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

Executive Summary

The South Carolina Department of Corrections (SCDC) has demonstrated efforts to improve care and meet the requirements of the Settlement Agreement. However, it continues to have great difficulty in achieving those goals for multiple reasons which will be described in this report. This eighth report of the Implementation Panel (IP) will provide our review and analysis of the status of compliance based on information presented in documents reviewed prior to and during the onsite visits to SCDC facilities from November 12-16, 2018, as well as on site discussions and technical assistance to the SCDC since our last IP visit from July 12-16, 2018. The Settlement Agreement is now in its third year of implementation, which began in May 2016. The Settlement Agreement requires three visits per twelve month period for the first three years with reductions to two visits per twelve month period for the successive years. The Settlement Agreement "year" is from May-April, and therefore the third "year" will end at the end of April 2019.

Beginning with the first visit and report by the IP based on the visit in May 2016, we have reported our very serious concerns regarding SCDC's inability or failures to attain substantial compliance largely because of: 1) Staffing deficiencies, including clinical, operations/custody, administrative and support staff; 2) Conditions of confinement, including specifically the Restrictive Housing Units (RHU), and segregation of any type; 3) Prolonged stays in Reception and Evaluation (R&E) and the quality and appropriateness of evaluation, referral and treatment components; 4) Lack of timely assessments and adequate treatment at the mental health programmatic levels; 5) Operations practices and adherence to policies and procedures; 6) Access to higher levels of care, particularly timely hospital and residential (Intermediate Care, Behavioral Management Units, Area Mental Health/Enhanced Outpatient) levels of care; and 7) Future planning for adequate numbers of beds, programmatic space and staffing for mental health higher levels of care, including Crisis Stabilization Units (CSU).

In our reports we have reviewed and commented on all of these areas, noting some improvements in clinical staffing, and R&E reductions in length of stays and services at Camille Graham, as well as successes with the BMUs. However the other areas above, despite efforts at specific facilities by administrative and operations staff, remain problematic. The conditions of confinement have not substantially improved, in fact, have worsened to include general population inmates with the system-wide lockdown beginning in April, 2018 following the riot at Lee C.I. The staffing deficiencies for Operations staffing continues to retard or prevent compliance with many of the basic requirements of SCDC policies and the Settlement Agreement. Although there have been some improvements in clinical staffing for psychiatrists and psycholiogists which was sorely needed, the deficiencies in nursing and medical staffing, and excessively high caseload numbers for Qualified Mental Health Professionals (QMHP) remain problematic and do not have a positive impact on mental health care, treatment and management of inmates with mental health needs.

In the Implementation Panel Report of Compliance for the July 2018 site visit the IP reported on the positive impact on mental health services and the requirements of the Settlement Agreement demonstrated by staff at facilities where the lockdown had been modified or eliminated. The IP provided similar feedback during this site visit and at the Exit Conference held on November 16 at the end of the visit. The IP continues to acknowledge the very positive efforts and impact of the Quality Improvement Risk Management staff and healthcare leadership, and is encouraged by the progression of the development and implementation of the electronic health record (EHR). The IP remains deeply concerned with the continuation of segregation conditions, medication management, planning of services for inmates who require higher levels of care and movement/relocation of mentally ill inmates. The mass movement of caseload inmates at Level 3 (Area Mental Health/Enhanced Outpatient) to Broad River C.I., and mass movement of female inmates from Graham C.I. to Leath C.I. remain problematic. The planning for movement, creation, and/or expansion of existing programs was discussed during this visit and the IP expressed our concerns for adequate needs assessments, preparation of inmates and staff and provision of adequate human resources, space and supportive services to facilitate successful implementation or changes. These discussions included proposals and plans that may directly affect inmates, services and programs at Kirkland C.I., Broad River C.I., Graham C.I., Lee C.I. and Evans C.I. and may indirectly impact other facilities and services.

The IP has reported on the suicide rates by calendar year for inmates living in SCDC. As of November, 2018 there have been six inmate suicides reported at SCDC. For an average daily population of approximately 20,000 inmates the annual suicide rate for calendar year 2018 is 30 per 100,000 at SCDC. The national average suicide rate for prisons reported by the Department of Justice, Bureau of Justice Statistics for the most recently available years is 16-17 per 100,000. The Suicide Prevention and Management program at SCDC requires collaboration and coordination by administrative, clinical and operations staff. The IP has strongly and repeatedly recommended the internal review, analysis and restructuring of the processes to include policies and procedures, timely and effective involvement of central classification at the Broad River C.I. CSU, and the review process and documentation by the Suicide Prevention Committees and clinicians involved in the Psychological Autopsy analysis. The IP has acknowledged the efforts and actions by SCDC to recruit and retain staff, and the positive impact regarding increased numbers of psychiatrists and psychologists is impressive and very helpful. However the continuing deficiencies in operations/correctional officer staff so adversely impacts inmates living with mental illness, as well as inmates not on the mental health caseload, and is exacerbated by the conditions of confinement, that basic services are compromised and may be over-utilized by inmates to attempt to obtain out of cell time and showers as well as to address safety concerns. More specifically, the IP notes the following progress and concerns:

Progress

- Developed RHU Training and began rolling the training out to designated employees in November 2018;
- Expanded the number of training hours offered correctional employees in Pre Service and In Service regarding appropriately managing mentally ill offenders;

- Inmates on RHU Security Detention status has been reduced to less than 300 as of November 14, 2018. SCDC data indicates approximately 100 inmates on Security Detention status have gone six months without a disciplinary report conviction;
- Lieber CI offering UOF Workshops to provide assistance and training to employees;
- Increasing availability of showers in RHU for inmates at Lieber CI and Broad River CI;
- Continued minimal use of the restraint chair;
- The MH UOF Coordinator conducting a study to identify inmates frequently involved in UOF and making recommendations for additional service to potentially reduce UOF;
- Overall improvement in operations at Kirkland CI and Lieber CI;
- The continued success of the BMU Programs.

Concerns

- Critical shortage of front line correctional officers particularly at Level 3 institutions preventing the providing of basic services to inmates in the general population and RHU;
- Deplorable conditions of confinement at Lee CI and Broad River CI Murray Unit;
- RHUs at male institutions not being provided cleaning supplies on a weekly basis to improve sanitation.
- The RHU Stepdown Policy has not been revised to mirror practice and inmates eligible for participation in the Stepdown Programs are not being placed (approximately 100 appear eligible for consideration and remain in RHU);
- Identified institutions are not following guidelines for placing inmates in Control Cells;
- Low number of UOF investigation based on the number of identified QIRM UOF violations and UOF/Physical Abuse Complaints;
- High number of grievances regarding UOF and Physical Abuse returned to inmates without being processed;
- High number of inmates in RHU without a crank radio;
- Access to Management Meetings are not being held with inmates in the housing units due to the lockdown hindering addressing inmate issues and concerns;
- SCDC data identifies Institution Upper Management presence in RHU is lacking and Duty Wardens are not making rounds in RHU on weekends as required by policy and procedure;
- Institution Lockdown tracking is insufficient. Institutions should provide the following information daily :

    - Areas/Locations of Institution on lockdown;
    - Number of hours each area/location was locked down for the 24 hour period;
    - Each service and/or program impacted by the lockdown;
    - Number of inmates impacted;
    - The reason for the lockdown for each institution area/location.

The IP has consistently reported grave concerns that SCDC is highly unlikely, if not completely unable, to meet the conditions and requirements of the Settlement Agreement and the provision of constitutionally adequate mental health care without major and consistent increases in staffing and resources and/or major reductions in the numbers of inmates housed in SCDC facilities. Consultants to SCDC have recommended security staffing levels necessary to provide adequate

services consistent with correctional practices and SCDC policies. SCDC has engaged in increased recruitment efforts, with some success, however retention of staff is also adversely affected by working conditions. Progress has been made in reducing the lockdown status at most facilities, however inmates in RHUs and in general population at some facilities continue to not receive out of cell time as required. The IP has also continued to provide technical assistance and suggestions on providing crank radios and other interventions to assist staff and inmates during these staff shortages and lockdown restrictions. The SCDC total population continues to decrease toward 19,000 inmates while the mental health caseload has increased from 3126 to 4163 at the time of this visit. The percentage of inmates on the mental health caseload is 21.8 %, with 52.2% of female and 19.1% of male inmates on the caseload. These increases are more consistent with national averages and represented the impressive improvements by SCDC to appropriately identify those inmates in need of mental health services. Unfortunately, even with the improvements in mental health staffing, the deficiencies in operations/security and nursing staffing compromise the delivery and consistency of mental health services. The wardens and their staff at several facilities, with the support of central administration and regional directors, are continuing to try to provide the services that they can and "think outside the box." However to implement and sustain necessary changes, including program development, requires the increased resources identified and discussed on site and in IP reports, including this report.

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

1. Substantial Compliance---20
2. Partial Compliance---33
3. Non-Compliance---7

The Implementation Panel clearly understands this is a complex and ongoing process. The difficulties in providing necessary and required services given the resource deficiencies and conditions of confinement is very challenging for all. The improvements in identification of inmates in need of mental health services, sincere and effective efforts at specific facilities to provide services, the essential role and participation by QIRM and the healthcare and operations leadership staff , and the development of the EHR are all very encouraging. We also appreciate the efforts to design or modify programs and have cautioned leadership to involve staff, consultants, and where appropriate inmates, in the discussions and planning process for expansion, relocation and inmate movement. The specific Settlement Agreement criteria, requirements, findings and recommendations are listed below.

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

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

Implementation Panel November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:
SCDC has established a mental health screening process which all inmates go through during intake at the Reception & Evaluation center (R&E). The goal of this screening process it to identify mild, moderate, and serious mental illness and/or crisis intervention needs that may be associated with psychiatric and psychological problems. As a result of the screening, inmates are classified either as needing no mental health services or as needing a routine, urgent, or emergent mental health follow-up evaluation. Policy provides timeframes for the completion of each category of follow-up evaluation: routine, urgent, or emergent. Follow-up evaluations are then conducted by Qualified Mental Health Professionals (QMHP) or Psychiatrists. When the first follow-up evaluation is completed by a QMHP, the QMHP can refer the inmate for an additional follow-up with a Psychiatrist, if necessary. A CQI study, was done 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.

Results of the study show that Camille Graham R&E administers mental health screenings as mandated at a rate of 95%-100%. Camille Graham's R&E has made continual efforts at identification with its compliance rate for QMHPs evaluating Routine referrals in a timely manner ranging from 73% to 100%. Overall, Kirkland R&E has demonstrated notable improvement in seeing Urgent and Emergent referrals in a timely manner – with a compliance rate of 100% for July and August. Graham R&E continues to encounter challenges in completing psychiatric follow-ups within the required timeframes for its Routine referrals, with its lowest compliance rate at 7% for the month of August. Kirkland continues to demonstrate major improvement in assessing Emergent referrals to the QMHP, as well, which may be attributed to the new tracking system for Urgent and Emergent referrals that has been implemented since the last IP visit. There remains opportunity for growth for both institutions to better manage, evaluate, and follow-up with all referral types.

The CQI study inclusive of the methodology, detailed analysis, chart summaries and planned actions are included as Appendix A.

November 2018 Implementation Panel findings: The above results are encouraging. Lack of achieving compliance appears to be a staffing issue (i.e., vacancies). Future QI studies should include in the sample inmates who were not placed on the mental health caseload as a result of the screening process.

November 2018 Implementation Panel Recommendations: As above.

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

Implementation Panel November 2018 Assessment: compliance (November 2018)

October 2018 SCDC Status Update:
There are several modes available for inmates to access mental health services. Inmates can be referred by medical staff, operations staff, self-referrals, and counselor referrals. A CQI study

was completed to determine how many inmates are not being accurately identified as mentally ill during the screening process and end up on the mental health caseload within 12 months after leaving R&E.

Results of the study show that less than 13% of all inmates who initially had a non-mental health classification upon leaving Kirkland R&E ended up on the mental health caseload within 12 months. The results of the study indicate that SCDC Mental Health staff perform an effective job at accurately identifying inmates who are mentally ill during the screening process.

The CQI study inclusive of the methodology, detailed analysis, chart summaries and planned actions are included as Appendix B.

November 2018 Implementation Panel findings: The referenced QI results were consistent with the R&E mental health screening process adequately identifying inmates with a mental illness.

November 2018 Implementation Panel Recommendations: The referenced QI could be improved as follows:

1. Assess whether the initial mental health screening was accurate at the time of the screening.
2. Classify the reasons for inmates, who had not been placed on the mental health caseload in R&E, were later placed on the caseload. Such an assessment may have relevance in the context of revising the mental health screening instrument.

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 November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:

The following summary, provided by BMHSAS includes findings from R&E Audits at Kirkland & Camille Graham. Nine out of ten cases reviewed reportedly did not present any documentation or clinical issues. Ten cases reviewed with the following results:

- 9/10 cases reviewed did not present any documentation or clinical issues
- One case documented significant clinical symptomology; however, was ruled out as not needing MH services. QMHP needed to document more precisely, why clinical decision was made to screen inmate as not needing further mental health evaluation/services.
- One case reviewed was an urgent referral and was triaged appropriately. Inmate remains at GPH.
- All assessments and evaluations completed by QMHP and Psychiatrist done in a timely manner.
- Two cases remaining at R&E after classified over 30 days. Transfer email sent to classification requesting inmates are sent to yard for MH Services.

Findings forwarded to R&E MH Manager for appropriate follow-up.

The detailed review is included as Appendix C.

November 2018 Implementation Panel findings: The methodology re: the above study was problematic for the following reasons:

1. The sample was too small.
2. The sample was not randomly chosen.
3. The findings were not consistent with other studies reported re: compliance with relevant timeframes.

November 2018 Implementation Panel Recommendations: Repeat the study with the above referenced methodological issues being adequately addressed.

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 November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:
The inmates who arrive at the Reception & Evaluation center (R&E) are scheduled to be transferred to their assigned institutions no more than 30 days after their admission. For inmates who are identified as mentally ill (MI) through the R&E screening processes that remain over 30 days in R&E, it is the goal of SCDC to ensure that those inmates are receiving adequate and appropriate mental health services to meet their needs. A CQI study was completed to identify whether MI inmates – as identified from mental health screenings and evaluations – who do not transfer from R&E to their institutions in a timely manner where they can: receive continual and consistent mental health care; have access to QMHP and psychiatrist follow-ups as clinically indicated; receive their psychotropic medications prescribed by the psychiatrist; have a treatment plan developed, and attend group therapy.

The MI inmates at Graham R&E over 30 days received group therapy sessions at a rate of between 73% and 100% for the months of June through August. No inmates remaining over 30 days at Kirkland R&E received group therapy sessions or had a treatment plan developed during the reviewed time period.

Treatment plans were not developed for any of the inmates at Graham R&E for over 30 days either. Given the typical short length of stay and changes in treatment plan after leaving R&E treatment plans have not been required.

Receiving follow-up evaluations with a QMHP after their initial assessments during their extended stay at R&E continues to be an issue. Of those inmates who had follow-up evaluations due with a QMHP during that timeframe, 0% to 78% actually received a follow-up QMHP evaluation.

Both programs continue to struggle with fully providing all necessary mental health services to inmates who are mentally ill and remain in R&E for more than 30 days. SCDC continues to

work towards compliance and transferring mentally ill inmates to their placed institutions within a reasonable time frame so that they can receive adequate and consistent care.

Beginning November 1 every inmate classified as L3 or higher, at R&E for over 30 days, will be seen by a QMHP every 30 days. At that time, if they present with a worsening psychiatric condition, they will be scheduled to see the psychiatrist for medication adjustment or possible treatment at a higher level of care.

The CQI study inclusive of the methodology, detailed analysis, chart summaries and planned actions are included as Appendix D.

November 2018 Implementation Panel findings: As per status update.

Camille Graham CI

During the morning of November 16, 2018, the IP met with most of the R&E inmates in a group setting during their one hour of out of cell time. They confirmed that they were receiving one hour per day of out of cell time in either the dayroom or outdoor yard (weather permitting). Only two of the inmates reported being in the R&E for more than 30 days. Many of the inmates, who had been receiving psychotropic medications in jail prior to their transfer to R&E, had not yet been prescribed psychotropic medications because they had not yet been evaluated by the psychiatrist. All the inmates described the mental health screening process to have been timely and comprehensive.

November 2018 Implementation Panel Recommendations:

1. Implement and QI the planned actions, which included the following: "Implement measures of corrective action for R&E staff who fail to provide available and appropriate services to mentally ill inmates who remain at R&E for an extended period of time."
2. Accurately track the out of cell time offered to R&E inmates on a weekly basis.
3. Continue to provide the average and median LOS data in the future for inmates in the R&E upon transfer from the R&E.
4. QI the R&E process re: the verification of prescribed medications and the bridge ordering process.

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 November 2018 Assessment: partial compliance

October 2018 SCDC Status Update: See response in 1.a.i.

November 2018 Implementation Panel findings: See 1.a.i.

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

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

2.a. Access to Higher Levels of Care

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

Implementation Panel July 2018 Assessment: noncompliance

October 2018 SCDC Status Update:

Area Mental Health Inmates

Data reported for each area may include different months. Institutional staff in Operations and Mental Health were responsible for writing reports and submitting documentation to support their reports. Some of these reports included different time frames; therefore, QIRM's audits were based on the time frames provided in the reports received. Some of the reports were not received by the deadline of October 3, 2018, and QIRM was unable to audit all of the reports that were not submitted timely.

Policy HS-19.04, section 5.3.4 defines L3 Higher Intensity Outpatient Treatment as inmates' ability to function in a general population is moderately impaired due to mental illness. They are easily overwhelmed by everyday pressures, demands, and frustrations, resulting in disorganization, impulsive behavior, poor judgment, delusions, hallucinations, or other exacerbations. They are seen by QMHPs at least monthly, or more routinely if clinically indicated, and require a treatment plan update every three (3) months. It is the practice that inmates with this mental health classification have sessions with the Psychiatrist every 90 days. A sample of ten inmates were reviewed for each institution. QIRM Analysts used the databases provided by mental health staff to choose the sample used for the data analyses. After the sample was chosen, the Analysts examined documentation in the AMR (Automated Medical Record) and/or NextGen (the electronic health record), depending on each institutions date of transition to NextGen, to review individual sessions with the QMHP and Psychiatrist. Every encounter was reviewed during the reporting period to ensure compliance rates were calculated based on all documented sessions with the QMHP and Psychiatrist.

Group Services

*Camille Graham (*Group Services)

Per Camille Graham's report submitted by mental health staff, approximately 22 groups are offered each week for the L3/L4 population. The institution reported the data is unavailable regarding how many inmates attended groups during this report period.

Timeliness of Sessions with the QMHP and Psychiatrist

Broad River

Based on data audited in NextGen and the AMR for June and July, the compliance rate for sessions with the QMHP was 100% and 89 % respectively. The compliance rate for sessions with the Psychiatrist was 67% and 56%, respectively.

Camille Graham
Based on data audited in NextGen for July, August and September, the compliance rate for sessions with the QMHP was 10%, 50% and 40% respectively. The compliance rate for sessions with the Psychiatrist was 40%, 70% and 90%, respectively.

Lee
Based on data audited in NextGen and the AMR for July, August and September, the compliance rate for sessions with the QMHP was 20%, 50% and 40% respectively. The compliance rate for sessions with the Psychiatrist was 40%, 40% and 30%, respectively.

Lieber
Based on data audited in NextGen and the AMR for July, August and September, the compliance rate for sessions with the QMHP was 60% and 40% respectively. The compliance rate for sessions with the Psychiatrist was 70% and 40%, respectively.

Mental Health Classifications for Area Mental Health Population
Source: RIM Weekly Mentally Ill Report for Institutional Population, female inmates at GEO Care and inmates at CoreCivic Weekly Report

Location	June	July	August	September 10, 2018
Allendale	1			
BRCI		142	163	180
GPH	150	6	4	
Graham	63	55	56	58
Graham R&E	7	10	9	6
Kershaw	2	3	2	2
Kirkland	5	9	11	16
Kirkland Infirm		1	2	
KCI Max	6	5	6	6
Leath	2	2	2	3
Lee	22	18	16	12
Lieber	29	29	28	29
MacDougall	1			
McCormick	6	7	9	8
Perry	12	20	27	22
Ridgeland			1	2
Turbeville	2	1	1	1
Tyger River			2	3
Total	308	308	339	348

Leath

Of the inmates who were transferred to Leath from Camille prior to the previous site visit, nineteen were identified for transfer back to Camille. As of the writing of this report, seventeen of the inmates have been transferred back to Camille. A report from Central Classification indicted that at time of transfers these two inmates were in ST Custody in Leath's RHU. The have been placed back into general population and could be transferred on October 25, 2018.

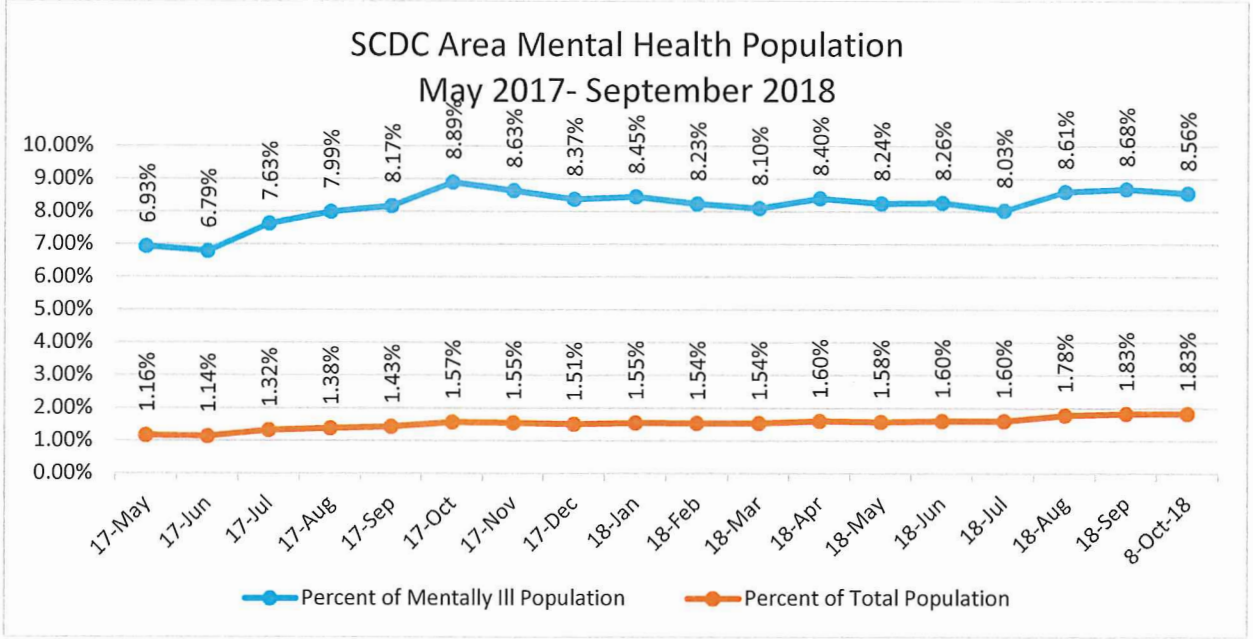
Although Leath Correctional Institution is not included in the current site visit, on August 16, 2018, the Division Director of BMHSAS verified through email that Leath CI no longer has a designated mental health dorm

Population of Area Mental Health Inmates

The chart below demonstrates SCDC's ability to track the percentage of L3 inmates in comparison to the mentally ill population and the percentage of the overall population. It also shows an increase in the percentages of inmates receiving services. Since May of 2017, this population has increased from 1.16% to 1.83% of the overall SCDC population and from 6.93% to 8.68% of the total mental health population.

Month	Female L3 inmates	Male L3 inmates	Total Population	Percent of Mentally Ill Population	Percent of Total Population
17-May	47	190	237	6.93%	1.16%
17-Jun	48	183	231	6.79%	1.14%
17-Jul	50	215	265	7.63%	1.32%
17-Aug	52	222	274	7.99%	1.38%
17-Sep	61	227	288	8.17%	1.43%
17-Oct	69	246	315	8.89%	1.57%
17-Nov	72	237	309	8.63%	1.55%
17-Dec	80	220	300	8.37%	1.51%
18-Jan	85	218	303	8.45%	1.55%
18-Feb	78	222	300	8.23%	1.54%
18-Mar	78	218	296	8.10%	1.54%
18-Apr	76	235	311	8.40%	1.60%
18-May	75	231	306	8.24%	1.58%
18-Jun	23	236	308	8.26%	1.60%
18-Jul	67	241	308	8.03%	1.60%
18-Aug	67	272	339	8.61%	1.78%
18-Sep	67	281	348	8.68%	1.83%
October 8, 2018	64	280	344	8.56	1.83%

Data source: RIM: Weekly Mentally Ill Report for Institutional and Female GEO Care Population (last week of each month)



Changes to Disciplinaries for Self-Injurious Behaviors

On Friday, July 27, 2018, the Assistant Deputy Director of Operations sent an email to all wardens, associate wardens and majors addressing self-mutilation disciplinaries. Staff were informed that charging inmates with disciplinary violations for cutting or hanging themselves was inappropriate and that these charges were to be discontinued immediately. Effective July 27, 2018, all cutting/hanging or any self- inflicted injury are not referred for a disciplinary hearing but referred to mental health staff.

