were used appropriately under objectively identifiable circumstances	# times crowd control devices were used
October	3	5
November	10	15
December	9	13
January	12	17

	# times crowd control devices were used appropriately under objectively identifiable circumstances IN WRITING	# times crowd control devices were used
October	3	5
Novembe r	10	15
Decembe r	9	13
January	12	17

	# times crowd control devices were used in volumes consistent with manufacturer's instructions	# times crowd control devices were used
October	2	5
November	8	15
December	12	13
January	14	17

March 2018 Implementation Panel findings: As per SCDC update. SCDC continues to identify incidents where crowd control canisters, such as MK-9, are used inappropriately and in volumes

that exceed manufacturer's and SCDC guidelines. SCDC has demonstrated improvement in using MK-9 as required by manufacturer's instructions. From October 1, 2017 through January 31, 2018 there were 34 (68%) incidents where the crowd control devices were used appropriately and under objectively identifiable circumstances in writing. This is up from 29 out of 51 (57%) from the last reporting. There were 36 (72%) incidents where the crowd control devices were used in volumes consistent with manufacturer's instructions. This is up from 45% in the last reporting period. SCDC has not revised Housing Unit Post Orders as they pertain to *Cover Teams* qualifying that MK-9 use will be consistent with manufacturer's instructions.

March 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 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**

February 2018 SCDC Status Update:
UOF reviewers continue to track the number of planned uses of force involving inmates with a mental health classification to determine if a mental health counselor is contacted prior to the incident The following reports shows the rates at which mental health counselors have been notified since May 2017.

The report is included as attachment 5.

March 2018 Implementation Panel findings: Per SCDC update from Attachment 5. 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. SCDC provided data for the period

of May 2017 through January 2018, that QMHPs were contacted prior to a planned use of force for mentally ill inmates as follows:

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%

It is concerning for the relevant period that SCDC Operations staff failed to request assistance from QMHPs before a planned UOF involving a mentally ill inmate in the majority of the incidents. It is unacceptable for this trend to continue.

March 2018 Implementation Panel Recommendations: Provide additional training to Operations Supervisory and Mental Health Staff on their duties and responsibilities in a planned use of force. Hold responsible employees 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 March 2018 Assessment: **partial compliance**

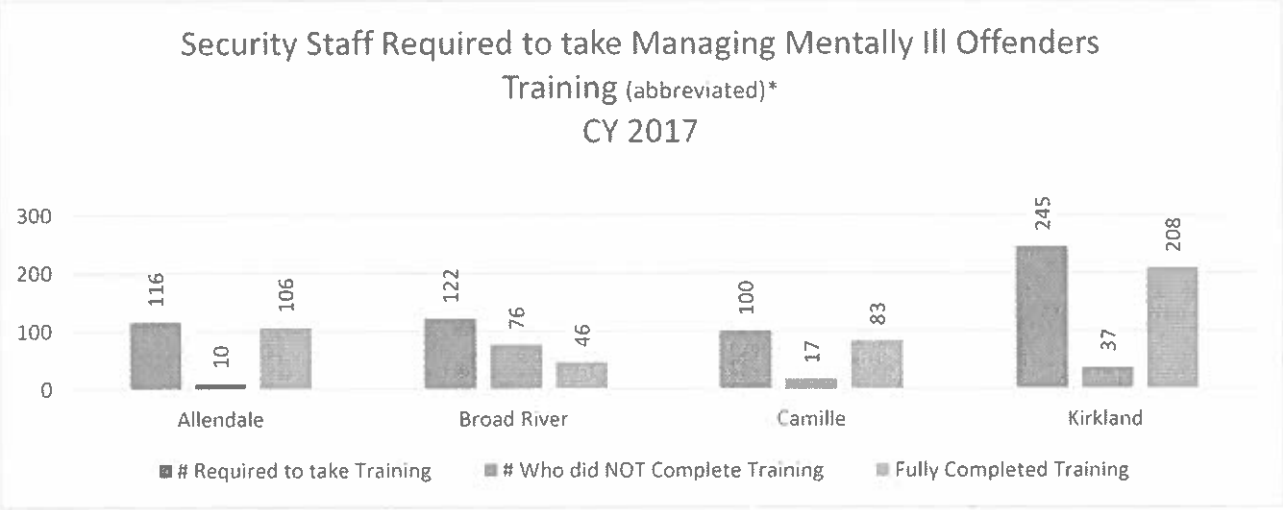
February 2018 SCDC Status Update:
The South Carolina Department of Corrections Training Academy reports the following information for Calendar Year 2017 for Allendale, Broad River, Camille Griffin Graham and Kirkland Correctional Institutions.

Allendale Correctional Institution was identified as having the most medium security employees required to take the Managing Mentally Ill Offenders training. They achieved the third highest level of completion for all institutions with a completion rate of 91.4%.

Broad River Correctional Institution had the third highest amount of maximum security employees required to take the training as well as the third lowest rate of completion for all institutions at 37.7%.

Camille Griffin Graham is one of two female institutions in South Carolina. Their completion rate for this training was 83% which is tenth for all institutions.

Kirkland Correctional Institution has the highest number of maximum security employees required to take the Managing Mentally Ill Offenders training. Kirkland had a completion rate of 85% which is thirteenth in the state for all institutions.



Source: Division of RIM Report

*The entire report of Security Staff Required to take Managing Mentally Ill Offenders Training in CY 2017 is located in the Sparkman Document Request 6 sections B,D and E.
This report was completed for all of SCDC. There were 2,171 employees required to take this training. The Agency had a completion rate of 74.9% for calendar year 2017.

March 2018 Implementation Panel findings: Per SCDC Update. There were 2171 Security Staff employees that completed the required Managing Mentally Ill Offenders training in the Calendar Year 2017 for a completion rate of 74.9 percent.

The mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates for the Calendar Year 2017 was as follows:

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

The SCDC Training Division reported the plan for training correctional officers concerning appropriate methods of managing mentally ill inmates is being revised for the Calendar Year 2018. The revised training plan will require review and approval by the IP.

March 2018 Implementation Panel Recommendations:

- The SCDC Training Division submit the revised plan for training correctional officers on the appropriate methods of managing mentally ill inmates to the IP for review and approval;
- 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 March 2018 Assessment: **compliance (3/2017)**

February 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 O.

This report is sent to the 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 following graphs show the UOF for mentally ill vs non-mentally ill inmates since January 2017.

March 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.

March 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 March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:

- An (UOF) coordinator for the Quality Management Section in the Division of Mental Health has been hired and scheduled to begin on March 19, 2018. This individual will be responsible for the following tasks:
  - reviewing the response of all planned UOF incidents from mental health employees, ensuring timely follow-up was completed and documented as outlined in policy;
  - monitoring the automated UOF system ensuring automated entries are documented and cleared as outlined in policy by mental health staff;
  - reviewing UOF video tapes to assess the effectiveness of interventions used by mental health staff determining if it was collaborative in nature following the "cool-down period" guidelines;
  - providing training and technical assistance to operations and mental health staff on the UOF policy and conflict resolution techniques;
  - tracking inmates on the mental health caseload who have repeated UOF incidents to determine if mental health treatment needs are appropriate; make recommendations to the Division Director or Chief of Psychiatry regarding the suitability of inmate's treatment needs;
  - working closely with the office of QIRM to report inappropriate UOF activities for inmates on the mental health caseload.

