South Carolina Department of Corrections

HENRY McMASTER, Governor
BRYAN P. STIRLING, Director

July 31, 2019

The Honorable Edward R. Tallon, Sr.
South Carolina House of Representatives
Post Office Box 11867
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Marcia A. Lindsay, Deputy Director
Legislative Audit Council
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RE: Implementation Panel Reports

Dear Representative Tallon and Ms. Lindsay:

I am forwarding reports issued by the Implementation Panel and Mediator during the on-going mediation of the mental health lawsuit and settlement agreement in the matter of *T.R., P. R., K.W. and A.M. et al. v. South Carolina Department of Corrections*. After a recent mediation session with mediator Judge William L. Howard, it was clarified by the parties that the reports issued by the Implementation Panel will not be considered confidential mediation matters. I am uncertain whether the reports are responsive to a particular request or question from the House Oversight Committee and may contain more information than requested; however, in view of the recent mediation session and clarification, I provide the reports out of an abundance of caution.

I note that the reports were previously provided to the Legislative Audit Council but were designated as confidential documents. I ask that the documents no longer be considered confidential. Note that private health, staff names and other identifying information are redacted from the reports.

Please advise should you require additional information or have any questions.

Respectfully,

Bryan P. Stirling

Bryan P. Stirling

cc: The Honorable Wm. Weston J. Newton
The Honorable Micajah P. Caskey, IV
The Honorable Gary E. Clary
The Honorable Chandra E. Dillard
The Honorable Joseph H. Jefferson, Jr.
The Honorable Jeffrey E. Johnson
The Honorable Robert Q. Williams

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June 3, 2016

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First Report of the Implementation Panel

Dear Judge Howard. Mr. Laney. and Mr. Westbrook:

Introduction

We are providing this first report of the Implementation Panel based on the initial site visit to the South Carolina Department of Corrections from May 2-5, 2016, pursuant to the Settlement Agreement in T.R. et all v S.C.D.C. et.al. As you will recall. the Implementation Panel is comprised of Raymond Patterson MD, and Emmitt Sparkman. with Tammie Pope as the Implementation Panel Coordinator. In addition, Subject Matter Expert, Jeffrey Metzner MD, has been retained for his expertise in this matter. All have contributed to this report.

The initial visit was scheduled with the anticipation that the Settlement Agreement would be finalized prior to the site visit. Further, our anticipation was that all of the policies and procedures would have been finalized prior to the initial site visit. However, as the parties are aware neither the Settlement Agreement nor the complete set of policies and procedures were finalized prior to the site visit. We, therefore, determined it would be more helpful to the process to provide consultative and technical assistance to SCDC for this initial site visit, tour a limited number of

facilities, and meet with their executive, clinical, and security staff to discuss their understanding of the process for implementation of the Settlement Agreement. This report will, therefore, be different from the anticipated upcoming reports which will focus on compliance with the provisions of the Settlement Agreement. Subsequent reports will be consistent with the essential requirements of the Implementation Goal including the 48 components identified in the Implementation Panel Report to a degree that satisfies the purposes and objectives of the goals, plans, and components in the Settlement Agreement, even if any particular formal requirement is not complied with in its entirety.

Overall, the site visit was very successful and in our view resulted with valuable assistance to SCDC at both the central and administrative levels as well as at the individual sites visited. In addition, we were able to tour various units at the sites to review the current processes and to explore the SCDC plans to expand their mental health programs to include the Crisis Intervention Unit, Behavioral Management Unit, and review space and other considerations for resource allocations, including clinical and custody staff and necessary space and physical plant proposals to accomplish the goals and objectives that we anticipate will be reflected in the Settlement Agreement.

We held an opening entrance conference with the SCDC administrative staff as well as an exit debriefing with the SCDC administrative staff to discuss the anticipated "road map" derived from the mediation as well as the results of the visit.

The baseline information provided by SCDC included the following:

Mental Health Classifications for Mentally Ill Institutional Population on May 2, 2016

SCDC Institutional Population = 20,427
SCDC Mentally Ill Population = 3,192

Mental Health Classification	Count	Percent of Mentally Ill Population	Percent of Total Population
L1	85	2.66%	.416%
L2	163	5.11%	.798%
L3	154	4.82%	.754%
L4	2,697	84.5%	13.2%
L5	54	1.69%	.264%
LC	13	.407%	.064%
MR	26	.815%	.127%

Explanation of Mental Health Classifications

(Code table pulled in directly from system and includes Non-Mentally Ill and retired codes. When an inmate returns, their previous Mental Health Classification is used until a new review is performed.)

CODE	DESCRIPTION
L1	MH-1 (HOSPITALIZATION)
L2	MH-2 (INTERMEDIATE CARE S
L3	MH-3 (AREA MENTAL HEALTH)
L4	MH-4 (OUTPATIENT)
L5	MH-5 (STABLE)
LC	SELF-INJURIOUS BEHAVIOR
M1	MI-1 (INPATIENT MENTAL HE
M2	MI-2 (MAJOR MENTAL ILLNES
M3	MI-3 (OUTPATIENT MENTAL H
M4	MI-4 (STABLE/MENTALLY ILL
MH	NMH (NO MENTAL HEALTH TRE
MI	MH-I (MENTALLY ILL)
MR	MH-R (MENTALLY RETARDED)
OK	MH-S (MENTALLY STABLE)
SA	SUBSTANCE ABUSE TREATMENT

Distribution by Institution

	Institutional Counts								Mentally Ill Inmates as Percent of				
Institution	L1	L2	L3	L4	L5	LC	MU	MR	Mentally Ill Inmates	Institution Total	Institution's Population	Agency's Mentally Ill Population	Agency's Total Population
ALLENDALE	0	0	0	159	6	0	0	0	**165**	1,147	14.4%	5.17%	.808%
BROAD RIVER	0	0	0	234	1	0	0	23	**258**	1,287	20.0%	8.08%	1.26%
CATAWBA	0	0	0	0	0	0	0	0	**0**	153	.000%	.000%	.000%
CENTRAL OFFICE ANNEX	0	0	0	0	0	0	0	0	**0**	1	.000%	.000%	.000%
EVANS	0	0	0	143	21	0	0	0	**164**	1,298	12.6%	5.14%	.803%
GILLIAM PSY	78	1	0	3	0	1	0	0	**83**	90	92.2%	2.60%	.406%
GOODMAN	0	0	0	0	0	0	0	0	**0**	226	.000%	.000%	.000%
GRAHAM CI	2	33	20	168	2	0	0	1	**226**	396	57.1%	7.08%	1.11%
GRAHAM R&E	0	4	2	33	0	0	0	1	**40**	183	21.9%	1.25%	.196%
KERSHAW	0	0	2	159	1	0	0	0	**162**	1,282	12.6%	5.08%	.79
KIRKLAND	1	125	3	74	1	12	0	0	**216**	1,503	14.4%	6.77%	1.06%
KIRKLAND INFRM	0	0	0	2	0	0	0	0	**2**	19	10.5%	.063%	.010%
KIRKLAND MAX	1	0	0	23	0	0	0	0	**24**	37	64.9%	.752%	.117%
LEATH	0	0	0	331	0	0	0	0	**331**	584	56.7%	10.4%	1.62%
LEE	1	0	33	225	10	0	0	0	**269**	1,423	18.9%	8.43%	1.32%
LIEBER	1	0	60	237	2	0	0	1	**301**	1,240	24.3%	9.43%	1.47%
LIVESAY	0	0	0	0	0	0	0	0	**0**	493	.000%	.000%	.000%
LOWER SAVANNAH	0	0	0	0	0	0	0	0	**0**	137	.000%	.000%	.000%
MACDOUGALL CI	0	0	0	81	0	0	0	0	**81**	606	13.4%	2.54%	.397%
MANNING	0	0	0	6	0	0	0	0	**6**	541	1.11%	.188%	.029%
MCCORMICK	0	0	1	157	1	0	0	0	**159**	1,090	14.6%	4.98%	.778%
PALMER	0	0	0	0	0	0	0	0	**0**	229	.000%	.000%	.000%
PERRY	0	0	33	219	0	0	0	0	**252**	899	28.0%	7.89%	1.2
RIDGELAND	1	0	0	157	0	0	0	0	**158**	1,171	13.5%	4.95%	.77
TRENTON	0	0	0	6	0	0	0	0	**6**	548	1.09%	.188%	.02

	Institutional Counts								Mentally Ill Inmates as Percent of				
Institution	L1	L2	L3	L4	L5	LC	MH	MR	Mentally Ill Inmates	Institution Total	Institution's Population	Agency's Mentally Ill Population	Agency's Total Population
TURBEVILLE	0	0	0	117	8	0	0	0	125	1,114	11.2%	3.92%	.612%
TYGER RIVER	0	0	0	163	1	0	0	0	164	1,277	12.8%	5.14%	.803%
WALDEN	0	0	0	0	0	0	0	0	0	630	.000%	.000%	.000%
WATEREE RIVER	0	0	0	0	0	0	0	0	0	823	.000%	.000%	.000%
TOTAL	85	163	154	2,695	4	13	0	26	[illegible]	[illegible]	[illegible]	100%	15.6%

Inmates in Lockup on April 27, 2016
by Institution and Mentally Ill vs. Non-Mentally Ill Population

Institution	Mentally Ill	Non-Mentally Ill	Total
ALLENDALE	24	92	116
BROAD RIVER	22	17	39
EVANS	18	70	88
GILLIAM PSY	8		8
GRAHAM R&E	15	16	31
KERSHAW	16	36	52
KIRKLAND	3	16	19
KIRKLAND MAX	23	13	36
LEATH	11	3	14
LEE	27	35	62
LIEBER	33	24	57
MANNING		18	18
MCCORMICK	9	32	41
MCLEOD REGIONAL		1	1
PERRY	27	69	96
RIDGELAND	6	26	32
TRENTON		41	41
TURBEVILLE	8	19	27
TYGER RIVER	7	36	43
WATEREE RIVER		6	6
Total	[illegible]	[illegible]	[illegible]

As a part of the consultative and technical assistance component of our site visit, our subject matter expert Jeffrey Metzner, MD provided a template as a potential model to SCDC administrative and compliance staff to assist them in the process of obtaining data and documenting the results pursuant to the requirements of the Settlement Agreement.

The specific details from this initial site visit are based on the clinical reviews and analysis by Drs. Patterson and Metzner, and security/operations reviews and analysis by Mr. Sparkman. In this report, "Panel" includes Dr. Metzner and Ms. Pope in terms of reviews and tours of facilities and programs.

Kirkland Correctional Institution (KCI)

During the morning of May 22, 2016 we had the opportunity to meet with the following staff:

Among the topics discussed was the method that would be used to calculate out of cell time to measure compliance with the GPH policy. Also with regard to out of cell time, Mr. Sparkman emphasized the need to determine the amount of security staff that will be required to provide the necessary hours. Dr. Metzner pointed out that in order to attain a level of 10 hours of structured therapeutic activities per week and 10 hours of unstructured therapeutic activities, SCDC would need to schedule 15 hours per week in order to allow for cancellations that inevitably will occur. He estimated it would take 6-12 months to begin to schedule 15 hours and to attain 10 per week per inmate. He emphasized that QI will be the key to reaching substantial compliance. He suggested if there were any questions about the methodology to employ, staff should call one of the panel members to make sure it is acceptable. He offered to provide the names of other agencies that have implemented ten hours of unstructured and ten hours of structured therapeutic activity ("10/10") so SCDC can get ideas from them about what has worked and what has not. According to Dr. Patterson, usually the time is tracked by number of hours offered, number of hours received, and number of hours that did not occur and why (refusals and cancellations). Dr. Metzner pointed out that as monitors, they will look at the amount of time offered and the amount of time used.

Gilliam Psychiatric Hospital (GPH)
The panel took a brief tour within the Gilliam Psychiatric Hospital and received a briefing by [redacted] regarding the plans for construction of a nursing station within each wing. The director of nursing had not yet been consulted in the context of the design and operation of the nursing station. We also toured the programming space that will include conversion of office space to two group therapy rooms that were off the housing unit. These rooms could likely accommodate 8 to 12 inmates in a group therapy setting if regular chairs were used.

The panel attended a GPH interdisciplinary treatment team, which was attended by a psychologist, [redacted] R.N., and mental health counselors (i.e., QMHPs). A psychiatrist was not at the meeting due to psychiatrist vacancy issues. Inmates being staffed were very briefly interviewed during the team meeting. Treatment plans were infrequently discussed during this meeting. We learned during our meeting with the treatment team staff that GPH inmates are currently offered about two group therapies per week.

Jeffrey Metzner, M.D. observed a group therapy for about eight GPH inmates that focused on substance abuse issues. This group was well run by the mental health clinician and the inmates, in general, were active participants.

GPH B Side was visited and activities observed. Discussions were held with Warden [redacted] and GPH Lieutenant [redacted] on the importance of developing security staffing necessary to provide revised activities that will include offenders' out of cell activities: 10 hours structured and 10 hours unstructured per week. The Implementation Panel offered that to accomplish 10 hours out of cell time normally took scheduling 15 hours.

Intermediate Care Services (ICS)
During the early afternoon we attended an intermediate care services interdisciplinary treatment team that was attended by a psychiatrist, lieutenant, classification officer, psychologist, and QMHPs. Inmates being reviewed by the treatment team were very briefly interviewed during the meeting. A treatment plan narrative was written during the meeting but the treatment plan was not discussed with the inmate.

Dr. Metzner observed the mental health rounding process in the segregation unit, which occurred on a monthly basis. The clinician would round on inmates who were in segregation following their disciplinary hearing. Inmates on lockdown in this housing unit, who were on pre-disciplinary hearing status, protective custody status, or youthful offenders on reception center status, were not rounded on by the mental health clinicians. Inmates reported they were not receiving one hour out of cell recreational time due to custody staffing shortages and complained that their food was routinely cold. The clinicians who performed the rounds did so in a competent manner.

Dr. Metzner also briefly toured the Self-Injurious Behavior Unit, which had three housing units based on the inmates' privilege level. The inmates were very complimentary of [redacted] M.D. and her mental health staff. They complained about lack of access to a reasonable outdoor

recreational area, which again appeared to be related to custody staffing issues. Inmates also complained about not being offered enough activities.

Mr. Sparkman provided additional information regarding his tour and discussions at Kirkland. A discussion was held with KCI Training Officer, Captain [redacted] KCI has not developed lesson plans for the new/revised Mental Health, Use of Force, Restricted Housing Unit, and Disciplinary Policies and Procedures. Feedback was provided to Captain [redacted] and other SCDC Officials that lesson plans needed to be developed for the aforementioned policies, Training Instructors needed to complete Train the Trainer on each of the policies and a roll out plan developed to ensure all SCDC staff were trained on the new/revised policies. Use of Force does not have a separate lesson plan and disciplinary is not offered for all staff at annual in-service.

Disciplinary Hearings were attended for two offenders. Each had a mental health designation. SCDC staff had completed a form identifying each offender could be held accountable for his behavior resulting in the rule violation. The offenders, due to their mental health designation, were assigned a staff Counsel Substitute to provide assistance at the disciplinary hearing. The Counsel Substitute was present at the disciplinary hearing with the offenders. SCDC officials advised offenders with a mental health designation, that are found unaccountable for a rule violation, can still be found guilty with no sanctions imposed or mitigated sanctions. Disciplinary Reports are reviewed by a Correctional Supervisor and graded (seriousness determined) by the Major or designee. The sanctions imposed by the Disciplinary Hearing Officer for offenders with a mental health designation are reviewed by the Disciplinary Treatment Team, which consists of the Warden and Treatment Staff. The Disciplinary Treatment Team reviews the sanctions recommended by the Disciplinary Hearing Officer for offenders with a mental health designation and determines the final sanctions. The Implementation Panel made a recommendation to consider revising the "guilty but not accountable" to the finding of guilty-mentally ill. SCDC officials were receptive to the recommendation. The revised disciplinary procedures that only allow 180 days maximum loss of privileges has not been fully implemented. The loss of privilege sanctions exceeding 180 days received prior to the revised disciplinary policies have not been adjusted by SCDC officials. It was reported this is in progress and should occur shortly.

Activities in ICS F Building B Side were observed. An offender was observed talking to himself and pacing in the housing unit. Other offenders reported the offender had decompensated over the last few days, was not sleeping and had discontinued personal hygiene. The information was reported to the ICS Treatment Team. A discussion was held between the Treatment Team and the Implementation Panel participants regarding the importance of identifying the medical/mental health and security staffing that would be necessary to provide increased services required by the Settlement Agreement.

Mr. Sparkman emphasized the issue of the mentally ill inmates being held in Security Detention ("SD") and the need to get them out of their cells. He asked when the Behavioral Management Unit ("BMU") would be up and running. Mr. [redacted] said they had to prioritize and were

focused on a high security ICS program before the BMU. Mr. Sparkman also raised the issue of the SSR policy being implemented and getting inmates out of that environment if they are behaving.

Dr. Metzner asked whether the inmates are not getting rec in RHU was accurate and Warden [redacted] said it was accurate and it's something they're working on. Dr. Metzner explained the recently approved position statement of the National Commission on Health Care (NCCHC) on solitary confinement and urged SCDC to have weekly mental health rounds, daily nursing rounds and rec time in RHU. Dr. Metzner said the quality of rounds was fine and he emphasized the same person should do them rather than rotating it. Dr. Patterson pointed out the harm in not doing the weekly mental health rounds (currently done monthly) is likely a contributor to the suicide rate which is currently three times the national rate. Mr. Sparkman pointed out that since the number of inmates in RHU has been cut in half, they can now send more resources to those who remain there.