Additional clarification was provided to staff informing that SCDC would no longer seek restitution for medical transport from inmates in these cases because these are mental-health-driven. Inmates attempting to hang themselves can no longer receive disciplinaries. If the Mental Health Treatment Team believes that the inmate's behavior is for manipulative reasons and not truly being driven by any mental health diagnosis, then an exception applies. This team's recommendation must be approved by an Agency Psychiatrist or Psychologist.

If an inmate hurts someone and/or damages property in the midst of harming themselves, and if, in the midst of this restraint, an employee is injured, the inmate will not be charged with a disciplinary violation. If staff believe the inmate intentionally harmed an employee and/or damaged property under the guise of harming themselves, disciplinary charges can be sought after review by the Mental Health Treatment Team and approval by an Agency Psychiatrist or Psychologist.

A RIM-generated a report of self-mutilation convictions since July 27, 2018 shows that of the seven (7) convictions, zero (0) included inmates attempting self-harm.

The initial email, clarification email, RIM report and supporting documentation for six of the seven inmates are included as Appendix E (1-Self Mutilation).

November 2018 Implementation Panel findings: As per status update section. The number of Area Mental Health inmates has increased (although not significantly). Significant issues remain in providing sufficient facilities for treatment with specific reference to staff resources as evidenced by partial compliance in meeting clinical timeframes.

During the afternoon of November 13, 2018, the Implementation Panel (IP) met with most of the Murray dormitory inmates in a community group setting. These inmates continued to complain about poor access to mental health and medical services since the system wide lockdown. Other complaints included the timing of the morning medication administration process, periodically missing medications, significant property and clothing issues, and conditions of confinement related to partial lockdown status. They also reported staff on inmate assaults and inmate on inmate assaults. Community meetings had just recently been restarted.

Most of the above information was not consistent with information obtained from staff.

November 2018 Implementation Panel Recommendations: We recommend that community meetings occur at least twice per week to address the above issues reported by inmates. These meetings should be attended by mental health, nursing and custody staff. The access to management meetings should resume on at least a monthly basis for similar reasons.

Lee Correctional Institution

The mental health dorm (Better Living in Community), which is not an area menta health level of care, is now on a modified lockdown status, meaning that some access to mental health groups on the unit is provided for these inmates. For somewhat unclear reasons, inmates over the age of 50 were not transferred to the East Yard dorm that is apparently not locked down or is on a more modified lockdown status.

The IP remains very concerned about the modified lockdown status of the mental health dorm due to the potential of the conditions of confinement exacerbating some of the inmates' mental disorders.

Lieber Correctional Institution

The inmate count was 1161 inmates. The mental health count during November 15, 2018 was 282 inmates with 36 of these inmates being in the RHU. The mental health staffing was as follows:

1.0+ FTE Psychiatrists
1. 0 FTE MHT
4.0 FTE QMHPs (1.0 FTE vacancy)

There were a total of 243 FTE correctional officer positions with 101 FTE vacancies.

Lieber CI remained on lock down status except for a character dorm and a faith based dorm. Refer to the relevant data in the status update section for information specific to meeting

timeframes for clinical contacts. Cooper dorm was reported to house a large number of mental health caseload inmates.

Camille Graham CI

We site visited CGCI during the morning of November 16, 2018. During November 14, 2018 the total inmate count was 633, which included 39 RHU inmates. Twenty of the RHU inmates were on the mental health caseload. The mental health caseload included 265 inmates with the following level of care designations:

Classification	Total	RHU
L1 inpatient	2	0
L2 ICS	18	0
L3 Area MH	57	0
L4 outpatient	159	14
L5 stable, but being monitored	27	2
Non-mental health	368	19
Crisis level	0	0

Staffing was as follows:

Psychiatrists: 2 psychiatrists providing a total of 47.5 hours coverage per week
Psychologists: .05 FTE (vacant)
QMHPs: 7.0 FTEs
MHTs: 3.0 FTEs
On-site clinical supervisor: 1.0 FTE

The average QMHP: inmate patient ratio was 1:60

There were significant nursing staff vacancies, especially on the second shift. Most vacancies were covered by agency nursing staff.

We observed a treatment team meeting during the morning of November 16, 2018, which was also attended by the psychiatrist and other clinical staff. The nature of the clinical discussion was negatively impacted by the size of the non-clinical team members observing the treatment team process.

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

Implementation Panel November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:

ICS (Intermediate Care Services)

Policy HS-19.12 states the ICS is a residential mental health program provided in a therapeutic environment...Inmates receive medication therapy, counseling services, and educational interventions aimed at managing psychiatric symptoms, improving basic coping skills, and developing general self-care skills. Policy also states during the first four weeks of the ICS program, the primary QMHP provides individual counseling to the inmate once per week or more often, as clinically indicated. After four (4) weeks, the primary QMHP conducts individual sessions no less than twice monthly, but these sessions may occur more often as clinically indicated and the psychiatrist assesses the inmate every thirty (30) days, or more often as clinically indicated.

A random sample of ten ICS inmates at Kirkland were reviewed for this analysis. The databases provided by mental health staff were used to choose the sample for the data analysis. The documentation was examined in the AMR (Automated Medical Record) and NextGen to review individual sessions with the QMHP and Psychiatrist. Every encounter was reviewed during the reporting period to ensure compliance rates were calculated based on all documented sessions with the QMHP and Psychiatrist. Since the Psychiatrist is required to see the ICS inmate at least every 30 days, a formula was added to the database to calculate the next session due date. For the month of July, if a session was held in the month of June, that session date was used to calculate compliance for the month of July. If there was no session documented in June, July sessions were out of compliance because the previous sessions would have exceeded 30 days.

Camille Graham

Based on data audited in NextGen for June, July, August and September, the compliance rates for sessions with the QMHP was 80%, 90%, 100% and 100% respectively. The compliance rates for sessions with the Psychiatrist was 20%, 80%, 10% and 90% respectively. While 80% of the Psychiatry sessions were out of compliance with policy in the month of June, all 10 ICS inmates in the sample were seen by the Psychiatrist with a few having more than one session. While 90% of the Psychiatry sessions were out of compliance with policy in the month of August, 9 out of the 10 ICS inmates in the sample were seen by the Psychiatrist.

Structured Out of Cell Time

Policy HS-19.12, section 3.4 states ICS inmates are provided ten (10) hours of structured out-of-cell activities weekly, which take place Monday through Friday.

The chart below includes structured out of cell time for ICS inmates as reported by mental health staff. This data was not audited by QIRM.

Structured Time Out-of-Cell (Groups, Community Meetings, QMHP Sessions, Psychiatry Sessions, Etc.,)

	Quarter: July - September*						
	July		August		September		Average
	Total #	Total %	Total #	Total %	Total #	Total %	Total %
n=	21	---	21	---	21	---	---
inmates getting 0 mins	2	10%	2	10%	0	0%	6%
inmates getting between 0 & 5 hrs	0	0%	2	10%	3	14%	8%
inmates getting between 5 & 10 hr	4	19%	5	24%	4	19%	21%
inmates getting 10 hours or more	15	71%	12	57%	14	67%	65%

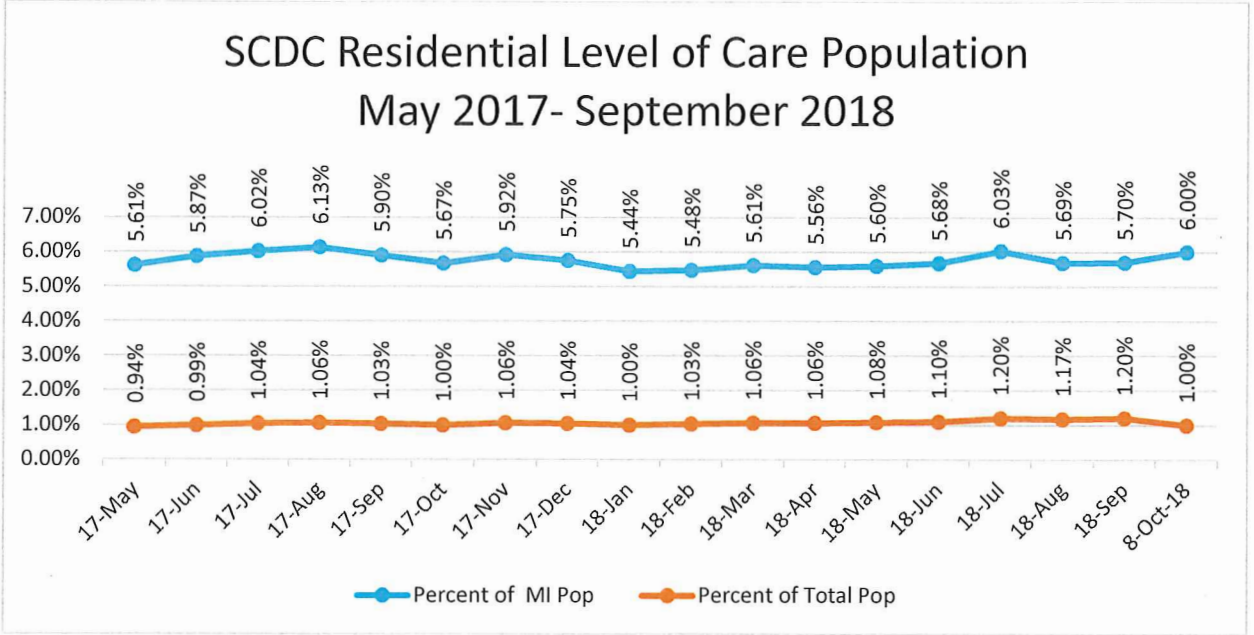
Data Source: Report Completed by Mental Health Staff

Population of Inmates Residential Level of Care (L2)

The chart below demonstrates SCDC's ability to track the percentage of L2 inmates in comparison to the mentally ill population and the percentage of the overall population. These numbers include L2, LLBMU and HLBMU. It also shows an increase in the percentages of inmates receiving services. Since May of 2017, this population has increased from 0.94% to 1.02% of the overall SCDC population and from 5.61% to 5.70% of the total mental health population.

Residential Level of Care (Includes LLMBU, HLBMU and ICS)					
Month	**Male**	**Female**	**Total Pop**	Percent of MI Pop	**Percent of Total Pop**
17-May	165	27	192	5.61%	0.94%
17-Jun	170	28	198	5.87%	0.99%
17-Jul	182	27	209	6.02%	1.04%
17-Aug	186	26	212	6.13%	1.06%
17-Sep	181	27	208	5.90%	1.03%
17-Oct	176	25	201	5.67%	1.00%
17-Nov	187	25	212	5.92%	1.06%
17-Dec	186	20	206	5.75%	1.04%
18-Jan	180	16	196	5.44%	1.00%
18-Feb	183	17	200	5.48%	1.03%
18-Mar	187	18	205	5.61%	1.06%
18-Apr	190	16	206	5.56%	1.06%
18-May	193	15	208	5.60%	1.08%
18-Jun	195	17	212	5.68%	1.10%
18-Jul	211	20	231	6.03%	1.20%
18-Aug	206	18	224	5.69%	1.17%
18-Sep	208	19	227	5.70%	1.20%
8-Oct-18	208	19	227	6.00%	1.00%

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



Provision of Facilities

In an effort to provide sufficient facilities and increase the number of male inmates receiving residential level-of-care and crisis stabilization services, Operations and Health Services have begun discussions to expand the BMU and the CSU. The following outlines plans under consideration discussed on September 4, 2018.

BMU Expansion- Conversations

The Division of Health Services requested that 96 total beds be designated for Behavioral Management Unit placement and programming at the two below facilities:

- Expand from 24 to 48 beds at Allendale (LLBMU)
- Utilize 48 beds at Broad River- Edisto Unit B-Side (KCI HBLMU will be relocated to this unit).

Both locations have adequate therapeutic space, both on or off the unit and proximate to the vicinity and the ability to recruit and retain critical healthcare/behavioral health and security staff, although admittedly the recruitment of professional staff in the rural community of Allendale is somewhat challenging than in the Columbia area. Once the 48 beds at Broad River –Edisto Unit become operational, the current 24-bed HLBMU program at Kirkland D-Dorm will be relocated to this area.

A memo sent to Operations for the Deputy Director of Health Services outline the need and recommendations for expansion is included as Appendix F.

CSU Expansion- Conversations pursued regarding the expansion of the centralized Crisis Stabilization Unit (CSU) at Broad River, Greenwood Unit- B-side. The expansion will increase capacity from 32 beds to a 64-bed facility. All cells housing inmates will remain on the lower tier on both sides. The Inmate Watcher program that currently exists will be

replicated for the B-side. The Division of Facilities Management have completed the drawings; however, have notified Ms. [redacted] that renovations could not begin earlier than January 2019 based on competing priorities. The Warden has expressed concerns with expanding the unit at his current staffing pattern. The following action items were identified:

1. Meet with Facilities Management to discuss time-line for work completion (Marshall Dennis, DuBose)
2. Identify, approve, and train additional Inmate Watchers/Mental Health Companions (Dennis, DuBose)
3. Meet with the Warden to address staffing concerns (McCabe)
4. Re-class current medical positions to expand clinical staffing for the B-side (Marshall, DuBose)

November 2018 Implementation Panel findings: As per status update section, which summarizes SCDC's plans for significantly increasing the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefore. Increased staffing allocations have been requested as part of SCDC's budget request that has been submitted to the governor.

Our previous two reports included the following:

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

Our opinion re: the above remains unchanged.

Kirkland Correctional Institution

Pre-site data included the following information:

Based on data audited in NextGen for July and August, the compliance rates for sessions with the QMHP was 10% and 0% respectively. The compliance rates for sessions with the Psychiatrist was 80% and 80% respectively.

Structured Out of Cell Time
Policy HS-19.12, section 3.4 states ICS inmates are provided ten (10) hours of structured out-of-cell activities weekly, which take place Monday through Friday.

The chart below includes structured out of cell time for ICS inmates as reported by mental health staff. This data was not audited by QIRM.

Structured Time Out-of-Cell (Groups, Community Meetings, QMHP Sessions, Psychiatry

Sessions, Etc.,)

	Quarter: July - September*								
	Week 1		Week 2		Week 3		Week 4		Average
	Total #	Total %	Total #	Total %	Total #	Total %	Total #	Total %	Total
n=	210	---	210	---	210	---	210	---	210
inmates getting 0 mins	0	0%	0	0%	0	0%	0	0%	0%
inmates getting between 0 & 5 hrs	200	95%	209	100%	210	100%	207	99%	98%
inmates getting between 5 & 10 hrs	6	3%	0	0%	0	0%	0	0%	1%
inmates getting 10 hours or more	0	0%	0	0%	0	0%	3	1%	0%

Data Source: Report Completed by Mental Health Staff

During the morning of November 13, 2018, we attended an ICS treatment team meeting/staffing and interviewed most of the F I ICS inmates in the community meeting setting. The process observed during the treatment team staffing meeting improved as compared to our previous site visit from the perspective of treatment planning.

The Fl ICS inmates were very complimentary of the treatment being provided although few inmates were being offered 10 hours of groups per week. They described the group treatment as being helpful as was individual treatment. In addition, good access to the psychiatrists and the QMHPs was reported by these inmates.
Clinical Staffing for the ICS was reported as follows:

1.58 FTE psychiatrists (# Hours/week on-site = 58.46)
0.37 Psychiatric Nurse Practitioner
8.0 FTE Mental Health Counselor (1.0 FTE vacancy)
3.0 FTE MHTs (1.0 F vacancy)
16.0 FTE RNs (14.0 FTE vacancies)
13.0 FTE LPNs (10.0 FTE vacancies)
4.0 FTE paramedics/tech (3.0 vacancies)

The above nursing staff cover for both GPH and Kirkland's ICS. Vacancies are covered, at least in part, by agency nursing staff.

Medication administration on an HS basis continues to occur around 4 :30 pm.

November 2018 Implementation Panel Recommendations:

1. Implement the proposed expansion of ICS.
2. Remedy the timing of hs medication administration

HLBMU

November 2018 Implementation Panel findings: During the morning of November 13, 2018, we interviewed all of the HLBMU inmates in two group settings. These inmates predominantly had very positive statements re: the treatment program in the HLBMU. Issues described during our previous site visit have been successfully resolved via the HLBMU program director and Warden Davis (e.g., access to the dining hall, not being cuffed when off the housing unit, etc.). The many group therapies offered to these inmates were reported to be very helpful to them.

We were very impressed with the continuing evolution of this program.

We also toured the physical plant of the proposed BMU at the BRCI, which has much more programming space than the current program.

November 2018 Implementation Panel Recommendations: We recommend that the current HLBMU inmates complete their program at the current location unless they want to be transferred to the new program at BRCI for several different reasons. They include allowing the culture at the new program to be established independent of the Kirkland BMU to avoid the inevitable conflicts that will arise related to "we didn't do it that way..." at Kirkland and to facilitate the termination process for these inmates from the BMU.

Please note that the above recommendation is only a recommendation and not a mandate. The potential advantage of not following this recommendation is that the culture of the program developed at Kirkland can be carried over to BRCI if both the staff and the inmates are transferred to the new program. If the staff are not transferred, maintaining the same culture will likely not occur and the potential for conflicts related to different correctional practices will increase as referenced above.

Regardless of which choice is made, the admission of new inmates to the BRCI HLBMU should be gradual to allow a therapeutic culture to be developed.

Camille Griffin Graham Correctional Institution

We interviewed 16 ICS inmates in a community meeting setting. They reported during the past 1-2 months being offered one hour of structured therapeutic group activities per day, which was a decrease from previous months. The groups were described as being helpful. Good access to their psychiatrist and individual counselors was described by these inmates. Many of these inmates reported having various cleaning jobs on the unit, which was clean in appearance.

Medication continuity issues did not appear to be present re: psychotropic medication but were described re: other types of medications.

We also interviewed most of the women on the C side of the Blue Ridge dorm, which included only two ICS inmates. A significant number of these women reported participating in one or more mental health groups per week, which were generally described as being helpful. Some access problems to the psychiatrist and counselors were reported by a minority of inmates. Both staff and inmates described various issues on this unit related to an increasing number of inmates housed on this unit with personality disorders. Medication continuity issues did not appear to be present although several inmates were very vocal re: the medications that were either prescribed or not prescribed to them. Many inmates reported having a job that was either on the unit or off the unit.

We discussed with staff issues re: community meetings on this unit. We recommended that such meetings occur at least twice per week and that staff debrief among themselves in a meeting that immediately follows the community meeting.

November 2018 Implementation Panel Recommendations:

1. Continue to increase the number of hours of structured therapeutic activities being offered to ICS inmates.
2. Community meeting recommendations as above.

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

Implementation Panel July 2018 Assessment. partial compliance

October 2018 SCDC Status Update:

GPH (Gilliam Psychiatric Hospital)

Policy HS-19.13, section 4.2.5 Individual Treatment*: All GPH inmates will be seen for individual treatment by their assigned psychiatrist and assigned QMHP. They may also be seen individually by other members of the Treatment Team as clinically indicated. Frequency of sessions is determined by clinical symptom presentation and treatment needs. Newly admitted inmates and acutely/severely ill inmates will be seen for formal individual sessions at least weekly. Individual interactions with the inmates that are of clinical significance or summarize behavior or treatment progress will be documented when they occur in the AMR. Longer term patients will be seen at least every other week.*

A random sample of 10 inmates was used to calculate the timeliness of sessions for QMHP and Psychiatry Sessions in GPH for the months of July 2018 – September 2018. The random sample of 10 inmates were selected from a database of inmates supplied by GPH and the sample of inmates used in this report, were selected from a larger sample size from that database.

Policy states that the "*Frequency of Session is determined by clinical symptom presentation and treatment needs*"; therefore, best practice has been established as "every other week" for QMHP sessions and Psychiatry sessions in GPH. Therefore compliance for both QMHPs and Psychiatry sessions will be calculated by inmate, based on whether they were seen "every other week".

A separate database was created from the random sample of name. QMHP and Psychiatry sessions dates were extracted from both the AMR (Automated Medical Record) or EHR (Electronic Health Record). The timeliness of QMHP Sessions were then calculated by individual inmate and on a month to month basis.

GPH Timeliness of Sessions

Based on data audited in NextGen and the AMR for July, August and September, the compliance rate for sessions with the QMHP was 50%, 20% and 20% respectively. The compliance rate for sessions with the Psychiatrist was 50%, 50% and 60%, respectively.

Structured Time Out-of-Cell (Groups, Community Meetings, QMHP Sessions, Psychiatry Sessions, Etc.,)

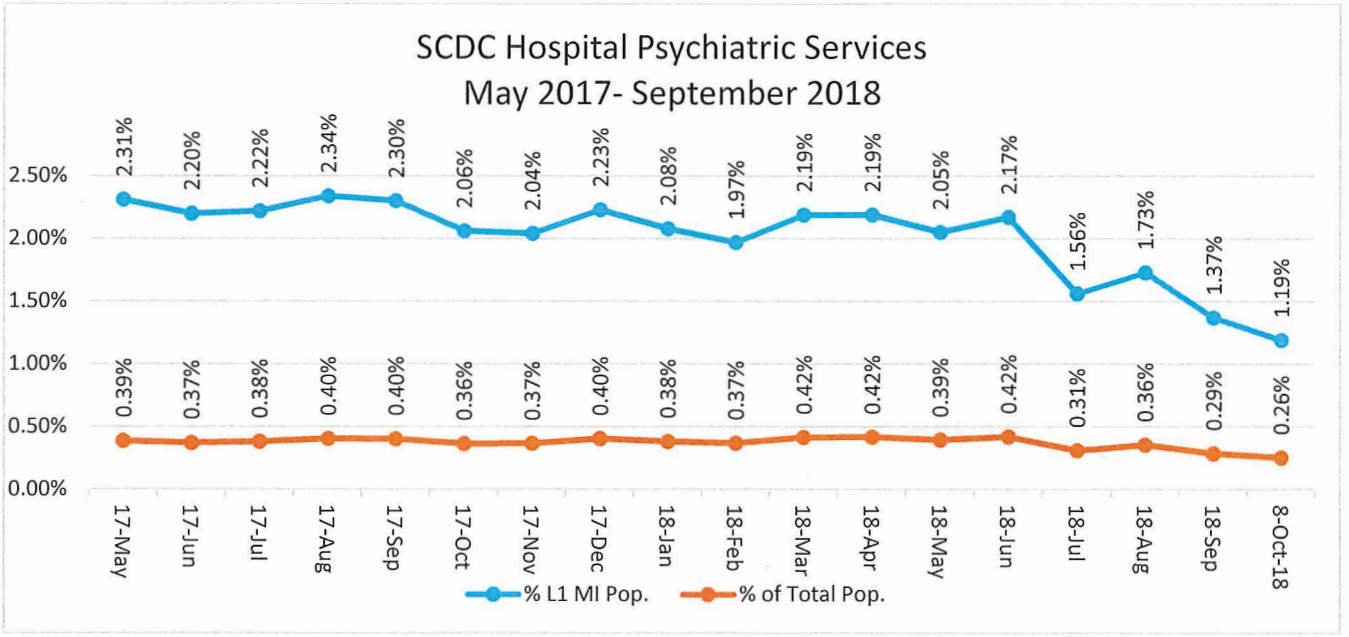
Per the report submitted by mental health staff, Inmates admitted and discharged during the month were deleted from the weeks they were not present. July 4th was holiday with limited staff and groups were not held on July 16 due to limited security personnel.

	Quarter: July - September*								
	Week 1		Week 2		Week 3		Week 4		Average
	Total #	Total %	Total #	Total %	Total #	Total %	Total #	Total %	Total %
n=	99	---	96	---	92	---	93	---	---
inmates getting 0 mins	33	33%	34	35%	46	50%	40	43%	40%
inmates getting between 0 & 5 hrs	50	51%	40	42%	24	26%	33	35%	38%
inmates getting between 5 & 10 hr	16	16%	10	10%	12	13%	16	17%	14%
inmates getting 10 hours or more	0	0%	9	9%	4	4%	2	2%	4%

Data Source: Report Completed by Mental Health Staff

Population of Inmates Hospital Psychiatric Services of Care (L1)

The chart below demonstrates SCDC's ability to track the percentage of L1 inmates in comparison to the mentally ill population and the percentage of the overall population. RIM produces and distributes a weekly M.I. Report for Inst., Female GEO Care and CoreCivic Population. For consistency, data are used from the last report produced each month.