March 2018 Implementation Panel findings: Per SCDC update. A UOF Coordinator for the Quality Management Section of the Division of Mental Health has been hired. The Coordinator began employment on March 19, 2018 and was introduced to the IP during the March 2018 Site Visits and participated in meetings and tours.

Procedures have been developed and a Coordinator has been hired to conduct formal Mental Health Quality Reviews of Use of Force Incidents involving mentally ill inmates; however, the reviews have not begun.

March 2018 Implementation Panel Recommendations:

- Begin Mental Health Quality Reviews of Use of Force Incidents involving mentally ill inmates; and
- QIRM conduct a CQI Study once the Mental Health Quality Review of Use of Force Incidents involving mentally ill inmates has been implemented.

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 March 2018 Assessment: **noncompliance**

February 2018 SCDC Status Update:
The following chart outlines the staffing ratios as reported by BMHSAS. (see staffing summary document)

March 2018 Implementation Panel findings: The staffing vacancies, and likely the staffing allocations, continue to result in inadequate employment of enough trained mental health professionals (see attachment 1). We are encouraged by the recruitment and retention efforts that have been recently initiated by SCDC.

The staffing summary chart does not provide ratios of clinicians to mental health caseload inmates. We discussed with appropriate staff providing such ratios by discipline and level of care.

March 2018 Implementation Panel Recommendations: Implement the above.

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

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
A report for showing treatment team participation rates at the Crisis Stabilization Unit (CSU), Kirkland ICS, Gilliam Psychiatric Hospital (GPH), Allendale's Low Level Behavioral Management Unit (LLBMU), and at Camille for the months of October, November, and December 2017 and January 2018 is included as Attachment 6.

March 2018 Implementation Panel findings: We expressed our concerns regarding the accuracy of the presented data due to questions relevant to psychiatrists' participation in the CSU treatment teams at the Broad River CI based on our prior site visits. During such visits we never observed the psychiatrist participating in a CSU IDTT except for the current assessment.

March 2018 Implementation Panel Recommendations: Confirm and/or correct the accuracy of the previously referenced data.

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 March 2018 Assessment: **compliance (March 2018)**

February 2018 SCDC Status Update:
The RIM-generated document reports the Mental Health Staff completing General Provisions Training but location. Eight of the ninety-five mental health staff required to complete the training did not complete the training.

Mental Health Staff
Required to take Mental Health General Provisions
in CY 2017
by Location and Training Completion

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	3	3	100.0%	0	0.0%
1	563	PALMER	0	0	N/A	0	N/A
Minimum Security			**3**	**3**	**100.0%**	**0**	**0.0%**
2	411	ALLENDALE	1	1	100.0%	0	0.0%
2	531	EVANS	2	2	100.0%	0	0.0%
2	541	KERSHAW	2	0	0.0%	2	100.0%
2	422	MACDOUGALL	1	1	100.0%	0	0.0%
2	442	RIDGELAND	1	1	100.0%	0	0.0%
2	222	TRENTON	1	1	100.0%	0	0.0%
2	571	TURBEVILLE	12	11	91.7%	1	8.3%
2	161	TYGER RIVER	0	0	N/A	0	N/A
2	582	WATEREE RIVER	0	0	N/A	0	N/A
Medium Security			**20**	**17**	**85.0%**	**3**	**15.0%**
3	211	BROAD RIVER	3	3	100.0%	0	0.0%
3	242	GILLIAM PSY	30	27	90.0%	3	10.0%
3	241	KIRKLAND	3	2	66.7%	1	33.3%
3	551	LEE	3	2	66.7%	1	33.3%
3	421	LIEBER	3	3	100.0%	0	0.0%
3	181	MCCORMICK	1	1	100.0%	0	0.0%
3	191	PERRY	3	3	100.0%	0	0.0%
Maximum Security			**46**	**41**	**89.1%**	**5**	**10.9%**
	331	GRAHAM	11	11	100.0%	0	0.0%
	171	LEATH	2	2	100.0%	0	0.0%
Female Institutions			**13**	**13**	**100.0%**	**0**	**0.0%**
	1	HEADQUARTERS	13	13	100.0%	0	0.0%
All Institutions			**95**	**87**	**91.6%**	**8**	**8.4%**

March 2018 Implementation Panel findings: At the time of the site visit, all the mental health staff required to receive such training had completed the training.

March 2018 Implementation Panel Recommendations: Continue to monitor this provision in the context of newly hired employees.

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

Implementation Panel March 2018 Assessment: **compliance** (December 2017)

February 2018 SCDC Status Update:

See 2.a.iv

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

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

3.e Require appropriate credentialing of mental health counselors;

Implementation Panel March 2018 Assessment: **compliance** (3/2017)

Allendale LLBMU	=	November 29, 2017
Lee CI	=	January 17, 2018
Kershaw CI	=	January 22, 2018
Evans CI	=	January 23, 2018
Turbeville CI	=	February 7, 2018
Broad River CI (CSU)	=	February 21, 2018
Camille CI (ICS & Area)	=	March 8, 2018
Broad River (Hab & Area)	=	March 13, 2018
Kirkland (GPH)	=	March 15, 2018
Kirkland (ICS)	=	April 16, 2018
Kirkland (HLBMU & Death Row)	=	April 18, 2018
MacDougall & Lieber	=	May 14, 2018
Ridgeland & Allendale (Pop)	=	May 21, 2018
Perry & Tyger River	=	June 4, 2018
Leath & McCormick	=	June 18, 2018

Final audit results are included for LLBMU, Lee, Kershaw, Evans and Turbeville as Attachment 2.

March 2018 Implementation Panel findings: Although data is available via the biannual individual institutional audits, they are not yet being used for purposes of this provision.

March 2018 Implementation Panel Recommendations: Implement a process to utilize the above referenced data for purposes of this provision.

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

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
See 3.f.

March 2018 Implementation Panel findings: See 3.f.

March 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 March 2018 Assessment: **compliance (3/2017)**

February 2018 SCDC Status Update:
RIM continues to produce and distribute a weekly "Medical Personnel Report." The following

February 2018 SCDC Status Update:
SCDC Policy 19.15, Mental Health Services - Mental Health Training, Section 3.4 stipulates that QMHPs will be required to maintain their professional licensure based on the requirements of their individual licensure board (Licensed Professional Counselor, Licensed Social Worker, etc.) and provide verification of continued licensure.

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

Based on the provisions outlined in policy, 40/40 or 100% are appropriately licensed.

March 2018 Implementation Panel findings: There was lack of clarity whether unlicensed mental health clinicians hired prior to the stipulated agreement were required to obtain licensure within several years in order to continue working as clinicians or whether continued supervision was required indefinitely.