Dr. Metzner also raised the fact that half of the inmates in RHU were not rounded because they were on protective custody, pre-hearing detention or were youthful offenders. Dr. Metzner pointed out that the greatest risk of suicide is in the first two weeks in RHU, and that weekly rounds on all inmates in all RHU's are necessary.

Self Injurious Behavior Unit (SIB)

With regard to the Self-Injurious Behavior (SIB) unit, Dr. Metzner suggested they focus on the quality of the treatment plan and look at outcome measures. He was concerned about the lack of access to a reasonable rec yard. He was impressed with Dr. [redacted] interactions with the inmates and the inmates' comments about the program, but he stressed the need to get them out on rec.

Mr. Sparkman also stressed the need to train on the new policies for use of force, disciplinary and restricted housing. Those are not policies that can just be handed to the training officers and expect them to train well on them. He suggested training the trainers because the new policies represent a huge culture change and controlling the message and explaining why the changes are being made is important for successful implementation. Nothing had been done in that area and it needs to be developed. He said when he returns in October, he will place a major emphasis on use of force implementation. He recommended having the training officers know the policies backward and forward and coming up with a plan to train the staff. Someone needs to be charged with that responsibility. It cannot be done overnight, but it will not ever get done without a plan.

Receiving and Evaluation

Areas visited during the morning of May 3, 2016 included the Receiving and Evaluation (R&E) and the Substantiated Security Risk (SSR) Units. The KCI R&E staff provided the Implementation Panel an overview of the Medical and Mental Health intake process for male offenders accepted to the South Carolina Department of Corrections. R & E areas involved in the medical/mental health intake process were toured by the Implementation Panel. The panel

toured the Men's R&E Unit during the morning of May 3, 2016. Issues identified included mental health evaluations not occurring in a confidential setting, which was related primarily to office doors being left open due to "safety concerns." We discussed potential remedies with key mental health and custody staff. Staff indicated approximately 60% of intake health care screenings result in a mental health care referral. We discussed with relevant staff tracking of this data and potential issues that may indicate a false positive rate. Dr. Patterson identified that Suicide Risk Screening is a component of the Mental Health Evaluation and not dependent on "clinical judgment."

Substantiated Security Risk (SSR)

After completing the KCI R&E Unit tour, the Implementation Panel proceeded to the KCI SSR Unit. The KCI SSR Unit is designated for the most dangerous and violent offenders identified in the SCDC. The SSR Unit has a capacity of 50 and the population on May 3, 2016 was 37. Offenders are classified SSR status that consist of three levels:

D-Disciplinary, poor behavior
I-Improved
R-Eligible for Release

Offenders entering the SSR Unit are initially placed on Improved Status; however, the first 72 hours the offender is on "stripped out" status in a suicide prevention smock and meals are finger foods. SCDC staff advised the initial harsh security procedures for 72 hours were policy but could not provide rationale for placing every offender in these harsh conditions upon arrival in the SSR. A review of SCDC records revealed the SSR population on May 3, 2016, was in the following levels;

Disciplinary-	5
Improved-	7
Eligible for Release-	22
Safe Keepers-	2
No Level-	3
Total-	39 (2 housed at Leiber Correctional Institution)

The panel interviewed inmates housed in the SSR. The census was 37 of 50 available cells. The conditions of confinement, including the recreation areas, which are inside the facility, with partially "open" (to sunlight), but covered by razor wire, and in which inmates remain shackled and cuffed were of great concern to the panel. Several inmates informed the panel they refused their one hour of out-of-cell time because of these conditions. The mental health professional (MHP) appeared to know the inmates well and engaged them effectively during rounds. Several inmates had been confined to the SSR, formerly MSU, for many years, including one inmate who had been there for 22 years, and Mr. Sparkman pursued clarification of the above designations and criteria for release from SSR with Mr. [redacted]

Before leaving Kirkland, the Panel and SCDC staff and leadership met in the warden's conference room to de-brief. Overall, Dr. Patterson described the day as good in that they were

able to see what they wanted to see and learned of areas in which work needs to be done. Areas of concern raised by the Panel included:

1. Inmates should always be a part of the treatment team at GPH rather than just at admission and discharge and a psychiatrist should be present;

2. GPH staff needs to assess how many long term residents they have because that affects their capacity for the rest of SCDC;

3. The GPH Treatment Team meetings did not focus on the treatment plan with the inmate and that should be the primary discussion;

4. If inmates are reluctant to leave GPH, that might indicate there are problems with treatment at the receiving institution, which should be investigated internally;

5. In the ICS, the mental health clinicians complained of not being able to get ICS inmates into GPH despite meeting the criteria for acute care which underscores the lack of capacity at GPH:

6. There should be joint meetings between ICS and GPH because if the two are at odds, bad things are going to happen:

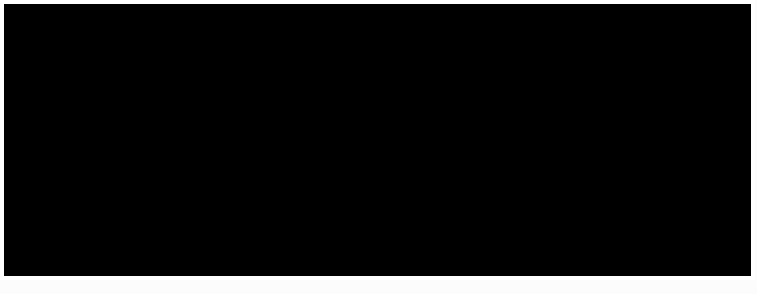
7. SCDC should look at what it would take to continue involuntary medications at institutions providing other levels of care (Dr. Metzner suggested looking at *Harper v. Washington*)

8. Programmatic activity is very low at the ICS—there was very little discussion in treatment team about what would happen with the inmate until the next meeting; and

9. The calculation of whether inmates are getting their 10/10 hrs will be labor-intensive, but it has to be done;

Camille Graham Correctional Institution (CGCI)

During the afternoon of May 3, 2016 we had the opportunity to meet with the following staff at Camille Graham Correctional Institution:



[redacted]

The basic overview of the mental health services at Graham was provided by Ms. [redacted] The ICS program is located in Blue Ridge dorm, which also houses some area mental health and some outpatient inmates. In R&E, there is one counselor now who does all of the screening and refers those in need of services to the psychiatrist. Treatment team is usually held on Fridays, but there was one planned that day so the Panel could sit in on it. Inmates in RHU are assessed within 30 days of arriving and every 90 days thereafter as long as they are in RHU. They were still working on the CI unit and currently had 3 women on CI. The average daily population at Graham was 579 and of those, 40 were ICS level of care ("LOC"), 23 were area LOC, 174 were outpatient LOC, 2 were L5 and 4 were at Geocare (3 for MH reasons and 1 for medical). There were a total of 36 women in RHU, 15 of whom were mentally ill. Dr. [redacted] is the psychiatrist who sees the women and she comes to Graham twice a week for 5 hours each time. There were 7 counselors including Ms. [redacted] and one Mental Health Tech. Ms. [redacted] provides administrative support for the mental health program. There are no psychiatric nurses or nurse practitioners.

Inmates currently have approximately 3-4 groups per week in the ICS. They are for the ICS and area LOC inmates. They also have crocheting, leisure and recreation and do physical activities on the yard 3 times per week. They have not been having community meetings recently. The overall capacity for Blue Ridge is 37 beds on the D-side and 48 beds on the C-side.

The R&E process for women is the same as for the men except they only receive women on Thursdays and Fridays and probably average about 30 per week, but the numbers vary from week to week.

The Panel was escorted to Blue Ridge Dorm to see the proposed location of the Women's CSU. [redacted] explained what renovations would be made to the rec yard to accommodate the CSU and the changes to the cells and the showers that would be used. He anticipated the work would begin in mid-June and had set September as a target completion date.

The Panel was then allowed to sit in on a treatment team meeting. Mr. Sparkman spent that time talking with the training officer and attended a DHO hearing. The usual attendees for their treatment team meetings are the warden, medical, the QMHPs, the administrative assistant, an Addictions Treatment Unit ("ATU") staff and security staff. The psychiatrist does not participate in the treatment team meetings due to staffing allocation/vacancy issues. A list of the women being staffed was handed out and each was discussed. Two of the inmates were called in to participate in the meeting. It was reported during the meeting that there were 135 inmates in R&E and some were being held in RHU because the R&E cells were full (despite being triple-celled).

After all of the inmates were discussed, Dr. Patterson asked the staff present if there were things they would like to have in order to be more effective. The MH tech said it would be helpful to have more recreational games and equipment for the recreational groups as she currently

provides supplies to inmates. The warden said she needs more staff so they could offer more structure and to have a full time psychiatrist. Dr. Patterson recommended they determine what staffing they need and what it will take to comply with the policies. The clinical supervisor noted that security often will not pull the inmates out of the cell and she believes it is unethical to yell through the cell door about private health matters. She also discussed how the diagnoses are not helpful because an inmate will retain a "rule out" or "unspecified" or "not otherwise specified" diagnosis for several months. The crisis beds are currently in the RHU. Mental health rounds in the RHU were not observed because they had been performed by staff earlier in the morning. They were reported to occur on a monthly basis. Dr. Patterson explained that RHU rounds should be once per week rather than once per month and the inmates should be pulled from their cells and assessed in a confidential setting as necessary or requested.

Dr. Metzner and Ms. Pope went to see where the R&E process occurs while Dr. Patterson observed a group. While at R&E, Dr. Metzner learned that the average length of stay in R&E was 3-4 months because it was taking that long to see the psychiatrist and/or medical. While in R&E, the women are triple-celled and are only allowed out of their cells to walk to meals and for one hour of rec and showers. About 30 female inmates are admitted on a once per week basis at Camille Graham CI. It was estimated that about 80% of the intakes result in a positive mental health screen.

During our afternoon tour. we visited the Blue Ridge Housing Unit, which houses predominantly ICS females inmates but also Area Mental Health Unit inmates. During the site visit there were 40 ICS inmates and 23 Area Mental Health inmates. The capacity was 37 inmates on D Unit and 48 inmates on C Unit. Mr. [redacted] showed us the plans for renovating space in this housing unit for purposes of creating programming space for group therapies and ten crisis cells. ICS inmates currently are offered 2-3 group activities per week.

Mr. Sparkman also stressed that health services (which include mental health services) have to continue. He explained that point will need to be stressed in training on the lockdown policy. Dr. Patterson added they will need to train the trainers on the new policies and explain why the policies are changing. Mr. Sparkman noted they have a good trainer in Lt. [redacted] and stressed that the trainers have to "walk the walk and talk the talk." In order for the policies and remedial plan to be successful. it will be important to train the trainers on the new policies and then let them train the staff on the new policies. Everyone has to be on message. As an example, he noted that when training on the new use of force policy, it would be important to teach new methods for handling situations. He recommended keeping the message simple so staff and inmates will understand.

Mr. Sparkman added that the intent of the DD policy was to limit DD time to 30 days, but allow for 60 days in extenuating situations. Instead, it seems 45-60 days has become the default. He said he is not blaming the DHO, but thinks the intent of the policy was not shared with the DHOs and it needs to be explained.

Mr. Sparkman interviewed Training Lieutenan[redacted]. Lieutenant [redacted] serves as the CGI and Goodman Correctional Institutions Training Officer and coordinator for the SCDC Columbia Midland Region consisting of six prisons. She directly reports to the CGI Warden

chain of command but also reports to the Training Academy chain of command. She and other Columbia Midland Region Training Officers have monthly two hour meetings. She reinforced previously provided information that SCDC staff had not received formal training on the revised Use of Force, Disciplinary, and Restrictive Housing Unit policies. She agreed that for consistency Training Officers needed "Train for Trainer" for these policies and the new/revised Medical and Mental Health policies before the training was offered to SCDC Staff. She reported staffing shortages made it very difficult for SCDC staff to receive the required annual training hours. She revealed SCDC correctional staff have difficulty meeting annual training hours to maintain their CLEE (Law Enforcement) certification. Staff availability results in approximately five attendees when class could be attended by twenty individuals. This results in having to offer additional classes to make courses available to staff further draining valuable SCDC resources. She estimated approximately 75 percent of the SCDC she is responsible for do not receive their required training hours. She provided information that correctional officers are required to attend 40 hours training before being assigned to an RHU Unit.

Both a Mental Health Disciplinary Treatment Team and Disciplinary Hearing were attended during the CGI site visit. The information received during KCI and CGI site visits indicates SCDC Hearing Officers are imposing the higher ranges for disciplinary detention (45-60 days). It is recommended that lower ranges (15-30 days) be considered by the Hearing Officers; unless, the violation is serious enough for security detention placement.

At the end of the day, everyone met back in the warden's conference room at Graham to discuss what the Panel had seen there. Dr. Patterson began by voicing two concerns. The first was a need to address the physical plant issues and to determine whether they will have space to accommodate the out of cell requirements necessary. The second was to assess and address the staffing needs at every level in every discipline. He recommended that non-mentally ill women not be placed in Blue Ridge. He noted that it would be important for future visits that staff be able to document what services are being provided at each LOC and they will need to distinguish between the structured and unstructured therapeutic activities. He explained they should only have mentally ill women in the mental health groups. For the ICS program, he suggested an itemized sheet demonstrating for each inmate that they are getting the 10/10 hrours and he added the services need to continue during periods of lockdown.

Dr. Metzner noted the Panel will be monitoring the compliance with policies and so the staff needs to know the policies. He also raised the issue of the length of stay in R&E especially since the women are triple-celled and not allowed dayroom time. The warden explained she does not allow the R&E women dayroom time because of the shortage of staff. Dr. Metzner discussed the NCCHC position statement and its implications for the situation in R&E. Due to the lack of out of cell time, he said the R&E women should be included in the mental health rounds once per week. He added the same would apply for the men if they are locked in their cells as much as the women. Mr. Sparkman noted even the American Correctional Association ("ACA") advocates that R&E should only take 4 weeks. Dr. Metzner offered that the ACA will also soon be coming out with a statement that any mentally ill inmates should be excluded from solitary confinement. Dr. Patterson added that if they cannot reduce the number of women per cell, they should at least make sure the women are allowed out of their cells for a decent amount of time per day.

Dr. Metzner encouraged the Graham staff that things will get better with time. He noted if the Panel prepared a report based on their visit, there would be criticisms despite the fact that they are doing the best they can with what they have. Dr. Patterson added that he understands it is difficult not to take the criticism personally, but the issue is the lack of resources, not poor performance.

Broad River Correctional Institution (BRCI)

During May 4, 2016 the Panel site visited the Crisis Stabilization Unit at the Broad River Correctional Institution, attended a treatment team meeting for this unit and observed the mental health rounds process within the RHU. We had the opportunity to meet with the following staff:

[redacted]

Crisis Stabilization Unit

The 32-cell crisis stabilization unit became operational during March 21, 2016. There were six inmates in this unit at the time of our site visit. The second floor of this unit, which also had about 32 cells. was used for permanent housing for the assigned inmate observers. Staff informed us that CSU inmates were receiving at least 10 hours of out of cell structured therapeutic activity per week in addition to another 10 hours of unstructured recreational time. The physical plant for this unit was impressive. CSU inmates did not have access to unstructured time in the dayroom area. Inmate observers are screened and selected by custody leadership staff and Dr. [redacted]

When general population inmates are participating in a group activity with higher security inmates such as RHU inmates, all inmates are cuffed during the group activity process. When higher security inmates are recreating in the outdoor yard in a congregate manner, they are all cuffed. Inmates are clothed in suicide smocks, without underwear, until the time of discharge.

Psychiatric time is provided on a three day per week basis by two different psychiatrists, which included coverage on at least one weekend day. The psychiatrists do not attend any of the daily treatment team staffing meetings.

The Panel observed a treatment planning team meeting, which involved team discussion of the inmates to be reviewed followed by each inmate being interviewed briefly in the team meeting. The healthcare records were not reviewed or available during the treatment team meeting and the conference room used for the staffing did not have computer access to the CRT.

There were 6 inmates staffed and of those, two had recently been admitted and four were nearing discharge. The inmates were a part of the staffing, but no treating psychiatrist was present. If they feel the need to include the psychiatrist, they can call and have them on the phone for a treatment team. Dr. Patterson advised Dr. [redacted] they need a full time psychiatrist for a 15 bed unit, so if they get to the capacity of 32 beds, they should have 2 full time psychiatrists. One inmate was ready to be taken off suicide precautions, but was not going to be discharged until there was a bed ready for him at the ATU. Ms. [redacted] asked whether the inmate's entire stay would count in determining the length of stay even though he was only being held there awaiting a bed in the ATU. Dr. Patterson said as long as the inmate is in the unit, his length of stay increases. He suggested that when the time comes when there is a waiting list for inmates to get into the unit and Dr. [redacted] has problems getting beds for discharges, he will need to track that so he can get the help he needs placing the discharged inmates.

Dr. Patterson asked those present in the treatment team meeting what they needed to do their jobs more effectively. QMHP [redacted] said she would like to have the complete medical record of the inmates who are admitted there. They also said computer access during treatment team meetings would be good. Dr. [redacted] said he would like to have a psychiatrist present at the treatment team meetings.