Nurse's Station

GPH has received approval from DHEC for the use of the nurse's station and treatment room and required locks have been installed in the new nurse's station in GPH. Nurses are currently working in the units.

November 2018 Implementation Panel findings: As per current status section.

Our last report included the following:

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.

We interviewed most of the GPH patients, who were housed on the open unit (side A), in a community meeting setting. These inmates reported access to the recreational cages 1-2 hours per day and 1-2 groups per weekday (3 hours per group). Meeting with the psychiatrist on a weekly basis in a private setting was also reported by these inmates. They were very complimentary of the treatment program, which was described as being helpful. Medication management issues did not appear to be present. The major recommendation was having access to more group programming.

During the afternoon of November 12, 2018, we also interviewed six inmates housed on the closed unit in GPH (side B). These inmates described very limited access to out of cell unstructured time (1-2 hours per day) and very limited out of cell structured therapeutic treatment programming (1-2 groups per week).

The major barrier to providing adequate out cell structured therapeutic time for inmates housed on side B was described by staff to be lack of adequate correctional officer coverage, which is exacerbated by correctional officers on this unit commonly being pulled to cover areas other than GPH. Staffing analysis has previously identified the need for 37 additional CO's, and additional Sergeants and Lieutenants.

The nursing coverage provided at GPH is not being provided by psychiatric nurses, which has obvious ramifications in the context of establishing a therapeutic milieu. This appears to be directly related to the current job requirements for these GPH nursing positions. The nursing staff allocations and vacancies were as follows:

16.0 FTE RNs (14.0 FTE vacancies)
13.0 FTE LPNs (10.0 FTE vacancies)
4.0 FTE paramedics/tech (3.0 vacancies)

The above nursing staff cover for both GPH and Kirkland's ICS. Vacancies are covered, at least in part, by agency nursing staff.

As reported in the status update section the relevant policy states that the "Frequency of Session is determined by clinical symptom presentation and treatment needs"; therefore, best practice has been established as "every other week" for QMHP sessions and Psychiatry sessions in GPH." We do not agree that best practice is every other week clinical contact by a QMHP and a psychiatrist. Best practice would be minimally every week contact in an inpatient psychiatric setting.

The clinical staffing for GPH was reported as follows:

Total FTE as of November 2018 Staffing Plan FTE

Psychiatrists:	1.68 (67.25 hrs/week)	4.0
Psychologists:	.56 (22.50 hrs/week)	.5
QMHP's:	7.00 (2.0 FTE vacancies)	8.00
MHT's:	7.00	16 .0

Recreational therapists 3.0 FTEs 3.0
Bay Counselors 9.0 FTEs (2.0 FTE vacancies)
Hospital Administrator 1.0 FTE

Renovations at GPH have been completed with specific reference to the nursing stations.

November 2018 Implementation Panel Recommendations: We stated the following in our July 2018 report:

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

We again recommend the above. We also recommend that the nursing staff gradually be transitioned to a nursing staff with significant inpatient psychiatric experience.

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

Implementation Panel November 2018 Assessment: compliance (November 2018)

October 2018 SCDC Status Update:
The following graph measures compliance with the staffing goals agreed upon in the settlement agreement as well as the subsequent staffing plan agreed upon by the parties. There are some areas in which SCDC exceeded the goal for some positions and that information is not depicted in the graph.

Mental Health Settlement Position Summary					
Position			**Current Filled Positions**	**Target Filled Positions**	**Filled Percentage**
Psychiatrist *			14.00	14.00	100%
Counselors (Licensed, Masters level)			90.00	100.00	90%
Mental Health Technicians			30.00	30.00	100%
Activity Therapist			2.00	3.00	67%
Clinical Activity Supervisor			1.00	1.00	100%
Quality Assurance (QA) Director			1.00	1.00	100%
Quality Assurance Monitors			3.00	5.00	60%
Health Services Recruiter			1.00	1.00	100%
Administrative Support Staff (ICS)			9.00	9.00	100%
Psychologist PhD			3.00	3.00	100%
Staffing Totals			**154.00**	**167.00**	**92%**
General Medical Physician			2	2	100%
Nurse Practitioner/Physician Assistant			3	3	100%
Registered Nurse (RN) *			108	108	100%
Licensed Practical Nurse (LPN) *			89	89	100%
Staffing Totals			**202.0**	**202**	**100%**
Totals Staffing Levels			**356.00**	**369.00**	96%
***includes contract positions**					
Psychiatry reduced by 2 positions and QMHP's reduced by 12 positions as agreed					

November 2018 Implementation Panel findings: The significant decrease in mental health staffing vacancies, especially the psychiatrists, is very encouraging. Compliance is present in the context of meeting the goals of the Settlement Agreement staffing plan.

Despite this significant achievement, SCDC is aware of the need for increased mental health staffing allocations based on the significantly increased numbers of inmates identified with mental health problems that require psychiatric intervention. This need is demonstrated by the budget request submitted to the governor's office for such increased allocations.

November 2018 Implementation Panel Recommendations: Continue to advocate for needed mental health staff allocations.

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

Implementation Panel July 2018 Assessment: compliance (July 2017)

October 2018 SCDC Status Update:

ICS

There were thirty-nine ICS denials reviewed by the Denials Committee for July 2018. Of the thirty-nine cases, the Committee concurred with twenty-eight (28), did not concur with eight (8) and returned five (5) for reconsideration or for additional information and/or clarification. Follow-up decisions as reported by Division Director of BMHSAS is included as Appendix G.

HAB

There were five HAB denials reviewed by the Denials Committee for July 2018. Of the cases, the Committee concurred with four (4), did not concur with one (1) and did not return any for reconsideration or for additional information and/or clarification. A detailed summary outlining the denial dates, background and reasons for denials. There is no indication that any of the denials resulted in an admission when the Committee did not agree with the program's decision based on the information provided.

Denial Reviews July 2018		
	ICS	**HAB**
Total Program Denials	39	5
Concurrence	26	4
Non-concurrence	8	1
Returned for Reconsideration/Clarification	5	0

November 2018 Implementation Panel findings: Staff were unclear whether the findings/recommendations of the Denials Committee were followed by the relevant program. It was also our understanding that the Denials Committee was also unaware of the outcome of their findings.

November 2018 Implementation Panel Recommendations: Future data should include the actual outcome of the Denials Committee's recommendations. It is our recommendation that the Denials Committee's name be changed (e.g., clinical assessment team), which could be used for both higher level of care rejection appeals and for consultation purposes re: recommended level of care. The appeals decision made by this team should be binding on the two institutions involved in the case.

2b. Segregation:

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

Implementation Panel November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:

Policy OP-22.38 section, 23.1 states the following, All inmates, as part of the intake and initial case management review at RHU, must be assessed by a behavioral/mental health staff member… If confinement continues after completion of the 30 day assessment, a behavioral/mental health staff member will assess inmates classified as mentally ill every month. Therefore, compliance for individual sessions with the QMHP was calculated based on monthly sessions for those inmates who met the above criteria, and by level of care for those who did not.

A random sample of 10 inmates were used to calculate the timeliness of sessions for QMHP sessions and Psychiatrist sessions in RHU for the months of June 2018 – September 2018. The

random sample of 10 inmates were selected from a database of inmates provided by mental health staff. All RHU inmates in the sample have a mental health classification.

The charts below illustrate timeliness of sessions with the QMHP and Psychiatrist for mentally-ill inmates in the RHU for Broad River, Evans, Lee and Lieber. Camille Graham was not included in this analysis because their report regarding inmates in the RHU was not received timely. Kirkland did not provide a report for this section.

Broad River
Based on data audited in NextGen and the AMR for June, July, August and September, the compliance rates for sessions with the QMHP was 70%, 80%, 50% and 60% respectively. The compliance rates for sessions with the Psychiatrist was 80%, 90%, 40% and 60% respectively.

Evans
Based on data audited in NextGen and the AMR for July and August, the compliance rates for sessions with the QMHP was 70% and 90 % respectively. The compliance rate for sessions with the Psychiatrist was 10% and 80%, respectively.

Lee
Based on data audited in NextGen for July, August and September, the compliance rate for sessions with the QMHP was 33%, 20% and 10% respectively. The compliance rate for sessions with the Psychiatrist was 33%, 0% and 10%, respectively.

Lieber
Based on data audited in NextGen and the AMR for July and August, the compliance rates for sessions with the QMHP was 50% and 80 % respectively. The compliance rate for sessions with the Psychiatrist was 40% and 40%, respectively.

An email from the Assistant Deputy Director of Operations dated October 12, 2018 indicates that all Area Mental Health (L3) SD inmates except those inmates who cannot be housed at BRCI due to security reasons will be transferred to Broad River's RHU. Institutions were instructed to begin coordinating transfers and provide weekly status updates of the moves. All AMH SD inmates.

Two inmates from each of the following institutions will be transferred: Evans, Lee, Lieber and Perry.

November 2018 Implementation Panel findings: As per status update section. The data re: lack of compliance with timely mental health contacts remains extremely problematic and continue to be related to correctional staff vacancies and the prolonged institutional lockdown.

We previously recommended the following:

> SCDC should identify strategies that could potentially immediately remove all inmates in RHU on Security Detention status with the Mental Health Designation Levels 1, 2, 3.

A QI Study should be conducted to assess why a high number of inmates that graduated from the LLBMU in March 2018 have been placed in RHU.

Since the above recommendation, 34 such inmates have been transferred to either a general population unit or to the BMU.

The QI re: LLBMU outcomes included the following:

About half of the inmates who graduated from the LLBMU in February returned to lock-up within 3 to 7 months of their graduation. However, none of the inmates were placed on Security Detention status, which was their original status before transferring to the LLBMU program. Three of the inmates who returned to lock-up had offenses that were serious – including attempted escape, striking an employee, and possession of a weapon. Other offenses that resulted in the inmates' return to lock-up were less serious issues that were pertaining to contraband, including possession of a cellphone or drug possession.

All the inmates who returned to RHU continued to receive appropriate and consistent Mental Health assessments, evaluations, follow-ups, and treatment as needed. Given the nature of the inmates' mental illness and behavioral issues, as evidenced by the above results, there is approximately a 50% chance that inmates who graduate from the LLBMU program will continue to exhibit behavioral problems once they leave the program. Those who transferred to a different institution altogether were more likely to present with serious offenses. The receipt of mental health services did not have an impact on the inmates returning to lock-up, as they all received consistent mental health care.

Planned Actions
QA will continue to review and assess the effectiveness of the LLBMU program and provide the appropriate mental health services to inmates while in the LLBMU to help prevent behaviors that result in a return to lock-up status. It is important to note, although 47% of inmates did return to RHU, none were placed on Security Detention status. This study will be shared with LLBMU staff to continue addressing the criminal thinking element of the program.

November 2018 Implementation Panel Recommendations:

1. Continue to QI outcomes re: graduates of the BMUs.
2. Remedy the above referenced issues.

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

Implementation Panel July 2018 Assessment: noncompliance

October 2018 SCDC Status Update:
The Lockdown Release Schedule (As of October 2, 2018) is outlined below:
1. Ridgeland CI – all units tiering

2. Evans CI – all units tiering
3. McCormick – tiering began 9/24 (one unit at a time)
4. Kershaw – tiering began week of 9/24 (one unit at a time)
5. Tuberville – tiering began 10/1 (one unit at a time)
6. Lieber – start date for search 10/9 – approximately 2 weeks to search and issue new uniforms
7. Broad River – start date tbd
8. Lee (Incident Occurred) start date tbd

***All character units are not locked down throughout the state.

To mitigate conditions of confinement within the RHUs, crank radios have been distributed in some of the RHUs.

The following graph summarizes the number and percentage of inmates in the RHU who have received radios.

Question	Crank radios in RHU?	What is the total number of radios that have been provided to this RHU?	What is the total number of radios that have been distributed in this RHU?	Percent of Contracts received by inmates in RHU	How are they assigned?	Do you need more?
Allendale	Yes	145	82	57%	By number	Yes
Broad River	Yes	100	21	21%	I/M signs contract	Yes
Evans	Yes	10	10	100%	Log	Yes
Graham	Yes	60	32	53%	I/M signs contract	Yes
Kershaw	Yes	55	32	58%	I/M signs contract	Yes
Kirkland	Yes	30	21	70%	DD & YOA's	Yes
Leath	Yes	19	13	68%	At least 3 days good behavior	Yes
Lee	Yes	88	88	100%	Radio assigned to cell	Yes
Lieber	yes	120	12	10%	N/A	Yes
McCormick	Yes	46	0	0%	I/M signs contract	Yes
Perry	Yes	100	100	100%	Log	Yes
Ridgeland	No	N/A	N/A		N/A	Yes
Trenton	Yes	47	46	98%	Log	Yes
Turbeville	Yes	50	44	88%	Issued	Yes

Tyger River	Yes	70	70	100%	Issued	No

Televisions

Per the Office of Operations, of the fifteen (15) institutions that requested televisions for the RHUs, fourteen (14) have completed installation. Overall 97% of requested televisions have been installed in the restrictive housing units agency-wide. Nineteen of the twenty-four televisions have been installed at Evans CI; however, work is ongoing to complete this project. A spreadsheet detailing progress is included as Appendix H.

Out-of-cell Recreation

Per the reports completed by institutional staff, most institutions did not offer outside recreation during the reporting period of June 2018 – September 2018. Recreation reported for Broad River and Camille is as follows:

Broad River

Per the report completed by the DW of Compliance the institution was on lockdown between June-September been on a statewide lockdown, which resulted in no recreation offered. RHU began to offer outside recreation on 9/27/18. The institution reports 12 inmates with approximately least 1 hour of recreation. These reports were confirmed through the OATS system.

A check of the OATS system shows there is documentation of recreation for 12 inmates on September 27, 2018, lasting about 1 hour per inmate.

Camille Graham

Based on data audited in the OATS for 1 week during each of the months of June, July, August and September, the rates for the percentage of inmates offered recreation at least 3 times during a week were 70%, 100%, 80% and 40% respectively. The rates for the percentages of inmates who were offered recreation 4 times during a week for the same months are 0%, 50%, 50% and 20% respectively.

November 2018 Implementation Panel findings: As per status update section. It is very concerning that most institutions did not offer outside recreation during the reporting period of June 2018 – September 2018 and are now only offering very limited access to out of cell recreational time.

Broad River Correctional Institution

November 2018 Implementation Panel findings: Conditions of Confinement continue to be impacted by correctional staff shortages. The system-wide lockdown has further exacerbated BRCI being able to provide basic services. Staff reported that showers are now being offered to RHU inmates on a three times per week basis. Outdoor recreation was reported being offered on Tuesdays and Thursdays for one hour each day.

A member of the Implementation Panel visited the BRCI on November 16, 2018. Inmates reported receiving showers three times weekly; however, disputed outside recreation was being provided.

Sanitation levels had marginally improved. Inmates complained cell maintenance issues were not addressed in a timely manner.

RHU inmates reported they had not received crank radios.

November 2018 Implementation Panel Recommendations:

Remedy the identified deficiencies and begin providing basic RHU services. Continue QI studies monitoring BRCI efforts to improve RHU conditions of confinement.

Lee Correctional Institution

During the morning of November 14, 2018, the IP briefly toured the RHU and interviewed at the cell front about 10 inmates. At least four of these inmates reported psychotic symptoms and one stated he had 4 CSU admissions during past six months. They reported access to showers but much less than a three per week basis. Similar to information obtained from staff, these inmates have not had access to out of cell recreation since the April 2018 lockdown. The unit was very dirty. Maintenance issues in the unit are not being addressed. RHU Supervisory staff reported approximately 20 cell lights were non-operational. A brief sample of the daily activity sheet indicated that 30-minute checks were not being completed.

Staff reported that on the day of the site visit that the RHU was allocated 17 FTE correctional officer positions with only 3.0 FTE positions filled. Related to staff shortages and a small number of inmates "dashing" (i.e., throwing urines and feces) at staff, it was not uncommon for nursing staff to not administer medications in the RHU once or twice per week.

Lee CI was reported to be scheduled to begin "tiering" after all of the other prisons have begun the tiering process. The date for Lee CI to begin such a process appeared to not yet be known.

Crank radios have been distributed to many of the RHU inmates. TVs were present in the RHU hallway that immediately face the cells.

Our July 2018 report included the following:

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

November 2018 Implementation Panel Recommendations: The conditions of confinement in the RHU are deplorable with little end in sight due to the chronic correctional officer shortages. These conditions put inmates with a mental illness at high risk of deterioration. Inmates without a mental illness are at significant risk of experiencing significant emotional distress that will

likely exacerbate behavioral dysfunction that led to their initial placement in RHU.

Related to the difficulties re: medication administration in the RHU, inmates with insulin dependent diabetes have been transferred to other institutions where such problems do not exist to the same extent. A similar argument can be made with respect to inmates in the RHU with a mental disorder diagnosis (i.e., such inmates should not be in a RHU with such conditions of confinement). These factors are extemely problematic for meeting the mental health needs of the population and compliance with the Settlement Agreement.

Evans Correctional Institution RHU

During our November 14, 2018 site visit, the RHU census was 100 inmates, which included 31 inmates on the mental health caseload. Inmates were reported to be offered showers on a two times per week basis. RHU inmates have not had access to outdoor recreation since 2017 due to chronic correctional vacancies (currently 42% for frontline COs). The unit was reasonably clean.

Lieber Correctional Institution RHU

During the morning of November 15, 2018, we briefly visited the RHU at the Lieber CI. The unit was clean and relatively quiet. Inmates confirmed that they were receiving 1-2 showers per week and were generally offered one hour per week of outdoor recreational time. Out of cell clinical contacts were being provided via a designated two days per week "mental health day." Medication management problems did not appear to be present. Four safety cells were present in the RHU. The two safety cells inspected by the IP were suicide resistant.

We attended a mental health treatment team meeting and observed the staffing of five inmates. The meeting was attended by a psychiatrist, classification officer, deputy warden for treatment, QMHPs, correctional officer and nursing staff. Each inmate attended the staffing, where their treatment plan was reviewed with the team. The process was conducted in a very respectful manner.

We were impressed by differences in the RHU environment/milieu at the Lieber RHU as compared to the Lee CI RHU, which was due, at least in part, to the improved conditions of confinement despite the significant correctional officer vacancies.

Camille Griffin Graham RHU

Twenty of the 39 RHU inmates were on the mental health caseload.

Inmates reported that two RHU groups per day are provided to mental health caseload inmates. RHU inmates reported generally being offered one hour per weekday of outdoor recreation, showers three times per week. Access issues to the psychiatrist were not present. Medication management issues did not appear to be present. Inmates complained requests to meet with their assigned QMHP were not being addressed.

Inmates consistently praised the staff for providing crank radios. The unit was clean and quiet.

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

Implementation Panel November 2018 Assessment: noncompliance

October 2018 SCDC Status Update
See report in *2.b.i*
November 2018 Implementation Panel findings: See 2.b.i.

November 2018 Implementation Panel recommendations: See 2.b.i.

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

Implementation Panel November 2018 Assessment: partial compliance

October 2018 SCDC Status Update
Per Operations, the Special Concerns unit is now scheduled to begin in mid-January 2019. Selections for the two vacant Associate Warden positions at Evans were made the week of October 14, 2018, with effective start dates for the AW of Programs to be 10/17/18 and the AW for Operations to be 10/22/18. [redacted] will be the AW for Programs and [redacted] will be the AW for Operations. Together, they will work with Warden [redacted] Regional Director [redacted], and Assistant Deputy Director for Programs [redacted] to develop the program designed to address issues of inmates afraid to live in general population and to prepare them for moving from restrictive housing back into the mainstream. The two new Associate Wardens will visit Virginia with Ms. [redacted] in the near future to review a similar program there before tailoring their approach to the specific needs of SCDC.

Programming is expected to be geared towards the specific needs of the individuals currently housed in restrictive housing to ensure that they have resources towards preparation for reintegration, and a safe environment to move to as they transition to general population. The program will use institutional staff, select volunteers, and mentors from Character Units to address the needs of the targeted inmate population. By developing additional character based housing at Evans, those targeted inmates should feel safer transitioning into the general population there.

November 2018 Implementation Panel findings: As per status update section. We toured the housing unit at Evans CI that will become the Special Concerns Unit. The program is still under development. We expressed concerns that recruitment of both correctional officers and QMHPs for this program will be very difficult based on the history at Evans CI re: relevant staff vacancies, which has clear program implications.

November 2018 Implementation Panel Recommendations: Please send us the pertinent policy

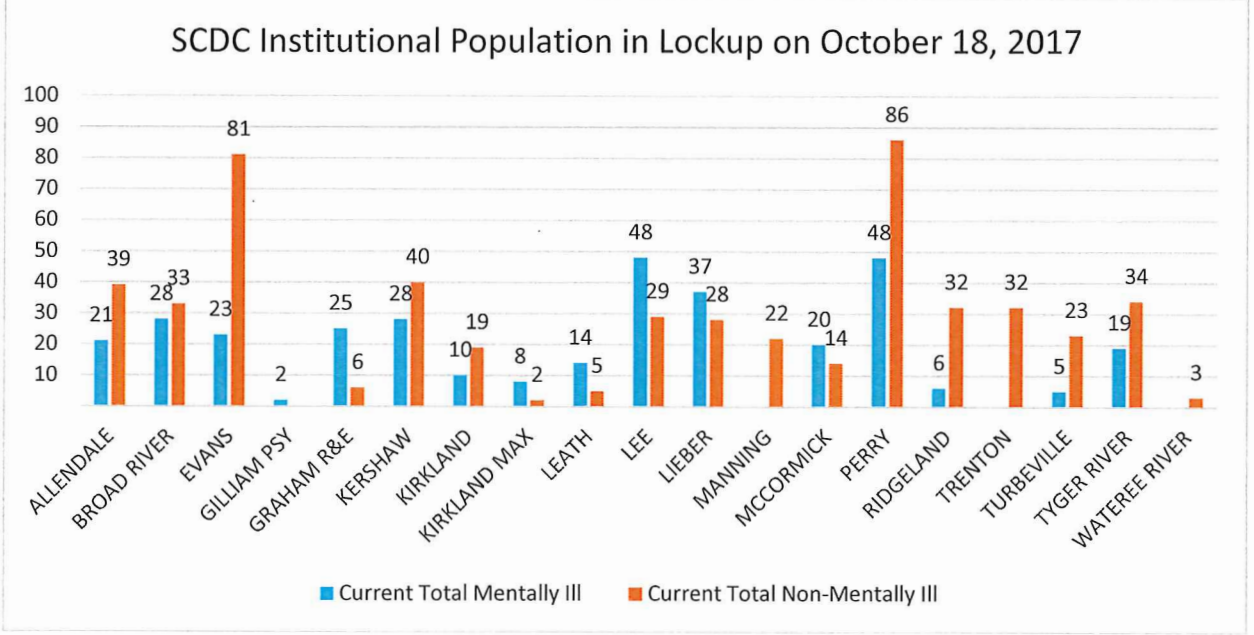
and procedure re: the Special Concerns Unit when it has been developed.

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

Implementation Panel November 2018 Assessment: compliance (November 2016)

October 2018 SCDC Status Update

RIM continues to produce and distribute weekly reports showing the SCDC institutional population in lockup by institution, custody and mentally health classification.



Data Source: RIM Report

The Mental Health Disciplinary Treatment Team (MHDTT) serves the function of allowing mental health care providers the opportunity to provide input in the disciplinary hearings of mentally ill inmates and offer alternative sanctions to lengthy stays in lockup. The Division of BMHSAS completed a CQI study to determine whether MHDTT meetings are effective in decreasing the number of mentally ill inmates in segregation and in reducing the amount of segregation time that inmates are given due to disciplinary problems.

The study included a random sample of inmates from all the inmates at Lee, Kirkland – ICS, HLBMU, and GPH, Lieber, and Evans Correctional Institutions who had disciplinary infraction reviews completed by QMHPs for possible alternative sanctions to be issued in the months of June 2018 to September 2018.

Of the 25 inmate cases reviewed, three (3) cases had alternative sanctions issued as a result of the

inmate's mental illness. The majority of the cases, 24, reviewed had inmates who were deemed competent and/or appeared to be stable at the time of the disciplinary hearing and when the Mental Health Disciplinary Statement was completed.

The results evidence that few alternative sanctions are being offered to mentally ill inmates, and those inmates who incur disciplinary infractions, overall, still serve extended periods of time in segregation. A significant percentage of the inmates who still receive extended lock-up time are inmates with an L3 mental health classification.