March 2018 Implementation Panel Recommendations: We are requesting guidance from the parties relevant to this issue. In either case, we will be monitoring proof of supervision for such clinicians during the next monitoring round.

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

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
Initial Audit Reviews for all programs are consultative. Refer to the attachment for the completed audit review findings for the institutions/programs listed below. The Division Director and QA Manager/Designee will meet with the institutional and mental health staff on the dates indicated to discuss the audit findings as well as the necessary action that is needed to meet policy requirements.

INSTITUTION	AUDIT REVIEW DATE	SCHEDULED DATE OF AUDIT DISCUSSION
Allendale - LLBMU	November 29, 2017	March 9, 2018
Lee CI	January 17, 2018	March 15, 2018
Kershaw CI	January 22, 2018	March 30, 2018
Evans CI	January 23, 2018	April 11, 2018
Turbeville CI	February 6, 2018	April 11, 2018
BRCI – CSU	February 21, 2018	April 13, 2018

Component 3g: Formal CQM program to review clinical staff.

Updated Audit Schedule
DIVISION OF BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE SERVICES
2017 – 2018 QA MENTAL HEALTH AUDIT DATES - REVISED

screenshot provides a snapshot of the detailed report. The most recent report was distributed on December 21, 2017. See screenshots below. The most recent report is included as Appendix P.

Detail of Medical Positions as of COB Yesterday
run on December 21, 2017

Employee Name	SCDC Position	Job Class	Job Class Title	Position Description	Budget Un	Location	Vacancy Start Date
AARON M MILLER	21014	EC20	TECH MEDICAL ASSOCIATE I	PARAMEDIC	32241	KIRKLAND	
ADETORO A SOBOWALE	15061	EA20	REGISTERED NURSE I	STAFF NURSE	31191	PERRY	
ALISHA A HUNT	12563	GA50	HUMAN SERVICES COORD I	QMHP- CCC IV	32331	GRAHAM	
ALLEN L WISE	21666	EC20	TECH MEDICAL ASSOCIATE I	PARAMEDIC	34551	LEE	
ALLISON B BRINSON	14572	EA20	REGISTERED NURSE I	RN	32211	BROAD RIVER	
ALLISON L GORDON	15921	EA80	NURSE ADMINISTRATOR MGR II	HLTH CARE AUTH II	34582	WATEREE RIVER	
ALLISON V JORDAN	19333	EC10	MEDICAL ASSISTANT TECH I	CNA	32241	KIRKLAND	
AMANDA F KELLY	18990	AA50	ADMIN SPECIALIST II	ADMIN SPEC II	53101	MEDICAL SUPPORT	
AMANDA HASSINO TUCKER	13947	GA50	HUMAN SERVICES COORD I	HUMAN SERV COORD I	32222	TRENTON	
AMANDA L MARTIN	14421	GA40	HUMAN SERVICES SPEC II	COUNSELOR	34571	TURBEVILLE	
AMANDA M DAVIS	20028	EC20	TECH MEDICAL ASSOCIATE I	PARAMEDIC	32241	KIRKLAND	
AMY L PULLIAM	15849	AA50	ADMIN SPECIALIST II	ADMIN SPEC II	34571	TURBEVILLE	
AMY L WHITTINGTON	10815	EA20	REGISTERED NURSE I	RN I - 2	34531	EVANS	
AMY M LAMPRECHT	19848	EA20	REGISTERED NURSE I	REGISTERED NURSE	33422	MACDOUGALL	
AMY R ENLOE	11753	EA65	NURSE PRACTITIONER II	NURSE PRACTITIONER II	31191	PERRY	
ANASTASIA J EUBANKS	19070	AH35	PROGRAM COORDINATOR I	COORD OF MH SUP SERV	45101	MENTAL HEALTH	
ANDRE T BROWN-DIXON	20573	BB20	STATISCL & RESRCH ANAL II	HEALTH SERV OFC ASST	32211	BROAD RIVER	
ANDRE T WHALEY	12549	GA40	HUMAN SERVICES SPEC II	CLIN CORR COUNS I	45101	MENTAL HEALTH	
ANDREW R HODGE	10287	GA50	HUMAN SERVICES COORD I	CLIN COUNS IV	45101	MENTAL HEALTH	
ANDREW W HEDGEPATH	21330	UB25	PSYCHIATRIST	PSYCHIATRIST	45101	MENTAL HEALTH	
ANGELA S GARCES	19717	EC15	MEDICAL ASST TECH II	DENTAL ASST	34541	KERSHAW	
ANGELON GRAVES	17244	GA40	HUMAN SERVICES SPEC II	COUNSELOR	34571	TURBEVILLE	

March 2018 Implementation Panel findings: Compliance continues.

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

Implementation Panel March 2018 Assessment: **compliance (July 14, 2017)**

February 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 Q.

March 2018 Implementation Panel findings: Compliance continues with regard to tracking referrals, however we are concerned about the high rate of denials of the referrals from the CSU to the ICS and that issue needs to be addressed.

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

Implementation Panel March 2018 Assessment: **partial compliance**

February 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. The time of each security check will be recorded in the RHU permanent log book and SCDC Form 19-7A, "Cell Check Log." These cell checks not only foster a safer security environment, but they also help to monitor the mental health of the inmates in RHU.

SCDC currently uses a manual system to track and document 30-minute irregular cell checks, as required by policy 22.38, and unstructured activities such as showers and recreation. QIRM conducted a QI study to the compliance with these checks at Allendale, Broad River, and Camille RHU.

The results from the CQI study indicated that as a whole, the three institution's compliance rate for cell checks occurring at least 30 minutes apart intervals is 33%. These results suggests that inmates are not being monitored regularly as required by Agency policy. This may be attributed to security staffing shortages. The compliance in doing the checks at irregular intervals was 74%, when the definition for "Not Irregular" was that three or more intervals were the identical number of minutes apart. However, it was noted that the checks were often just two or three minutes apart, in effect, still being fairly regular intervals.

The collection of the data was all in a paper form as opposed to an electronic form that would allow more accuracy and eliminate the issues of legibility. SCDC's IT department is working to create the electronic version of this form, as this will eliminate errors, save time, and make monitoring more effective.

The final report is attached as Appendix R.

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

March 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 March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
Clinical encounter data is available in the AMR (with additional information in the paper chart at GPH). New encounter types have been created that will better account for the type of care provided in each encounter. Staff have now received training on the new types of encounters.