Drs. Metzner and Patterson encouraged Dr. [redacted] to tailor the clothing allowed to each inmate and use clinical judgment in assessing the risk. For example, Dr. Metzner suggested an inmate on constant observation probably doesn't need to be in a smock and almost certainly could at least have boxers under the smock unless he had a history of using boxers to try to hang himself. Dr. Patterson advised doing assessments all the way through and adjusting management of the inmates accordingly. He also cautioned they should be aware that what they do in the CSU may translate to outer institutions without a psychiatrist and incomplete treatment team.

With regard to discharge planning, Dr. Metzner suggested they coordinate their management plan with the receiving institution (mental health at the CSU communicating with mental health at the receiving institution). Operations staff may also need to know the management plan. He suggested they track inmates who have two or more admissions to the CSU during a 6 month period. That will indicate there is a problem with the discharge process.

The Panel was very impressed with the physical plant of the crisis stabilization unit and very encouraged by the enthusiasm of the staff and inmate access to out of cell programming. The lack of a psychiatrist during the treatment team meetings as well as the scarce number of hours of psychiatric time is very problematic and needs to be remedied.

The Panel discussed with staff issues related to inmate clothing restrictions. Specifically, inmates who are no longer on suicide precautions should not be in suicide smocks. We also recommended that inmates on suicide precautions, who are clothed in suicide smocks, should have underwear unless clinically contraindicated.

The Panel made specific suggestions related to the ADA cells from the perspective of further making them suicide resistant with specific reference to the toilets and the hand bar railings.

Correctional Staffing given for CSP was:

Unit Manager
Day Shift- Lieutenant and 4-5 Correctional Officers (minimum is 3 Correctional Staff)
Night Shift- Sergeant with 3 Correctional Officers (minimum is 3 Correctional Staff)

The CSP Unit has 32 offender observers. The observers shift are for a maximum of five hours

Groups are being held for offenders placed in the CSP Unit. A review of CSP Group roster found the following:

4/11/16	1 group
4/12/16	1 group
4/13/16	1 group (roster did not have the ending time for the group session)
4/17/16	1 group
4/18/16	1 group (roster did not have the start and ending time for the group)
4/19/16	1 group
4/20/16	1 group
4/21/16	4 groups
4/22/16	2 groups (2 rosters did not have the start and ending time for the group)
4/25/16	1 group (2 rosters were provided indicating offenders attended different groups at the same time)
4/26/16	3 groups
4/27/16	4 groups (2 rosters did not have the start and ending time for the group)
4/28/16	3 groups
4/29/16	2 groups (1 roster did not have the start and ending time for the group)
5/1/16	3 groups
5/2/16	3 groups (1 roster did not have the group end time)

SCDC staff holding the groups need to ensure roster forms are filled out correctly and completely.

Treatment Team meetings for CSP offenders were attended. Information was received from team members that a high number of CS offenders were coming from an identified SCDC Institution and something must be "going on". Team members acknowledged their perceptions about the increased number of offenders from this Institution had not been relayed to the

Institution or responsible SCDC Operations officials. The Implementation Panel stressed this type information should be communicated.

Restricted Housing Unit (RHU)

The Panel observed the mental health rounding process within the RHU, which was reported to occur on a monthly basis. This unit was very noisy and many inmates were disruptive during the process (e.g., banging on doors, flooding their cell). Inmates reported significant problems regarding access to mental health staff (e.g., not receiving timely responses to health care requests). Staff indicated that they had not received healthcare requests that were reportedly sent by several inmates.

Many of these cells appeared to be very dirty. Inmates did not appear to have access to daily outdoor recreation. At least one inmate, who appeared to be psychotic, was on the waiting list for admission to GPH. He flooded his cell during the rounding process.

RHU Correctional Staffing in the Saluda Unit is Day Shift- Lieutenant, Sergeant, Floor Officer, Control Room Officer and Night Shift Lieutenant, Sergeant, Floor Officer and Control Room Officer. Assigned staff acknowledged current staffing is insufficient to provide services to the assigned offenders. On a "good week" offenders only received three days per week recreation out of cell when policy requires five days per week. A provided RHU Roster indicated a number of offenders are being recreated in full restraints (4 out of 29 on the provided roster).

One inmate was released from SSR and was being held in the BRCI RHU after being cleared by an investigation. Reportedly, the offender had been observed by a staff member attempting to assault a Major during a disturbance but an investigation could not substantiate the attempted assault. Because of the conflict between the correctional staff eye witness account claiming to have observed the attempted assault and the investigation clearing the offender, no decision had been made to release the offender from RHU. The offender's version was he could not be released because he had a "separation requirement" from an offender at the General Population Step Down Program he had been initially recommended for by SCDC. The continued housing of the offender in RHU does not appear justified. Another offender complained he had threatened suicide and requested crisis stabilization but was denied by the Area Mental Health Supervisor. Mr. Sparkman requested the SCDC Director of Mental Health interview the offender. Empty cells in BRCI RHU cells were observed needing cleaning. The Implementation Panel recommended procedures and practice to clean cells after the release of offenders from RHU and the development of a cell inspection form to document the cleaning and condition of the cell. Common areas in RHU had peeling paint and needed general cleaning, particularly the shower areas.

The conditions of confinement within the RHU were very problematic, which exacerbated symptoms of inmates who were housed in this unit and on the mental health caseload. Mental health rounds on this unit should be performed on at least a weekly basis.

Behavioral Management Unit (BMU)
The Housing Unit proposed for the Behavior Management Unit (BMU) was toured. The BMU has 126 beds doubled celled. SCDC has not identified the number of offenders with a mental health designation currently in Restrictive Housing Unit beds that will be eligible for the BMU. The Implementation Panel stressed to responsible SCDC officials the actual BMU Program and number of beds could not be finalized until the projected number of BMU offenders were identified. Recommendations were made that the capacity of the proposed BMU Unit size should not have a capacity exceeding 50 beds. If more BMU beds are needed, after conducting an assessment of the RH offender with a mental health designation, an additional location will be needed for BMU.

Additional Meetings and Information

During the afternoon of May 4, 2016 we met with a large group of mental health providers (e.g. psychiatrists, nurse managers, pharmacy staff, PAs, etc.) from various institutions within SCDC in a group setting to discuss issues related to the proposed Settlement Agreement and the monitoring process.

We also met with key mental health and correctional staff leadership to discuss issues related to policies and procedures and again re-emphasized the need to develop a concrete plan relevant to the Behavioral Management Unit, with an emphasis on performing a needs assessment study.

Summary of Findings regarding Compliance

The final day of the visit, May 5, began with a meeting in the Director's Conference Room at SCDC Headquarters at 8am. Present for the meeting were Deputy Director of Operations [redacted] Dr. [redacted] and the Implementation Panel team members. The meeting began with Ms. [redacted], who spoke about the step down programs currently in existence at McCormick, Lee and Lieber. She discussed the pilot program at McCormick and the success they have had with it and provided anecdotal evidence of the difference it is making, as well as statistical evidence of the outcomes that have been measured. She also discussed plans to expand the step down programs and to include different specialized populations.

After remarks from Deputy Director [redacted] and Mr. [redacted] the floor was opened for final comments from the Implementation Panel members. Dr. Patterson began by explaining the purpose of the visit, which was largely consultative in nature. He acknowledged the needs in the areas of staffing, programs and construction. He noted that because the policies and settlement agreement are not yet final, the visit could not be a true monitoring visit. However, a template has been provided to the compliance staff for use at future visits to begin measuring compliance with the components of the agreement. He reported the feedback from staff was helpful and that the cultural change that will have to take place is major. He acknowledged the step down program is a really positive surprise. The Panel informed the participants that at the time of the site visit it is our view that based on review of Exhibit B provided by SCDC and reviewed by the

parties, SCDC mental health services would not be in compliance with any of the proposed Exhibit B criteria or what we anticipate to be the requirements of the Settlement Agreement.

Dr. Patterson noted the Panel did not review medical records or talk to many inmates, so their report will be shorter than usual. He suggested some priorities for moving forward. He advised finalizing the policies that have been the subject of negotiation and the settlement agreement. The next highest priority is getting the BMU up and running. An overall priority is to increase staffing. He noted that while the CSU is a promising program, it is incomplete without a full time psychiatrist who attends treatment team meetings and provides direct services. There should be a psychiatrist providing their expertise and recommendations regarding treatment and discharge planning and when inmates leave the CSU. He also encouraged communication between the operational staff in the CSU with the operational staff in the outlying institutions as they become aware of issues through interactions at the CSU. He noted that operational staffing issues are also important to compliance because the out of cell time required by the agreement can't be met without adequate security staff.

On the positive side, the team reported the CSU is a great improvement over how the CI inmates have been managed for years in SCDC. There are still some hiccups such as an inmate who had to stop over in the BRCI RHU before being taken to the CSU from Kershaw, but overall it is a huge improvement. He warned that with regard to the CSU, if there are 64 beds in the unit and only 32 are for CI, they will run out of beds. He also addressed the problems mentioned by staff about the staff at the CSU having been taken from GPH. He suggested explaining to the GPH staff why the CSU is a good thing for them also.

Dr. Patterson addressed the monthly rounds in the RHUs and said it is not sufficient. The rounds should be done weekly beginning immediately. This will allow staff to assess and meet the needs of inmates in segregation.

Mr. Sparkman reiterated the need for an overall mental health services plan and noted there should not be separate master plans, but one plan with optimistic goals. He said the best example he could provide about the problems with lack of planning is the BMU. It is still unclear how many beds are needed and without that basic piece of information there is no reason to move forward. He noted the plan can evolve, but there must be a plan. He recommended fast-tracking the development of the plan and shooting to have it completed within 30 days.

The next issue Mr. Sparkman addressed was the need for training. He emphasized that staff have to understand why the changes are being made to the way things are being done and have been done for a long time. He said he understands the tendency when staff is short to reduce or eliminate training, but he advised against it. He noted that everything in the new policies is a complete turn from what has been done for years and training is essential to making the changes. He warned that if the new policy is just handed to the trainers and they are told to train on it, there will be five different versions of the new policy being taught. He emphasized a roll-out plan for training including training for the trainers. He also suggested focus groups in some places to help understand where there are problems or a misunderstanding of the new policies.

He applauded SCDC for reducing the number of inmates in RHU from 1600 to 800 despite their lack of resources. With the reduction in numbers in RHU, he stressed the need to get the inmates still in RHU out of their cells for rec. He suggested focusing on those in SD who have been in RHU for over 60 days (of which there are approximately 300 inmates). He strongly advised starting with the provision of services for those approximately 300 even if they cannot do so for every inmate in RHU.

Mr. Sparkman also reiterated the need to expedite the opening of the BMU because it will help the RHU operations. He noted the BRCI RHU is a tough environment for staff to have to work in and he noted if the mentally ill inmates can be pulled out of the RHU that will help improve things for everyone. Another measure he recommended to help with RHU was to reduce the sentences in DD from 45-60 days to 0-30 days. He noted that additional days in RHU will not cure inmates. The main thing a stay in RHU will accomplish is to give the staff a break from an inmate's behavior. He also suggested when he returns in October if they have the behavior levels in RHU that will also mitigate the numbers because the inmates will not be in their cells 23-24 hours per day.

Mr. Sparkman observed that the staff need to follow the new policies—he observed many staff do not know how the new disciplinary policy works. When there is a staff shortage, it is taken for granted that the inmates will not get rec. That should not be the default position. The goal is to always provide rec especially for the SD inmates.

With regard to the use of force training. Mr. Sparkman emphasized the need to explain why the policy is better for the staff (i.e. what's in it for the staff as opposed to the inmates). Otherwise, staff will feel like there is no concern for their safety. He suggested reaching out to the NIC to look at defense tactics for safe crisis management. There are alternatives that should be used with the use of force training. He also recommended the use of force training be separated out by itself as part of the annual training to stress the importance. Deputy Director [redacted] noted he wished the training had been done prior to rolling out the policy and Mr. Sparkman agreed saying the staff still do not understand why he policy changed.

On a positive note. Mr. Sparkman commended SCDC for having completed the major re-write of the three policies (RHU. Disciplinary and Use of Force) and for reducing the population in RHU from 1600 to 800. He noted that because of that change. they really only have less than 300 inmates who have been in RHU for greater than 60 days and if they implement the reduction in sentences he suggested. the number will drop even more. SCDC Operations staff need to ensure only offenders in SSR and SD are in RHU for over sixty days. Reviewed records continue to identify offenders that are ST and DD status remain in RHU over 60 days. Lack of bed space is not acceptable justification for offenders on ST and DD status to remain in RHU beyond 60 days.

Dr. Metzner recommended that when the staff are trained on the new use of force policy, mental health staff should be there and be included in breakout sessions dispersed among the security staff. He recommended a contact at the DOC in California who has created some training videos with scenarios that would be useful to SCDC in their training efforts.

Mr. Sparkman also commended SCDC for the CSU and the huge improvement it means in the management of inmates on CI. Deputy Director [redacted] noted they are purposely moving slowly in getting it up and running so they can make adjustments it as it grows.

Mr. Sparkman explained that the staff at Lee initially wanted nothing to do with the character dorm. After they saw the environment in that dorm with the programming going on, they all wanted to work in there as opposed to an environment with no programming. Deputy Director [redacted] agreed and reiterated that it all comes down to a culture change.

Mr. Sparkman also discussed his findings in the SSR unit. He asked for the levels of the inmates there and learned that 22 of the 27 inmates there were in "R" status which indicates they are ready for release from there once approved by the Release Board. Referencing what has occurred in the step down programs discussed by Ms. [redacted], he said he believed 90% of those inmates could adjust to a similar program. He acknowledged there are 5-7 inmates who may not be, but stressed again that the unusual scary events should not dictate policy and the 99% successes should not be ignored.

Mr. Sparkman also commended SCDC for reducing the DD charges and being 99% of the way there in reducing the privilege restrictions. Finally, he is very pleased with the reduction in the use of the restraint chair noting there were no uses in January or February of 2016. He pointed out that with the changes that have been implemented, the violence has not gone up as many probably expected it would. Deputy Director [redacted] said inmate assaults have gone up, but not like it was before the changes.

Dr. Patterson's final issue was suicide prevention and management. He noted that SCDC's rate for the last year is three times the national average. He recommended looking at the problem in a self-critical way. It requires looking at the process, management and emergency response. The policy is written and the Columbia screen is being utilized to assess risk. He said the Panel will be focused on suicide prevention and management.

With regard to the master plan referenced earlier, Mr. Sparkman stressed that it has to be detailed and include all the disciplines. As an example, he said SCDC would need to determine how many security staff are needed in GPH in order to accomplish the out of cell time required and put that in the plan and then strive to achieve those numbers. Dr. Patterson added that the number of clinical staff will also affect the security staffing. Facilities Management also needs to be a part of the planning because the physical plant needs will be affected.

Mr. [redacted] noted that they need to find out where every mentally ill inmate in RHU is going. Mr. [redacted] added that they will need to prioritize their time on the things that they can accomplish by October. Dr. Patterson explained that 30 days should be the goal to have the plan and then begin implementing the goals. Mr. Sparkman encouraged them to include staff at all levels and to know they can change the plan, but everyone has to know about the change. Everyone needs to be at the table if there is a change because it could impact other areas.

Another issue is that the GPH and ICS clinical staff members need to work in collaboration for continuity of care. Mr. [redacted] said he can get the policies signed, but they are currently out of

compliance. There are things required in the policies that they cannot do now. Dr. Metzner pointed out that the agreement requires compliance with the policies. He strongly urged SCDC to finalize the policies in the next 30 days. He asked that Mr. [redacted] send a disc with copies of all of the final policies to Ms. Pope for her to distribute to the Panel members. He recommended that all of the staff be required to read the settlement agreement and the policies and have discussions with their supervisors. He suggested putting more emphasis on the particular policies staff will be working from, but staff should have familiarity with all of the policies. He noted that if there is a way to get CME credit for a presentation that could be done in which the policies are discussed, people are more likely to get on board with investing the time.

The Panel advised it would return October 31 thru November 4 and will probably be in Columbia for three days and at Lieber and Lee for the last two days. Lieber and Lee will be more consultative in nature. The Panel will want to see RHU rounds, treatment teams, DHO hearings, etc. similar to the current visit. Dr. Metzner noted the Panel had no problem with people shadowing them but not too many people because it affects the process.

Dr. Patterson noted that usually for the exit, both plaintiffs' and defendants' counsel are present in person or by conferen e call. That should be the case for the next visit. Dr. Metzner also asked that Dr. Patterson be n tified when there is a suicide. Dr. Patterson also added that the Panel needs to see the SL D report and the Suicide Prevention Committee ("SPC") reports. The Panel are not interested in making them public, but they need to see how the suicides are being managed and revi ed. [redacted] s sured the Panel the SPC is meeting and minutes are being kept. Dr. Patters rec n ended they be vigilant about the composition and scheduling of the committee.

[redacted] asked if there was anything they expected to see before their arrival that was not there. Dr. Patterson identified three things: final policies, an executed settlement agreement and training on the new policies. Dr. Metzner said when the Panel returns, they would like to see inmates in restricted cells (GPH. RHU, CSU) getting more out of cell time—the more the better. When they return to GPH. they would like to see twice as many groups as this time. RHU should at least be getting rec and showers 5 days per week mental health rounds weekly by the same person every week.