Additional details and planned actions are included in the Patterson Document Drop, folder 6-Quality Improvement-Assurance, subfolder 21. The document is entitled *CQI Study DHO Alternative Sanctions for MI.*

November 2018 Implementation Panel findings: The above findings are very concerning. We agree with the planned actions, which are as follows:

> Follow-up with the Wardens and Mental Health Supervisors, reiterating the purpose of this process as it relates to identifying sanctions that align with the inmate's symptomology and reducing the amount of time an inmate is housed in restrictive housing. Coordinate with the Division of Operations recommending this metric is added to the Division of Operations dashboard to be additionally monitored by Regional Directors.

November 2018 Implementation Panel Recommendations: As above and QIRM should continue to perform CQI studies. The SCDC planned action is critical for the provision to remain in compliance.

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

Implementation Panel November 2018 Assessment: partial compliance

October 2018 SCDC Status Update

As a part of the overall agency quality management plan relative to the Settlement Agreement and practices impacting areas under the purview of Operations, institutional staff were identified to assist leadership with collecting documentation, analyzing, reporting, presentation and monitoring of information at the institutional level. Among these reports included reports to monitor the documentation of cleanliness and temperature of segregation cells.

Operations provided a training for five institutions (Kershaw, Evans, Manning Lieber and Perry) on October 3, 2018 to train staff on entering temperatures in the automated system).

The entry of temperature and sanitation information in this system is intended to assist in tracking that data temperature and sanitation issues.

Institutions reported results of temperature and cell checks for the reporting period. To audit this information, QIRM conducted a CQI evaluating the temperature and cleanliness of segregation cells as self-reported by the officers in Broad River CSU and RHU; Camille CSU and RHU; and Kirkland's D-Unit, F-1, and GPH; Evans RHU; Lee RHU; and Lieber RHU. The results of the audits substantiated the information included in the institutional reports. One exception was for Evans where it was reported that a large percent of the cells with an Out-of-Range Temperatures, had corrective action taken to correct the problem. The review of the documentation reported that in most of these instances the documentation stated that the inmate had a blanket. A more appropriate response for compliance would be that the inmate was provided with n addition blanket, if this was the action taken to address the deficiency.

A summary QIRM's CQI results is as follows. The CQI study with detailed analyses of each institution is included as Appendix I.

June - Sept 2018 Institution / Average (MEAN)	Mean % Eligible Cells Checked (8 Cells/Day Minimum)	Of those Cells Checked, Mean % that Had Temperature Checked	Of the Temperatures Checked, Mean % Temperatures Within Acceptable Range (68^0-78^0)	Of the Out-of-Range Temperatures, Mean % >+/- 8^0 Out of Range (<60^0 or >86^0)	Of the Out-of-Range Temperatures, Mean % Addressed with Corrective Action	Of Cells Checked, Mean % Cell Cleanliness /Sanitation Checked	Of the Cells Checked for Cleanliness /Sanitation, Mean % Within Normal Limits	Of Cells Needing to be Cleaned, Mean % Addressed with Corrective Action
Broad River CSU	75%	100%	98%	0%	25%	100%	100%	0%
Broad River RHU	19%	100%	94%	4%	4%	100%	99%	0%
Camille RHU	70%	100%	70%	0%	47%	100%	74%	17%
Camille CSU	38%	100%	99%	0%	0%	100%	99%	50%
Evans	100%	100%	87%	16%	6%	100%	86%	65%
Kirkland D-Unit	62%	100%	95%	0%	1%	97%	95%	5%
Kirkland F-1	0%							
Kirkland GPH	7%	100%	68%	0%	0%	100%	93%	22%
Lee RHU	88%	100%	91%	20%	1%	100%	96%	2%
Lieber RHU	0%							

November 2018 Implementation Panel findings: Based on the QIRM data several correctional institutions monitoring cells for sanitation and temperature are at an unacceptable level. When deficiencies are identified corrective action is not taken to address the deficiencies. RHU inmates complained supplies were not provided to clean their cells on a regular basis. The exception being CGCI where inmates are provided cell cleaning opportunities two times per week. CGCI also had the cleanest RHU of any visited by the IP Panel.

November 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 uploaded in the shared file;
3) SCDC QIRM continue to perform QI Studies regarding Correctional Staff performing daily, random cell temperatures and cleanliness inspections.

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

Implementation Panel November 2018 Assessment: partial compliance

October 2018 SCDC Status Update

The following update highlights changes to SCDC's overall quality management program to include quality management of segregation practices and conditions.

Operations Quality Management and Reporting

Development of a dashboard

- The current dashboard requires institutions to report: the number of SD boards conducted, number of inmates in RHU that are DD/ST status over 60 days, number of inmates in Protective Concerns status and how many inmates Protective Custody boards are held. Each dashboard conference call covers the last two weeks of data. Discussions are held with the wardens and staff about these components and how to address them.

Monthly conference calls

- Operations Regional Directors lead monthly conference calls with an interdisciplinary institutional team to include, mental health, operations/security, classification, and medical to address items from the dashboard.

Institutional Monitoring and Reporting

Training for Operations staff for agency reporting

On August 21, 2018, Assistant Deputy Director of Operations, Mr. [redacted] sent an email to the wardens of the institutions being visited for this current site visit requesting staff to be identified to assist with collection of documentation and reporting required of Operations related to the Settlement Agreement's reporting. Identified staff from Evans, Kirkland, Lee, Lieber and Perry Correctional Institutions participated in a training for data reporting on September 7, 2018 led by Deputy Wardens of Compliance for Broad River CI and Camille Graham CI, Tamara Collins and Brandi Lathan.

Topics covered in this training included: Organization of documentation, Acceptable documentation, and frequency of data collection and reporting.
Reporting areas included the following:

- Cell Check Logs
- 15-Minute CI Cell Checks
- Cleanliness and Temperature

- Constant Observation
- Showers
- RHU Required Visitation by Operations Staff
- Institutional Restraint Chair Usage
- Planned vs. Unplanned UOF in MH vs. NMH Inmates

The agenda and participation log for the training are included as Appendix J. QIRM's proposed plan for reporting for Operations is included as Appendix K.

QIRM Audits

Because data and reports were submitted early October, QIRM staff audited timeliness of sessions with QMHP and psychiatry, MH assessments for mentally ill and non-mentally ill inmates and, temperature and sanitation, cell check compliance, weekly rounds by MH staff, RHU staff visitation, recreation and showers. This information is included in the institutional audits in the Patterson document drop, folder 6- Quality Improvement-Assurance, QIRM Institutional Audits folder.

ICQMC Meetings

Institutional ICQMC meetings will be held during the week of October 29, 2018.

November 2018 Implementation Panel findings: SCDC continues to develop their formal quality management program under which segregation practices and conditions are reviewed. Per the Status Update audits and meetings are scheduled to address deficiencies.

November 2018 Implementation Panel Recommendations: Continue to develop the SCDC formal quality management program to review segregation practices and conditions. Ensure Operations has sufficient qualified staff at institutions before relevant continuous quality improvement responsibilities are transitioned from QIRM.

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 November 2018 Assessment: partial compliance

October 2018 SCDC Status Update

In the event of Use of Force on a Mental Health Caseload Client, the MH UOF Coordinator conducts a Mental Health Case Review to include a review of documentation in the AMR and/or NextGen records. The Coordinator reviews recent Psychiatry visits to determine if Psychiatry visits are occurring every 90 days or more as clinically indicated. If he determines Psychiatry visits are not occurring as prescribed by the inmate's level of care, the Coordinator will contact Clinical Supervisor for resolution.

The Coordinator tracks by way of Excel spreadsheets, Qualified Mental Health Professional follow-up (or lack thereof) to uses of force involving inmates on the Mental Health Caseload.

This will be tracked through the automated Use of Force screen in the SCDC secure login. The Coordinator determines from the AUOF system, the frequency of QMHP involvement prior to a use of force and after a use of force and if security staff contacted the QMHP as outlined by policy and procedure. He also tracks the time when a call is placed to a QMHP after hours and the time of the response. When it is determined that protocol has not been followed or other reasons a timely response was not received, a report is sent to the BMHSAS Division Director for further action as he deems appropriate.

Mental Health UOF has formalized procedures to review use of force incidents involving inmates with a mental health designation which outlines the goals, processes and responsibilities for this position. The detailed procedure and responsibilities the MH UOF Coordinator is included as Appendix L.

November 2018 Implementation Panel findings:
The SCDC Division of Behavioral Health has developed formalized procedures to review UOF involving inmates with a mental health designation. The MH UOF Coordinator and Operations Administrative Regional Director are working closely together to address UOF issues. QIRM staff continues to meet weekly with Operations Leadership and the MH UOF Coordinator to discuss UOF and other relevant issues. During the meetings, QIRM 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. Disproportionate UOF involving inmates with mental health designation remains an issue. Restraint Chair use is the exception with SCDC having only having two uses of the restraint chair for the relevant months.

November 2018 Implementation Panel Recommendations:

1. SCDC continue to monitor all Use of Force incidents to identify and address the reasons for disproportionate Use of Force involving inmates with mental illness;
2. SCDC formalize the draft policy to review inmates with a mental health designation that are involved in use of force incidents.
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. IP Panel Mental Health Experts review the draft policy regarding review of UOF incidents involving inmates with a mental health designation.

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 November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:
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. QIRM reports have been updated to include K-9 use, or lack thereof. The October 2018 update is included as Appendix M.

QIRM's UOF Reviewers continue to monitor and review the Use of Force Incidents entered into the Automated Use of Force System and complete a daily review of MINs. 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.

A new MIN code for the canine (K-9) has been created to capture any time the K-9 team is used in a UOF. This MIN Code was created for use whenever the Special Operations K-9s are used for situational purposes. Canine Team refers to one (1) dog assigned to one (1) handler who is, at a minimum, a Class II Correctional Officer certified in proper canine training. Canine team presence is the same as officer presence in the use of force continuum to prevent situations from occurring. This code (1062) will be used when canine teams are deployed to assist other officers/agents in crowd control or management of one or more inmates as permitted by agency policy.

UOF Training

According to the RIM report, *Number of SCDC Employees who have Completed Use of Force Training in Basic January 1, 2018 - October 15, 2018,* 752 have completed this training. This is the number of people who have completed basic training this year and includes staff that may no longer be at SCDC. In CY 2018 UOF training has only been taught as part of basic training and has not been offered as an in-service course this year.

November 2018 Implementation Panel findings:

Per Status Update. SCDC has revised the applicable UOF Reports to include Canines. There were no UOF incidents identified involving canines for the relevant months. SCDC Operations Leadership and QIRM has made progress addressing Chemical Agent MK9 use through additional oversight and training. Although more progress is needed, the developed action plan appears to be making an impact. Revisions to the Housing Unit Post Orders requiring *Cover Teams* to use MK-9 consistent with manufacturer's instructions has not been provided the IP.

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

SCDC had two incidents during the relevant period that required restraint chair use: June (1) and August (1). A documented review for each restraint chair use was conducted. UOF Reports identified that hard restraints were utilized a total of two times. The IP was not provided data on the amount of time the inmates remained in hard restraints nor was information provided regarding whether an assessment was conducted to determine if SCDC guidelines for hard restraint use were followed.

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

SCDC has been unsuccessful providing UOF Training for In-Service for existing employees. As of September 30, 2018, 97.6 percent of the required SCDC employees have not completed the necessary UOF training for the Calendar Year 2018. The SCDC UOF Training for Calendar Year 2019 has been revised and it is critical required staff receive the UOF training.

November 2018 Implementation Panel Recommendations:

1. Operations, the MH UOF Coordinator 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. Operations and QIRM begin tracking the amount of time inmates remained in hard restraints and perform assessments to determine if SCDC guidelines for hard restraint use were followed;
3. QIRM continue to meet weekly with Operations leadership and the MH UOF Coordinator to discuss UOF and other relevant issues;
4. Revise Housing Unit Post Orders requiring *Cover Teams* to use MK-9 consistent with manufacturer's instructions;
5. Revise the MINs Electronic Form to include the Mental Health Classification of inmates involved in UOF;
6. Revise the SCDC UOF policy and require an annual review of the Agency List of approved UOF instruments and munitions;
7. Required Staff complete Use of Force Training in Calendar Year 2019.

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 November 2018 Assessment: compliance (July 2017)

October 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 June- August 2018 of inmates being placed the crucifix or other positions that do not conform to generally acceptable correctional standards.

November 2018 Implementation Panel findings:

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

November 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 November 2018 Assessment: compliance (March 2018)

October 2018 SCDC Status Update:

During October 2018, the Division of Quality Improvement & Risk Management (QIRM) reviewed SCDC restraint chair usage agency-wide, for the period June 1, 2018 through August 31, 2018. HS-19.08 § 2.8.6. Data sources queried were SCDC Management Information Notes (MINs), automated Use of Force Reports, Incident Reports and video records.

Reviewers identified two restraint chair incidents during this reporting period; one involved an inmate with a mental health classification.

Restraint Chair Usage at a Glance

MIN Number	Date	Institution	Inmate	Mental Health Status	Time in Chair
[redacted]	6/15/2018	Evans CI	INMATE 1	NMH	120 min.
	8/28/2018	Broad River CI	INMATE 2	L3	42 min.

Table 1: A review by the Division of Quality Improvement & Risk Management identified two restraint chair incidents in SCDC Institutions during the period June 1, 2018 – August 31, 2018. The incidents did not occur in the same institution. One incident involved an inmate with a mental health classification. The average time of restraint reported was 81 minutes.

Source: Management Information Notes, Use of Force Reports.

The maximum allowable period of restraint in a restraint chair, for security purposes, is three hours. (Restraint exceeding two hours requires medical assessment.) OP-22.01 § 13.5. For medical purposes, a physician may initially order restraint in a restraint chair for up to four hours, renewable in increments of up to four hours. HS-19.08 § 2.4. In neither incident this reporting period was the inmate remain restrained for the maximum period allowable by policy; however, the duration of use for security purposes was for the maximum period allowable without medical assessment.

The detailed report for Restraint Chair Use is included as Appendix N.

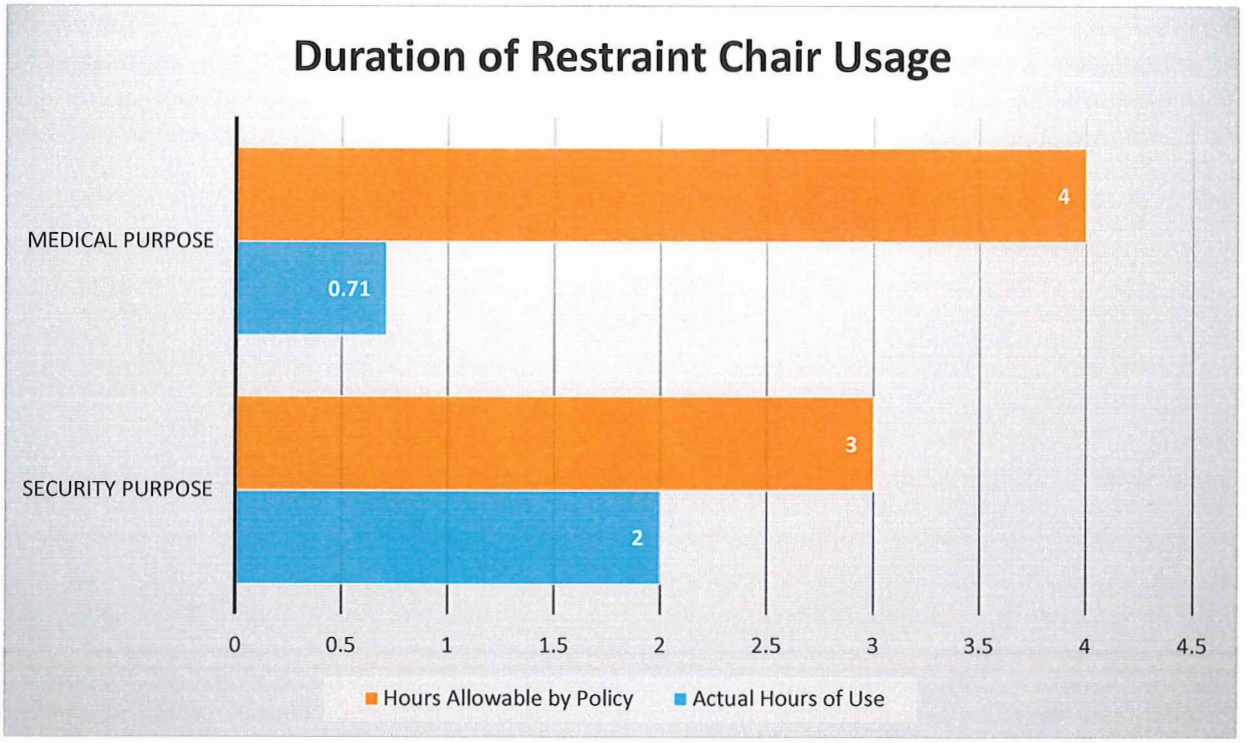


Table 2: A review by the Division of Quality Improvement & Risk Management identified one use of a restraint chair for medical purposes and one use for security purposes in SCDC Institutions during the period June 1, 2018 – August 31, 2018. The duration of the use of the medically ordered use was 43 minutes (0.71 hour) – 18% of the allowable initial restraint order (4 hours). The duration of the use for security purposes was 120 minutes (2 hours) – 66% of the maximum period allowable (3 hours), 100% of the maximum period allowable without medical assessment (2 hours).
Source: Management Information Notes, Use of Force Reports.

November 2018 Implementation Panel findings:
As per status update sections. There were two (2) reported uses of the restraint chair: June (1) and August (1). The June 18 Restraint Chair use was on the orders of Operations and the August 18 Restraint Chair use was by Mental Health order. The inmate placed in the restraint by Operations remained for 120 minutes and the inmate placed by Mental Health remained for 43 minutes. Both restraint chair uses were reviewed by SCDC officials with recommendations for improvement. The inmate placed in the restraint chair by Operations did not appear to meet SCDC guidelines for placement. Alternatives were not exhausted and written and video documentation indicate the restraint chair was initiated at a time when the inmate was not disruptive, nor a threat of physical harm to himself or others, nor actively damaging state property. SCDC has been very successful in limiting restraint chair use and remains in compliance. UOF Reports identified that hard restraints were utilized a total of two times during the relevant period. The IP needs data on the amount of time inmates remained in hard restraints and whether SCDC guidelines for hard restraint use were followed.

November 2018 Implementation Panel Recommendations:
QIRM continue to track and monitor compliance with use of the restraint chairs. Inmates placed in hard restraints should be monitored and tracked by QIRM in addition to restraint chairs to

include: compliance with guidelines and the amount of time in hard restraints.

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

Implementation Panel November 2018 Assessment: compliance (December 2017)

October 2018 SCDC Status Update:

The QIRM Use of Force Reviewers were able to substantiate the length of time for the inmates were placed in the restraint chair during this reporting period as reported in 2.c.iv.

MIN Number	Date	Institution	Inmate	Mental Health Status	Time in Chair
[redacted]	6/15/2018	Evans CI	INMATE 1	NMH	120 min.
	8/28/2018	Broad River CI	INMATE 2	L3	42 min.

November 2018 Implementation Panel findings:
Per SCDC update. QIRM collects data and issues quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs. For the two restraint chair uses in the relevant period, the time inmates were in the restraint chair followed SCDC guidelines: 120 minutes and 43 minutes respectively (SCDC Update time of 42 minutes differs from the SCDC Restraint Chair Report of 43 minutes).

November 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 November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:
A system to track employee corrective action has been in place for since 1998 within SCDC. Documents included in the Sparkman document drop, *3f, Use of Force*, provide, by institution, all corrective action imposed for staff for the current reporting period.

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

UOF incidents reviewed for investigation, opened, pending and closed for months of June 18, July 18, August 18 and September 18;

	June	July	August	September
Incidents Reviewed	1*	0*	0*	0*
Opened	1	1	4	3
Pending	4	4	3	6
Closed	0	1	3	1

* SCDC Police Services does not track the number of incidents reviewed except those incidents where were referred for review through the Use of Force System

Use of Force Violations

Reviews of Use of Force incidents agency-wide, conducted by the Division of Quality Improvement & Risk Management (QIRM) between May 1, 2018, and September 30, 2018, and identified 160 violations of SCDC Use of Force policy which were forwarded to the Division of Operations for action.

The Division of Operations did not concur with QIRM findings in 11, Use of Force reviews as summarized in the chart below. Of those non-concurrences, ten asserted justification of chemical munitions expenditures that exceeded SCDC guidelines. As of October 15, 2018, 63 incidents were pending review by the Division of Operations.
A detailed review of Policy Violation for May - September 2018 is in included in the Sparkman document drop, 2-Use of Force subfolder d.

Use of Force Policy Violations Identified Compliance Reviews June- September 2018

Month	Incident Location	MIN #	Incident Date	Date Referred	Status of Operations Action
June	PERRY	[redacted]	05/18/18	06/14/2018	disagreed amount of chemicals used appropriate
August	TRENTON		11/23/17	08/30/2018	OC overage justified, recommend inmate discipline.
August	TRENTON		01/09/18	08/24/2018	Justified OC overage.
August	TURBEVILLE		03/05/18	08/09/2018	disagreed amount of chemicals used appropriate
August	TURBEVILLE		03/13/18	08/09/2018	concur however chemicals deployed appropriate
August	PERRY		05/01/18	08/24/2018	disagreed amount of chemicals used appropriate
August	EVANS		05/14/18	08/02/2018	disagreed amount of chemicals used appropriate
August	TURBEVILLE		05/23/18	08/02/2018	disagreed that the amount of chemicals were appropriate
August	PERRY		07/16/18	08/22/2018	concur however the chemicals were ineffective

August	PERRY	18-07-0191-0049	07/22/18	08/21/2018	disagreed that the immediate UOF was appropriate
September	PERRY	18-08-0191-0043	08/16/18	09/18/2018	amount of chemicals used explained

Grievances

The Grievance Branch was charged with completing a CQI study for the months of May-July 2018 that includes the number of grievances filed that meet the following inclusion criteria:

- The narrative of the grievances described excessive use of force or an alleged action by the officer that lead to a physical injury to an inmate.
- Of those grievances that meet the inclusion criteria, for each month, please report those that were unprocessed and returned to the inmates and those that were processed per policy.
- For those processed, report the status or the outcome of each for each month.
- For those unprocessed, report the status or outcome of the unprocessed grievances for each month.

The report indicates that is designed to evaluate how inmate grievances in the three categories stated above were processed for the period stated. All grievances that were reported by RIM for the three-month covered period are reflected in this Report. Data provided by RIM was used to construct this Report. The grievance use of force report is included as Appendix O.

		Filed	Processed/ **Returned** (to inmates)	% Processed/ **Returned** (to inmates)	Processed/ Investigated	%Processed/ Investigated	Grievance referred for investigation to Police Services
Use of Force:	May-18	18	14	78%	3	17%	3
Use of Force:	Jun-18	12	9	75%	2	17%	0
Use of Force:	Jul-18	13	11	85%	2	15%	1
Unprofessional Conduct:	May-18	77	68	88%	6	8%	0
Unprofessional Conduct:	Jun-18	73	59	81%	14	19%	2
Unprofessional Conduct:	Jul-18	62	55	89%	6	10%	1
Physical Abuse:	May-18	11	11	100%	0	0%	0
Physical Abuse:	Jun-18	5	4	80%	1	20%	1
Physical Abuse:	Jul-18	11	9	82%	2	18%	0

P/R: Processed/Returned – Grievance returned to inmates due to defect in the filing.
P/I: Processed/Investigates – Grievance was investigated for Step 1 Decision.
DOPS: Division of Police Services – Grievance referred for investigation.

Processed and returned grievances are those that are returned to the inmate by the Inmate Grievance Coordinator (IGC) because there exist a defect in the grievance according to SCDC Inmate Grievance System. The inmate is given five (5) working days to correct such defect as described by the IGC. If the inmate makes such corrections the grievance is then Processed/Investigated. If the inmate fails to correct such defects, the grievance is closed. Grievances that are processed and investigated are those submitted by an inmate that have no defects according to SCDC Inmate Grievance System. They are investigated by the IGC by securing information from SCDC Staff. Once all the available information has been gathered, a draft Step 1, Warden's Decision is prepared and submitted to the Warden for his/her review and signature.

Clarification was requested regarding the specific recurring problems identified that caused the grievances to be returned. Although the percentage of grievances returned to inmates due to defects is high, the Grievance Branch reported neither RIM nor the Inmate Grievance Branch tracks these occurrences as it is impossible to track and the need to do so has not been identified.