Activity and cell check logs remain on paper and are addressed in 4.a.iii., but RIM is working to create an automated system. On December 4, 2017 SCDC introduced the Offender Activity Tracking System (OATS) which is an electronic cell check log system. This new method of recording the activities of an inmate relies on the use of handheld tablets, updated employee identification cards with a barcode and QR codes that were created for the cell doors. The officers who are utilizing this system will now scan the QR code on the outside of the cell and select the appropriate inmate from the provided drop down box. This information is fielded by the dorm roster and available in real time. At this time only the unstructured out of cell time such as recreation and showers can be captured by indicating if the inmate refused, was ineligible or participated. The in cell activity options available are standing, lying down and sitting which are the same options that were previously available on the paper cell check logs. When the inmate provided a meal can also be captured through the use of the electronic cell check log. The

implementation of this technology provides approved users access the electronic OATS Report through the secured login section of the intranet.
This technology is being introduced on a rollout schedule to the Restrictive Housing Units and Crisis Stabilization Units in the Columbia area initially. OATS has the ability to be customized to fit most needs of the Agency. Through the rollout schedule the CSU at Broad River Correctional Institution and RHU of Camille Griffin Graham Institution have had the opportunity to weigh in on what would make this system successful.

March 2018 Implementation Panel findings: As per status update section. The electronic medical record is going to be rolled out to all the other institutions in the very near future. However, there continue to be various issues with the EMR that should be resolved prior to the planned rollout.

March 2018 Implementation Panel Recommendations: Resolve the previously referenced issues prior to implementing the EMR system wide.

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

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

February 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.

March 2018 Implementation Panel findings: As per SCDC update.

March 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 March 2018 Assessment: **compliance (March 2017)**

February 2018 SCDC Status Update:
RIM continues to produce and disseminate a monthly, "UOF Report Mentally Ill vs. Non-Mentally Ill," report.

- 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 is included as Appendix S.

March 2018 Implementation Panel findings: As per SCDC update.

March 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 March 2018 Assessment: **compliance (March 2017)**

February 2018 SCDC Status Update:
A "CY CISP Admissions" report continues to be produced quarterly by RIM. This report shows if an inmate stays in a CI cell in an outlying institution longer than the 60 hours allowed to have him transferred to CSU. The most recent report is included as Appendix T.

RIM continues to produce and a weekly spreadsheet that provides a list of inmates currently in SD, DD, MX or SR custody by institution. The most recent report was disseminated on February 28, 2018. See screenshot below. The most recent report is included as Appendix U.

March 2018 Implementation Panel findings: Per SCDC update.

March 2018 Implementation Panel Recommendations: Compliance continues.

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 March 2018 Assessment: **compliance (March 2017)**

February 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 November 8, 2017. The most recent report is included as Appendix U.

March 2018 Implementation Panel findings: Per SCDC update.

March 2018 Implementation Panel findings: Compliance continues.

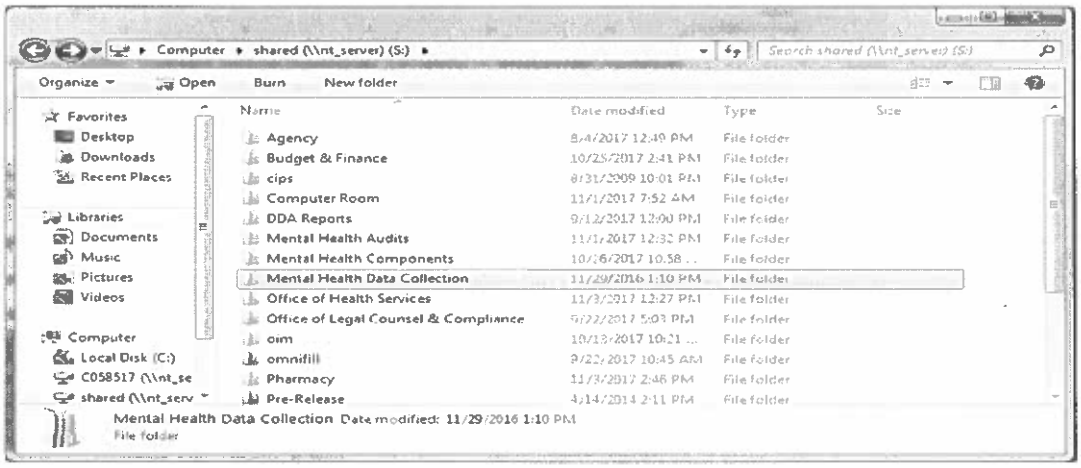
4.a.ix. Quality management documents; and

Implementation Panel March 2018 Assessment: **partial compliance**

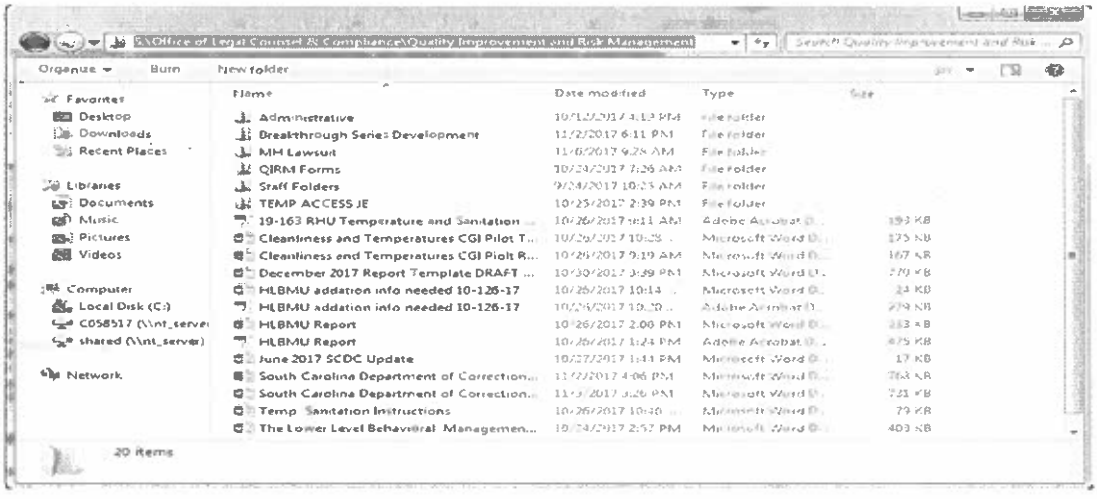
February 2018 SCDC Status Update:

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. SCDC is also working to automate as many processes as possible to make data collection simpler and easier. Cell check logs have been automated at Broad River CSU and Camille Graham RHU.

Shared Drive:



QIRM folder:



March 2018 Implementation Panel findings: Significant improvement continues relevant to the implementation of this provision.

March 2018 Implementation Panel Recommendations: Provide all requested and necessary documentation to QIRM for provision and distribution to the IP in the requested timeframes.

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

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:

SCDC Electronic Medical Record Implementation – UPDATE

Task:	Start	End
Male Facility End User Training Week 1	4/3/18	4/6/18
Male Facility End User Training Week 2	4/17/18	4/20/18
Level 3 Institution Go Live (except Kirkland) – Broad River, Lee, Lieber, McCormick, Perry	4/30/18	5/4/18
Male Facility End User Training Week 3	5/15/18	5/18/18
Kirkland Go Live (EHR, EDR, Scheduling only)	5/22/18	5/24/18
Male Facility End User Training Week 4	6/5/18	6/8/18
Level 2 Institutions Go Live (partial) – Allendale, Evans, Ridgeland, Turbeville	6/19/18	6/22/18
Male Facility End User Training Week 5 (if needed)	6/26/18	6/28/18
All remaining Institutions Go Live – Catawba, Goodman, Kershaw, Livesay, MacDougall, Manning, Trenton, Tyger River, Wateree	7/10/18	7/12/18
Kirkland eZmar Go Live	7/24/18	7/26/18

SCDC is in the process of hiring and training 8 new staff members to help support the EHR.