Mr. [redacted] also asked how the Panel viewed training being done by video. Dr. Patterson voiced a concern about whether there would be someone to ensure the trainees are paying attention to the video. Dr. Metzner said that type of training does not work well for use of force training. He recommends the security and mental health staff train together for that policy. Mr. Sparkman suggested they break down the policy and tweak the training when they train the trainers. He would expect the use of force training would take no less than 8 hours. Dr. Metzner reported his experience that videos that show scenarios of what to do and what not to do and then the trainees are broken into groups and have to determine how to handle different scenarios are helpful. Mr. Sparkman suggested in developing the training, SCDC should get some of the negative comments from staff and cover them during the training. He said it may be useful to have some focus groups on use of force. [redacted] reported they included myths and rumors in the first part of the training presentation done for key operational staff and trainers.

Mr. [redacted] asked about the outcome of the discussion concerning the Guilty But Not Accountable (GBNA) finding. Dr. Metzner suggested mental health input should include three questions: (1) is the inmate Mentally Ill; (2) if yes, was his Mental Illness related to his actions?; and (3) if yes. are there recommendations concerning mitigation? The most important thing is the determination of whether there are mitigating circumstances.

Dr. Patterson noted it is also important for security staff to hear what mental health staff has to offer as far as recommendations about how to manage the inmate. He advised mental health should not be endorsing punishment, but alternative interventions, such as a transfer to the BMU or the ICS would be appropriate. Dr. Metzner expressed concern about the term "not accountable" hurting the relationship between mental health and security staff. Mr. Sparkman's concern is that a finding of guilty affects future classification decisions for the inmate. Mr. [redacted] advised he is going to see how it factors into those decisions if the finding is guilty but not accountable. Dr. Metzner asserted that guilty with mitigating factors is still guilty and should be reported that way. Guilty but not accountable is different and if the inmate is truly not accountable, which is very rare. the disciplinary should be dismissed. Dr. Metzner suggested they get rid of GBNA because if the inmate is truly not accountable, he should not be found guilty.

The final issue discussed was the length of stay in R&E at Graham, which Mr. [redacted] acknowledged is four months for the women who are triple-celled and kept in their rooms except for 1 hour of rec. showers and meals. Dr. Metzner strongly urged that they be allowed out into the dayroom.

The Panel advised that the Panel will be sending a document request and would like to have the documents by October 15 for the next visit which will begin on October 31, 2016.

Respectfully submitted,

Raymond Patterson. M.D.,
Implementation Panel

South Carolina Department of Corrections
Implementation Panel Report of Compliance
November 30, 2016

Executive Summary

This second report of the Implementation Panel ("IP") is provided as stipulated in the Settlement Agreement in the above-referenced matter, and it is based on the first and second site visits to the South Carolina Department of Corrections facilities and our review and analysis of SCDC's compliance with the Settlement Agreement criteria. The first site visit by the IP was from May 2 thru May 5, 2016. During the course of this visit the IP including their subject matter expert made onsite inspections at Camille Graham C.I., Kirkland C.I. and Broad River C.I. including reviews of specific units and mental health related programs. The second site visit by the IP was October 31 thru November 4, 2016 to those same facilities and also included Perry C.I. and Lee C.I. We have received a plethora of documents, including policies and procedures and additional reports as noted in this report. In addition, we have had conference calls with the plaintiffs and defendants as well as discussions with SCDC staff, inmates, and plaintiffs, and we reviewed additional documents during the onsite visits. We conducted an Exit Conference on November 4, 2016, which was attended by Director Bryan Sterling and the administrative, operations, and clinical staff of SCDC; plaintiffs' counsel Daniel Westbrook and Stuart Andrews; defendant's counsel Roy Laney; and the mediator, Judge William Howard. During the Exit Conference we provided our preliminary findings based on the two site visits and addressed questions and concerns offered by any of the participants.

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

1. Substantial Compliance – one component
2. Partial Compliance – thirty components
3. Noncompliance – twenty-eight components

As discussed during the site visits and during our Exit Conference with the parties, the IP's primary concerns regarding SCDC's failure to demonstrate substantial compliance with the Settlement Agreement have to do with the following issues: (1) Staffing, including, clinical, operations, administrative, and support staff; (2) Conditions of Confinement including specifically the Restrictive Housing Units (RHU), segregation of any type; (3) prolonged stays in Reception and

Evaluation and the quality/appropriateness of evaluation and treatment components; (4) lack of timely assessments and adequate treatment at the mental health programmatic levels; and (5) operations practices and adherence to policies and procedures.

Despite the ongoing efforts during mediation to finalize policies, we were apprised during the site visits that several policies were still being developed or were under revision, as the finalization of specific policies did not comport with the necessary requirements of the Settlement Agreement and/or the needs of inmates for adequate mental health care. The first step in policy and procedural development and implementation is the actual writing of the policies and finalization within SCDC. The other necessary components including training staff regarding the policies and procedures, implementation, supervision regarding those policies and procedures, and quality management review via the quality assurance/improvement mechanisms within SCDC are currently incomplete and inadequate.

A major achievement has been development of the Quality Assurance Risk Management (QARM) component within SCDC as an essential oversight and analysis component and mechanism. The IP was very positively impressed by their efforts and strongly encourages the continuation and expansion of their efforts at the central levels. However, as we have emphasized repeatedly during our discussions and on-site reviews, the data collection component of the quality management program must be accomplished at the facility level and relate to policies and procedures, and specific facility parameters and mental health programs, operations, support, and ultimately inmate mental health needs. This has not been accomplished, and the dire need for staffing (as noted in this report) and active on-site and central support for instituting, developing, and/or maintaining adequate services and support functions at the facility level has not been achieved.

Another major achievement has been the progress towards closing the SSR unit and plans for the High Intensity/Level Behavioral Management Unit. In addition, closure of the Super Max unit at Lee is recognized as another major achievement.

During this calendar year, SCDC has reported two deaths by suicide, and while the IP has received notice of these and other deaths, the establishment of an adequate and effective Mortality and Morbidity Review process including psychological autopsies has not been developed. SCDC central offices have requested that the IP provide direction and actual documents regarding a "Master Plan" for compliance with the Settlement Agreement by SCDC, as well as a model formal "Psychological Autopsy" format. In addition, SCDC requested the IP coordinator (Ms. Tammie Pope) participate in ongoing meetings with SCDC staff to facilitate this process.

While the IP has provided technical assistance and suggestions regarding how obtaining compliance with the Settlement Agreement criteria and its requirements could be accomplished, the IP has also emphasized repeatedly that these processes should be developed within SCDC by the appropriate staff within the SCDC and consultants, if necessary, who are responsible for their implementation, training, and supervision of staff on the actual requirements. SCDC must continue to develop and implement an internal process that supports and assures effective quality management so that the process will be developed and sustained beginning with the Settlement Agreement monitoring process and continuing after the settlement agreement has been satisfied

and/or otherwise resolved. The timely development and implementation will also facilitate transition to the anticipated Electronic Health Record (EHR).

Accordingly, the following description and appendices are reflective of our overviews of the specific facilities that were inspected during this site visit, namely Camille Graham Correctional Institution, Kirkland Correctional Institution, Broad River Correctional Institution, Perry Correctional Institution, and Lee Correctional Institution. As reported during our Exit Conference, the IP considers the conditions at Perry Correctional Institution to be at a severe crisis level that requires immediate correction. Not only are the staffing levels for clinicians, as well as operations staff, unacceptably low, preventing the implementation of effective treatment measures, but also based on the operations staffing this facility has experienced frequent lockdowns since at least February 2016 and has been unable to provide adequate recreation or showers, and inmates who have been cleared from restrictive housing remain in restrictive housing status because of the lack of available beds to which to transfer those inmates. These conditions must be corrected immediately, and plans to address the multiple factors contributing to the crisis at Perry must be developed and implemented.

Below are the specific findings followed by the appendices that provide overview information on the system as a whole as well as the individual facilities within the system. As noted, Policies and Procedures are in Partial Compliance.

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

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

Implementation Panel Assessment: partial compliance

November 2016 SCDC Status Update: Policy H.S.-19.11: Mental Health Services - Reception and Evaluation: Mental Health Screening, Evaluation, and Classification has stated goal of referring inmates to the appropriate treatment programs. "*Based on the initial, secondary, and/or psychiatric evaluation, mental health personnel will resolve to identify a program or service provided by the SCDC Division of Mental Health Services suitable for the mentally ill inmate's individual mental health care needs.*"

At R&E, there are 3 opportunities for screening/evaluation of inmates to ensure those with SMI are accurately diagnosed and referred to appropriate treatment programs.

- Intake Assessment Interview
- Medical Intake Screening
- Mental Health Screening

Note: to increase compliance percentage, an internal monitoring process will be implemented by Division of Mental Health.

In a review of 202 (100%) of females entering SCDC from April – May 2016:

Process	Average (Days)	Min	Max	Standard (Days)
Days elapsed from intake to Mental Health Screen (3 days)	[redacted]	2	17	3
Days elapsed from MH screen date to QMHP assessment	10	0	65	Emergent 4 hours; Urgent 24 hours; Routine 14 days
Days elapsed from MH screen to Psychiatric evaluation	[redacted]	3	45	Emergent 4 hours; Urgent 24 hours; Routine 14 days
Days elapsed from intake to Physical Exam	6	0	13	7
Days elapsed from intake to Medical Classification	23	6	46	30
Days elapsed from intake to transfer out of R&E (45 days)	36	3	81	45

In a review of 270 (20%) of males entering SCDC from June-July 2016:

Process	Average	Min	Max	Standard
Days elapsed from intake to Mental Health Screen (3 days)	[redacted]	1	45	3
Days elapsed from MH screen date to QMHP assessment	[redacted]	2	47	Emergent 4 hours; Urgent 24 hours; Routine 14 days
Days elapsed from MH screen to Psychiatric evaluation	[redacted]	1	49	Emergent 4 hours; Urgent 24 hours; Routine 14 days
Days elapsed from intake to Physical Exam	3	0	30	7
Days elapsed from intake to Medical Classification	[redacted]	10	68	30
Days elapsed from intake to transfer out of R&E (45 days)	45	0	111	45

November 2016 Implementation Panel findings: Implementation of the relevant policy and procedure has been problematic, especially in meeting the required timeframes as demonstrated by the SCDC status update data. We discussed with staff the need to determine the percentage of inmates receiving evaluations by the QMHPs and/or psychiatrists in the required timeframes. In addition, a summary should be provided, when compliance is not present, regarding the identified obstacles in achieving compliance and the plan to achieve compliance.

We also emphasized that the data needs to be gathered and analyzed locally in contrast to being the responsibility of the central office QARM, although it should be reviewed by the QARM. We

met with the central office IT staff to discuss the use of a web based data system to collect the needed information.

We met with R&E staff during the morning of November 2, 2016. One of the three FTE staff allocations assigned to this unit has been vacant for many months with partial coverage provided by a clinician from the ICS. Staff reported the need for additional staff, although they would have office space issues if additional staff was provided. It was not uncommon that their efficiency was significantly hampered due to the lack of available custody officers for escort purposes. A psychiatrist provided coverage on a two-day per week basis, which resulted in significant delays for inmates referred to the psychiatrist to be seen.

Staff also indicated that they over-referred inmates for both QMHP evaluations and psychiatric assessments based on screening results due to instructions received from supervisory staff regarding the threshold for such referrals. As a result there was a significantly high percentage of "false positives" being referred.

R & E staff were also responsible for reception center inmates referred for a crisis stabilization level of care. Such inmates were housed in unit F-1 for weeks at a time and were not transferred to the CSU at the Broad River Correctional Institution. We briefly inspected the crisis stabilization unit cells in unit F-1, which were not suicide resistant.

Recommendations: Work with IT staff to develop a web based data collection system. Work with the local prisons to implement a process for collecting and analyzing the pertinent data.

Clinicians should be allowed to exercise reasonable clinical judgment relevant to mental health referrals following the mental health screening assessment process.

The "crisis stabilization cells" in unit F-1 should only be used when beds are not available at the Broad River CI CSU.

a. (continued) Accurately determine and track the percentage of the SCDC population that is mentally ill.

Implementation Panel Assessment: partial compliance

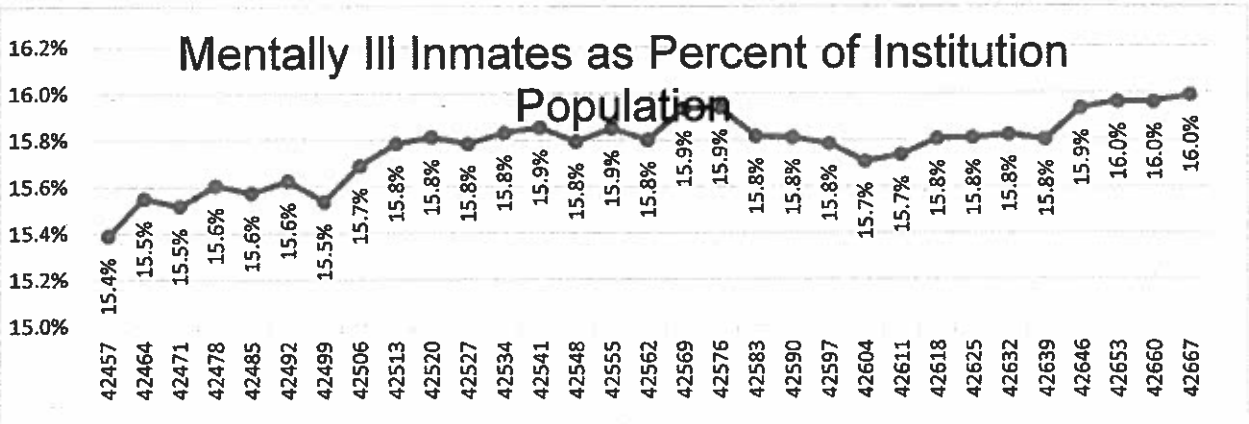
November 2016 SCDC Status Update: The Division of Resources and Information Management generates a weekly report of Mental Health Classifications for Mentally Ill Institutional Population. This report includes the numbers of mentally ill inmates by classification, the percentage of mentally ill by classification as a percentage of the mentally ill population, and the percentage of mentally ill inmates as a percentage of the total population. In addition, this information is provided by institution.

Mental Health Classifications for Mentally Ill Institutional Population

Date	SCDC Institutional Population	SCDC MI Population	Mentally Ill Inmates as % of Institution Population
3/28/2016	20,603	3,171	15.4%
4/4/2016	20,328	3,161	15.5%
4/11/2016	20,410	3,167	15.5%
4/18/2016	20,511	3,201	15.6%
4/25/2016	20,689	3,222	15.6%

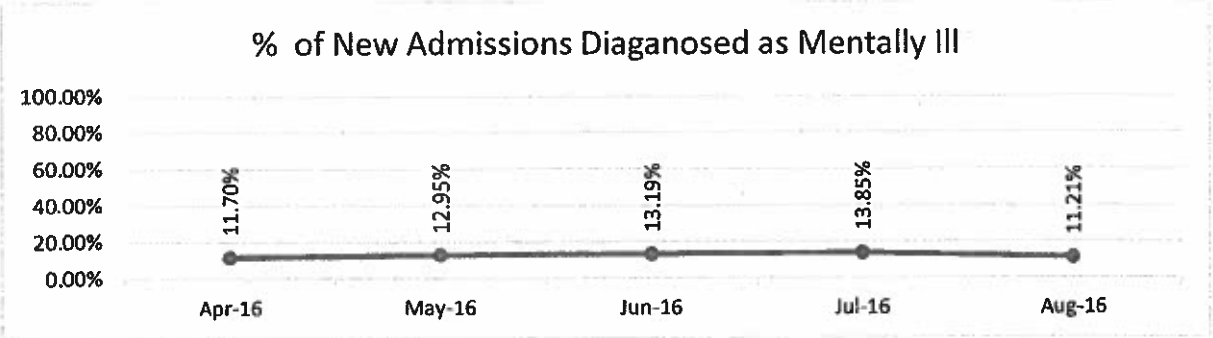
5/2/2016	20,427	3,192	15.6%
5/9/2016	20,506	3,186	15.5%
5/16/2016	20,541	3,223	15.7%
5/23/2016	20,721	3,271	15.8%
5/30/2016	20,831	3,294	15.8%
6/6/2016	20,398	3,220	15.8%
6/13/2016	20,497	3,245	15.8%
6/20/2016	20,619	3,269	15.9%
6/27/2016	20,793	3,284	15.8%
7/4/2016	20,498	3,249	15.9%
7/11/2016	20,487	3,237	15.8%
Date	SCDC Institutional Population	SCDC MI Population	Mentally Ill Inmates as % of Institution Population

7/18/2016	20,509	3,268	15.9%
7/25/2016	20,690	3,298	15.9%
8/1/2016	20,771	3,285	15.8%
8/8/2016	20,492	3,240	15.8%
8/15/2016	20,660	3,261	15.8%
8/22/2016	20,773	3,263	15.7%
8/29/2016	20,871	3,284	15.7%
9/5/2016	20,577	3,252	15.8%
9/12/2016	20,667	3,267	15.8%
9/19/2016	20,807	3,292	15.8%
9/26/2016	21,004	3,319	15.8%
10/3/2016	20,686	3,296	15.9%
10/10/2016	20,605	3,289	16.0%
10/17/2016	20,749	3,312	16.0%
10/24/2016	20,823	3,330	16.0%



The following chart illustrates the number of diagnoses for new admissions from April-September 2016:

Admission Month	Total # Admissions	Total # Mentally Ill or Retarded	Total % Mentally Ill or Retarded
04 Apr	863	101	11.70%
05 May	718	93	12.95%
06 Jun	864	114	13.19%
07 Jul	657	91	13.85%
08 Aug	812	91	11.21%
09 Sep	932	10	1.07%



November 2016 Implementation Panel findings: As per SCDC status update. It is very likely that the percentage of inmates within SCDC that are on the mental health caseload is underrepresented based on national statistics.