In August 2018, the Branch reported it prepares monthly statistical reports. Because copies of these reports were only submitted on October 15, QIRM was unable to analyze and provide a summary report. Copies of the following reports are included in Appendix P as additional information:

- June 2018: MacDougall, Wateree River
- July 2018: Lieber; MacDougall, Wateree River
- August 2018: MacDougall, Wateree River
- September 2018: Broad River, MacDougall

November 2018 Implementation Panel findings:
The IP continues to monitor SCDC Use of Force MINS Narratives monthly and identify incidents where there did not appear to be a reasonably perceived immediate threat that required a use of force. Headquarters Operations Leadership continues meetings with Institution Management staff where high numbers of problematic UOF incidents are identified to develop strategies to address inappropriate UOF. QIRM, Operations Leadership and the MH UOF Coordinator regularly meet to discuss Agency UOF issues. The IP Use of Force Reviewer and SCDC Operations Leadership also continue to jointly review Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of force. Lieber CI in February 2018 and November 2018 held Workshops to provide additional training and assistance to their staff regarding UOF. Similar specialized training for staff should be considered by other institutions experiencing UOF issues. Especially since as of September 30, 2018, over 96 percent of the Agency staff has not received the required annual in-service UOF training.

SCDC Use of Force MINS for June 2018 through September 2018:

June 2018	115
July 2018	125
August 2018	129
September 2018	136

The number of UOF incidents has increased each month since June 2018 to a high of 136 UOF incidents in September 2018. The May 2018 high of 156 UOF incidents was not surpassed in any of the four months.

SCDC had 43 UOF and 27 Physical Abuse Inmate Grievances submitted by inmates during the relevant months. The QIRM update indicated the majority of the grievances were returned to the inmate and only five (5) inmate UOF and Physical Abuse grievances were referred to Police Services for investigation. This is problematic.

SCDC Police Services provided data identifying nine Use of Force investigations opened during the relevant months. The number of Police Services UOF investigations is alarmingly low with a system that averages 100 plus UOF incidents per month and had 70 UOF/Physical Abuse Grievances for the relevant months. QIRM UOF Reviewers identified a possible 160 UOF Policy violations during the relevant months. This provides additional evidence the number of Police Services UOF investigations is low.

SCDC provides monthly documentation on the number of employees receiving formal corrective action for UOF violations. The Agency clarified there is a system to track employee discipline (See Update), albeit it does not currently track informal employee action for UOF violations. Discussions are underway to revise the system to capture the informal measures used to address UOF violations, i.e. verbal counseling, additional training.

SCDC continues to pilot the Canine Policy and Training prior to full implementation. There have been no UOF incidents involving canines reported to the responsible IP Member during the relevant period to assess if there are any issues or concerns.

SCDC is implementing strategies to address inappropriate and excessive use of force by employees. The IP is encouraged by the Agency's recent efforts. The low number of Police Services UOF investigations based on the number of QIRM identified UOF violations and high number of UOF/Physical Abuse inmate grievances returned without processing is concerning to the IP.

November 2018 Implementation Panel Recommendations:

1. Operations, the MH UOF Coordinator and QIRM continue to review use of force incidents utilizing the automated system to identify use of force violations;
2. QIRM, the MH UOF Coordinator 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, QIRM, the MH UOF Coordinator and SCDC Operations Leadership continue to jointly review Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of force;
5. QIRM and the Agency Grievance Coordinator continue to QI Inmate Grievances related to UOF and Physical Abuse;
6. QIRM QI incidents and grievances referred to Police Services related to UOF and Physical Abuse;
7. Police Services begin tracking the number of referrals received for UOF and Physical Abuse and document the reasons an investigation is not opened;
8. Remedy the high percentage of employees not receiving annual Use of Force Training; and
9. Require meaningful corrective action 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;

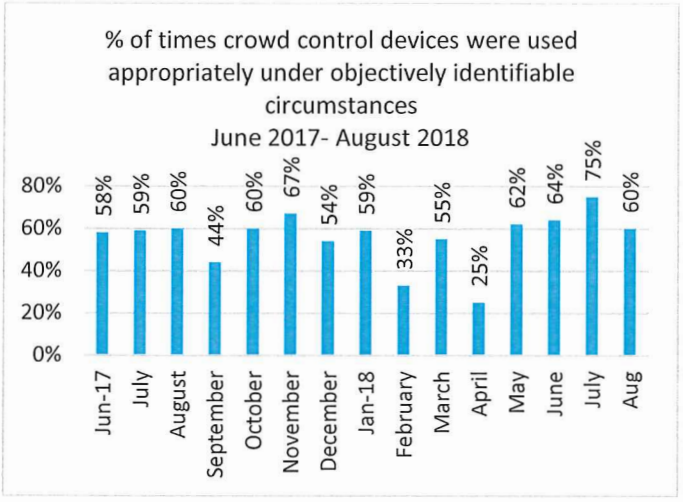
Implementation Panel November 2018 Assessment: partial compliance

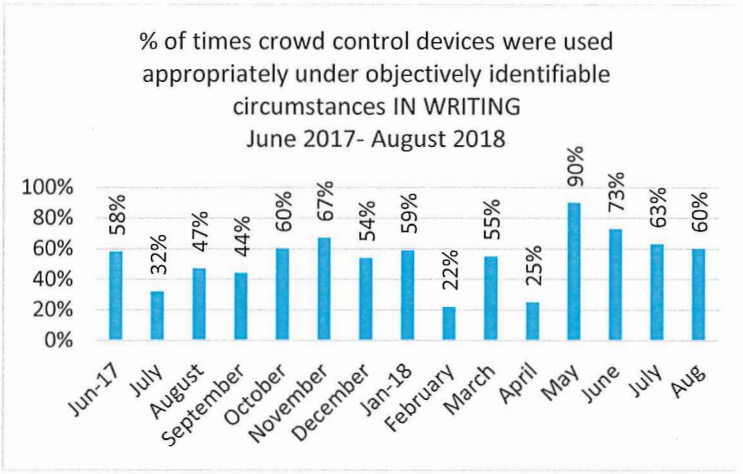
October 2018 SCDC Status Update:

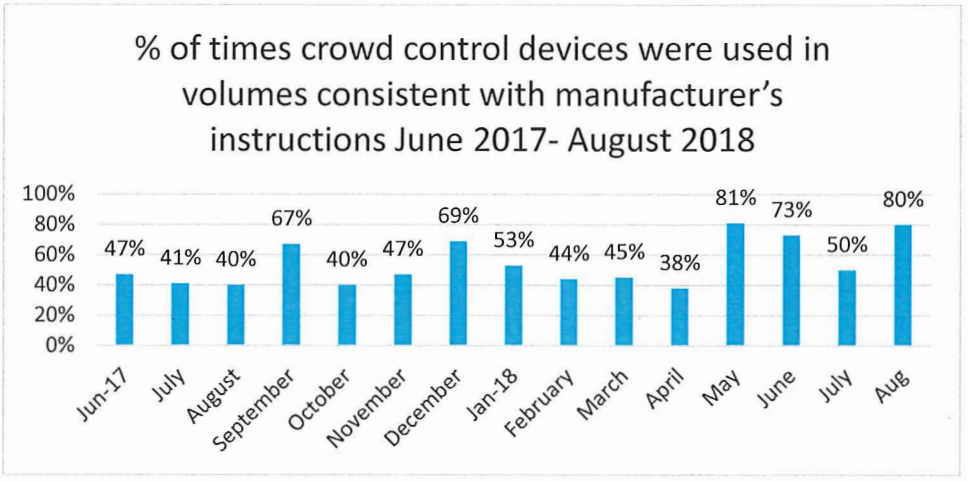
QIRM UOF reviewers continue to review daily MINS and documentation in the automated use of force system to assess appropriate use of crowd control canisters to include MK-9.

A detailed chart showing of the number of times a crowd control devices were used, the number that were used appropriately under objectively identifiable circumstances following are included as Appendix Q.

The graphs provides the percentages of times crowd control devices were used appropriately under objectively identifiable circumstances, incidents where the crowd control devices were used appropriately under objectively identifiable circumstances in writing and incidents where the crowd control devices were used in consistent with manufacturer's instructions based on these values.







QIRM UOF Reviewer began looking at the number of times crowd control devices were used appropriately under identifiable circumstances, the number of times crowd control devices were used appropriately under objectively identifiable circumstances in writing and the number of times crowd control devices were used in volumes consistent with manufacture's instruction in June of 2017. MK-9 was used in 193 use of force incidents between June 1, 2017 and August 31, 2018.

- There were 110 (57%) uses of force incidents in which the officer's actions were justifiable based on circumstances set forth in agency policy OP-22.01 Use of Force.
- There were 107 (55%) incidents where the crowd control devices were used appropriately under objectively identifiable circumstances in writing.
- There were 106 (55%) incidents where the crowd control devices were used in consistent with manufacturer's instructions.

QIRM continues to meet with Operations leadership meetings to discuss UOF and other relevant issues. The frequency has been changed to biweekly; however, when issues of concern are identified by the UOF Reviewers, they are immediately shared via email or telephone call with Operations leadership staff.

Operations and QIRM staff continues to participate in Monthly Use of Force MINS reviews with the IP Use of Force Reviewer to discuss issues with a goal of reducing the inappropriate use of crowd control canisters including MK-9.

According to the RIM report, *Number of SCDC Employees who have Completed Use of Force Training in Basic January 1, 2018 - October 15, 2018,* 752 have completed this training. This is the number of people who have completed basic training this year and includes staff that may no longer be at SCDC. In CY 2018 UOF training has only been taught as part of basic training and has not been offered as an in-service course this year.

November 2018 Implementation Panel findings:
SCDC has made a concerted effort to address the misuse of MK9. For the relevant period MK9 non-compliance was:

% of time MK9 identified as not being used within SCDC guidelines: June 18 (64%), July 18(75%) and August 18 (60%);
% of time MK9 volumes exceeded SCDC guidelines: June 18 (73%), July 18 (50%), and August 18 (80%).

Additional improvement is needed. The majority of correctional staff have not received UOF training for the calendar year. Lack of training most likely contributes to employee MK9 use issues.

November 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. Provide correctional staff additional training on the proper use of MK9.

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 November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:

The MH UOF Coordinator reports forty-three (43) planned uses of force (PUOF) involving MH inmates occurred during the June-September 2018 reporting period. The following charts provides a summary by month, the number of planned used of force involving an inmate diagnosed with mental illness and the percentage of time the QMHP was contacted proper to a planned use of force. A detailed report of the following, by institution is included as Appendix R. The report further details QMHP after-hours and weekend contacts, with timely & appropriate documented responses.

	# Times QMHP Contacted prior to a PUOF	# Incidents	% Times QMHP Contacted prior to a PUOF
June	2	10	20%
July	1	6	17%
August	9	11	88%
September	6	16	46%
Quarter	**18**	**43**	**42%**

November 2018 Implementation Panel findings:

Per the update Section. 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. Except for September 18 (88%) clinical counselors (QMHPs) were contacted less than fifty percent of the time prior to a planned UOF. It is inexcusable that institutional staff have failed to address the continued failure to notify a clinical counselor prior to a planned UOF. The average for four months was 42 percent.

November 2018 Implementation Panel Recommendations:

Remedy the above. As identified in previous reports, additional training to Operations Supervisory and Mental Health Staff on their duties and responsibilities in a planned use of force is needed. Employees must be held accountable when the required assistance from QMHPs is not requested prior to a planned UOF incident involving mentally ill inmates. When operations employees notify mental health staff of a planned UOF, the mental health staff must complete a face to face interaction to assist or document reasons the interaction was not completed.

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

Implementation Panel November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:

The training plan to for Certified Uniform Staff concerning appropriate methods of managing mentally ill inmates; is outlined below. The chart outlines the specialized in-service training schedule for the recently developed lesson plan to train certified uniformed staff at Allendale,

Broad River, Camille Graham, Kirkland, and Leath beginning October 2018 through 12/31/18. These five institutions sites were identified as initial locations to receive training because of the high concentration of inmates on the mental health caseload. The training commenced at the Training Academy, on October 16, 2018 with sixty five (65) participants. The target audiences to receive the training are certified staff assigned to institutions with a hire date prior to January 01, 2018. Staff hired after January 01, 2018 received the same information during orientation and Basic Training. The plan is to train 815 certified staff by 12/31/18. Phase II of the plan will involve presenting the same training at the following institutions by June 30, 2019: Evans, Kershaw, Lee, Lieber, MacDougall, McCormick, Perry, Ridgeland, Turbeville, and Tyger River. Each institution will be capped at thirty (30) training slots per location. The effort is being coordinated with the Training Academy to ensure the institutions are notified.

Recognizing and Appropriately Responding to Mentally Ill Inmates" Training for Certified Uniform Staff*
Year: 2018

Institution	Presenter	Dates Provided
Allendale (N = 138)	Dr. [redacted]	10/19; 10/26; 11/02
	Dr.	10/30; 11/20
Broad River (N = 163)	Ms.	10/18; 11/01
	Mr.	10/26; 11/30
	Dr.	10/22; 11/05
Camille Graham (N = 125)	Dr.	10/24; 11/21; 12/12
	Ms.	10/31; 12/6
Kirkland (N=310)	Ms.	10/24; 10/31
	Ms.	10/26; 11/02; 11/30
	Ms.	11/7; 11/28
	Mr.	10/30; 11/20
	Dr.	10/25; 11/8; 12/13
Leath (N = 79)	Ms.	10/30; 11/07; 12/13
	Dr. (back up)	

Institutions	COs	Classes Needed	Classes Scheduled	# Slots *(30 Slots per Class)*	Average per Class
Allendale	138	4.600	5	150	27.600
Broad River	163	5.433	6	180	27.167
Graham	125	4.167	5	150	25.000
Kirkland	310	10.333	12	360	25.833
Leath	79	2.633	3	90	26.333

Source: RIM

Correctional Officers must attend and complete Agency Orientation, Basic and Annual In-Service training concerning the appropriate method of managing mentally ill offenders.

Provided below is the required mandatory training program for correctional officers managing mentally ill offenders. This is provided by program, course/class code, number of hours per course and total number of hours per program.

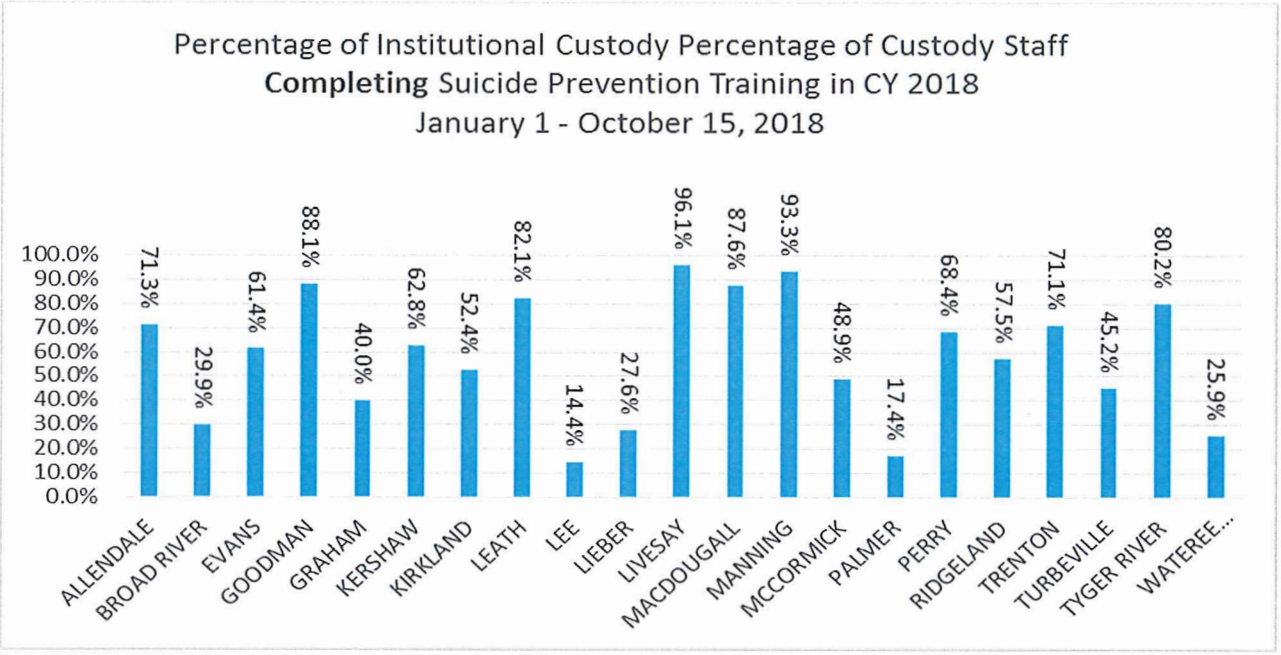
Managing Mentally Ill Offenders Curriculum

Program	Course/Class Code	Hours	Total
Agency Orientation - 1.00	Intro to Mental Health	2.0	4.0
	Suicide	2.0	
Basic Training Uniform (Certified) - 3.00 Non-Uniform Certified - 3.60 Cadet (Trainee) - 3.99	Pre-Crisis Communication	3.0	7.0
	Mental Health	2.0	
	Suicide	2.0	
In-Service*	Suicide (Instructor Led) - Basic or 1015.16	2.0	4.0
	Inmate Suicide Prevention Part 1 - 1015.17V or 1015.17	1.0	
	Inmate Suicide Prevention Part 2 - 1015.18V or 1015.18	1.0	

* **Recognizing Signs and Symptoms of Mental Illness and Appropriately Responding** (1096.11) has been added for 5 institutions with the first class being held on 10/16/2018. Not required agency-wide this year and therefore not included in this report. This course is 2.0 - 2.5 hours. CY 2019 this course will be required for all certified and security staff agency-wide.

A RIM-generated report, *Suicide Training in CY 2018 (Jan 1 - Oct 15, 2018)* is included in the Patterson request for documentation, Suicide Prevention items 33 and 34.

The following chart, based on information included in this database shows only the percentage of staff who have **fully completed** all required suicide prevention training from January 1- October 15, 2018.



Source: RIM *Suicide Training in CY 2018 (Jan 1 - Oct 15, 2018)*

The RIM report, *C.O.s Required to take Managing MI Offenders Training in CY 2018 (Jan 1 - Oct 15, 2018)* included in the Sparkman document drop, folder number 5- subfolder 5b. See --- Training Needed by institution, the number and percentage of staff who have not completed the following required training is included below as quick reference.

One-Time Training

- Agency Orientation
- Basic Training

Annual/In-Service Training

- Suicide (Basic)
- Inmate Suicide Prevention Part 1
- Inmate Suicide Prevention Part 2

Number of Security Staff Needing to take Course(s) in Order to Complete Managing Mentally Ill Offenders Training in CY 2018 by Location and Training Completion as of October 15, 2018

Level		Location	# Required to take Training	One Time Training				Annual/In-Service Training					
				Agency Orientation (1.00)		Basic Training		Suicide (1015.16 or Basic)		Inmate Suicide Prevention Part 1 (1015.17)		Inmate Suicide Prevention Part 2 (1015.18)	
				#	%	#	%	#	%	#	%	#	%
1	232	GOODMAN	67	0	0.0%	0	0.0%	2	3.0%	5	7.5%	5	7.5%
1	173	LIVESAY	51	1	2.0%	0	0.0%	2	3.9%	1	2.0%	1	2.0%
1	251	MANNING	89	0	0.0%	0	0.0%	4	4.5%	5	5.6%	4	4.5%
1	563	PALMER	23	0	0.0%	0	0.0%	4	17.4%	15	65.2%	16	69.6%
Minimum Security			**230**	**1**	**0.4%**	**0**	**0.0%**	**12**	**5.2%**	**26**	**11.3%**	**26**	**11.3%**
2	411	ALLENDALE	122	1	0.8%	0	0.0%	9	7.4%	28	23.0%	31	25.4%
2	531	EVANS	88	0	0.0%	0	0.0%	28	31.8%	30	34.1%	30	34.1%
2	541	KERSHAW	113	0	0.0%	0	0.0%	28	24.8%	28	24.8%	25	22.1%
2	422	MACDOUGALL	105	1	1.0%	0	0.0%	9	8.6%	12	11.4%	13	12.4%
2	442	RIDGELAND	87	0	0.0%	0	0.0%	22	25.3%	29	33.3%	30	34.5%
2	222	TRENTON	83	1	1.2%	0	0.0%	10	12.0%	16	19.3%	18	21.7%
2	571	TURBEVILLE	124	0	0.0%	0	0.0%	35	28.2%	51	41.1%	54	43.5%
2	161	TYGER RIVER	116	1	0.9%	0	0.0%	13	11.2%	8	6.9%	14	12.1%
2	582	WATEREE RIVER	112	0	0.0%	0	0.0%	31	27.7%	75	67.0%	77	68.8%
Medium Security			**950**	**4**	**0.4%**	**0**	**0.0%**	**185**	**19.5%**	**277**	**29.2%**	**292**	**30.7%**
3	211	BROAD RIVER	144	3	2.1%	0	0.0%	42	29.2%	85	59.0%	87	60.4%
3	241	KIRKLAND	269	2	0.7%	0	0.0%	50	18.6%	98	36.4%	106	39.4%
3	551	LEE	125	0	0.0%	1	0.8%	81	64.8%	82	65.6%	90	72.0%
3	421	LIEBER	98	0	0.0%	0	0.0%	42	42.9%	51	52.0%	48	49.0%
3	181	MCCORMICK	90	0	0.0%	0	0.0%	5	5.6%	39	43.3%	43	47.8%
3	191	PERRY	114	1	0.9%	0	0.0%	8	7.0%	21	18.4%	31	27.2%
Maximum Security			**840**	**6**	**0.7%**	**1**	**0.1%**	**228**	**27.1%**	**376**	**44.8%**	**405**	**48.2%**
	331	GRAHAM	110	0	0.0%	0	0.0%	34	30.9%	39	35.5%	48	43.6%
	171	LEATH	67	1	1.5%	0	0.0%	4	6.0%	10	14.9%	8	11.9%
Female Institutions			**177**	**1**	**0.6%**	**0**	**0.0%**	**38**	**21.5%**	**49**	**27.7%**	**56**	**31.6%**
	123	CATAWBA	1	0	0.0%	0	0.0%	1	100.0%	1	100.0%	1	100.0%
	40	CORRECTIONAL INDUSTRIES	1	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	1	HEADQUARTERS	59	0	0.0%	0	0.0%	20	33.9%	20	33.9%	21	35.6%
	26	HQ ANNEX #2	30	0	0.0%	0	0.0%	3	10.0%	2	6.7%	2	6.7%
	45	INMATE TRANSPORTATION TER	38	0	0.0%	0	0.0%	2	5.3%	0	0.0%	1	2.6%
	22	RECRUITING & EMPLOYMENT	1	0	0.0%	0	0.0%	1	100.0%	0	0.0%	1	100.0%
	30	SUPPORT SERVICES	1	0	0.0%	0	0.0%	1	100.0%	1	100.0%	1	100.0%
	23	TRAINING ACADEMY	14	0	0.0%	1	7.1%	9	64.3%	3	21.4%	2	14.3%
Non-Institutional			**145**	**0**	**0.0%**	**1**	**0.7%**	**37**	**25.5%**	**27**	**18.6%**	**29**	**20.0%**
Agency Total			**2,342**	**12**	**0.5%**	**2**	**0.1%**	**500**	**21.3%**	**755**	**32.2%**	**808**	**34.5%**

Source: RIM CO's Required to take Managing MI Offenders Training in CY 2018 (Jan 1 - Oct 15, 2018).

The *C.O.s Required to take Managing MI Offenders Training in CY 2018 (Jan 1 - Oct 15, 2018)* report also includes a compliance summary tab that shows the number and percentage of staff who have partially, fully or failed to complete the required training.

The schedule below, provided by the Training Academy, outlines the scheduled institutional training classes.