- 1 additional Help Desk staff member able to specifically address NextGen issues.
- 1 additional RIM staff member to conduct system configuration edits and produce reports and analysis of the NextGen data.
- 6 additional 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.
- 4 of the 6 support staff and the additional Help Desk member have been hired and will have started before the next panel visit.
- The remaining 2 support staff and 1 business analyst are still in the hiring process.

March 2018 Implementation Panel findings: See prior comments regarding rollout of the EHR.

March 2018 Implementation Panel Recommendations: Continue to assess and validate documentation from HER to support the Quality Management program.

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 March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:

The system is being updated on a continual basis.

End users continue to able to submit change requests to RIM for review and implementation by the system administrator after consultation with subject matter experts. Necessary changes and improvements will be rolled out on a continual basis rather than annually. Below is a list of enhancements already implemented since the two female facilities went live on NextGen on March 28, 2016:

- Improved user maintenance: [redacted] now has the capability to create accounts, re-enable accounts and reset passwords immediately instead of having to log a support case with NextGen for them to do so.
- Added max out date to the patient's demographics bar.
- New Standing Order medication ordering template to all Standing Order meds can be ordered from one place within the nursing visit. Continued maintenance of picklists (visit types, copay exempt reasons, reasons for visit, treatment plan objectives, etc.).
- More user workgroups (Scheduling, Lab, R&E) to help separate areas of responsibility within the Clinical Tasking Workflow. Staff can now control which workgroups they are participating in based on their job role for the day.
- Increased nurse/provider communication: Nurses and providers can write comments from their own templates that get saved to the record on the document and routed to the intended recipient for follow up or response.
- An overhaul of the SCDC formulary has taken place in the medications module. All provider are defaulted to only search the formulary list instead of the complete FDB medication listing. This should hopefully cut down on unusual meds being requested from the pharmacy and improve standardization of the rigs.
- Improved Referral workflow that will mirror the FE Medication template and be more user friendly.
- Improved printing workflows.
- EHR software upgrades are published by the vendor on an intermittent basis. Adoption of each new release will be determined by weighing the degree of technical and end user functionality gained against the resources required to implement the upgrade.
- Initial install: NextGen version 5.8.22/KBM version 8.3.10
- Upgrade completed 3/1/17: NextGen version 5.8.3/KBM version 8.3.11
- October, 2017: New release announced
- June, 2018: Tentative upgrade to NextGen version 5.9/KBM 8.4

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

March 2018 Implementation Panel Recommendations: As per status update section.

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

March 2018 Implementation Panel findings: **noncompliance**

February 2018 SCDC Status Update

The report addressing the following topics is included as Attachment 7 :

1) RHU Medication Procedure
2) Medication Assistance Device Photos
3) Medication Assistance Device Procedure
4) Pill Line Times

March 2018 Implementation Panel findings: 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.

Ironically, #s 2, 3 & 4 exacerbate the unacceptable nursing staff vacancies systemwide.

March 2018 Implementation Panel Recommendations:

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.

5.a. Improve the quality of MAR documentation;

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
Please see the *Medication Administration Update* report above

March 2018 Implementation Panel findings: Significant problems were identified with the reliability of the MAR documentation because nurses generally do not have access to the electronic MAR during the time of the actual medication administration. In addition, nurses do not have proper equipment for medication administration when it is not being delivered via a pill line. For example, medication carts are not available. See provision 5.

March 2018 Implementation Panel Recommendations: See provision 5.

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

Implementation Panel March 2018 Assessment: **noncompliance**

February 2018 SCDC Status Update:
Please see the *Medication Administration Update* report above

March 2018 Implementation Panel findings: 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.

March 2018 Implementation Panel Recommendations: As above.

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

Implementation Panel March 2018 Assessment: **noncompliance**

February 2018 SCDC Status Update:
Pill line times are attached at Appendix W.

March 2018 Implementation Panel findings: HS medications were still not being provided to the ICS at Kirkland CI or at Camille Griffin Graham CI. Morning pill lines at 4 AM within the Broad River CI are not reasonable if breakfast does not begin until 6 AM.

March 18, 2017 Implementation Panel Recommendations: Implement the appropriate steps to resume HS medication administration at the ICS's and elsewhere when clinically indicated. Adequately identify and address other pill call line issues. For example, issues related to 4 AM pill call lines should be identified and remedied.

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

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
Please see the *Medication Administration Update* report above

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

March 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 March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
The Deputy Director of Health Services and Division Director for BMHSAS evaluated all CI cells for approval for use for CI purposes.
Approvals- Allendale, Lee, Ridgeland, Kirkland F1, and Camille Graham's CSU.

Problems were noted with water faucets at CSU and statewide, but have since been approved (pictures are included as Appendix X).

Problems were also noted with sprinkler heads at Broad River CSU.
Evans visited, however need some cosmetic work (sealing of holes) and painting are needed.

March 2018 Implementation Panel findings: As per SCDC status update section.
March 2018 Implementation Panel Recommendations:

1. Complete the inspection and renovation process re: suicide resistant cells systemwide; and
2. Begin to assess the implementation of the suicide prevention policy via the QI process.

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

Implementation Panel March 2018 Assessment: **compliance (December 2017)**

February 2018 SCDC Status Update:

Logs provided to the HSOAs (QIAs) 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 the cells being used were prohibited alternative spaces.

March 2018 Implementation Panel findings: As per SCDC status update.

March 2018 Implementation Panel Recommendations: Compliance continues.

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

Implementation Panel March 2018 Assessment: **partial compliance**

February 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, CSU continues to be the only area where this is documented consistently based on the use of the 19-7C, Inmate Constant observation log. QIRM staff provided information and instructions on uses of the continuous logs during institutional site visits and ICQMC meetings with Lee, Allendale, Perry, Kirkland, Camille and Broad River Correctional Institutions.

Recommendations continue to be the same:
1. Update the policy to reflect the new and appropriate forms (A, B, C, D). (Remove reference to 19-7).
2. Address the use of the correct forms during shift briefing and provide instructions when to use each form and document through signatures that that staff have been briefed on the use of the appropriate.

March 2018 Implementation Panel findings: As per SCDC status update.

March 2018 Implementation Panel Recommendations: As per SCDC recommendations.

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

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
During institutional visits to Allendale, Broad River, Camille and Perry CIs, QIRM staff assess the processes for issuing, cleaning and providing clean suicide-resistant clothing and equipment for inmates when placed on CI. Interview with inmates and an assessment of supplies indicated that clean, suicide-resistant supplies were available and being supplied to inmates when placed on CI.