Recommendations: The "accurate determination" element needs to be assessed via a quality improvement study.

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 Assessment: partial compliance

November 2016 SCDC Status Update: The Division of Quality Assurance and Risk Management (QARM) conducts an audit of R & E intakes at Camille Graham and Kirkland R&E Centers for quarterly reporting. Because the number of females entering the system is significantly less than males entering the system, the sample from the first audit included 100% of CGCI R&E intakes in April and May 2016. A sample of 20% per month of the June and July intakes at KCI R&E were reviewed, as the intakes can average 800-900 per month.

During the review QARM staff assessed the days elapsed from intake to:

- MH initial screening
- QMHP assessment
- Psychiatric evaluation
- Physical exam
- Transfer from R & E to an institution

The purpose of the review was to ensure timeliness of services, based on restraints as dictated by the R & E policy. As deficiencies were identified, QARM staff immediately reported findings to counselors, the Division Director for Behavioral/Mental Health and Substance Abuse Services and other staff as identified, with directives to provide updates and corrections as completed.

Since the Division of QARM was established, approximately 34 individual cases of deficiencies were identified during the auditing of SCDC R&E Mental Health Services. When these deficiencies were identified, the auditor sent the findings to the QMHP or supervisor responsible for the area, notifying him/her of the deficiency and asking that it be corrected. At least 12 of

those have been corrected to date, and QARM will follow up to ensure compliance. Significant to the findings are multiple times that:

- A MEDCLASS is entered incorrectly at R&E (e.g., the psychiatrist orders "L-4", but the MEDCLASS is entered as "NMH" or "SA")
- A psychiatrist evaluates a NMH patient and starts him/her on psychiatric medication, but the MEDCLASS is not updated to reflect the new level of care.

The following chart captures defectives as noted during the QARM review of the R&E process:

R&E Deficiencies	
MEDCLASS at R&E does not match psyche recommendations	45%
Referral from R&E Medical not done timely	3%
At R&E Psyche ordered observe for a time, MEDCLASS entered as NMH	3%
R&E MEDCLASS entered before I/M sees psyche	5%
Transfer from R&E causes the process to not be completed, and is not picked up at next institution.	3%
Improper MH Triage	3%
At the institutions	
Psyche starts on psychiatric meds but MEDCLASS is not updated	16%
Referral not done in timely manner	0%
Psyche ordered observe for 90 days, MEDCLASS does not reflect L4	5%
No-show not followed up	3%
Self-referral not seen timely	3%
Classification Issues	
Old SCDC # vs. New SCDC #	3%
Institutional classification issues	3%
Other	5%

November 2016 Implementation Panel findings: Staff have made an initial start in complying with this provision. Issues remain regarding the need for a more accurate and efficient database as described earlier in addition to producing quality improvement reports. In general, quality improvement reports should be "stand-alone" documents that include the following subsections:

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

Recommendations: See 1(a).

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 Assessment: partial compliance

November 2016 SCDC Status Update: SCDC recently created the Division of Quality Assurance

and Risk Management (QARM) within the Office of Legal and Compliance to develop and implement an agency quality assurance and risk management system to track and measure agency compliance with the sixteen new or amended policies referenced in the settlement agreement. The division is developing data collection tools to capture information relating to screening, timeliness, and continuity of care for inmates identified as needing mental health services as well as data relating to other matters such as use of force, discipline, and restrictive housing with a focus on inmates classified as mentally ill.

The QARM team members will visit SCDC institutions, request information, and conduct ongoing audits similar to that of the outside monitors. It is the goal of SCDC's QARM staff to provide monitoring reports to the compliance team as requested, advise the agency on the status of its progress in implementing the requirements of the Remedial Plan, to make recommendations to assist staff in accomplishing compliance, and to prepare the agency and institutions for the outside monitors and their audits. Unfortunately, this left a vacuum internal to Health Services, as the internal QA monitors were moved out of Health Services so the Agency would have a centralized, independent means of monitoring and assessing.

SCDC Policy HS-19.07 was written prior to these changes, and while it addresses the aforementioned component relative to enforcement of timeliness of assessment and treatment, the specifics need to be updated to reflect actual practice and structure. To address these concerns, QARM is drafting an Agency CQI policy to reflect its activities and practices.

As a lack of compliance was found in the timeliness of assessment and treatment for intakes of inmates determined to be mentally ill at R&E, per section 3.3.10 of Policy HS-19.07, improvement action plans will be initiated and documented for each area for improvement as identified. If the findings are determined to be related to an individual, the clinician and the regional manager/program supervisor will develop and implement an improvement action plan. If the findings are determined to be systemic, the division director will develop and implement an investigatory review and corrective action process plan.

Though policy dictates the CQM Director in part develop and implement the investigatory review and corrective action process plan, it has been recommended that a change be made to allow the QARM Division Director to complete this action.

An additional recommendation has been made for an internal CQI Team to be established to fulfill the role of the ARC team.

Currently there is no documentation relative to 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.

However, based on the initial review, the following report highlights compliance with timely review of screenings and assessments for 100% females entering Camille Graham R&E April-May 2016 (n=202). Areas not in compliance with the standard as outlined in policy included

1) days elapsed from intake to MH screen and
2) days elapsed from date of screening to psychiatric evaluation.

Based on the initial review, the following report highlights compliance with timely review of screenings and assessments for a 20% sample of males entering Kirkland R&E June-July 2016 (n=270). Areas not in compliance with the standard outlined in policy included:

1) days elapsed from intake to MH screen,
2) days elapsed from MH screen date to QMHP assessment,
3) days elapsed from MH screen date to psychiatric evaluation, and
4) days elapsed from intake to medical classification.

These reports have been distributed to the Division of Mental Health.

November 2016 Implementation Panel findings: As per the SCDC status report.

Recommendations: See provision 1(a).

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 Assessment: noncompliance

November 2016 SCDC Status Update: SCDC does not have a program to regularly assess general population inmates for developing mental illness; however, when inmates transfer from one institution to another, nursing or other trained personnel provide screening that includes questions assessing mental health changes (SCDC Form M-14). This assessment does not capture all inmates, as not every inmate transfers regularly.

A recommendation has been made by the QARM staff for screenings to be done in conjunction with the annual TB testing, as this would cover all inmates annually.

Information to substantiate the effectiveness of identifying inmates in the general population as they transfer from institution was not available at the time this report was completed. A request has been submitted to the Division of Resource Information Management to begin generating this data. It will include information identifying all inmates who have a MEDCLASS change within 30 days of a transfer. From this list a sample will be assessed to determine if the MEDCLASS change was as a result of the mental health screen done at the time of transfer.

November 2016 Implementation Panel findings: See SCDC status update. We discussed with key staff various options for meeting the requirements of this provision. It appeared that the most practical solution was to perform a mental health screening at the time of the inmate's annual classification review. Such a screening would be very similar to the reception center mental health screening process.

Recommendations: Develop and implement the required program.

2. The development of a comprehensive mental health treatment program that prohibits inappropriate segregation of inmates in mental health crisis, generally requires improved

treatment of mentally ill inmates, and substantially improves/increases mental health care facilities within SCDC.

a. Access to Higher Levels of Care

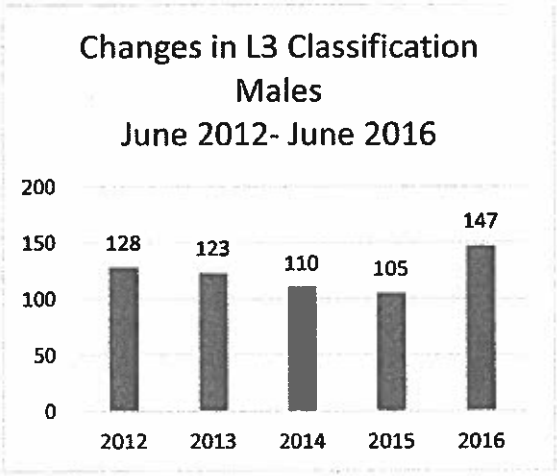
i. Significantly increase the number of Area Mental Health inmates vis-a-vis outpatient mental health inmates and provide sufficient facilities therefore;

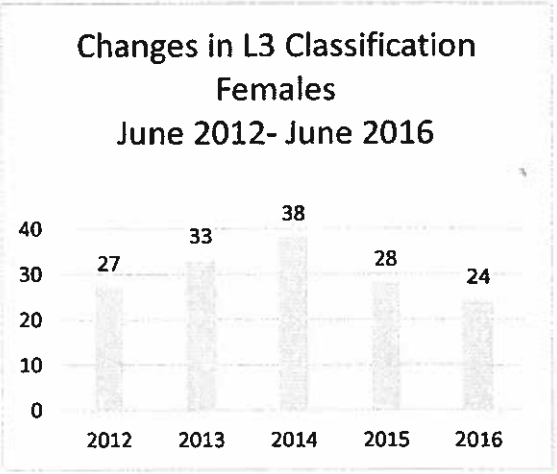
Implementation Panel Assessment: noncompliance

November 2016 SCDC Status Update: During the 90-day psychiatric appointments, the MEDCLASS should be reviewed to determine if an inmate needs a higher level of care. QARM has not been able to evaluate this practice effectively as this is not recorded as discreet data and there are inconsistences in how this information is documented. It has been recommended that Mental Health receive training on how to document this information consistently. Post training, QARM staff will begin to track these reviews.

Although a specific plan has not been articulated, QARM staff are currently tracking the Area Mental Health numbers to determine changes in the data.

No documentation is available to support this MEDCLASS review; however, from June 2012-June 2016, male inmates receiving Area Mental Health Services has increased 14.8%. From June 2012-June 2016, female inmates receiving Area Mental Health Services has decreased 11.1%.





November 2016 Implementation Panel findings: as per SCDC status update that indicates a decrease in female inmates receiving area mental health services.

We suggested that QI studies be performed on target populations to assess the appropriateness of the level of care being offered to inmates within these target populations. These target populations include, but are not limited to, the following:

1. Inmates with two or more CSU admissions within the past six months.

2. Inmates with two or more GPH admissions within the past six months.
3. Inmates discharged from GPH directly to outpatient services (in contrast to an ICS level of care).
4. Mental health caseload inmates receiving multiple disciplinary reports.

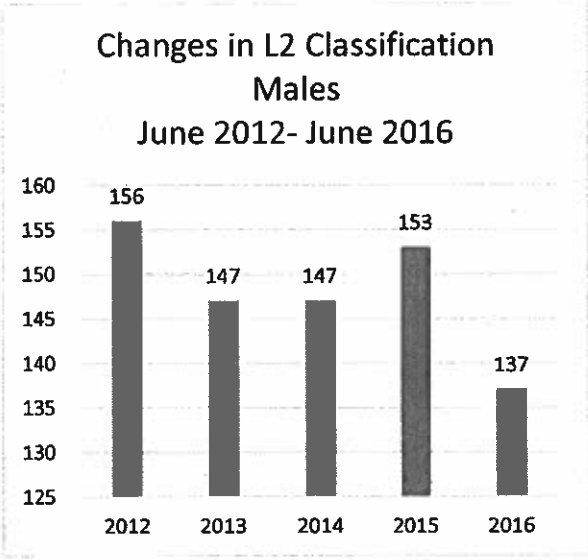
Recommendations: as above.

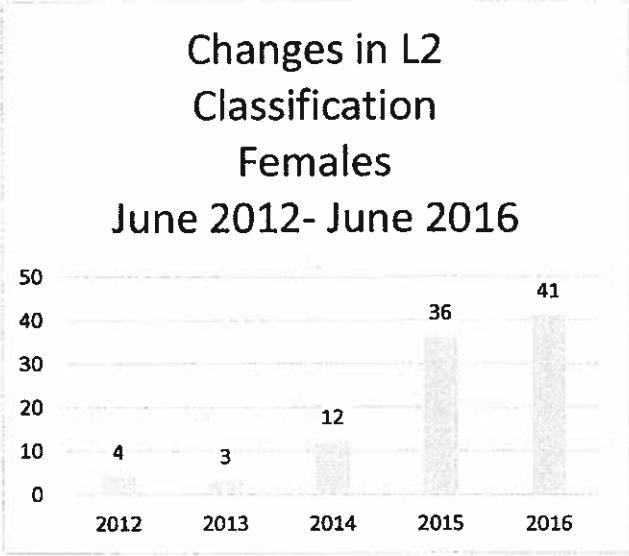
ii. Significantly increase the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefore;

Implementation Panel Assessment: noncompliance

November 2016 SCDC Status Update: During the 90-day psychiatric appointments, MEDCLASS should be reviewed to determine if an inmate needs a higher level of care. QARM has not been able to evaluate this practice effectively as this is not recorded as discreet data and inconsistences in how this information is documented. It has been recommended that Mental Health staff receive training on how to document this information. Post training, QARM staff will begin to track these reviews.

Although a specific plan has not been articulated, QARM staff are currently tracking the number of males and females identified as requiring intermediate care services. No documentation is available to support this MEDCLASS review; however, from June 2012-June 2016 review, male inmates receiving intermediate care services has decreased 12.2%. From June 2012-June 2016, female inmates receiving intermediate care services has increased 925%.





November 2016 Implementation Panel findings: It has been our experience that inmates receiving an ICS level of care generally comprise 10% to 15% of the total mental health caseload population.

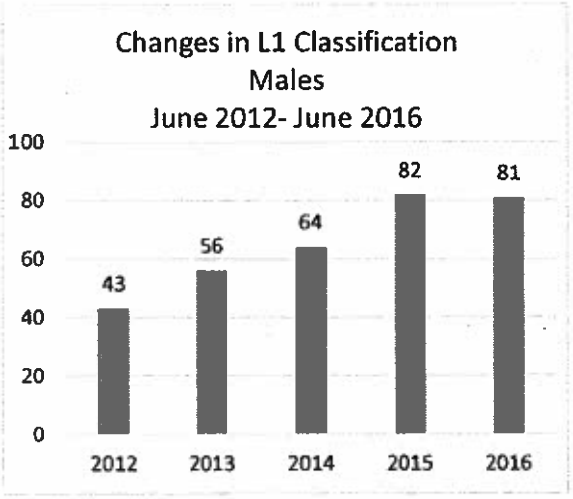
Recommendations: See 2(a)(i) recommendations. We also recommend that a QI be performed relevant to referrals made to ICS that are not accepted for program participation.

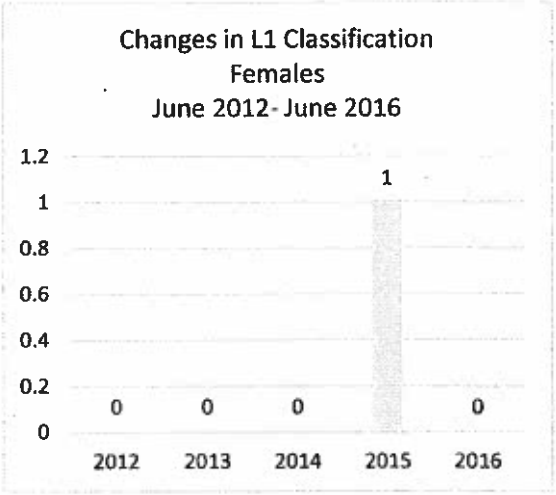
iii. Significantly increase the number of male and female inmates receiving inpatient psychiatric services, requiring the substantial renovation and upgrade of Gilliam Psychiatric Hospital, or its demolition for construction of a new facility;

Implementation Panel Assessment: partial compliance

November 2016 SCDC Status Update: GPH maintains a consistent, full census, averaging approximately 80 inmates. Plans to improve/renovate the GPH facility are on-going. Because GPH's capacity is 80% consistently, without a documented waiting list or list of denials due to bed space, QARM is unable to determine increases. During the 90-day psychiatric appointments, MEDCLASS should be reviewed to determine if an inmate needs a higher level of care. QARM has not been able to evaluate this practice effectively as this is not recorded as discreet data and inconsistences in how this information is documented. It has been recommend that Mental Health staff receive training on how to document this information. Post training, QARM staff will begin to track these reviews.

Although a specific plan has not been articulated, QARM staff are currently tracking the number of males and females identified as requiring inpatient psychiatric services.