Scheduled Institutional Training Classes By Institution and Region

Institutions	COs	Classes Completed	COs needing Training	Number of Slots	Training Block Dates	Suicide (Instructor Led (IL) Inmate Suicide Pt. I & II Video (V)
EASTERN						
						Nov. 6th & 8th

Evans	88	54	34	20	Nov. 6th – 8th	7:00 AM – 9:00 AM (V) Nov. 6th 12:30 PM – 2:30 PM (IL)
Kershaw	113	70	43	25	Oct. 23rd – 26th, Nov. 6th – 9th	Oct. 29th – 3oth (V) Nov. 1st – Nov. 2nd (IL)
Lee	125	18	107	30	Oct. 17th – 18th, Oct. 22nd – 23rd, Oct. 25th – 26th, Oct. 30th	Oct. 5th & Oct. 26th 8:00 AM – 10:00 AM (IL)
Palmer	23	4	19	20	Attends Lee CI training	
Turbeville	124	55	69	25	Oct. 9th; Nov. 2nd;Nov. 5th – 9th	Oct. 29th & Nov. 5th (IL) 10:00 AM – 12:00 PM Oct. 30th & Nov. 6th 2:00 PM – 4:00 PM (V)
Wateree	112	29	83	20-50	Oct. 9th Nov. 2nd Nov. 5th – 9th	Oct. 29th & Nov.1st 9:30 AM – 11:30 AM (IL) Dec. 3rd – 6th 9:30 AM – 11:30 am (IL)
MIDLANDS						
Broad River	144	44	100	35	Oct.22nd – 25th Nov. 1st	Oct. 15th (V) Oct. 18th & Oct. 25th (IL)
Camille Graham	110	42	68	30	Attends BRCC & Goodman CI training.	
Goodman	67	59	8	40	Nov. 5th – 8th	Oct. 15th & Nov. 11th (IL) Oct. 18th & Nov. 8th (V)
Kirkland R&E	269	141	128	70-100	Nov. 5th – 8th	Nov. 9th 8:30 AM – 10:30 AM (IL) Nov. 15th 1:00 PM – 3:00 PM (V)
Manning	89	82	6	25	Dec. 5th – 7th	Dec. 4th 9:00 AM – 11:00 AM (V) Dec. 7th 9:00 AM – 11:00 AM (IL)
COASTAL						
Allendale	122	86	26	30	Oct. 15th – 19th Oct. 22nd – 27th	Oct. 22nd 12:00 PM – 2:00 PM (IL) Oct. 23rd 8:00 AM – 10:00 AM (V)
Lieber	98	27	71	25	Nov. 6th , 8th, & 13th Nov. 9th * 16th	Nov. 6th, 8th & 13th (IL) Nov. 9th & 6th (V)
MacDougall	105	91	14	20	Oct. 29th – 31st	Oct. 29th 8:00 AM – 10:00 AM (V) Oct. 29th 10:00 AM – 12:00 PM
						Oct. 22nd

Ridgeland	87	50	37	25	Oct. 22nd – 2th, Nov. 5th – 9th Nov. 26th – 30th, Dec. 3rd – 7th Dec. 10th – 14th	8:00 AM – 10:00 AM (V) Oct. 23rd 9:30 AM – 11:30 AM (IL)
APPALACHIAN						
Leath	67	55	12	25	Attends McCormick CI training	
Livesay	51	48	3	60	Attends Tyger River CI training	
McCormick	90	44	46	30	Nov. 6th – 8th Nov. 13th – 15th	Nov. 6th & Nov. 13th 10:00 AM – 12:00 PM
Perry	114	78	36	30	Attending Tyger River CI training	
Trenton	83	59	24	16	Oct. 22nd – 25th Nov. 12th – 15th	Oct. 29th (V) Nov. 12th *& 19th (IL)
Tyger River	116	93	23	40	Nov. 13th – 15th	Nov. 13th & Nov. 15th 8:00 AM – 10:00 AM (V) 10:00 AM – 12:00 PM (IL)

November 2018 Implementation Panel findings:
The current SCDC training program for correctional officers concerning the appropriate methods of managing mentally ill inmates is an 11 hour program for new correctional officers. Permanent correctional officers receive 4 hours annual training concerning the appropriate methods of managing mentally ill inmates. A revised training program was rolled out in October 2018 and will be fully implemented in the Calendar Year 2019. The revised program will expand the annual training 2-2.5 hours for a total of 6-6.5 hours annually for permanent correctional officers. Per the SCDC Update, only 34.5 percent of the required employees have received annual training concerning the appropriate methods of managing mentally ill inmates thus far for the Calendar Year 2018.

November 2018 Implementation Panel Recommendations:

- Continue to document and track the number of required employees completing the mandatory training for appropriate methods of managing mentally ill inmates in the Calendar Year; 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 November 2018 Assessment: compliance (March 2017)

October 2018 SCDC Status Update:
QIRM's Use-of-Force Reviewers continue to produce and disseminate monthly and quarterly

UOF Reports. The most recent report, October 2018 is included as Appendix M.

This report is sent to the Wardens, and Agency leadership. This report also details:

- Planned vs unplanned uses of force
- Use of force incidents of Mentally Ill vs Not Mentally Ill type of force used on inmates classified as mentally ill
- Types of force used involving chemical munitions, defensive tactics and the Restraint Chair
- Incidents of unprofessional conduct

November 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.

November 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 November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:
In the event of Use of Force on a Mental Health Caseload Client, the MH UOF Coordinator conducts a Mental Health Case Review to include a review of documentation in the AMR and/or NextGen records. The Coordinator reviews recent Psychiatry visits to determine if Psychiatry visits are occurring every 90 days or more as clinically indicated. If he determines Psychiatry visits are not occurring as prescribed by the inmate's level of care, the Coordinator will contact Clinical Supervisor for resolution.

The Coordinator tracks by way of Excel spreadsheets, Qualified Mental Health Professional follow-up (or lack thereof) to uses of force involving inmates on the Mental Health Caseload. This will be tracked through the automated Use of Force screen in the SCDC secure login. The Coordinator determines from the AUOF system, the frequency of QMHP involvement prior to a use of force and after a use of force and if security staff contacted the QMHP as outlined by policy and procedure. He also tracks the time when a call is placed to a QMHP after hours and the time of the response. When it is determined that protocol has not been followed or other reasons a timely response was not received, a report is sent to the BMHSAS Division Director for further action as he deems appropriate.
Mental Health UOF procedures which outlines the goals, processes and responsibilities of the MH UOF Coordinator, developed by the Division of BMHSAS, is included as Appendix L.

November 2018 Implementation Panel findings:
The MH UOF Coordinator has implemented procedures and is monitoring UOF incidents involving inmates with a mental health designation. The draft policy has been submitted and is

awaiting approval. The IP Mental Health Experts have not reviewed the policies and procedures. A QI study was conducted and examined current placement (lock up, institution, program,) for inmates involved in 3 or more uses of force in a six month period. (December 2017-May 2018) Twenty nine inmates were involved in three or more uses of force between December 2017 and May 2018. BMU placement was recommended for 34 percent of the identified inmates.

November 2018 Implementation Panel Recommendations:
Once the policies and procedures are approved, responsible Behavioral Health staff should receive training on the policy. QIRM should perform QI studies assessing the Department of Behavioral Health review of UOF incidents involving inmates with a mental health designation. The IP Mental Health Experts will need to review the policy before final approval. SCDC should continue monitoring inmates with a mental health designation identified as high risk for use of force and repeat the High Risk UOF Case Study for each relevant period. Responsible officials should diligently strive to place recommended RHU inmates in a BMU Program and track their status while awaiting placement.

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

Implementation Panel July 2018 Assessment: partial compliance

October 2018 SCDC Status Update:
The staffing and hiring plan is included in *2.a.iv*.

BMHSAS included a chart in in the Patterson document drop, folder number 3, Staffing, subfolder 10, as an Excel spreadsheet entitled *Copy of DRAFT - Staff Ratios - As of 10-01-18 - updated 10-03-18 – QMHP* that shows the staff to inmate ratio for each program and institution by Levels.

The number of Mentally Ill inmates in each Med Class (L1, L2, L3, L4 or L5) is shown in each program (GPH, BRCI/CSU, KR&E/HLBMU, KR&E/ICS, ACI/LLBMU, and CRCC). The number of Mentally Ill inmates that are L3, L4 and L5 are shown (by level) in each institution.

November 2018 Implementation Panel findings: As per status update section. Compliance is achieved in the context of QMHPs' ratios for GPH, CSU and ICS. Psychiatrists' ratios are short by about 10 FTEs.

November 2018 Implementation Panel Recommendations: Begin to remedy the above via the annual budgetary request process.

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

Implementation Panel November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:

Policy HS-19.05 section 3.1 states mental health multidisciplinary treatment teams provide integrated treatment in which team members work collaboratively, sharing responsibility for the individuals served. An analysis of treatment team participation by discipline was completed by QIRM. Treatment team documentation was requested from the institutional staff and the findings are based on a review of the documentation. Reporting varies depending on reports received from institutional staff and a summary of the results for each institution are as follows:

Evans

- During the month of July 2018, Psychiatry participated 100% of the time, 0% for Psychology, 100% for QMHP, 0% for medical, 100% for Operations, 0% for Classification and 0% for inmates.
- During the month of August 2018, Psychiatry participated 100% of the time, 0% for Psychology, 100% for QMHP, 0% for medical, 100% for Operations, 0% for Classification, and 0% for inmates.

Broad River CSU

- During the month of June 2018, Psychiatry participated 55% of the time, 0% for Psychology, 93% for QMHP, 66% for medical, 0% for Operations, 90% for classification, and 100% for inmates.
- During the month of July 2018, Psychiatry participated 56% of the time, 19% for Psychology, 67% for QMHP, 70% for medical, 15% for Operations, 82% for classification, and 81% for inmates.

Broad River

- During the month of June 2018, Psychiatry participated 0% of the time, 0% for Psychology, 100% for QMHP, 67% for medical, 33% for Operations, 100% for Classification, and 0% for inmates.
- During the month of July 2018, Psychiatry participated 0% of the time, 0% for Psychology, 100% for QMHP, 67% for medical, 67% for Operations, 33% for Classification, and 0% for inmates.
- During the month of August 2018, Psychiatry participated 0% of the time, 0% for Psychology, 100% for QMHP, 0% for medical, 38% for Operations, 62% for Classification, and 0% for Inmates.
- During the month of September 2018, Psychiatry participated 0% of the time, 0% for Psychology, 100% for QMHP, 0% for medical, 100% for Operations, 0% for Classification, and 0% for inmates.

Lee

- During the month of July 2018, Psychiatry participated 14%, 0% for Psychology, 100% for QMHP, 0% for medical, 14% for Operations, 0% for Classification, and 0% for inmates.
- During the month of August 2018, Psychiatry participated 38%, 0% for Psychology, 100% for QMHP, 100% for medical, 0% for Operations, 0% for Classification, and 0% for inmates.
- During the month of September 2018, Psychiatry participated 100%, 0% for Psychology, 10% for QMHP, 14% for medical, 0% for Operations, 0% for Classification, and 0% for inmates.

Kirkland ICS

- During the month of July 2018, Psychiatry participated 88% of the time, 0% for Psychology, 76% for QMHP, 88% for medical, 71% for Operations, 0% for classification, and 79% for inmates.
- During the month of August 2018, Psychiatry participated 90% of the time, 0% for Psychology, 70% for QMHP, 0% for medical, 83% for Operations, 0% for classification, and 63% for inmates.
- During the month of September 2018, Psychiatry participated 100% of the time, 0% for Psychology, 100% for QMHP, 0% for medical, 43% for Operations, 0% for classification, and 100% for inmates.

Kirkland GPH

- During the month of June 2018, Psychiatry participated 100% of the time, 100% for Psychology, 100% for QMHP, 100% for medical, 50% for Operations, 0% for classification, and 10% for inmates.
- During the month of July 2018, Psychiatry participated 100% of the time, 100% for Psychology, 100% for QMHP, 100% for medical, 0% for Operations, 0% for classification, and 0% for inmates.
- During the month of August 2018, Psychiatry participated 80% of the time, 40% for Psychology, 100% for QMHP, 100% for medical, 0% for Operations, 80% for classification, and 40% for inmates.
- During the month of September 2018, Psychiatry participated 80% of the time, 80% for Psychology, 100% for QMHP, 80% for medical, 20% for Operations, 60% for classification, and 60% for inmates.

HLMBU

- An analysis could not be conducted for this area because submission of the institutional report and supporting documentation was not submitted timely.

Lieber

- During the month of July 2018, Psychiatry participated 0% of the time, 0% for Psychology, 100% for QMHP, 100% for medical, 0% for Operations, 0% for classification, and 0% for inmates.
- During the month of August 2018, Psychiatry participated 0% of the time, 0% for Psychology, 75% for QMHP, 100% for medical, 75% for Operations, 0% for classification, and 0% for inmates.

Camille

- During the month of June 2018, Psychiatry participated 0% of the time, 0% for Psychology, 100% for QMHP, 100% for medical, 100% for Operations, 100% for classification, and 50% for inmates.
- During the month of July 2018, Psychiatry participated 0% of the time, 0% for Psychology, 100% for QMHP, 100% for medical, 53% for Operations, 13% for classification, and 0% for inmates.
- During the month of August 2018, Psychiatry participated 0% of the time, 0% for Psychology, 100% for QMHP, 100% for medical, 56% for Operations, 88% for classification, and 40% for inmates.

November 2018 Implementation Panel findings: As per status update section. It was unclear the causes of the partial compliance—staffing vacancies, scheduling issues, etc.?

November 2018 Implementation Panel Recommendations: Assess the causes of the partial compliance and devise a corrective course of action.

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

Implementation Panel July 2018 Assessment: compliance (March 2018)

October 2018 SCDC Status Update:

The chart below contains a list of employees who were hired, or transferred to Mental Health in CY 2018 (January 1 – September 30, 2018) and, if completed, the date they took Mental Health General Provisions training. This chart shows the number of staff who completed the training within 45 days of joining Mental Health is included as Appendix S.

Mental Health General Provisions Training taken by New Mental Health Staff (Hires and Transfers) by Location and Training Completion New Hires/Transfers January 1 - September 30, 2018

Level	Budget Unit	Institution	# Required to take Training	Completed 45 Days or Less from Hire/Transfer		Completed		Not Completed	
				#	%	#	%	#	%
1	123	CATAWBA	0	0	N/A	0	N/A	0	N/A
1	232	GOODMAN	0	0	N/A	0	N/A	0	N/A
1	173	LIVESAY	1	1	100.0%	1	100.0%	0	0.0%
1	251	MANNING	1	0	0.0%	0	0.0%	1	100.0%
1	563	PALMER	0	0	N/A	0	N/A	0	N/A
Minimum Security			**2**	**1**	**50.0%**	**1**	**50.0%**	**1**	**50.0%**
2	411	ALLENDALE	3	2	66.7%	3	100.0%	0	0.0%

2	531	EVANS	3	1	33.3%	1	33.3%	2	66.7%
2	541	KERSHAW	4	0	0.0%	1	25.0%	3	75.0%
2	422	MACDOUGALL	0	0	N/A	0	N/A	0	N/A
2	442	RIDGELAND	4	1	25.0%	2	50.0%	2	50.0%
2	222	TRENTON	0	0	N/A	0	N/A	0	N/A
2	571	TURBEVILLE	9	0	0.0%	0	0.0%	9	100.0%
2	161	TYGER RIVER	2	1	50.0%	2	100.0%	0	0.0%
2	582	WATEREE RIVER	0	0	N/A	0	N/A	0	N/A
Medium Security			**25**	**5**	**20.0%**	**9**	**36.0%**	**16**	**64.0%**
3	211	BROAD RIVER	10	2	20.0%	2	20.0%	8	80.0%
3	242	GILLIAM PSY	23	6	26.1%	13	56.5%	10	43.5%
3	241	KIRKLAND	8	2	25.0%	3	37.5%	5	62.5%
3	551	LEE	8	0	0.0%	0	0.0%	8	100.0%
3	421	LIEBER	6	4	66.7%	4	66.7%	2	33.3%
3	181	MCCORMICK	2	1	50.0%	1	50.0%	1	50.0%
3	191	PERRY	7	2	28.6%	3	42.9%	4	57.1%
Maximum Security			**64**	**17**	**26.6%**	**26**	**40.6%**	**38**	**59.4%**
	331	GRAHAM	7	1	14.3%	1	14.3%	6	85.7%
	171	LEATH	0	0	N/A	0	N/A	0	N/A
Female Institutions			**7**	**1**	**14.3%**	**1**	**14.3%**	**6**	**85.7%**
	1	HEADQUARTERS	9	4	44.4%	4	44.4%	5	55.6%
	26	HQ ANNEX #2	0	0	N/A	0	N/A	0	N/A
Non-Institutional Locations			**9**	**4**	**44.4%**	**4**	**44.4%**	**5**	**55.6%**
All Institutions			**107**	**28**	**26.2%**	**41**	**38.3%**	**66**	**61.7%**

November 2018 Implementation Panel findings: It was not clear the percentage of staff not yet trained who had been working for at least 45 days.

November 2018 Implementation Panel Recommendations: Determine the answer to the above issue and implement appropriate correction actions.

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 November 2018 Assessment: compliance (December 2017)

October 2018 SCDC Status Update:

In addition to the previously reported recruitment and retention efforts, the following includes a list of new and ongoing recruitment and retention initiatives:

- Now offer a signing bonus for numerous positions-competitive with area hospitals
- hired an experienced recruiting director to run recruiting department
- Instituted emergency pay at critical locations

- Received final report from consultant hired to look at retention and recruitment
- Started a focus group to discuss and troubleshoot any NextGen issues
- Video featured on SC careers page
- Targeted advertising for nursing staff
- Using geo tracking to determine where to advertise for specific positions-
- Commercials now feature testimonials from current employees
- SCDC hosted a hiring event at the Georgia Dept. of Labor in Augusta on July 27th to extend the potential hiring pool

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

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

3.e Require appropriate credentialing of mental health counselors;

Implementation Panel November 2018 Assessment: compliance (March 2017)

October 2018 SCDC Status Update:

The Deputy Director of Health Services, Terre Marshall, sent a memo dated August 3 2018, on the subject of licensure and to provide further clarification regarding requirements and expectations. The letter clarified that unlicensed mental health staff will be allowed to continue employment in their QMHP positions under close supervision by the licensed QMHP. It was also notated that unlicensed staff are encouraged to pursue their license as a mental health professional to advance personally and professionally within SCDC. The agency has agreed to offer a $500 bonus to those who sit for the exam within one year of the date of the memorandum and successfully complete the licensure requirements. Employees were also reminded that salaries would increase beyond licensure as a LPC-I or LMSW.

There are currently 16 unlicensed individuals within SCDC Division of Health Services. Three (3) of the 16 are either unable or likely not able to qualify for licensure due to the lack of educational credentials. One employee is at Camille Graham, one at Kershaw, and the third is a Kirkland ICS. For these three employees, job duties and assignments will be realigned, remaining consistent with QMHP job duties, to more psychoeducational activities instead of therapy.

The mental health staff currently licensed after the change in policy continues to be 66/68 or 97% are appropriately licensed.

A list of current licensed staff, as of 10-08-2018, a list of unlicensed QMHPs with appointed supervisors with plans of actions and a memo clarifying licensure requirements are included as APPENDIX T.

November 2018 Implementation Panel findings: As per status update section Compliance continues.

November 2018 Implementation Panel Recommendations: Continue to monitor.

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

Implementation Panel November 2018 Assessment: compliance (July 2018)

October 2018 SCDC Status Update:
The BMHSAS Division reports that initial audit reviews for all programs continue to be consultative. All reviews are shared with the Division Director for review and then forwarded to the Warden, Associate Warden, and Mental Health staff at each program.

The audit schedule since last reporting period is outlined below. Mental Health Audit report and findings from Broad River and Lieber included as Appendix U.

- Broad River (Hab & Area) August 1, 2018
- Lieber CI August 7, 2018

The Quality Improvement Manager for Behavioral Health resigned from the agency July 16, 2018. BMHSAS reports that the position has been posted twice and is currently posted as of the writing of this report. The specific requirements for the position are included as Appendix V.

November 2018 Implementation Panel findings: As per status update section. We will re-assess compliance during the next site visit with the assumption that this position will no longer be vacant.

November 2018 Implementation Panel Recommendations: Continue efforts to fill the Quality Improvement Manager for Behavioral Health vacancy.

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

Implementation Panel November2018 Assessment: compliance (July 2018)

October 2018 SCDC Status Update:
See response in *3.f.*

November 2018 Implementation Panel findings: 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 November 2018 Assessment: compliance (March 2017)

October 2018 SCDC Status Update:
RIM continues to produce and distribute a weekly "Medical Personnel Report." The following screenshot provides a snapshot of the detailed report. The most recent report was distributed on

October 8, 2018.. The most recent report is included as Appendix W.

November 2018 Implementation Panel findings: Compliance continues.

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

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

October 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, *Male ICS Admissions and Discharge for June 2018-September 2018 i*s included as Appendix X.

Per MH, the waiting lists for GPH and CSU have diminished since employing full- time or increasing provider (psychiatry hours). There has not been a delay getting inmates accepted into GPH from CSU this reporting period. However, cases being referred to ICS from CSU continue to problematic and not appropriate for the program in its current design (F1 & F2). The plan to improve this includes:

- Re-purpose F1 into a new program (CHOICES) which will have a different treatment model more applicable for behavior disordered inmates. SCDC is working hard to have this program operational by the spring of 2019.
- Increase capacity of Behavioral Management beds to 96 across the two programs (HLBMU and LLBMU). This will involve additional staffing (security and clinical) which has been requested in the 2020 budget.

November 2018 Implementation Panel findings: Compliance continues from the perspective of tracking such referrals. We will continue to monitor the outcome of such referrals (rates for acceptance, rejection, waiting lists).

November 2018 Implementation Panel Recommendations: Continue to keep data re: the above.

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

Implementation Panel November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:
Policy, OP-22.38, Restrictive Housing Unit (RHU), section 3, number 14 requires correctional officers assigned to the RHU to conduct security checks and to personally observe each inmate at least every 30 minutes on an irregular, unannounced schedule. A CQI study was done to assess compliance with 30- minute cell checks. The results are included in the Patterson document drop folder 6- Quality Improvement-Assurance, subfolder 21.

- At Broad River, Lee and Evans, the security cell checks routinely exceed the 30-minute limit which may be indicative of insufficient staffing and/or lack of training for officers

completing the required cell checks. Regardless of whether they are done irregularly, the extended time between cell checks creates high risk for the inmates and the Agency.

- At Broad River and Lee during the months of July, August and September, the longest time between checks decreased from month to month. For Broad River, this may be attributable to the introduction of the new scanning system and associated training.
- With the exception of Camille, cell check compliance continues to be problematic.

November 2018 Implementation Panel findings: As per status update section

November 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 November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:
The EHR Business Analyst was hired on October 17, 2018. One of RIM's EHR specialists, Heather Tennyson-Halliday was selected for the position, having an existing knowledge of the system's data layout, end user processes, as well as a background in analytics. Her role is to develop and manage the reporting processes necessary to the data requests of the Agency and Settlement Agreement.

Additionally, Teresa Mcilvride was hired as a contractor through Beeline on September 9, 2018 to assist our team in further development and enhancement of the system to better accommodate the data management requirements. With her, she brings a wealth of knowledge and experience with the NextGen systems in behavioral health settings; she has been actively working on the framework creation for our EHR reporting needs.

November 2018 Implementation Panel findings: As per status update section

November 2018 Implementation Panel Recommendations: Develop the above referenced reporting processes.

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

Implementation Panel November 2018 Assessment: compliance (March 2017)

October 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. Administrative Regional Director for Operations, QIRM Use of Force Reviews and UOF Coordinator for BMHSAS continue to monitor use of force documentation and videotapes through the SCDC automated use of force system.

November 2018 Implementation Panel findings: As per SCDC update.