The complete report is included as Appendix Y.

March 2018 Implementation Panel findings: As per SCDC status update section. In recent weeks, CSU inmates at Camille Graham CI were not receiving mattresses.

March 2018 Implementation Panel Recommendations: Remedy the above.

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

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
Logs used to record cell checks for CI inmates do not include documentation of the provision of showers.

QIRM recommended that SCDC Form M-120, "Crisis Intervention" be evaluated by the Mental Health and Substance Abuse Division Director, Mr. [redacted] and Quality Assurance Manager, [redacted] for updates to include information about showers for inmates on CI status. Pursuant to a preliminary review, Mr. [redacted] has suggested this form be changed to require a mental health professional to evaluate the inmate for a shower once on CI for 24 hours. This would provide the security staff with specific instructions on the inmate's ability to shower versus current instructions which state "showers as tolerated. As of the writing of this report, this forma has not been updated to reflect the recommended change.

March 2018 Implementation Panel findings: As per SCDC status update. Security Staff do not allow CI inmates access to showers without documented authorization from the responsible clinician on SCDC Form M-120 Crisis Intervention. The identified form does not include a section for the clinician to authorize showers. Mental Health and Substance Abuse Director [redacted] and his staff have recommended a form revision requiring a mental health professional evaluate an inmate on CI status for a shower every 24 hours.

March 2018 Implementation Panel Recommendations: As per SCDC recommendations.

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

Implementation Panel March 2018 Assessment: **partial compliance**

February 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, this study was undertaken to assess where SCDC is in reaching that goal and to identify barriers to success. This study 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 17% and 24%, of the mental health sessions provided to CI/SP inmates in the months of October, November, and December 2017 and January 2018 in the studied institutions. Cell front sessions made up the largest category, between 42% and 47%, but sessions conducted in other places accounted for a significant minority, between 33% and 38%. Mental Health staff chose to conduct sessions in other locations in an effort to provide the inmates with as much privacy as possible, even when they cannot be totally confidential. While this effort is laudable, it falls short of SCDC's goal to provide confidential mental health sessions to inmates on CI/SP status and in CSU.

Among the three categories of mental health sessions used for this study, confidential sessions accounted for the smallest portion and cell front sessions for the largest.

Moving forward, SCDC will continue its aggressive recruitment campaign in order to alleviate security staffing issues. Outside of CSU, Mental Health staff continues to face challenges having inmates removed from cells for individual counseling sessions based on security shortages. CSU, at Broad River, has been mandated to have a minimum of two security officers per shift, in addition to Mental Health Techs who will assist with the pulling of inmates for individual counseling sessions. This should assist with improving their compliance rate.

The complete study is attached as Appendix Z

March 2018 Implementation Panel findings: As per SCDC status update section.

March 2018 Implementation Panel Recommendations: As per SCDC recommendations.

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

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
See 2b.vi.

March 2018 Implementation Panel findings: Operations maintains a shared folder for institutions to upload daily cell inspections and temperature logs. SCDC QIRM conducted a CQI Study and the study can be found in Appendix L. All institutions are not uploading daily cell inspections and

temperature logs. The information provided also identified correctional facilities failing to conduct the required daily inspections and temperature checks. Correctional facilities were identified not maintaining their temperatures within the acceptable range and there were correctional facilities with significant problems. Broad River Correctional Institution had the highest compliance with 89% in CSU and 100% in RHU although this was based on the fewest days recorded. Allendale CI had only 36% of their temperatures within the acceptable range. Allendale CI temperature issues are very concerning because cell temperatures were reported as a problem by inmates on a previous site visit to the correctional facility approximately one year ago. Further, when Allendale CI Maintenance was contacted by telephone during the March 18 Site Visit, they were unaware of a significant number of cells being outside the acceptable temperature range. Kirkland SSR had extreme deficiencies that should be an urgent priority. The revised SCDC Form 19-163 piloted at CGCI has the potential to improve staff documenting corrective action for cleanliness deficiencies. In the CQI Study, 4 of the 7 correctional facilities had zero percent of their deficiencies corrected. Two more facilities had 50 percent or less. Only Allendale CI had an acceptable correction action rate of 92%. A mechanism is needed to ensure work orders generated by correctional staff are addressed and the deficiencies are actually resolved. All institutions need improvement in documenting corrective measures when there are cleanliness and temperature deficiencies.

March 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; and
3. SCDC QIRM continue to perform QI Studies regarding Correctional Staff performing daily, random cell temperatures and cleanliness inspections.

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

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
See 2.b.vii.

March 2018 Implementation Panel findings: Pre-site information included the following:

CY 2018 CISP Entries through February 28, 2018
Entries in CISP Application = 315
Average Days on Crisis = 5
Average Time to CSU Placement = 41:16 (Hours:Minutes)
Average Days in CSU = 5
Average Days in Outlying Facility = 4
Active Cases = 69

Staff provided the following mental health staffing data for the BRCI:

Clinical Staffing for Area/Outpatient

Discipline	Allotted	Filled	Vacant
Clinical Supervisor – LPC(s)	1	1	0
Program Manager – LMSW	1	1	0
QMHPs	5	2	3
Mental Health Technicians	3	3	0

Psychiatry Coverage

- Dr. [redacted] 6 hours weekly (tele-psychiatry)
- Dr. [redacted] 2 hours every other week
- NP [redacted] 5 hours weekly

Psychology- None

Clinical Staffing/CSU

Discipline	Allotted	Filled	Vacant
Unit Manager	1	1	0
Mental Health Supervisor	1	1	0
QMPHs	3	1	2
Mental Health Technicians	8	4	4

Psychiatry Coverage

- Dr. [redacted] 5 hours weekly (tele-psychiatry)
- Dr, [redacted] 16 hours every other week
- Dr. [redacted] 5 hours weekly (tele-psychiatry)
- NP [redacted] 6 hours weekly (tele-psychiatry)
- Dr. [redacted] PRN (as needed)

During the morning of March 21, 2018, we observed a CSU treatment team meeting at the BRCI CSU. Dr. [redacted] attended via telepsychiatry. The treatment team was essentially led by Dr. [redacted] in a very competent manner. It appeared that this time was used for both psychiatric assessments of new admissions as well as follow-up for other CSU patients.

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 due 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.

March 2018 Implementation Panel Recommendations: Consider remedying and implementing the recommendations as summarized above.

Conclusions and Recommendations:

This Sixth Report of the IP represents its findings and recommendations as of March 23, 2018. As always we hope this report has been informative and helpful. We continue to look forward to further development of the mental health services delivery system within the South Carolina Department of Corrections and appreciate the cooperation of all parties in pursuit of adequate mental health care for inmates living in SCDC.

We recognize that the severe staffing shortages among medical, nursing, mental health and security staffs result in lack of compliance with many of the Settlement Agreement provisions in addition to SCDC policies and procedures that are not covered by the Settlement Agreement (SA) but negatively impact compliance with the SA (e.g., frequent lockdowns in general population housing units, 24-hour lockdowns in RHUs, etc.). Under such circumstances, we strongly recommend implementation of measures that would mitigate lack of compliance with the SCDC policies. The effort to place TVs in the RHUs is such an example, although thus far not a successful one since the televisions obtained months ago still have not been installed.