GPH Renovations

The chart below outlines planned and completed renovations to GPH Division Maintenance & Engineering plans for GPH:

1) Kirkland Correctional Institution -- Gilliam Psychiatric Hospital (GPH)	
a) Administration Area:	
i) Four (4) group counseling rooms:	
• Renovate two (2) offices for group counseling rooms and two (2) conference rooms.	[redacted]
• Add cameras (2 ea. per room). Add cameras to view corridor.	Larger Glazing view panels. Complete. Cameras received awaiting IP address for programing. Furniture/chairs to be determined
• Add larger security glazing view panels in doors.	
• Furniture / chairs.	
b) Existing Nurse's Station in Admin Area – scope of work has not been determined at this time.	
c) Hospital Housing Unit: *(Note: Must be mindful not to violate the current 87 bed SCDHEC hospital license)*	
i) The cells and door view panels are adequate at this time.	
ii) Install 5 benches and 2 restraint group tables with stools per wing of the housing unit..	[redacted]
iii) Provide an enclosed nurse's station to include hand sink ("no restroom facilities") to both A & B wings. Preliminary plans are being developed for submission and review by SCDHEC – Health Services.	Projected Completion December 1, 2017 *(If construction documents have SCDHEC & OSE approvals by January 1, 2017)*
iv) Install security cameras in hospital cells -- 1st floor one wing.	
v) Renovate showers on both wings to include push button valves and an ADA shower with ADA with ligature resistant ADA fixtures	
vi) Install four (4) silent TV's in security cages in the dayroom for both wings.	B- Wing Complete A-Wing TV's are on order
d) All areas to be painted to accommodate a more therapeutic setting.	Color(s) selected
2) Kirkland Correctional Institution -- Modular Unit at GPH	
a) Additional office space:	
i) Renovate the open area for additional office spaces and add a wall in the existing ICS pill room to make two offices.	ICS Pill room must be relocated before the renovations can begin. The new area in the Admin. Area is ready for the ICS pill room. Awaiting notification of the move

November 2016 Implementation Panel findings: Some of the planned renovations have been completed as per the SCDC status update section.

We met with GPH line staff during the afternoon of November 1, 2016. Inmates continued to receive a minimal amount of out-of-cell structured therapeutic time per week. Related, in part, to psychiatric staffing vacancies, the treatment team process does not include a psychiatrist.

Inmates do not have access to dayroom time within the housing unit. A therapeutic milieu did not appear to exist within the housing unit. The renovations have not yet resulted in increased inpatient services for any inmates.

Data provided prior to the site visit indicated no waiting lists for male or female inmates for access to hospital level care; however, during the site visit, the IP was apprised there had been three referrals for female inmates and occasional waiting lists for male inmates. SCDC must track all referrals for inpatient/hospital level care as well as waiting lists and rejections of referrals.

Recommendations: As per the SCDC status update section relevant to renovations. Implement a QI process relevant to a needs assessment specific to an inpatient level of care. See 2(a)(i) recommendations.

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

Implementation Panel Assessment: partial compliance

November 2016 SCDC Status Update: The Division of Mental Health has demonstrated an increase in the number of positions allotted to provide more mental health services at all levels of care since October 2014. From October 2014 to October 2016, the Division saw an increase in total positions (filled + vacant) of 49.0%.

The following chart demonstrates clinical staffing totals from October 2014-October 2016:

10/2014	Full-Time		Pink Slip		Dual		Contract	
	Filled	Vacant	Filled	Vacant	Filled	Vacant	Filled	Vacant
Administration Totals	6	0	0	0	0	0	0	0
REGIONAL MENTAL HEALTH								
Totals	**69**	**8**	**0**	**0**	**0**	**0**	**1**	**0**
CENTRAL SERVICES								
Central Services Totals	**26**	**1**	**7.26**					
Division Totals	**97**	**9**	**7.26**					

10/2016	Full-Time		Pink Slip		Dual		Contract	
	Filled	Vacant	Filled	Vacant	Filled	Vacant	Filled	Vacant
Administration Totals	6	0	0	0	0	0	0	0
REGIONAL MENTAL HEALTH								
Totals	**71**	**45**	**0**	**0**	**0**	**0**	**0**	**0**

CENTRAL SERVICES								
Central Services Totals	24	18	3.3	0	1.67	0	1.7	0
Division Totals	**95**	**63**	**3.3**	**0**	**1.67**	**0**	**1.7**	**0**

November 2016 Implementation Panel findings: The 40% vacancy rate is very concerning and is most likely due to noncompetitive salaries. It will be extremely difficult, if not impossible, to achieve compliance with most clinical elements of the settlement agreement unless the staffing vacancies issue is remedied.

Recommendations: Effectively address the salary issues.

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 Assessment: partial compliance

November 2016 SCDC Status Update: The treatment team at each program reviews each patient that is presented for admission. The treatment team submits to the Division Director of MH a report including those who are denied admission. These reports will be forwarded to Division QARM to identify trends for denials. These reports will also be reviewed by the CQI committee which is being developed. This is a new process, and very little documentation is available.

Monthly Admission Recommendation Record, in month of September, ICS had 14 referrals. 3 were accepted, and 11 were denied. Reasons were provided in 91% of the denials. During intake, staff participated as follows for those denied admission to ICS:

- Psychiatrist 90%
- Psychologist 0%
- QMHP 90%
- Medical 0%
- Operations 90%

November 2016 Implementation Panel findings: A preliminary plan for the required QI process has been formulated.

Recommendations: More comprehensively develop a QI process and implement it. See 1(a).

b. Segregation:

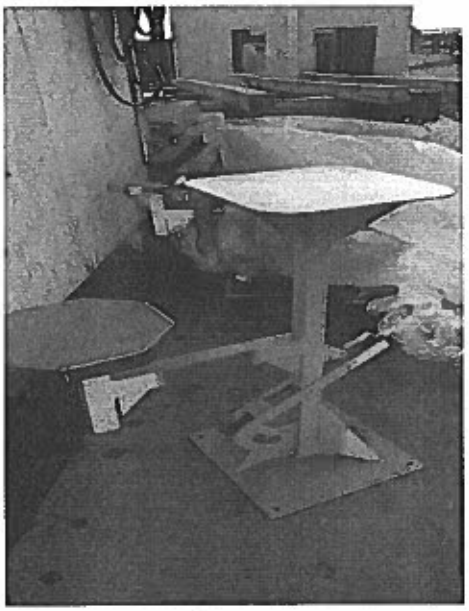
i. Provide access for segregated inmates to group and individual therapy services;

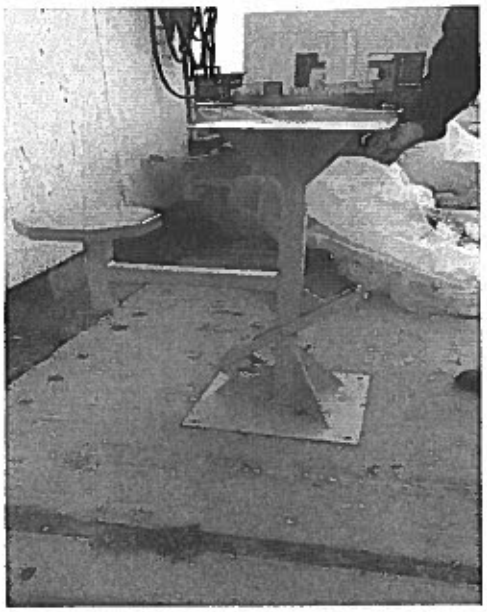
Implementation Panel Assessment: noncompliance

November 2016 SCDC Status Update: Provisions are underway to accommodate for therapy for inmates in segregation. SCDC has built "group therapy chairs" that will allow for group sessions while providing security, in that each inmate will be secured to his/her own chair, which is bolted to the floor, and will remain in restraints during the groups, as determined by mental health and security staff. Provisions will be made to accommodate up to six inmates per groups.

Currently there is no documentation available to track the number of RHU inmates participating in groups. In the CSU group therapy rosters have been provided, but they failed to indicate those inmates participating in groups with a designated segregation status. Although groups are reported as ongoing, this documentation is insufficient to support this requirement.

Therapeutic chairs have been constructed:





November 2016 Implementation Panel findings: as per SCDC status update section.

Recommendations: complete the required renovations and implement the treatment program.

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

Implementation Panel Assessment: noncompliance

November 2016 SCDC Status Update: An electronic tool for calculating and tracking structured versus unstructured out-of-cell time was created and shared for consideration with Operations to be used at CSU, GPH, CGCI, and RHUs.

CSU has pilot-tested the data collection tool, which tracks inmate name, SCDC number, structured versus unstructured activity type, specific activity (groups, activity therapy, recreation indoors, recreation outdoors, individual counseling), whether or not the inmate participated, name/time of groups, and time out and time returned to cell. The database automatically calculates the out of cell time. Although the database in and of itself does not increase out of cell time, it allows staff to see if an inmate is not being provided out of cell time per policy and may act as a catalyst in establishing opportunities for more time out of cell.

Audit of Total Out-of-Cell time for 10% of inmates in CSU (Crisis Stabilization Unit)

Month	# of Inmates in CSU	Structured	Unstructured	Total
May 2016	24	28 hours: 20 minutes	63 hours: 18 minutes	91 hours: 38 minutes
Inmate A		17 hours: 34 minutes	41 hours: 34 minutes	59 hours: 8 minutes
Inmate B		10 hours: 46 minutes; refused structured groups	21 hours: 44 minutes	32 hours: 30 minutes
June 2016	36	17 hours: 28 minutes	85 hours: 34 minutes	103 hours: 2 minutes
Inmate C		1 hour: 15 minutes	1 hour: 46 minutes	3 hours: 1 minute
Inmate D		1 hour: 21 minutes	14 hours: 48 minutes; refused activities	16 hours: 9 minutes
Inmate E		1 hour: 1 minute	12 hours: 40 minutes	13 hours: 41 minutes
Inmate F		13 hours: 51 minutes	56 hours: 20 minutes	70 hours: 11 minutes
July 2016	52	4 hours: 34 minutes	22 hours: 53 minutes	27 hours: 27minutes
Inmate G		40 minutes	5 hours: 1 minute	5 hours: 41 minutes
Inmate H		58 minutes	10 hours: 41 minutes	11 hours: 39 minutes
Inmate I		28 minutes	1 hour: 42 minutes; refusal of activities	2 hours: 10 minutes
Inmate J		4 hours: 41 minutes	6 hours: 10 minutes	10 hours: 51 minutes
Inmate K		2 hours: 56 minutes	5 hours: 10 minutes	8 hours: 6 minutes
August 2016	43	3 hours: 39 minutes	52 hours: 41 minutes	56 hours: 20 minutes
Inmate L		1 hour: 1 minute	6 hours: 56 minutes	7 hours: 57 minutes
Inmate M		1 hour: 8 minutes	14 hours: 59 minutes	16 hours: 1 minute
Inmate N		1 hour: 30 minutes	26 hours: 44 minutes	28 hours: 14 minutes
Inmate O		0 hours: 0 minutes	30 minutes	30 minutes

Results based on a 10% sample of inmates in the CSU in May 2016 –August 2016

Based on the sample of 15 inmates, 3 received the minimum 10 hours structured/10 hours unstructured out-of-cell time.

November 2016 Implementation Panel findings: This particular provision is applicable specifically to inmates in segregation in contrast to those in CSU.

During the afternoon of November 2, 2016, we briefly toured the RHU at the Broad River CI. In addition to not having access to group therapies, inmates in this unit had access to outdoor yard on only three occasions during the month of October 2016. The lack of adequate numbers of custody staff was reported to be the cause of this problem.

During November 3, 2016, we site-visited the Perry Correctional Institution (PCI). This correctional institution had an average daily census of about 900 inmates with 380 inmates during November 3, 2016, on the mental health caseload. Seventy (70) of the 127 RHU inmates were also on the mental health caseload, with 22 of these inmates in security detention housing, 43 inmates

in short term housing and three inmates in disciplinary detention housing. About 40 inmates remained in the RHU for at least weeks at a time due to lack of general population housing beds systemwide being available to them.

The PCI workforce included 289 FTE positions, with 218 of these positions being security positions. At the time of the site visit, there were 96 FTE vacancies, which included 14 non-uniform vacant positions. It was our understanding that this significant vacancy rate was due to salary issues specific to the correctional officers and the surrounding availability of much higher paying jobs in the local community. As a result of these correctional officer vacancies, RHU inmates have not had access to out of cell recreational time since at least February 2016. Access to showers was reported limited to 1-2 times per week.

Three (3) of the seven FTE mental health staff positions at PCI were vacant. Coverage by a psychiatrist was limited to 10 clinics per month that included four clinics being held via telepsychiatry.

We were also informed that all mental health caseload inmates, as well as inmates requiring an outpatient or higher level of medical care, can only be housed in level III facilities related to the healthcare staffing of facilities systemwide within SCDC.

We site-visited Lee CI during the morning of November 4, 2016. Of the 1357 inmates, 252 (19.3%) were on the mental health caseload. About 200 inmates were receiving an outpatient level of care, 37 inmates an area services level of care and 24 inmates were receiving an L5 service level of care. Mental health staff reported providing up to 24 group therapies per week.

The capacity of the RHU was 200 beds with 92 beds occupied. There were 65 inmates in the RHU on an RHU status with 24 of these inmates being mental health caseload inmates. The RHU also housed inmates who did not want to leave the RHU due to their safety concerns as well as pretrial "safe keepers" from county jails. Staff reported that inmates received access to recreational time on a three times per week basis although this was not consistent with information provided by inmates and review of activity log documentation. Showers reportedly were provided on a three times per week basis. Inmates reported that there were significant issues with intermittent lack of cold water in the showers, which appeared to be accurate based on our observation of two showers.

The "Super Max" housing unit has been shut down for close to two years.

The mental health dormitory housed 136 inmates with the vast majority of these inmates receiving an outpatient mental health level of care. Lee Correctional Institution also had an Addiction Treatment Unit.

There were 4.0 FTE mental health staff vacancies of the 7.0 FTE allocations. Two psychiatrists provided on-site clinics twice per month and two telepsychiatrists provided clinics on a twice per week basis. About 11 hours per week of psychiatrist time was provided.

96 of the 268 operational staff positions were vacant.

Recommendations: See 2(b)(i) recommendations.

The lack of access to out-of-cell group therapies is exacerbated by the inadequate access to outdoor recreation. We discussed with staff at Perry Correctional Institution specific steps that, if taken, would help mitigate the extremely harsh conditions of confinement in the RHU. They included providing increased privileges to RHU inmates, who were only in the RHU due to lack of access to general population beds, providing crank radios to all RHU inmates and consideration of providing break-resistant iPads to RHU inmates on a privilege-level basis.

Related to the factors contributing to the significant correctional and healthcare staff vacancies, it is our recommendation that PCI not house inmates requiring an area mental health services level of care because such services are essentially not available to most inmates requiring an area mental health services level of care.

We also recommend that strong consideration be given to staffing facilities classified as either level I or II in order to be able to house levels I & II inmates requiring healthcare services for reasons that include costs and fairness.

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 Assessment: noncompliance

November 2016 SCDC Status Update: An electronic tool for tracking caseload and clinical services was created, shared, and demonstrated for Mental Health staff. This electronic tool had the capacity to track the following:

- Number of New Admissions
- Number Transferred to Caseload
- Number Admitted to GPH/ICS/Geo
- Number Admitted to SIB
- Number Released from Caseload
- Number Crisis added to caseload
- Percent Crisis NOT seen with 24 hours (1 day) OUT OF Compliance
- Percent Crisis NOT seen with 7 days hours OUT OF Compliance
- Number GPH added to caseload
- Percent GPH Admissions NOT seen within 48 hours (2 days) hours OUT OF Compliance
- Percent seen by counselor within 14 days of arrival
- Number recommended for Group Therapy
- % recommended for Group Therapy
- % QMHP visits OUT OF compliance with 30 day standard
- % Tx plans OUT OF compliance with 90 day standard
- % Psych appointments OUT OF compliance with 90 day standard
- Number released from SCDC
- % released with MH appointment
- % released with 30 day script
- AVERAGE Total days in caseload

Mental Health Staff are utilizing a variation of the tool but on a more limited scale and scope. The current system does not allow for flagging when services are out of compliance and is limited in reporting capabilities.

In a review of four randomly selected institutions—Perry, Lee, Allendale and Broad River—timeliness of sessions for seeing the QMHP and Psychiatrist were reviewed for inmates in RHU. 100% of inmates had a MEDCLASS of L-4. Results are below:

Institution	Average days to QMHP Review	Range of days to see QMPH	Average days to QMHP Review
Perry	32	7-142	Unable to determine
Lee	56	27-149	Unable to determine
Broad River	NO DATA RECORDED	NO DATA RECORDED	NO DATA RECORDED
Allendale	92	36-129	Unable to determine

November 2016 Implementation Panel findings: Consultation needs to be obtained with central office IT staff as per recommendation 1.a. in order to develop an adequate management information system relevant to this provision.

Recommendations: as above.

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

Implementation Panel Assessment: partial compliance

November 2016 SCDC Status Update: Policy # HS-19.10 Mental Health Services - Behavioral Management Unit (BMU) has been written and signed.

The BMU and LLBMU are designed with the intent of better providing mental health services to inmates who frequently find themselves in segregation, those with a mental health diagnosis and personality disorder. Projected opening date for the LLBMU at Allendale is December 2016.

QMHPs report conducting weekly rounds with inmates in RHUs. Counselors currently document contact in the AMR but a tracking and reporting system to quantify visits has not been established. Effective next month, this information must be submitted to Mr. [redacted] on a monthly basis.

Fourteen institutions have submitted reports to the Division of Mental Health. There is not a standardized method for reporting and information provided is limited in indicating compliance. In cases where staff report that they are out of compliance, in many cases the reason is not provided. Staff do not report the number or percentages of rounds completed.

QARM has not conducted an audit to validate reported information.

November 2016 Implementation Panel findings: Partial compliance is found related to the policy developed relevant to the concept of a behavioral management unit.