November 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 November 2018 Assessment: compliance (March 2017)

October 2018 SCDC Status Update:

RIM continues to produce and disseminate a monthly, "UOF Report Mentally Ill vs. Non-Mentally Ill," report on the 22nd of each month for the previous month's information.
UOF Reviewers continue to track and report the number of UOF incidents involving mentally ill vs non-mentally ill inmates. This quarterly report is sent to it IP UOF expert, Wardens, and Agency leadership. This report also details:

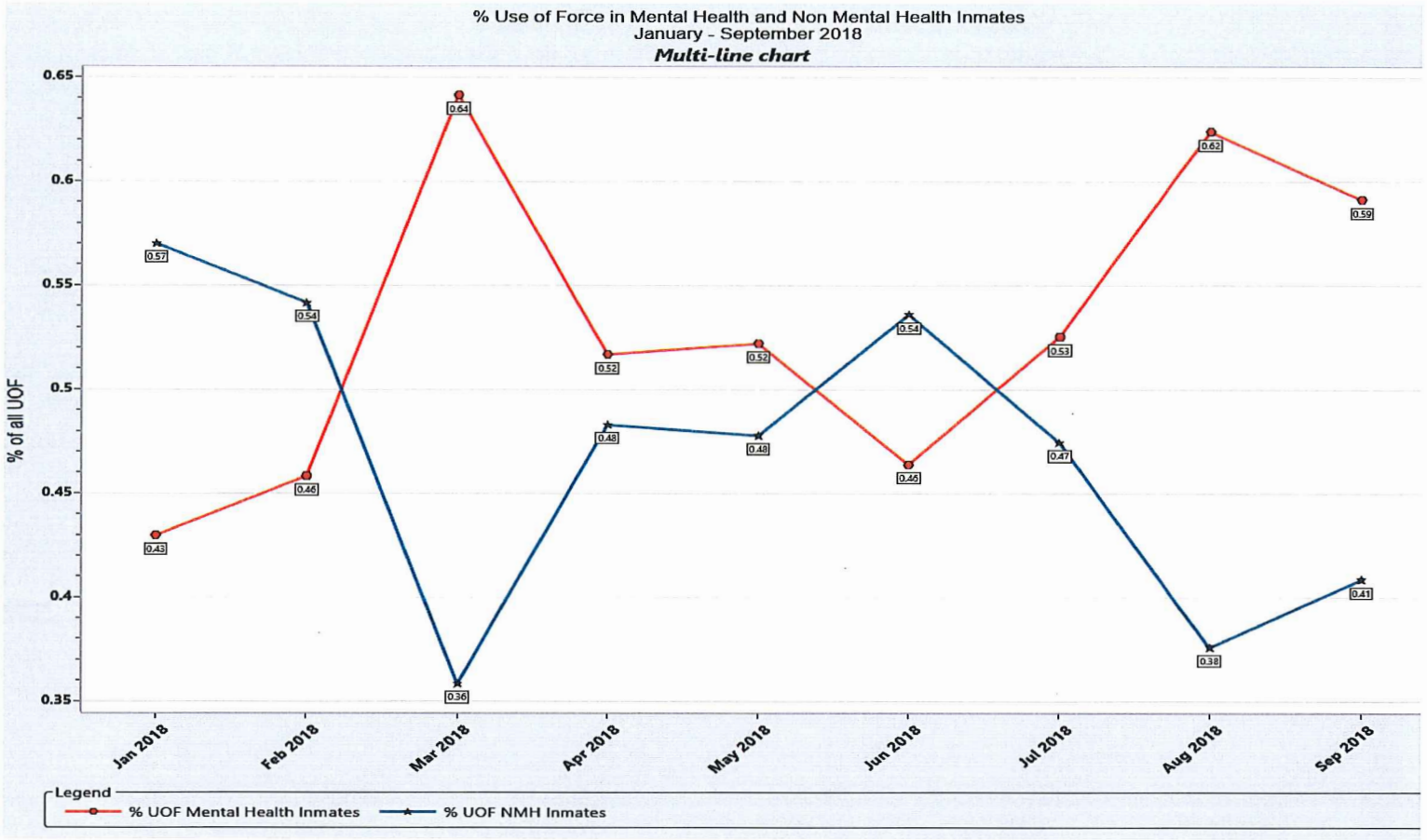
- Agency Use of Force by Type
- Video Review
- Grievances Related to Use of Force
- Grievances Filed by Inmates with a Mental Health Classification
- MINS: Mainframe vs Use of Force Application

- Exception Reports

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

The following chart shows a comparison of use of force incidents in mentally ill and non-mentally ill inmates. The data took into account the number of use of force incidents. The data continues to show a disparity in UOF incidents involving mentally ill inmates.

A larger picture of the following chart is also included in Appendix Z.



November 2018 Implementation Panel findings: As per SCDC update.

November 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 November 2018 Assessment: compliance (March 2017)

October 2018 SCDC Status Update:

RIM produces monthly that provide data on time served (in days) for removals from long-term and short term RHU from January –September 2018. See screenshots below. The most recent reports, distributed on October 4, 2018 are included as Appendix A1.

Time Served (in days) for Removals from **Short Term RHU Custody (DD and ST)** during **SEPTEMBER 2018**

	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	435	1	141	26	20
Non-Mentally Ill Removals from RHU	250	1	141	26	20
Mentally Ill Removals from RHU	185	1	133	26	20

Note: Numbers reflect removals from short term RHU custody (DD – disciplinary detention and ST – short term lockup) during each month. 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.

RIM also produces and distributes, by institution, lists of inmates in SD, DD, MX, ST, AP and SP custody that includes inmates' name, beginning date in custody level, number of days at custody level, dorm, and current mental health classification. See screenshots below. Inmates' names and SCDC numbers have been removed for confidentiality reasons. See Appendix A2 for the complete RIM reports.

Listing of Inmates Currently in SD, DD, MX, ST or AP Custody in SCDC Institutions, as of 20SEP18

Institution=ALLENDALE

Days in DD/SD/MX/ST/AP Cust	SCDC #	Name	Current Custody	Begin Date in DD/SD/MX/ ST/AP Custody	Dorm	Current Mental Classif
591	INMATE 1	NAME 1	SD	02/06/17	MA 0111A	MH
504	INMATE 2	NAME 2	SD	05/04/17	MA 0123A	L4
472	INMATE 3	NAME 3	SD	06/05/17	MA 0208A	L4
462	INMATE 4	NAME 4	SD	06/15/17	MA 0114A	L4

The most recent CISP admissions report is included as in the Patterson Document Drop, Mental Health Caseload Information, and number 15, CISP Entries including Average Length of Stay for Inmates who were on Crisis during the monitory period. This report is based on the CISP application and not just admissions to CSU.

The following summarizes CISP Admissions June 2018 - September 2018:
Admissions = 980
Average Length of Stay = 7.32 days
Median Length of Stay = 5 days
Average and Median include Active (used Today - Date on Crisis)

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

November 2018 Implementation Panel Recommendations: Continue to produce and disseminate quarterly reports reflecting total and average lengths of stay in segregation and CI for mentally ill

and non-mentally ill inmates by segregation status and by institution

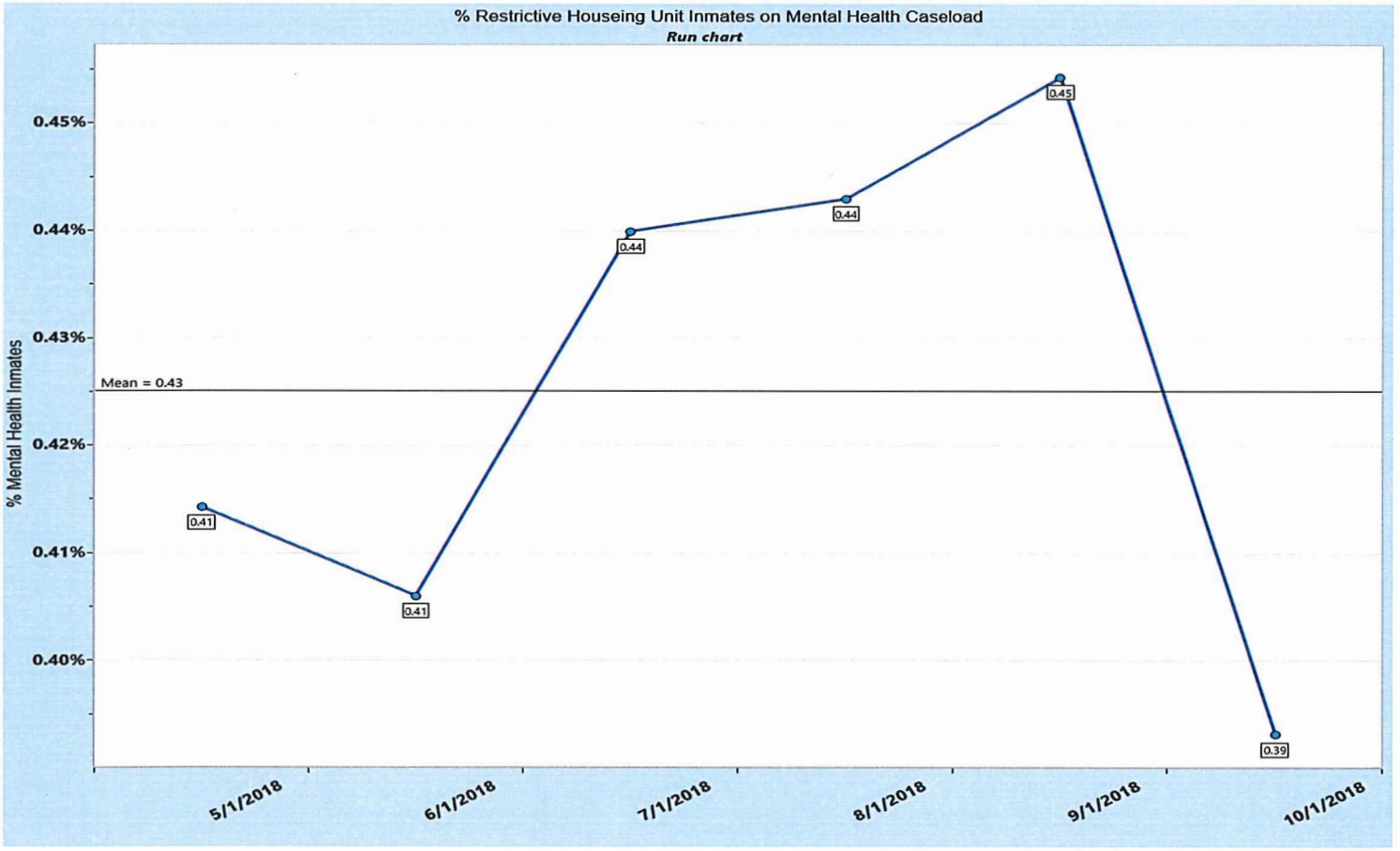
4.a.viii. Quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution;

Implementation Panel July 2018 Assessment: compliance (March 2017)

October 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 following chart shows a percentage on the mental health caseload who are in currently in the RHU.

A larger picture of the following chart is also included in Appendix Z.



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

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

4.a.ix. Quality management documents; and

Implementation Panel November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:

The maintenance of accurate, complete, and confidential mental health treatment records continues to be improved through using an interdisciplinary approach involving RIM (EHR), QIRM, Operations, Administration, Medical and Mental Health. These areas continue to meet to identify methods to will dramatically improve SCDC's ability to store and retrieve, on a reasonably expedited basis, quality management document's including databases and reports to drive improvement and compliance initiatives.

On Monday, October 8, 2018 a meeting was convened to discuss documents and reporting from the EHR as it relates to ongoing reporting of information required tor monitoring the provision of services. The following reports that had been regularly generated from the AMR but would now be generated from the EHR were discussed in the meeting:

1. **Treatment plans (new report)** - this would be a new report that includes the dates the initial treatment plan was completed and the dates the treatment plans were updated
2. **Structured time for MI inmates**- includes sessions with the QMHP and Psychiatrist and group services along with duration of time for each service
3. **Structured Time for MI inmates in the RHU**– per Monday's discussion, this can be included on the report above with an indicator that the inmate has a custody level for RHU
4. **Confidential sessions with the QMHP and Psychiatrist** – an indicator can be included in the structured time report that will show whether the sessions with the QMHP and Psychiatrist were marked as cell front or confidential
5. **Caseload Monitoring**- used to monitor timeliness of sessions with the QMHP and Psychiatrist, includes the last 5 sessions with the QMHP and Psychiatrist and includes an indicator for overdue sessions
6. **Medication administration (new report)** – this would be a new report used to monitor medication compliance; per the discussion on Monday, this report can be generated by institutional staff and QIRM staff
7. **Inmates with psychotropic meds prescribed and received (new report)** - Per the discussion on Monday, a request should be made to [redacted] o run a CIPS report

A follow-up email was sent from QIRM Manager, [redacted] to outline reports needed but not discussed during the meeting to include:

1. **RHU rounds**– includes RHU weekly rounds conducted by the QMHP and/or MHT
2. **Treatment team participation (new report)** - this would be a new report that would include all treatment team participation by discipline documented in NextGen.

EHR staff stated that the first reports would be distributed on December 1, 2018 to include data from November 2018.

RIM/EHR staff have trained the entire help desk staff to be able to address generic user issues, with one help desk team member designated as a point of escalation and advanced knowledge. Four RIM staff members 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.

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

November 2018 Implementation Panel Recommendations: Implement the above referenced reports.

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

Implementation Panel November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:
The EHR staff has completed the roll out to all of facilities, and anticipates the utilization of eZmar for reporting and validation purposes. Staff are currently able to pull preliminary medication compliance reports and will transition to formalized versions in the coming weeks.

Systems Reviews and Upgrades completed since the July 2018 IP visit:

- Laboratory Interface developed and deployed
- Reconfiguration of pharmaceutical formulary within the system to streamline prescriber access and increase ease of clinician workflow.
- Configuration of backend reporting services is ongoing with targeted completion of training and full utilization by November 1, 2018

Planned EHR improvements relative to medical and medication administration include:

- Simplification of workflows to optimize end user efficiency
- Go live of a functional interface with our x-ray imaging system (PACS).
- Clinical decision tree development to assist end user clinicians in determining appropriate standards for care.
- Development of pharmaceutical encounters and review templates to provide tracking of therapeutic levels of prescribed medications, timeliness of follow-ups, and provide enhanced clinical oversight.

November 2018 Implementation Panel findings: As per status update section

November 2018 Implementation Panel Recommendations: Implement the planned EHR improvements.

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 November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:
See response for *4.a.iv.*

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

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

November 2018 Implementation Panel findings: noncompliance

October 2018 SCDC Status Update:
Food flap are currently being installed in the general population units. The installation of food flaps in the general population will decrease the need for medication delivery under the door. The parenthetical numbers indicate the order in which the food flaps are being installed.

Institutions	Food Flap Fabrication			
	Institution Level	Food Flaps Needed	Food Flaps Installed	% Food Flaps Installed
Allendale	L2	500	130	26%
Broad River (3)	L3	856	856	100%
Evans (7)	L2	612	380	62%
Kershaw (10)	L2	736	532	72%
Kirkland	L3	None	None	N/A
Lee (1)	L3	None	None	N/A
Lieber (2)	L3	504	279	55%
McCormick (4)	L3	496	174	35%
Perry (5)	L3	384	256	67%
Ridgeland (6)	L2	None	None	N/A
Turbeville (8)	L2	None	None	N/A
Tyger River (9)	L2	211	151	72%
Total		4299	2758	64%

In addition, SCDC is supplementing the current food flaps in the RHUs with "non-contact" food flaps to prevent inmates from throwing substances or assaulting staff when the food flaps are opened.

Institutions	Food Flap Fabrication			
	Institution Level	No-Contact Food Flaps Needed	No-Contact Food Flaps Installed	% No-Contact Food Flaps Installed
Allendale	L2	0	0	N/A
Broad River (3)	L3	96	2	2%
Evans (7)	L2	96	5	5%
Kershaw (10)	L2	96	0	0%
Kirkland	L3	0	0	N/A
Lee (1)	L3	192	0	0%
Lieber (2)	L3	95	0	0%
McCormick (4)	L3	96	1	1%
Perry (5)	L3	192	2	1%
Ridgeland (6)	L2	42	2	5%
Turbeville (8)	L2	42	0	0%
Tyger River (9)	L2	84	0	0%
Total		1031	12	1%

November 2018 Implementation Panel findings: Staff reported that three institutions continue to have medications delivered under the cell door. Our opinion remains unchanged that this practice is below the standard of care.

November 2018 Implementation Panel Recommendations: Remedy the above.

5.a. Improve the quality of MAR documentation;

Implementation Panel November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:
With the exception of a MARS summary from BRCI, no reports were submitted from the institutions from the medical and health services staff at the institutions; however QIRM conducted a CQI study reviewing Medication Administration Records (MARs) of inmates housed at Camille, Kirkland, Broad River, Evans, Lee, and Lieber Correctional Institutions.

As was anticipated, the introducing of the NextGen EHR and eZmar has made medication administration more cumbersome as nurses are learning the system at most institutions. Camille, Broad River, Lee, and Lieber submitted printouts of the eZmars. Except for Camille, who has been using the eZmars for about a year, these institutions' percent compliance in nursing documentation and % of doses documented as received by the inmates was poor, as was expected. At BRCI, which provided two months of eZmars, and Lieber, where three months of

eZmars were provided, each subsequent month showed improvement in the nurse documentation and inmate compliance. It is hoped that this improvement will continue in future months.

QIRM reports the summary of the MARS reviews by institution in the CQI study in APPENDIX A3.

November 2018 Implementation Panel findings: As per status update section. eZmars continues to be a work in progress.

November 2018 Implementation Panel Recommendations: As per status update.

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

Implementation Panel November 2018 Assessment: noncompliance

October 2018 SCDC Status Update:

Medication Issues (In General)

The conversion from the AMR to NextGen has now been completed with the final Level 1 and 2 facilities coming on board in late September. This transition includes the electronic Medication Administration Record, eZmar, which is a stand-alone module, purchased in addition to NextGen. There have been numerous difficulties during this transition, as there are with any conversion from paper to an Electronic Health Record (EHR) but even more so with transitioning to two products from two separate manufacturers, particularly with NextGen having a separate vendor outsourced for the correctional specialized, that being Medicalistics, which somewhat complicates the navigation of problem resolution.

Data gathering from this system has been especially problematic. As such, several efforts have been undertaken to expedite report-writing and information development.

1) The agency has hired a consultant in an attempt to glean reports for structured time to get data and information from the record system.
2) In addition, the Business Analyst position has finally been filled with a candidate familiar with report writing and she is focusing on the eZmar medication information, Heather Halliday.

As such, although detailed reports and data may not be readily available for this reporting period due to the recent conversion of the entire statewide system to the EHR and the eZmar and the prior lack of report-writing capability, future endeavors should show improvement.

The Deputy Director and Assistant Deputy Director of Administration, the Deputy Director of Health Services, the Branch Chief responsible for the roll-out of the EHR and the Division Director for IT, and key clinical stakeholders from Health Services , are now meeting together every few weeks to identify key issues and deliverables and target resolution for improved field use.

November 2018 Implementation Panel findings: As per status update section. Our March 2018 findings included the following:

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

Our opinion remains the same.

November 2018 Implementation Panel Recommendations: Remedy the nursing shortage.

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

Implementation Panel November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:
A chart outlining agency pill limes are included in the Patterson Document Drop, folder 8-Medication Issues, subfolder 30, document, *Copy of SCDC Pill Lines Nov 2018*. This document includes:

- Yard pill pass times
- RHU pill pass time
- Meal Times
- Psychiatry Visits
- Method of Delivery
- Method of use for administering
- RHU

Health services reports an improvement. McCormick is still doing under-the-door medications in three units and is tiering now to come off of lockdown. In July six facilities were using this method.

November 2018 Implementation Panel findings: As summarized in a previous section, administration of medication under the door is not acceptable. Many morning and hs medication pill call lines are scheduled at unreasonable hours related to nursing staff shortages.

November 2018 Implementation Panel Recommendations: Remedy the above.

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

Implementation Panel November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:
Nursing reports the missed doses of medication/noncompliance to the QMHP regarding the missed mental health medication. The QMHP then assesses the inmate and notifies the mental health provider.

The EHR/EZMAR/Nextgen system automatically notifies the provider of 3 consecutive missed doses of medication. After receiving the notice of missed medications, the provider notifies the QMHP via NextGen to schedule the inmate for additional counseling/review.

Industrial Engineer is coming to South Carolina on November 19 and 20 to visit our pharmacy as well as BRCI, KCI and Ridgeland to do a time/motion study to evaluate the current methodology of medication packaging and dispensing and the time spent by nursing staff in checking in the medication against the manifest, preparing the medication into pill/coin envelopes for AM and PM dosing by day, setting up the medication and repackaging for multiple days, administering the medication and storing the medication in the facilities. He will then prepare an objective report assessing the various packaging options potentially available, vendor neutral, to improve efficiency and effective and free up nursing time to improve job satisfaction and safety and patient adherence to medications and compliance as well as documentation such as scanning. Health Services will use this report to determine the packaging system most opportune to move forward with a RFP for purchasing.

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

November 2018 Implementation Panel Recommendations: It is anticipated that the eZmar system will eventually facilitate an adequate QI process for reviewing the medication administration process.

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 November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:
All CI cells remain approved as reported by the Division Director of BMHSAS. A safe cell inspection form has been developed and is attached as Appendix A4. MH Managers will be required to submit this form with their monthly statistics beginning November 2018.

SCDC continues to make improvement in safe cells. The following provides a status update on the installation of anti-ligature camera in the crisis intervention cells. Eight of the twenty-one areas with crisis cells are 100% complete; one is 75% complete; and two are 50% complete.

Broad River – Greenwood Dorm	32 – 100% Complete 7/10/2018
Camille – Blue Ridge Dorm	10 – 100% Complete 7/12/18
Camille - RHU	2 – 100% Complete 7/11/18
Kirkland – F1	8 – 100% Complete 7/19/18
Kirkland – GPH CI Cells	10 – 100% complete 7/19/18
Allendale	4 Cameras – 10% complete - Waiting on RIM to complete programming of the Switches and to provide IP addresses for our equipment.
Camille	6 Cameras – Verification is being done to see if all CI cells at Camille have been complete. Verified with Warden Boulware that all anti-ligature cameras

	have been installed. 9/25/18
Evans	3 Cameras
Kershaw	4 Cameras –Mental Health and Major have stated that there are only two CI Cells here. We will start on installation of Infrastructure week of 10/1/18. Waiting on RIM to complete programming of the Switches and to provide IP addresses for our equipment.
Kirkland GPH – Mental Health Cells	19 Cameras - 100% Complete
Leath	4 Cameras – 40% complete - Waiting on RIM to complete programming of the Switches and to provide IP addresses for our equipment.
Lee	4 Cameras - 100% Complete 8/23/18
Lieber	4 Cameras
McCormick	2 Cameras –Project is 50% Complete Camera infrastructure has been installed. Waiting on RIM to complete programming of the Switches and to provide IP addresses for our equipment.
Perry	6 Cameras – 50% Complete - Waiting on RIM to complete programming of the Switches and to provide IP addresses for our equipment.
Ridgeland	2 Cameras – 10% Complete - Waiting on RIM to complete programming of the Switches and to provide IP addresses for our equipment.
Trenton	1 Cameras - Camera infrastructure has been installed. Waiting on RIM to complete programming of the Switches and to provide IP addresses for our equipment.
Turbeville	4 Cameras – 10% Complete - Waiting on RIM to complete programming of the Switches and to provide IP addresses for our equipment.
Wateree	2 Cameras – 75% Complete Camera infrastructure has been installed. Waiting on RIM to complete programming of the Switches and to provide IP addresses for our equipment.
Tyger River	2 Cameras

November 2018 Implementation Panel findings: Compliance is present re: all CSU cells being located in a healthcare setting. Due to custody staffing shortages, it was common for QMHP clinical contacts to not occur in a setting with adequate confidentiality.

During the afternoon of November 13th, we observed a staffing of three inmates in the BRCI CSU. Similar to our past observation of such staffings, two of the inmates' precipitating factor for the admission appeared to be primarily a safety concern.

Our March and July 2018 findings included the following:

> It was very common that CSU patients had been admitted following a self-harming event or suicide attempt which was later assessed to have been directly related to safety and security concerns or other custodial issues. Interventions within the CSU frequently involved a "therapeutic transfer" that was often only a temporary solution as evidenced by subsequent repeat CSU admissions within the next six months. Such interventions turned out to be temporary solutions due to resource issues at the

receiving institution that resulted in recommended interventions not being implemented.

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

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

November 2018 Implementation Panel Recommendations: The above issues have not yet been resolved. Please refer to our recommendations, summarized in the provision re: the "Denials Committee," for additional recommendations.

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

Implementation Panel November 2018 Assessment: compliance (December 2017)

October 2018 SCDC Status Update:
Logs continue to be provided to the QIRM analysts and observation during institutional audits did not identify inmates being placed in a holding cell or other alternative space. In a review of the cell check logs by QIRM staff, there was no documentation to indicate that shower stalls, rec cages, holding cells, and interview booths were being used for CI purposes.

November 2018 Implementation Panel findings: As per status update section

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

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

Implementation Panel November 2018 Assessment: noncompliance

October 2018 SCDC Status Update:
Prior to the July 2018 site visit, the Assistant Deputy Director of Operation sent an email to all wardens, associate wardens, and majors with a reminder of various forms available through the intranet including the Constant Observation Log SCDC Form 19-7. A follow-up email was sent on August 29, 2018 referencing the July 27, 2018 email reiterating appropriate documentation and of constant observation.

After the August 29 email, Operations leadership staff were made aware that some staff were still using the wrong form to document employee constant observation. An email providing clarification with the appropriate form attached was sent on September 18, 2018. The form was further updated, changing the heading from "CONSTANT OBSERVATION LOG/EMPLOYEE" to "CONSTANT OBSERVATION LOG (FOR USE BY EMPLOYEE" to ensure staff utilized the appropriate form for documentation.

The Crisis Stabilization Unit (CSU) was opened over two years ago at BRCI and at CGCI approximately one year ago. A staple of this program is the implementation of the inmate watcher program wherein selected inmates were trained on how to monitor inmates while in crisis. The Inmate Watchers observe and document the inmates' behavior, much like the uniformed staff do when they are watching inmates placed on "constant observation" status. Considering the staffing issues most institutions have, SCDC has determined that it would be beneficial for each institution with an RHU to implement the inmate watcher program to assist in monitoring inmates placed on constant observation status.