We have discussed with leadership staff the use of tablets in locked down settings as part such an effort in addition to an incentive program.

The enforced rule in certain prisons of inmates not being allowed to talk in the dining room is an example of a practice that instead of mitigating effects of the staffing shortages actually exacerbates

such effects. For reasons that were summarized during the exit conference it is our recommendation to rescind such a rule and/or practice. We recognized that this recommendation is outside of the confines of the Settlement Agreement and is a recommendation only.

The IP has provided its recommendations on specific items in the Settlement Agreement in this Sixth Report as well as past reports. We provided our preliminary findings at the full Exit Briefing on 3/23/18 and have provided partial preliminary reports at each of the facilities that we visited during this site visit. We continue to encourage SCDC to develop and implement their own internal processes and support systems to provide access, and monitor an adequate mental health services delivery system and quality management system. The quality management system in SCDC is complex based on the size and the requirements in the Settlement Agreement. It includes at its forefront Quality Improvement and Risk Management (QIRM), from whom the IP expects to receive the documents, reports and data requested prior to site visits, Research and Information Management (RIM), and the Division of Behavioral Health and Substance Abuse Services.

We must reemphasize, as we have throughout our site visits and during our Exit Briefings, the need for adequate resources to allow the SCDC to provide adequate mental health care and meet the requirements of the Settlement Agreement. The need for adequate resources cannot be overstated and even with some modest increases in operations staff and efforts to increase clinical staff, the deficiencies have not been corrected to the extent of providing substantial compliance in the elements of the Settlement Agreement. It is the view of the IP that fulfilling the requirements of the Settlement Agreement cannot be accomplished without there being a provision of adequate resources which have been woefully inadequate for years. The allocations that have been requested and approved, while increases, in our view based on the population and their mental health needs including the development of additional programs to address the issues of inappropriate use of segregation and restricted housing have not been alleviated. Based on our ongoing site visits, the staffing deficiencies are reflective of the SCDC's inability to provide even the very basic requirements as reflected in its policies and procedures regarding all inmates having access to out of cell time, humane conditions and appropriate mental health services.

Sincerely,

Raymond F. Patterson, MD
Implementation Panel Member

On behalf of himself and:

Emmitt Sparkman
Implementation Panel Member

Jeffrey Metzner, MD
Subject Matter Expert

Tammie M. Pope
Implementation Panel Coordinator

EXHIBIT B
IMPLEMENTATION PANEL REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
1.	**The development of a systematic program for screening and evaluating inmates to more accurately identify those in need of mental health care:**			
	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. Accurately determine and track the percentage of the SCDC population that is mentally ill.	HS 19.10	10/31/16 Partial compliance	10/31/16 Partial Compliance
		HS 19.07	10/31/16 Partial compliance	10/31/16 Partial Compliance
	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;	HS 19.07	10/31/16 Partial compliance	10/31/16 Partial Compliance
	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; and	HS 19.07 HS 19.10	10/31/16 Partial compliance	10/31/16 Partial Compliance
	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.	HS 19.07 HS 19.10	10/31/16 Noncompliance	10/31/16 Noncompliance
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:**			
	a. Access to Higher Levels of Care:			

[1] The Order components are for reference only and are to be used as references to identify those aspects of the Policies which apply to the Implementation.

EXHIBIT B
IMPLEMENTATION PANEL REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	i. Significantly increase the number of Area Mental Health inmates vis-a-vis outpatient mental health inmates and provide sufficient facilities therefore;	HS 19.04 HS 19.11	10/31/16 Noncompliance	10/31/16 Noncompliance
	ii. Significantly increase the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefore;[2]	HS 19.04, HS 19.07, HS 19.11	10/31/16 Noncompliance	10/31/16 Noncompliance
	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;	HS 19.04, HS 19.07 HS 19.09	10/31/16 Partial compliance	10/31/16 Partial Compliance
		Gilliam Construction Plan	10/31/16 Noncompliance	10/31/16 Noncompliance
	iv. Significantly increase clinical staffing at all levels to provide more mental health services at all levels of care; and	Hiring Plan attached as Exhibit E to the Settlement Agreement	10/31/16 Partial compliance	10/31/16 Partial Compliance
	v. The implementation of a formal quality management program under which denial of access to higher levels of mental health care is reviewed.	HS 19.07	10/31/16 Partial compliance	10/31/16 Partial Compliance
	b. Segregation:			
	i. Provide access for segregated inmates to group and individual therapy services;			
		OP RHU Policy _22.38 Section 3.23 H.S. 19.04	10/31/16 Noncompliance	10/31/16 Noncompliance
	ii. Provide more out-of-cell time for segregated mentally ill inmates;	HS 19.12 OP RHU Policy 22.38 Section 3.14.4 & Section 3.25	10/31/16 Noncompliance	10/31/16 Noncompliance
	iii. Document timeliness of sessions for segregated inmates with psychiatrists, psychiatric nurse practitioners, and mental health counselors and timely review of such documentation;	HS 19.04 OP RHU Policy 22.38 Section 3.15	10/31/16 Noncompliance	10/31/16 Noncompliance

[2] The Parties agree that 10-15% of male inmates and 15-20% female inmates on the mental health case load should receive Intermediate Care Services.

EXHIBIT B
IMPLEMENTATION PANEL REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	iv. Provide access for segregated inmates to higher levels of mental health services when needed;	HS 19.04 HS 19.06	10/31/16 Partial compliance	10/31/16 Partial Compliance
	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;	HS 19.07 OP RHU Policy 22.38 Section 1 and Section 2	10/31/16 Substantial compliance	10/31/16 Substantial compliance
	vi. Undertake significant, documented improvement in the cleanliness and temperature of segregation cells; and	To be determined	10/31/16 Noncompliance	10/31/16 Noncompliance
	vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.	HS 19.07	10/31/16 Noncompliance	10/31/16 Noncompliance
	c. Use of Force:			
	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;	OP 22.01 HS 19.08	10/31/16 Noncompliance	10/31/16 Noncompliance
	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;	OP 22.01 HS 19.08	10/31/16 Partial compliance	10/31/16 Partial Compliance
	iii. Prohibit the use of restraints in the crucifix or other positions that do not conform to generally accepted correctional standards and enforce compliance;	OP 22.01 HS 19.08	10/31/16 Noncompliance	10/31/16 Noncompliance
	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;	OP 22.01 HS 19.08	10/31/16 Partial compliance	10/31/16 Partial Compliance
	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;	HS 19.07 OP Use of Force 22.01 Section 13	10/31/16 Partial compliance	10/31/16 Partial Compliance
	vi. Prohibit the use of force in the absence of a reasonably perceived immediate threat;	OP 22.01 HS 19.08	10/31/16 Noncompliance	10/31/16 Noncompliance **See addendum note 1**
	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;	OP 22.01 HS 19.08	10/31/16 Noncompliance	10/31/16 Noncompliance