The "60-hours holding crisis" cells in the Broad River CI RHU, the R&E (Unit F-1), the Perry CI RHU, and the Lee CI RHU were not suicide resistant. The crisis cells at the Broad River RHU did

not have beds. It was our understanding that the CSU at the Broad River CI will no longer be a pilot project beginning November 7, 2016.

Recommendations: Implement Policy # HS-19.10 and the suicide prevention policy.

Track the occupancy rate of the Broad River CSU and the waiting list, if any, that develops.

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 Assessment: compliance

November 2016 SCDC Status Update: QARM has recently started compiling data to track the number of inmates in security detention, disciplinary detention, maximum security, and short term lock up by inmates with and without a mental health classification. Data currently reflects that inmates without a mental health classification spend more days in all areas of lock-up as compared to those with a mental health classification. Resource Information Management (RIM) distributes spreadsheets weekly outlining the following:

- Institution
- "Days in lock-up".
  - o
- SCDC #
- Name
- Current Custody
  - DD
  - SD
  - MX
  - ST
- "Begin Date in DD
- SD
- MX
- ST Custody"
- Dorm

This information is analyzed and reports sent to the wardens and headquarters leadership.

Comparison of the Average Number of Days Spent in Segregation by Mental Health or Non Mental Health Classification between September 22 & October 6, 2016

September 22, 2016		October 6, 2016	

Mental Health Class	Avg Days in/Custody		Avg Days in/Custody	Percent change
L1	254		187	-26%
L2	29		45	55%
L3	143		135	-6%
L4	483		450	-7%
L5	90		93	3%
MH/OK	137		227	66%
MR	34			
SA	48		44	-8%
UNCLAS	18		19	6%

November 2016 Implementation Panel findings: See SCDC status update.

Recommendations: Continue to monitor.

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

Implementation Panel Assessment: noncompliance

November 2016 SCDC Status Update: BRCI CSU was audited in August. Observation showed that the cells were being cleaned when inmates were taken to their showers, but this was not documented anywhere. Temperatures were not being checked in the cells.

This data has not been provided to the Division QARM from any other institutions.

A cell-side log is being developed that will allow for tracking of cell cleaning and temperatures. Equipment (for checking temperature) has been purchased for GPH, and additional units have been ordered to cover the other segregation areas.

November 2016 Implementation Panel findings: See SCDC status update.

Recommendations: Implement a cell-side log.

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

Implementation Panel Assessment: noncompliance

November 2016 SCDC Status Update: QARM will established a Continuous Quality Improvement Review Committee (CQIRC) to review data concerning inmate safety and

security, analyze operational performance, identify deficiencies, recommend corrective actions, and ensure compliance on an ongoing basis.

This committee has not been formally established. A policy is currently being drafted for consideration for its operation.

November 2016 Implementation Panel findings: As per SCDC status update section.

Recommendations: Establish and implement the CQIRC.

c. Use of Force:

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

Implementation Panel Assessment: noncompliance

November 2016 SCDC Status Update: The automated Use of Force (UoF) System was developed to provide a means of review and tracking use of force within the SCDC. In this system, when a use of force occurs, a MIN is created and uploaded into the automated UoF System, where it is reviewed at multiple levels for compliance with policy and training. The QARM UoF review staff track these incidents to look for trends, disparities in the use of force between inmates with and without SMI. The following outlines the types of reports that will be generated and their content.

Use of Force Reviews and Reports

1. Review All MINS daily **(Weekly Report)**
    a. Track Use-of-Force (UoF) allegations
        i. Track UoF allegations total
            1. Track and report by institutions
        ii. Track and compare UoF allegations by MI vs NMH
            1. Track and report UoF MI vs NMH by institutions
2. Review UoF Videos daily **(Weekly Report)**
    a. Report of videos with excessive use of force
    b. Review all documentation uploaded to UOF system
3. Monthly Use of Force MINS review **(Monthly Report)**
    a. Compare the number of UoF MINS with the number of UoF uploads to the automated UoF system
        i. Report total number not uploaded
        ii. Review by institution any discrepancies
4. Grievances **(Monthly)**
    a. Track by institution total and number of grievances related to excessive UOF
5. Use of Force from MINS and Automated UoF **(Weekly with Monthly Summary)**
    a. Total # UoF by institutions
        i. Where UoF occurring
        ii. # UoF against MI vs NMH
        iii. By categories

iv. Planned vs unplanned
1. UoF against MI vs NMH

6. Use of Force involving chemical munitions **(Weekly with Monthly Summary)**
   a. By institutions
   b. By type
      i. Chemicals
      ii. Type
         1. Amount used
            a. Within reason or excessive
               i. If excessive, justification to support
   c. MI vs NMH
7. Report UoF returned to institutions **(Weekly with Monthly Summary)**
   a. By institution
   b. Reasons for kickbacks
   c. Patterns of UoF with staff and inmates

In a review of UoF incidents between June 1-August 29, 2016:

- 93% of were unplanned uses of force.
- 67% involved inmates without a mental health classification.
- 69% involved chemical munitions;
- 30% involved defensive tactics;
- 0% involved the use of a restraint chair;
- 2% involved the use of hard restraints, and
- less than 1% involved the Forced Cell Movement Team.
- Perry and Tuberville had the most uses of force.

November 2016 Implementation Panel findings: The SCDC has developed an electronic use of force reporting and reviewing process. Monthly use of force statistics identified in the SCDC Status Update are provided to the designated IP member in a monthly report. Use of Force statistics include inmates and employees involved in use of force incidents. There is a serious concern SCDC management does not have formalized procedures to address administrative violations and excessive force identified during the electronic use of force reviews. The designated IP Member is reviewing SCDC Management Information Notes (MINS) narratives and provides feedback to SCDC Compliance and Operations officials on a monthly basis. SCDC reported there were no employees disciplined for use of force violations for the time frame June 1 to October 31, 2016. SCDC has not developed or implemented a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness. SCDC does not currently have an acceptable system of accountability for when employees commit use of force violations and/or are found to have used excessive use of force.

Recommendations: SCDC must develop and implement a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness. A policy and monitoring of use of force on mentally ill and non-mentally ill inmates has been developed; however, the monitoring does not have an accountability component. All staff need training on the new Use of Force Policy. An SCDC department independent of the

SCDC Compliance and Operations Departments will need to be designated to investigate and take action when use of force violations and/or excessive use of force is substantiated.

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 Assessment: partial compliance

November 2016 SCDC Status Update: UoF Review staff track these incidents and provide reports to Operations, to include types of force and compliance with policy, and compares the UoF incidents against inmates with and without SMI. QARM has been unable to determine manufacturer's guidelines that specifically dictate exact quantities appropriate for use of chemical munitions. Therefore, a quantifiable amount of agent has not yet been defined to be excessive in the use of force involving various chemical munitions.

November 2016 Implementation Panel findings: SCDC has revised the OP 22.01 Use of Force Policy and requires all instruments of force, (e.g., chemical agents and restraint chairs) be employed in a manner fully consistent with manufacturer's instructions. An electronics use of force reporting system has been developed and implemented by SCDC to track instruments of force; however, the monitoring/tracking system does not have an enforcement component for compliance. In a November 11, 2016, meeting with the SCDC Director of Training it was determined the Use of Force Policy and Training Lesson Plans contained language that contradicted manufacturer guidelines for instruments of force in some cases.

Recommendations: The SCDC Use of Force Policy and Lesson Plans will require review to ensure the policy and lesson plan language that is contradictory to instruments of force manufacturer guidelines is removed. The Use of Force Master Plan will need to designate a SCDC Department independent of the SCDC Compliance and Operations Departments to investigate, take action, and enforce compliance when instruments of force are used in a manner not consistent with manufacturer guidelines.

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 Assessment: noncompliance

November 2016 SCDC Status Update: SCDC does not use the crucifix position or others that do not conform to generally-accepted correctional standards. A recommendation to formally ban this practice by stating such in policy has been submitted by Division QARM.

November 2016 Implementation Panel findings: As identified by SCDC QARM, Use of Force OP 22.01 does not prohibit the use of the crucifix position or others that do not conform to generally accepted correctional standards. The SCDC Electronic Use of Force Monitoring and Tracking System does not assess incidents to determine if the use of the crucifix position or others that do not conform to generally accepted correctional standards have been utilized in use of force

incidents. The Use of Force Monitoring and Tracking System does not have an enforcement component for compliance.

Recommendations: SCDC will need to adopt the recommendation formally submitted by the Division of QARM to revise Use of Force OP 22.01 to prohibit the use of the crucifix position or others that do not conform to generally accepted correctional standards. The SCDC Electronic Use of Force Monitoring and Tracking System will need to include verifying the use of the crucifix position or others that do not conform to generally accepted correctional standards are not utilized in use of force incidents. An enforcement component for compliance independent of the Operations and Compliance Departments needs to be developed.

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 Assessment: partial compliance

November 2016 SCDC Status Update: No documentation has been provided to indicate that staff are removing restraints before a predetermined period of time if the inmate complies. QARM has discussed the need internally and will make the recommendation for further training and policy revision to specifically include in HS 19.08, Mental Health Services - Clinical Use of Restraints for Mental Health Purposes, language that distinctly states that a predetermined period of time is prohibited.

November 2016 Implementation Panel findings: SCDC OP 22.01 Use of Force Policy establishes restraints can only be utilized for the period of time necessary to gain control. The SCDC Electronic Use of Force Monitoring and Tracking System tracks use of force incidents involving the use of restraints. During a meeting with SCDC officials at the Broad River CI CSU on November 2, 2016, it was discovered there had been inaccurate data on the use of restraint chairs. SCDC reported one use of force incident involving restraint chair use from June 1, to September 30, 2016. In the meeting, it was discovered there had actually been three use of force incidents involving the restraint chair.

Recommendations: SCDC needs to review use of force reporting procedures and ensure responsible staff are re-trained on electronic use of force reporting and tracking.

SCDC needs to ensure the Electronic Use of Force Monitoring and Tracking System has a requirement that any use of force involving use of restraints includes a review to determine if restraints were only used for the time necessary to gain control.

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 Assessment: partial compliance

November 2016 SCDC Status Update: At this point, Division QARM has not tracked or trended this information.

November 2016 Implementation Panel findings: SCDC OP 22.01 Use of Force establishes protocols for use of the restraint chair including length of time an offender can remain in a restraint chair. The SCDC Electronic Use of Force Monitoring and Tracking identifies the mental health status of inmates involved in a use of force incident. As identified in the November 2016 SCDC Status Update, the Division QARM has not tracked or trended the length of time or mental health status of inmates placed in restraints. Also, as indicated in the previous section, SCDC has not submitted accurate data regarding use of force incidents involving the restraint chair.

Recommendations: SCDC needs to utilize the Electronic Use of Force Monitoring and Tracking System to identify the length of time and mental health status of offenders placed in the restraint chair.

SCDC QARM should immediately begin monitoring and tracking use of the restraint chair including the length of time in the restraint chair and the mental health status of the offender.

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

Implementation Panel Assessment: noncompliance

November 2016 SCDC Status Update: Policy OP-22.01 and training for use of force describe circumstances where a use of force is acceptable because of a particular threat. However, the policy does not prohibit use of force in the absence of a reasonably perceived immediate threat, although it is implied. QARM has discussed the need internally and will make the recommendation for further training and policy revision as follows: "The use of force in the absence of a reasonably perceived immediate threat is prohibited."

QARM has not reviewed the training curriculum to determine the extent to which this is covered.

November 2016 Implementation Panel findings: SCDC OP 22.01 Use of Force Policy and Training Use of Force Lesson Plans do not prohibit the use of force in the absence of a reasonably perceived immediate threat. Staff conducting SCDC Electronic Use of Force Monitoring and Tracking are not reviewing use of force incidents to identify if use of force was due to a reasonably perceived immediate threat.

Recommendations: Revise SCDC OP 22.01 Use of Force Policy and Training Use of Force Lesson Plans to prohibit the use of force without a reasonably perceived immediate threat.

Require all SCDC employees to receive training that use of force is prohibited without a reasonably perceived immediate threat. Staff should utilize the SCDC Electronic Use of Force Monitoring and Tracking System to review use of force incidents to identify if use of force was due to a reasonably perceived immediate threat.

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 Assessment: noncompliance

November 2016 SCDC Status Update: Policy OP-22.01 and training for use of force describe circumstances crowd-control canisters can be used. However, the policy does not explicitly state that their use is prohibited in individual cells in the absence of objectively identifiable circumstances set forth in writing and only in volumes consistent with manufacturer's instruction, although it is implied. QARM has discussed the need internally and will make the recommendation for further training and policy revision as indicated below.

"The use of crowd-control canisters such as MK-9 is prohibited in individual cells in the absence of the following circumstances, and only in volumes consistent with manufacturer's instruction." (The list of objectively identifiable circumstances will need to be determined by Operations managers and included in the policy.)

QARM has not reviewed the training curriculum to determine the extent to which this is covered.

November 2016 Implementation Panel findings: In the SCDC November 2016 Status Update, QARM has identified the OP 22.01 Use of Force Policy does not explicitly 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 in volumes consistent with manufacturer's instructions. A meeting between the responsible IP Member and the SCDC Director of Training on October 31, 2016, confirmed employees have not been trained on the revised Use of Force Policy that includes circumstances in which crowd control canisters can be used in use of force incidents. Review of SCDC July, August, and September 2016 Use of Force MINS narratives by the responsible IP Member identified a significant number of use of force incidents in which MK-9 munitions were not utilized in a manner consistent with manufacturer guidelines, including excessive amounts of munitions.

Recommendations: Revise the OP 22.01 Use of Force Policy as recommended by QARM and ensure the Use of Force Lesson Plans include the requirements to 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 in volumes consistent with manufacturer's instructions.

Retrain all employees certified to utilize chemical munitions on proper use in accordance with manufacturer guidelines. The SCDC Use of Force Master Plan will need to designate a SCDC department, independent of the SCDC Compliance and Operations Departments, to investigate, and take action when violations are identified on the use of crowd control canisters, such as MK-9, being utilized in individual cells in the absence of objectively identifiable circumstances set forth in writing and utilized volumes are not consistent with manufacturer guidelines.

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 Assessment: partial compliance

November 2016 SCDC Status Update: In a review of MINS narratives, it has been observed that counselors are being notified prior to a planned use of force; however, this information has not been tracked specifically to date. Since the recent hiring of two additional Use of Force Reviewers, QARM will be able to more effectively capture and report this data.

November 2016 Implementation Panel findings: SCDC OP 22.01 Use of Force Policy Section 11.6 identifies when on duty a mental health practitioner shall conduct the intervention for mentally ill inmates prior to a planned use of force. In a meeting with the responsible IP Member on October 31, 2016, the SCDC Director of Training verified employees have not been trained on the reviewed SCDC Use of Force Policy. The November 2016 SCDC Status Update reports QARM has not been specifically monitoring and tracking this requirement in planned use of force incidents. A review of July, August, and September 2016 SCDC Use of Force MINS Narratives by the responsible IP Member has identified planned use of force incidents where the counselors were notified for intervention prior to the use of force.

Recommendations: Train all SCDC employees on the revised OP 22.01 Use of Force Policy including the requirement when on duty, a mental health practitioner shall conduct the intervention for mentally ill inmates prior to a planned use of force.

QARM should begin specifically monitoring and tracking the requirement when reviewing planned use of force incidents.

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

Implementation Panel Assessment: partial compliance

November 2016 SCDC Status Update: The Division of Mental Health and the Division of Staff Development and Training have developed a mandatory training schedule for staff related to managing mentally ill inmates.

QARM did not request the full training outline prior to completion of this report. Although QARM is aware that this is standard practice, this Division failed to acquire the appropriate documentation in time for reporting.

November 2016 Implementation Panel findings: In a meeting with the responsible IP Member on October 31, 2016, the SCDC Director of Training provided information that a training plan to provide correctional officers training on the appropriate methods of managing mentally ill inmates has been developed. The IP Mental Health Experts have not reviewed the training plan to assess

if the curriculum provides acceptable training to correctional officers on the appropriate methods of managing mentally ill inmates.

Recommendations: The IP Mental Health Experts review the SCDC Training Lesson Plans regarding Methods of Managing Mentally Ill Inmates for Correctional Officers and determine if it is appropriate.

After approval by the IP Mental Health Experts, SCDC needs to establish and finalize how the training will be delivered, develop a schedule for rollout of the training, and ensure all SCDC correctional officers receive the training.

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

Implementation Panel Assessment: partial compliance

November 2016 SCDC Status Update: The Use of Force Reviewer is collecting data based on information uploaded to the Automated Use of Force system and, to date, has shared findings with operations staff leadership at both the institutional and corporate levels.

November 2016 Implementation Panel findings: SCDC has developed use of force data reports and generates monthly reports. The responsible IP Member began receiving the monthly use of force reports in March 2016. The SCDC QARM generated an October 17, 2016, Use of Force Summary Report for the time frame June 1 through August 29, 2016, and distributed the report to SCDC officials and the IP. The quality and accuracy of the SCDC use of force incident data and reports is questionable. During the site visit at the Broad River CI CSU on November 2, 2016, SCDC staff revealed three (3) use of force-restraint chair incidents for the reporting period. SCDC collected data and provided use of force reports that identified only one (1) use of force-restraint chair incident during the reporting period. Further assessment is needed by QARM and the responsible IP Member to verify the collected use of force incident data accurately reflects the SCDC use of force incidents occurring.