Inmate Watchers must be under the supervision of uniformed staff while performing their constant observation duties, but the inmate watcher would be posted directly in front of the cell while the supervising uniformed staff can perform other tasks while frequently monitoring the performance of the inmate watcher.
On September 4, 2018, the Assistant Deputy Director of Operations requested each institution with an RHU to submit names of at least ten (10) that could perform this duty. Special training would be coordinated for these inmates prior to them actual serving in this role.

As of September 21, 2018, the following number of potential inmates were identified by institution. QIRM and Operations will monitor and report completion of training and final selections.

Institution	# Potential Inmate Watchers Identified
Allendale	10
Broad River	12
Camille	11
Evans	10
Kershaw	3
Kirkland	10
Leath	10
Lee	10
Lieber	10
McCormick	15
Perry	10
Ridgeland	10
Trenton	11

Turbeville	11
Tyger River	10

Staff

Documentation of constant observation in institutions continues to be concerning. A request from the DDO for constant observation forms resulted in documentation for two inmates being sent to QIRM. Inmate 1 had two forms, one of which had illegible documentation on the bottom which impacted the ability to analyze the data. The institution was unable to locate the original document for resubmission. There were three forms for Inmate 2. The summary of the analysis is below:

SUMMARY	Inmate 1	Inmate 2
% Compliance with <= 15min checks	64%	68%
Longest time between checks	24	135
Average time between checks >15	18	23
COUNT # Checks > 15 min	31	80

A second request was submitted with a new deadline by the DDO; however, one of the two responding institutions submitted the wrong documentation. The second institution submitted the documentation too late for QIRM to complete an analysis.

Inmate Watchers

At Camille Graham, of the eight logs submitted for Inmate 1, the constant documentation every 15 minutes was consistent; however, there was no documentation provided to show that continuous watch continued throughout the night until the next watcher shift started in the morning.

At Broad River CSU, there were multiple times, and sometimes multiple times for within a day on the same inmate, when watchers would document that an inmate was out of the cell (Code "4") and the next time documented was more than 15 minutes later, but no staff documentation accompanied the watcher logs to fill in the gaps of time unaccounted for. Most of the time, along with the code "4", the watcher would document the reason the inmate left the observation cell. Typical reasons were, "Shower," "Treatment room," "Group", etc. The amount of time out of the cell was not always consistent with the reason documented for leaving (such as being gone 2 hours for a shower).

The results of this review are included in the Patterson document drop, folder 6- Quality Improvement –Assurance, subfolder 24.

November 2018 Implementation Panel findings: As per status update section. We strongly disagree with the use of inmate observers outside of the CSU due to both supervision issues and current data as reported in the status update section.

Lee CI

Information provided prior to the site visit indicated 23 inmates had been placed on crisis intervention (CI) status and none were referred and transferred to the CSU at Broad River within 60 hours as required by policy. Staff informed the IP that none of these inmates had been placed on constant observation as required by policy. The staff reported that all 23 inmates received a Columbia Suicide Risk Assessment (SRA) prior to release from suicide precautions as per policy and all 23 were "low risk". The IP requested 10 of the 23 SRA's be provided and the IP and Dr. Salley Johnson, SCDC consultant, received only 6 of the 10 requested. Of the 6 reviewed, only 2 document submissions had a suicide risk screening form which was a daily suicide screening document, not the SRA required. The staff could not demonstrate or provide the requested SRA's and acknowledged they had not been done. This is a very serious and unacceptable practice. The IP recommends a system wide QI to assess whether this practice is occurring in other facilities, with corrective action plans.

Evans CI

Staff reported that the decision whether or not to place inmates on constant observation prior to being seen by a QMHP is generally being made by a registered nurse. We discussed with staff that inmates waiting to be seen by a QMHP following a referral for suicide risk should always be placed on constant observation. R.N.s generally do not have the credentials to perform an adequate suicide risk assessment.

November 2018 Implementation Panel Recommendations: Remedy the above.

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

Implementation Panel November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:

The July 2, 2018 email referenced above in 6.c included directives regarding the availability of suicide resistant mattresses. Staff were directed to ensure suicide-resistant mattresses were in stock or, in places where mattresses may not be available, staff were instructed to coordinate with the commissary manager immediately to place an order.

Per Health Services, all vendors have been notified of SCDC's intent to not renew current contracts for the suicide smocks, blankets and all-in-one beds. The end date for smocks is October 9, 2018 and December 4, 2018 for all-in-ones. A large quantity of the all-in-ones remain in stock in the Commissary that will need to be utilized.

An email on September 26, 2018, from the BMHSAS Division Director reports an order for new suicide-resistant mattresses has been placed with an expected arrival dates in December.

November 2018 Implementation Panel findings: As per status update section. Review of a November 2018 QIRM report indicated that this directive was not implemented at all prisons. For example, inmates in Unit F1 at Kirkland were not provided with a mattress because

"inmates destroy them and use them as weapons." Similar issues were present at the Broad River RHU.

November 2018 Implementation Panel Recommendations: The default exclusion of mattresses at the above institutions should be changed so that the decision to not provide a mattress is based on factors specific to the individual in question.

6.e Increase access to showers for CI inmates;

Implementation Panel November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:
Institutions reported the percent of showers offered in the RHUs for each of the reporting months but did not include a report of the percentage of inmates who were offered the minimum number of showers required by policy nor were CI cells identified as being specifically included in the institutional review.

Broad River and Camille CSU staff provided a databases of showers for June-September 2018 (July-September 2018 BRCI). Policy HS 19.03 INMATE SUICIDE PREVENTION AND CRISIS INTERVENTION section *8.5 stipulates RHU inmates in CSU will be allowed daily showers if security staffing presence permits. Otherwise, RHU inmates with be allowed to shower a minimum of 3 times a week. Non-RHU inmates will be allowed to shower daily, unless restricted by a psychiatrist or licensed psychologist for clinical reasons.*

The compliance rates are framed by policy as it relates to RHU-status inmates' receipt of a minimum of three showers and non-RHU inmates' receipt of showers daily. In an effort to assess showers based on the IP's recommendation that *SCDC Operations and Mental Health Staff need to implement revised procedures to ensure inmates on CI status receive their required access to showers. An accurate electronic or manual system needs to be developed and implemented to record CI inmates are receiving showers in compliance with the established shower schedule,"* an analysis of the information submitted by both CSUs was completed to show compliance rates by assessing the number and percentage of inmates who received showers in compliance with the established shower schedule.

The following charts provide a snapshot of showers for inmates in the CSU based on data provided by the institutions. The detailed reports for both CSUs are included as APPENDIX A5.

Camille Graham

CAMILLE GRAHAM CSU	June 2018 CSU	July 2018 CSU	August 2018 CSU	September 2018 CSU
GP (Non-RHU) status inmates (Daily showers offered)				
# inmates in this sample	9	10	6	6
# Non-RHU inmates offered daily showers as required by policy	1	2	0	0
% Non-RHU inmates offered daily showers as required by policy	11%	20%	0%	0%

Minimum of Three Showers

RHU status inmates (Minimum of 3 showers offered)	July 2018	August 2018	September 2018
# inmates in this sample	2	1	1
# inmates offered the required minimum of 3 showers	0	0	0
% RHU-status inmates offered and received a minimum of 3 showers as required by policy (offered + refused)	0%	0%	0%

Broad River

BRCI CSU	July 2018 CSU	August 2018 CSU	September 2018 CSU
GP (Non-RHU) status inmates (Daily showers offered)			
# inmates in this sample	15	12	19
# Non-RHU inmates offered daily showers as required by policy	0	0	5
% Non-RHU inmates offered daily showers as required by policy (offered + refused)	0%	0%	26%

Broad River			
RHU status inmates (Minimum of 3 showers offered)			
# inmates in this sample	4	6	5
# inmates offered the required minimum of 3 showers	3	4	5
% RHU-status inmates offered and received a minimum of 3 showers (offered + refused)	75%	67%	100%

RHU Inmates with a 7-day CSU Admission

When security staffing presence doesn't allow for three showers per week RHU inmates should be allowed to shower a minimum of 3 times a week. The following chart shows showers offered and provided to RHU inmates with a one-week admission. Limitations to determining shower allotment for inmates with a less that one-week stay is outlined below.

Percentage of RHU Inmates with a 7-day CSU Admission Receiving a Minimum of Three Showers Per Week			
	July	August	September
# RHU Inmates with a 7-day CSU Admission	3	2	2
# RHU Inmates with a 7-day CSU Admission receiving 3 showers (offered + refused)	2	2	2
	67%	100%	100%

Policy OP-22.38, section **35.3 states** inmates in the RHU will be afforded the opportunity to shower three (3) times per week. An analysis was completed to determine if inmates in the RHU were offered 3 showers a week. A sample of ten inmates were used for each of the months of June – September. The analysis included reviewing showers for one week per month. At Broad

River and Camille Graham, before the sample was chosen, the RHU Drop Down Report for Saturday of each of the weeks reviewed was filtered to show inmates who were in the RHU for at least 7 days. Next, the OATS report was exported for that week for each of the months. A random sample of 10 inmates was chosen from the RHU Drop Down Report and the OATS report was filtered to for those 10 inmates. For Evans and Lee, the cell check logs received from the institution were used as documentation for showers. A shower was counted as offered if the documentation reflected a "Y", "R", or "I" in the shower column.

Rates are listed as offered and received because the documentation reflects that inmates who were offered the showers also received them.

Broad River
Out of a sample of 10 inmates, the compliance rates for showers offered and received 3 times during a week in the months of June, July, August and September were 100%, 0%, 0%, and 10% respectively.

Camille Graham
Out of a sample of 10 inmates, the compliance rates for showers offered and received 3 times during a week in the months of June, July, August and September were 80%, 0%, 90%, and 90% respectively.

Evans
Out of a sample of 10 inmates, the compliance rates for showers offered 3 times during a week in the months of June, July, August and September were 0%, 0%, 0%, and 0% respectively.

Lee
Out of a sample of 10 inmates, the compliance rates for showers offered and received 3 times during a week in the months of July and August were 40% and 30% respectively.

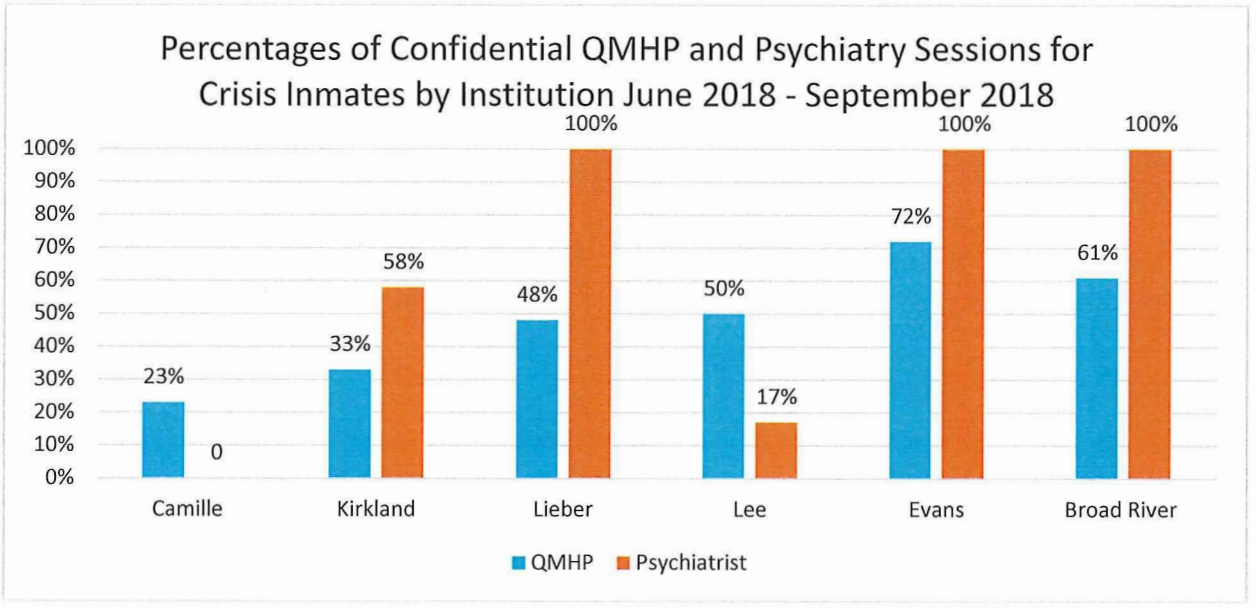
November 2018 Implementation Panel findings: As per status update section.

November 2018 Implementation Panel Recommendations: Remedy the above.

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

Implementation Panel November 2018 Assessment: noncompliance

October 2018 SCDC Status Update:
A random sample of 10 inmates who were on crisis intervention status at some time during the reporting period of June 2018 – September 2018 were selected from each institution. An analysis was completed to determine if sessions with the QMHP and Psychiatrist were documented as confidential. The inmates were chosen from the databases provided by mental health staff. A review of documentation in NextGen and/or the AMR was conducted to complete the analysis. The percentages are based on the total number of documented sessions by both disciplines and the number of those sessions that were documented as confidential.



November 2018 Implementation Panel findings: As per status update section. Access to confidential spaces continues to be problematic.

November 2018 Implementation Panel Recommendations: Remedy the above.

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

Implementation Panel November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:
See *2b.vi*.

November 2018 Implementation Panel findings: See 2 b.vi.

November 2018 Implementation Panel Recommendations: See 2 b.vi.

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

Implementation Panel November 2018 Assessment: partial compliance

October 2018 SCDC Status Update:
Mental Health Reporting
Training for MH staff for institutional reporting
The Division of BMHSAS conducted a training for data reporting on August 23, 2018 led by Chief of Psychology, Dr. [redacted] Areas of reporting for MH Managers included:

- Timeliness of QMHP/Psychiatry Sessions
- Staff training/Supervision
- Treatment Team Meeting Attendance
- Treatment Plan Updates
- Structured Time Out of Cell
- RHU Rounds & Services Provided
- Crisis Intervention/Suicide Precaution
- Mental Health Disciplinary Treatment Team Report
- Referrals to MH
- Mental Health Group Therapy Attendance

MH leadership reiterated the importance of taking ownership of the data and developing an internal process to measure compliance.

Institutional staff began submitting reports and documentation to QIRM on October 3, 2018. Additional reports and supporting documentation continued to be provided through late October.

BMHSAS has established a process of regular reporting and submission of data. A follow-up email to an October 8, 2018 conference call reminded staff the monthly data reports would be due by the 10th of each month. A shared folder was created, providing accessibility to QIRM for auditing purposes as of October 8, 2018.

The Division Director of Behavioral Health Services reports he and the Deputy Director of Health Services meet with all MH Program Managers quarterly to review compliance reports and to identify/resolve root causes for why programs are able to come into compliance with the MH Settlement Agreement.

October 2018 SCDC Status Update:

The following chart outlines the process for monitoring SCDC policy, *19.03 Inmate Suicide Prevention and Crisis Intervention*

Component to be Monitored	Process for Monitoring	
Monitor and track all suicides and suicide attempts statewide.	Agency Suicide Prevention Committee convenes a meeting after every completed suicide to identify root causes from an institution and systems perspective. A report is compiled listing findings and recommendations from every review. QIRM recently announced at the Agency Suicide Prevention Committee they will begin monitoring follow-up from recommendations made at the committee. Local Suicide Prevention Committee-meets every quarter and review all suicide attempts statewide.	The ASPC makes recommendations based on information discussed during the ASPC meeting. Wardens and program leadership were recently asked to submit responses to the recommendations. Review of responses in ongoing to track and monitor improvements.
Provide for the selection and dispatch of a mental health suicide reviewer (MHSR) after a suicide occurs.	Agency Suicide Prevention Committee – The Mental Health Suicide Reviewer (MHSR) dispatches 72 hours after a completed suicide. A roster and summary report is included as part of the Agency Suicide Prevention Committee final report.	Six MHSR reviews were completed. Two of the six (33%) MHSR reviews were completed within the 72 hours. Per the Division Director of BMHSAS, because of the length of time it took for the coroner to officially rule the death a suicide, an agency-briefing with front line staff was not applicable. Regarding scheduling of the MHSR's, the BMHSAS Division Director reports the timeliness of scheduling the reviews within 72 hours is dependent on the schedules of security and nursing staff who were on duty at the time of the suicide.

All staff with the responsibility for inmate supervision will receive 8 hours of training in mental health related content to include suicide prevention and intervention. New employees will receive the training during institutional orientation and/or during the Correctional Officer Certification Course.	Training Records kept on file regarding employees who have completed mandatory trainings. This information is available to QIRM.	The RIM report, *C.O.s Required to take Managing MI Offenders Training in CY 2018 (Jan 1 - Oct 15, 2018)* included as Sparkman document drop, folder number 5- subfolder 5b (tab Training Needed-included below), shows by institution, the number and percentage of staff who have not completed the following required training. **One-Time Training** • Agency Orientation • Basic Training **Annual/In-Service Training** • Suicide (Basic) • Inmate Suicide Prevention Part 1 • Inmate Suicide Prevention Part 2
SCDC certified correctional officers, and all medical and mental health staff (SCDC and contract) are required to maintain CPR certification every two (2) years. All other employees with direct inmate contact/supervision are strongly encouraged to become certified.	Training Records kept on file regarding employees who have completed mandatory trainings. This information is available to QIRM.	Reports for correctional officers, and all medical and mental health staff (SCDC and contract) are included in Appendix A6
Suicide Risk Assessment - All inmates scoring a positive result for suicidality on the MHSF-III and receiving an emergent or urgent evaluation are administered the Columbia Suicide Severity Rating Scale (C-SSRS)-Lifetime/Recent form by a QMHP to identify modifiable or treatable acute, high-risk suicide factors, and available protective factors that inform of inmate's treatment and safety management requirements.	Information tracked through Divisional Audits performed by Q/A staff within the Division of Behavioral Health and results shared with QIRM. The Division of QIRM also conducts independent on site audits at institutions to collect information.	Institutional staff self-reported. No documentation was included with reports for auditing purposes; however, these items have been requested for assessment and monitoring. An update will being available for discussion and written reports available during the site visit.

Upon referral, during normal working hours, the QMHP assigned to the institution will provide a confidential, face-to-face evaluation the same working day and the C-SSRS Lifetime/Recent form will be utilized. This evaluation will be documented in the Automated Medical Record (AMR or EHR). During off duty hours, the on-call Mental Health Professional will provide a telephone consultation within 30 minutes of being paged by Medical or Correctional staff. Continuous observation (face-to face, in person) will be provided while awaiting an assessment by a QMHP.	Information gathered from documentation completed by the QMPHs and audited by Behavioral Health Q/A and QIRM staff.	Institutional staff self-reported. No documentation was included with reports for auditing purposes; however, these items have been requested for assessment and monitoring. An update will being available for discussion and written reports available during the site visit.
Inmates on CI/SP or Observation Status are re-assessed at a minimum every 24 hours to identify changes in condition that indicate a need for a change in supervision level and placement. The C-SSRS Daily/Shift Screen form is completed as a part of the re-assessment	Information gathered from documentation completed by the QMPHs and audited by Behavioral Health Q/A and QIRM staff.	Institutional staff self-reported. No documentation was included with reports for auditing purposes; however, these items have been requested for assessment and monitoring. An update will being available for discussion and written reports available during the site visit.
Prior to an inmate's removal from CI, the inmate must be re-evaluated either face-to-face or via tele-psychiatry technology by a licensed psychologist or psychiatrist. The reason for removal shall be documented in the AMR	Information gathered from documentation completed by the QMPHs and audited by Behavioral Health Q/A and QIRM staff.	Institutional staff self-reported. No documentation was included with reports for auditing purposes; however, these items have been requested for assessment and monitoring. An update will being available for discussion and written reports available during the site visit.
Inmates needing CSU level of care will be transferred to the CSU at Graham (females) or Broad River (males) within 60 hours of the initial referral. If the QMHP determines a CSU level of care is not needed, or is undecided, the QMHP will consult with a psychiatrist or licensed psychologist within 48 hours of the initial referral regarding disposition. When an	Regarding the 60-hour threshold, information entered into Crisis Intervention/Suicide Precaution web based application by the QMHP is time stamped. Weekly reports are generated from the Division of Resource Information Management (RIM) system to the Division of Behavioral Health and QIRM for	Institutional staff self-reported. No documentation was included with reports for auditing purposes; however, these items have been requested for assessment and monitoring. An update will being available for discussion and written reports available during the site visit.

inmate arrives at the CSU, he/she will be evaluated by the psychiatrist or licensed psychologist within 24 hours. A preliminary treatment plan will be developed by a QMHP after conducting a clinical assessment.	compliance monitoring. Documented sessions for inmates arriving at CSU are obtained from chart reviews conducted by Behavioral Health Q/A and QIRM staff.	
All safe cells must be kept clean and temperatures regularly monitored and documented to assure they are in an appropriate range.	Cell check reports submitted from each institution to QIRM.	CQI Study completed and submitted in the Patterson document, folder 6- Quality Improvement-Assurance, subfolder number 21. .
All non-RHU CSU inmates, unless clinically contraindicated, shall have access to out-of-cell time for 10 hours of structured and 10 hours of unstructured activity in a seven day period. This includes access to the dayroom and outdoor recreation.	Structured time reports generated from EHR and unstructured time reports generated from the OATS automated system submitted from both CSU programs to the Division of BH and QIRM.	Reporting is not available through the EHR nor EMR. Institutional staff self-reported.
Training of Inmate Observers. Inmate Observers will receive at least four hours of initial training before being considered eligible for suicide watch duty. Additionally, each observer will also receive at least four hours of training semiannually	Bi-annual report submitted from CSU program staff to QIRM outlining training received from all Inmate Observers.	Documentation of training for current BRCI CSU inmate observers inmate observers Only 50% of BRCI's current CSU inmate observes have documentation of the completion of initial training. A summary of a review of the inmate observers' program at BRCI is included in the Patterson document drop, folder 6, Quality Improvement-Assurance, subfolder number 21. This information was not received for CSU inmate observes at Camille Graham by the writing of this report. This information will be available for discussion, with written reports available, at the IP site visit.

November 2018 Implementation Panel findings: As per status update section. We discussed with leadership staff the importance of involving nursing, custody and mental health staff in the QIRM process from the very beginning of the QI process for a variety of different reasons. Consultation with Dr. Johnson would also be very beneficial to the process.

November 2018 Implementation Panel Recommendations: As above.

Conclusions and Recommendations:

The Implementation Panel has provided its analysis, findings and recommendations in this report and on-site for this eighth site visit, which took place from November 12-16, 2018. Our recommendations have been consistent with those in previous reports for the great majority of the Settlement Agreement criteria. We have continued discussions with staff and inmates regarding the impact and sequelae of the major riot that occurred at Lee C.I. on April 15, 2018 which has impacted the whole system. The majority of facilities have had modifications or elimination of the statewide lockdown, however others have not. The Implementation Panel understands and appreciates the difficulties and complexities to totally ending the lockdown, which again is even more complicated because of the pre-existing and continuing staff deficiencies. The Implementation Panel re-iterated during the visit and in this report re-emphasizes that the IP does not endorse nor recommend SCDC engage in any practices that are unsafe for staff or inmates. However, the ongoing impact of these factors has been extremely problematic for the adequate delivery of mental health care and achieving substantial compliance with the Settlement Agreement. During the course of this visit the IP was requested to change the dates for the next site visit from March, 2019 to later next year, and to modify the IP document request to lessen the volume of documents. As stated earlier in this report, and clarified for staff on site, the third year of implementation of the Settlement Agreement ends on April 30, 2019. The IP is not able to change the March 4-8, 2019 site visit dates; however, based on discussions with SCDC leadership staff the IP has agreed to modify the document request on a trial basis for the March visit. The discussions included the process for specific criteria to "sunset," i.e. to no longer require IP review once the specific criterion has been in substantial compliance for a continuous 18 month period, unless there are significant changes relative to that criterion. We hope this process will be helpful, however strongly encouraged SCDC to continue their own internal monitoring to be able to demonstrate continuing compliance. We also understand SCDC is reformulating its process for data collection between QIRM and Mental Health and hope the anticipated changes will support consistent, valid and reliable information and analysis. The work done to date by QIRM has been very helpful to the IP and we look forward to even more improvement as the EHR becomes more functional for data mining and analysis.

As always, we hope this report has been informative and the technical assistance provided has been helpful. We appreciate the cooperation and assistance of all parties in the pursuit of these goals. The IP wishes a safe and happy holiday season to all, and we look forward to the next site visit in March, 2019.

SIGNATURE ON THE FOLLOWING PAGE

Sincerely,

Raymond F. Patterson, MD
Implementation Panel Member

On behalf of himself and:

Emmitt Sparkman
Implementation Panel Member