EXHIBIT B
IMPLEMENTATION PANEL REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	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;	OP 22.01 HS 19.08	10/31/16 Partial compliance	10/31/16 Partial Compliance
	ix. Develop a mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates;	OP 22.01 ADM 17.01 Employee Training Standards, SCDC Annual Training Plan HS 19.08	10/31/16 Partial compliance	10/31/16 Partial Compliance
	x. Collection of data and issuance of quarterly reports concerning the use-of-force incidents against mentally ill and non-mentally ill inmates; and	OP 22.01 HS 19.07	10/31/16 Partial compliance	10/31/16 Partial Compliance
	xi. The development of a formal quality management program under which use-of-force incidents involving mentally ill inmates are reviewed.	OP 22.01 HS 19.07	10/31/16 Noncompliance	10/31/16 Noncompliance
3.	**Employment of a sufficient number of trained mental health Professionals:**			
	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;	Hiring Plan attached as Exhibit E to the Settlement Agreement	10/31/16 Partial compliance	10/31/16 Partial Compliance
	b. Increase the involvement of appropriate SCDC mental health clinicians in treatment planning and treatment teams;	HS 19.05	10/31/16 Partial compliance	10/31/16 Partial Compliance
	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;	Mental Health Training Policy Addendum	10/31/16 Partial compliance	10/31/16 Partial Compliance
	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;	Hiring Plan attached as Exhibit E to the Settlement Agreement	10/31/16 Partial compliance	10/31/16 Partial Compliance
	e. Require appropriate credentialing of mental health counselors;	HS 19.04	10/31/16 Partial compliance	10/31/16 Partial Compliance
	f. Develop a remedial program with provisions for dismissal of clinical staff who repetitively fail audits; and	HS 19.07	10/31/16 Noncompliance	10/31/16 Partial Compliance **See addendum note 2**
	g. Implement a formal quality management program under which clinical staff is reviewed.	HS 19.07	10/31/16 Partial compliance	10/31/16 Partial Compliance

EXHIBIT B
IMPLEMENTATION PANEL REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
4.	**Maintenance of accurate, complete, and confidential mental health treatment records:**			
	a. Develop a program that dramatically improves SCDC's ability to store and retrieve, on a reasonably expedited basis:	HS 200.7		
	i. Names and numbers of FTE clinicians who provide mental health services;		10/31/16 Compliance	10/31/16 Compliance
	ii. Inmates transferred for ICS and inpatient services;		10/31/16 Partial compliance	10/31/16 Partial Compliance
	iii. Segregation and crisis intervention logs;		10/31/16 Noncompliance	10/31/16 Noncompliance
	iv. Records related to any mental health program or unit (including behavior management or self-injurious behavior programs);		10/31/16 Noncompliance	10/31/16 Noncompliance
	v. Use of force documentation and videotapes;		10/31/16 Partial compliance	10/31/16 Partial Compliance
	vi. Quarterly reports reflecting total use-of-force incidents against mentally ill and non-mentally ill inmates by institution;		10/31/16 Partial compliance	10/31/16 Partial Compliance
	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;		10/31/16 Partial compliance	10/31/16 Partial Compliance
	viii. Quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution;		10/31/16 Partial compliance	10/31/16 Partial Compliance
	ix. Quality management documents; and		10/31/16 Partial compliance	10/31/16 Partial Compliance
	x. Medical, medication administration, and disciplinary records.		10/31/16 Partial compliance	10/31/16 Partial Compliance
	b. The development of a formal quality management program under which the mental health management information system is annually reviewed and upgraded as needed.	HS 19.07	10/31/16 Noncompliance	10/31/16 Partial Compliance **See addendum note 3**
5.	**Administration of psychotropic medication only with appropriate supervision and periodic evaluation:**			
	a. Improve the quality of MAR documentation;	HS 18.16	10/31/16 Noncompliance	10/31/16 Noncompliance
	b. Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs;	HS 18.16	10/31/16	10/31/16

EXHIBIT B
IMPLEMENTATION PANEL REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
			Noncompliance	Noncompliance
	c. Review the reasonableness of times scheduled for pill lines; and	HS 18.16	10/31/16 Noncompliance	10/31/16 Noncompliance
	d. Develop a formal quality management program under which medication administration records are reviewed.	HS 18.16	10/31/16 Noncompliance	10/31/16 Noncompliance
6.	**A basic program to identify. treat, and supervise inmates at risk for suicide:**			
	a. Locate all CI cells in a healthcare setting;	HS 19.03 OP RHU 22.38 Section 3.39	10/31/16 Noncompliance	10/31/16 Noncompliance
	b. Prohibit any use for CI purposes of alternative spaces such as shower stalls, rec cages, holding cells, and interview booths;	HS 19.03 OP RHU 22.38 Section 3.39	10/31/16 Partial compliance	10/31/16 Partial Compliance
	c. Implement the practice of continuous observation of suicidal inmates;	HS 19.03	10/31/16 Partial compliance	10/31/16 Partial Compliance
	d. Provide clean, suicide-resistant clothing, blankets, and mattresses to inmates in CI;	HS 19.03	10/31/16 Partial compliance	10/31/16 Partial Compliance
	e. Increase access to showers for CI inmates;	HS 19.03	10/31/16 Partial compliance	10/31/16 Partial Compliance
	f. Provide access to confidential meetings with mental health counselors, psychiatrists, and psychiatric nurse practitioners for CI inmates;	HS 19.03	10/31/16 Noncompliance	10/31/16 Noncompliance
	g. Undertake significant, documented improvement in the cleanliness and temperature of CI cells; and	HS 19.03	10/31/16 Noncompliance	10/31/16 Noncompliance
	h. Implement a formal quality management program under which crisis intervention practices are reviewed.	HS 19.03	10/31/16 Partial compliance	10/31/16 Partial Compliance

SEE NEXT PAGE FOR MEDIATOR'S ADDENDUM:

EXHIBIT B
IMPLEMENTATION PANEL REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES

1) The Settlement Agreement incorporates provisions from Judge Baxley's Order specifically delineating the requirement that use of force is prohibited in the absence of a reasonably perceived immediate threat. See Settlement Agreement, Provision 4(g)("The components of the Remedial Plan shall consist of each subpart as identified in the Implementation Report"); See Exhibit B, Implementation Report, subsection 2(c)(vi), incorporating this provision. The current version of the Use of Force policy does not specifically delineate the threshold requirement that use of force is prohibited in the absence of a reasonably perceived immediate threat. It would appear this could be easily added as a threshold requirement to the Policy.
2) The Remedial Plan constitutes a first step towards the development of a program and compliance, although, as the IP has indicated, implementation of a properly working program is necessary to obtain Substantial Compliance.
3) The approved policy HS 19.07 constitutes a first step toward compliance, although, as the IP has indicated, implementation of a properly working program is necessary to obtain Substantial Compliance.