Recommendations: QARM should continue to generate a quarterly use of force summary report for distribution to responsible SCDC officials and the IP and assess the quality and accuracy of the SCDC obtained data and issued quarterly reports concerning the use-of-force incidents against mentally ill and non-mentally ill inmates.

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

Implementation Panel Assessment: noncompliance

November 2016 SCDC Status Update: SCDC is operating under the UoF policy as it exists now. There is the automated UoF review system, but not all the MIN's are uploaded into the system, and therefore, the appropriate review is not always done as required. In order to capture those that are not uploaded, the QARM has begun monitoring all UoF MINs daily and reporting when inappropriate use of force is suspected.

Any discrepancy between UoF MINs and those uploaded in the automated UoF system are tracked and reported to the warden and Division of Operations.

The QARM has found deficiencies in the process outlined in the policy and has made recommendations for change.

QARM is developing a mechanism to track UoF allegations for compliance and has recommended that Operations put into policy that allegations will be documented in the MINs and automated UoF system.

QARM consulted with Use of Force expert Emmitt Sparkman to outline a system for more effectively tracking and reviewing Use of Force at all levels. This information has not been formally implemented as QARM awaits final approval from the Division of Operations.

November 2016 Implementation Panel findings: SCDC has developed an electronic monitoring and tracking system for use of force incidents. The November 2016 SCDC Status Update identifies the deficiencies with the formal quality management program under which use-of-force incidents involving mentally ill inmates are reviewed. As identified earlier in this document, the quality management system does not have an accountability component for when employees commit use of force violations and/or are found to have used excessive force. SCDC needs to designate a department, independent of the SCDC Compliance and Operations Departments, to investigate and take action when use of force violations and/or excessive use of force is substantiated. A formal quality management program without an accountability component is incomplete and unacceptable.

Recommendations: SCDC should accept the QARM recommendations to address the deficiencies identified in the Electronic Monitoring and Tracking System utilized as the formal quality management system to review use of force incidents involving mentally ill inmates. Develop an accountability component for the SCDC Electronic Use of Force Monitoring and Tracking system utilized as the formal quality management system. Designate a department, independent of the SCDC Compliance and Operations Departments, to investigate and take action when use of force violations and/or excessive use of force is substantiated.

3. Employment of a sufficient number of trained mental health professionals:

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

Implementation Panel Assessment: partial compliance

November 2016 SCDC Status Update: Division of Mental Health has demonstrated an increase in the number of positions allotted to provide more mental health services at all levels of care since October 2014. From October 2014 to October 2016, the Division saw an increase in total positions (filled + vacant) of 49.0%. Full-time Staffing numbers have not increased significantly.

The following chart demonstrates clinical staffing totals from October 2014-October 2016; however, QARM has not compared these figures to those recommended by APA and ACA.

10/2014	Full-Time		Pink Slip		Dual		Contract	
	Filled	Vacant	Filled	Vacant	Filled	Vacant	Filled	Vacant
Administration Totals	6	0	0	0	0	0	0	0
REGIONAL MENTAL HEALTH								
Totals	69	8	0	0	0	0	1	0
CENTRAL SERVICES								
Central Services Totals	26	1	7.26					
Division Totals	**97**	**9**	**7.26**					

10/2016	Full-Time		Pink Slip		Dual		Contract	
	Filled	Vacant	Filled	Vacant	Filled	Vacant	Filled	Vacant
Administration Totals	6	0	0	0	0	0	0	0
REGIONAL MENTAL HEALTH								
Totals	71	45	0	0	0	0	0	0
CENTRAL SERVICES								
Central Services Totals	24	18	3.3	0	1.67	0	1.7	0
Division Totals	**95**	**63**	**3.3**	**0**	**1.67**	**0**	**1.7**	**0**

November 2016 Implementation Panel findings: See 2(a)(iv).

Recommendations: See 2(a)(iv).

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

Implementation Panel Assessment: partial compliance

November 2016 SCDC Status Update: QARM initially collected, entered, and analyzed data and created reports for GPH treatment team participation. Since August 2016, Division Mental Health has begun internal tracking of this information. Staff pilot tested data collection tools at GPH so data are limited.

Data collected and tracked by QARM

Week of July 27

GPH Treatment Team Participation	
PSYCHIATRIST	100.00%
PSYCHOLOGIST	59.52%
OMHP	4.76%
MEDICAL	0.00%
OPERATIONS	0.00%
INMATE	0.00%

Week of July 4

GPH Treatment Team Participation	
PSYCHIATRIST	0.00%
PSYCHOLOGIST	111.54%
OMHP	111.54%
MEDICAL	107.69%
OPERATIONS	0.00%
INMATE	73.08%

Week of July 11

GPH Treatment Team Participation	
PSYCHIATRIST	0.00%
PSYCHOLOGIST	100.00%
OMHP	100.00%
MEDICAL	100.00%
OPERATIONS	0.00%
INMATE	70.00%
INMATE REFUSALS	

Data Reported form Division of MH

Week of August 1

GPH Treatment Team Participation	
PSYCHIATRIST	0.00%
PSYCHOLOGIST	0.00%
OMHP	0.00%
MEDICAL	0.00%
OPERATIONS	0.00%
INMATE	0.00%

November 2016 Implementation Panel findings: Problems relevant to the treatment planning process included the lack of a psychiatrist on a regular basis at the treatment team meetings at all levels of care except for ICS and the self-injurious behavioral unit. Psychiatrists were not present at any other Treatment Team meetings observed or reported. An additional problem was identified at Camille Graham based on a limited records review in which staff inserted "See treatment team note," referring to the sign-in sheet of the meeting; however, several listed disciplines, including

psychiatrists, were not present. This practice must stop. Further, SCDC only recently began regular inmate participation at treatment plans with the exception of ICS and CSU.

It was encouraging that inmates were just recently included in the treatment planning meetings at the Perry Correctional Institution and the Lee CI.

Recommendations: See recommendations relevant to mental health staffing. Training regarding treatment plan meetings is recommended.

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 Assessment: partial compliance

November 2016 SCDC Status Update: The Division of Mental Health has made it mandatory for all newly hired full-time MH clinicians to attend the 4-week Basic Training, which teaches them an overview of the correctional system, including the above. To date, 125 mental health clinicians have completed the training. Furthermore, our training plan includes a review of all the newly developed policies that were drafted to bring us into compliance with the mental health lawsuit. All SCDC employees and contract staff are being required to complete a training module on each policy. These training modules are still being developed.

The chart below reports the number of staff completing the Mandatory/Inmate Suicide Prevention Training Requirements 2016.

2016 AGENCY INMATE SUICIDE TRAINING MANDATES	**Hours**	**Information**	**# complete**	**# not complete**
Suicide Prevention Training (Instructor-Led) Training Available 04/27/16-present	2.0	Custody Staff Total: 3035	1692	1343
Inmate Suicide Prevention Training, Video Part 1 Training Available 9/02/16-present	1.0	Mandates as Indicated Below Total: 693	300	393
Inmate Suicide Prevention Training, Video Part 2 Training Available 09/22/16-present	1.0	Mandated as Indicated Below Total: 693	258	435

November 2016 Implementation Panel findings: as above.

Recommendations: Complete training for all mental health clinicians.

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 Assessment: partial compliance

November 2016 SCDC Status Update: SCDC Health Services hired a recruiter in November 2015. The position was later vacated, and a replacement was hired in the fall of 2016. QARM has not determined increases in pay grades and decreases in workloads. Efforts have been made by SCDC's Recruiting and Employment to streamline the process, decreasing the time frame from interview to on-boarding.

November 2016 Implementation Panel findings: See 2(a)(iv).

Recommendations: See 2(a)(iv).

e. Require appropriate credentialing of mental health counselors;

Implementation Panel Assessment: partial compliance

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

November 2016 SCDC Status Update: As of 10-10-16, the following report indicates a licensure rate of 37%:

DIVISION OF BEHAVIORAL/MENTAL HEALTH and SUBSTANCE ABUSE SERVICES
MENTAL HEALTH LICENSED STAFF

Name	Job Title	Hire Date	Licensure Type (LPC, LMSW, LISW, LPC-I, LPC, LPC-S, PH.D.)	Location
CURRENT STAFF WITH LICENSURE HIRED PRIOR TO 2013				
Hollifield, Deborah	HSC I/CCC IV	6/7/1999	LPC	GPH
~~Caldwell, Donald~~	~~HSC I/CCC IV~~	~~10/1/2007~~	~~LBSW~~	~~ICS~~
Bradley, Antionette	HSC II/CCC V	1/28/2008	LMSW	ICS
Goodson, Charles	HSC I/CCC III	10/6/2008	LMFT	R&E
Gordon, J. Blake	HSC II/Clinical Supervisor	3/9/2009	LPC	BMHSAS
Foulks, Fawn	HSC II/Clinical Supervisor	5/2/2012	LPC	BMHSAS
Oberman, Bruce	HSC II	2/17/2009	LMSW	R&E
DuBose, Kennard	Division Director	5/2/2012	LMSW, CAC II	BMHSAS
TOTAL = 7				
NEW STAFF WITH LICENSURE HIRED AS OF 2013				
Jones, Kim	HSC II/Regional Manager	7/17/2013	LMSW	BMHSAS
Russell, Crystal	Assistant Director - BMHSAS	11/4/2013	LPC-S	Watkins
~~Burgess, Bradley~~	~~HSC I/CCC IV - Lead Counselor~~	~~11/18/2013~~	~~LPC-I~~	~~Kershaw~~
~~Gales, Dana~~	~~HSC I/CCC IV~~	~~12/2/2013~~	~~LPC~~	~~GPH~~
~~Reeser, Nel~~	~~HSC I/CCC IV~~	~~4/2/2014~~	~~LMSW~~	~~GPH~~
Richardson, Cindy	HSC III/Clinical Supervisor	5/2/2014	LPC	BMHSAS
~~Delgado, Yolanda~~	~~HSC III/Program Manager~~	~~5/2/2014~~	~~LPC-I~~	~~BMHSAS~~
~~Tucker, Bernice~~	~~HSC I/CCC IV~~	~~8/17/2014~~	~~LPC~~	~~C. Graham~~
Privette, Rosa	HSC I/CCC IV	11/17/2014	LPC-S	Lee
Ridgeway, Reuben	Chief Psychologist	12/2/2014	Ph.D.	BMHSAS
S. Watson/T.Anderson	Psychologists (sharing 1 position)		Ph.D.	GPH
Thomas, Helena	HSC I/CCC IV	12/17/2014	LPC-I	Evans
Porter, Shawana	HSC I/CCC IV	1/2/2015	LPC-I	Turbeville
Holzmann, Diane	HSC I/CCC IV	2/17/2015	LPC-I	Broad River
Watson, Lottie	HSC I/CCC IV	3/17/2016	LMSW	GPH
Cunningham, Nastassjiah	HSC I/CCC IV	4/2/2015	LMSW	ICS
Singleton, Shirley	HSC I/CCC IV	6/2/2015	LMSW	Lieber
~~Taylor, Kenneth~~	~~HSC I/CCC IV~~	~~10/2/2015~~	~~LPC-I~~	~~GPH~~
Jones, Joseph "Frank"	HSC I/CCC IV	10/2/2015	LMSW	McCormick
~~Morgan, Margaret~~	~~HSC I/CCC IV~~	~~10/19/2015~~	~~LMSW~~	~~Broad River~~
~~Kennedy, Kelli~~	~~HSC I/CCC IV~~	~~11/2/2015~~	~~LPC-I~~	~~Lieber~~
Gibson, Charlette	HSC I/CCC IV	12/2/2015	LMSW	KR&E
~~Johnson, Sandra~~	~~HSC I/CCC IV~~	~~12/2/2015~~	~~LMSW~~	~~KR&E/ICS~~
Bisson, Martie	HSC I/CCC IV	1/4/2016	LPC-I	Perry
Means, Cassandra	HSC II/CCC V - Regional Manager	2/17/2016	Ph.D.; LPC, LPC-S	Lieber
Amick, Toni	HSC I/CCC IV	3/2/2016	LPC	BRCI/CS Unit
~~Clark, Lisa~~	~~HSC I/CCC IV~~	~~3/2/2016~~	~~LPC-I~~	~~BRCI/CS Unit~~
Holloman, Kathy	HSC I/CCC IV	3/17/2016	LPC-I	BRCI/CS Unit
Valverde, Paola	HSC I/CCC IV	5/2/2016	LPC-I	C. Graham
Feemster, Ryan	HSC I/CCC IV	7/5/2016	LPC	Tyger River
Houck, Susan	HSC I/CCC IV	7/5/2016	LMSW	Allendale
Hunt, Alisha	HSC I/CCC IV	7/5/2016	LMSW	C. Graham
Otano, Naomi	HSC I/CCC IV	7/5/2016	LMSW	Kershaw
~~Shirley, Kimberly~~	~~HSC I/CCC IV~~	~~7/5/2016~~	~~LMSW~~	~~McCormick~~

Current Licensure as of 10-10-2016 (Updated: 10/10/2016)

November 2016 Implementation Panel findings: See SCDC status update.

Recommendations: Perform a QI study relevant to the pertinent provisions of SCDC Policy 19.15, Mental Health Services - Mental Health Training, Section 3.4.

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

Implementation Panel Assessment: noncompliance

November 2016 SCDC Status Update: This remedial program was developed in Policy HS-19.07.

3.3.10 Improvement Action Plans:

- When problems or opportunities for improvement are identified from any of the above sources, a CQM action plan will be created and documented for each area for improvement identified.
- An identified finding can be determined to be either an individual or system finding (or both). The following actions are then initiated:

  1) Individual: The clinician and the Regional Manager/Program Supervisor complete the development and implementation of an improvement action plan; and

  2) System: The Division Director, the CQM Director, and the ARC Team complete the development and implementation of an investigatory review and corrective action process plan.

- The improvement action plan will specify tasks, suggest completion dates, and parties responsible.
- The improvement action plan should focus on specific findings so as to help prevent the occurrence of similar problems in the same or other areas or individuals. The plan may include, but is not limited to:
  1) policy, procedure, and/or system changes;
  2) designating ways to handle compliance issues;
  3) additional training;
  4) restricting work responsibilities of individual employees for whom there are compliance or competence concerns;
  5) disclosure of the matter to external parties providing assistance; and
  6) recommendation for sanctions or discipline.

- The CQM Director approves the plan prior to implementation and monitors implementation to ensure successful and sustained resolution. If the problem is systemic, the Division Director and/or Deputy Director will also approve the plan prior to any substantial change.

- Improvement actions that involve personnel-specific intervention will require the establishment and monitoring of an individual performance improvement plan.

No documentation is currently available to substantiate full compliance.

November 2016 Implementation Panel findings: The SCDC status update provided a plan that was too generic.

Recommendations: Refer to g (below).

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

Implementation Panel Assessment: noncompliance

November 2016 SCDC Status Update: H.S Policy 19.07, Section 3.3.1 stipulates that the "Mental Health Services Quality Management Director or designee will conduct on-site audits of mental health services at each facility on a twice annual basis. Additional audits may be conducted as recommended by administrative or clinical staff or the ARC Team. Each audit is designed to systematically evaluate mental health service delivery at each institution by:

- Assessing service components for compliance with current practices, policies and procedures including, but not limited to: a review of service delivery logs, treatment plans, individual and group counseling records, timely and effective case management, crisis intervention follow-up, medication monitoring, and discharge planning.
- Reviewing treatment team staffing logs;
- Reviewing quarterly administrative staff training and meetings;
- interviewing inmates and staff."

The role of the Mental Health Services Quality Management Director has been absorbed into the QARM; however, it has been recommended to the Division Director for Mental Health this role should be reestablished within the Division of Mental Health to provide more direct MH internal audits and feedback as the current position under compliance is responsible for tracking all policies associated with the Mental Health Lawsuit.

November 2016 Implementation Panel findings: The above plan is too generic. It is our understanding that peer reviews and performance audits performed by the regional mental health staff will help satisfy the requirements of this provision.

Recommendations: As above.

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

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

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

Implementation Panel Assessment: partial compliance

November 2016 SCDC Status Update: SCDC currently uses an antiquated system for its automated medical record. We have contracted with a vendor to build an electronic health record (EHR), with a target date of prior to 2018 to begin using it. This EHR will more adequately manage confidential medical records and ensure accuracy in medication identifying the number of FTE clinicians who provide MH services.

November 2016 Implementation Panel findings: The EHR and the planned web based management information system should facilitate compliance with this provision.

Recommendations: See above.

ii. Inmates transferred for ICS and inpatient services;

Implementation Panel Assessment: partial compliance

November 2016 SCDC Status Update: Once implemented, the EHR will more adequately manage confidential medical records and ensure accuracy in tracking inmates who transferred for ICS and inpatient services.

November 2016 Implementation Panel findings: See 4(a).

iii. Segregation and crisis intervention logs;

Implementation Panel Assessment: noncompliance

November 2016 SCDC Status Update: QARM has not obtained documentation outlining a system that dramatically improves SCDC's ability to store and retrieve on a reasonably expedited basis. Logs are currently documented on paper. An electronic system would be more feasible in meeting this requirement.

November 2016 Implementation Panel findings: See 4(a).

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

Implementation Panel Assessment: noncompliance

November 2016 SCDC Status Update: SCDC currently uses an antiquated system for its automated medical record. We have contracted with a vendor to build an electronic health record (EHR), with a target date of prior to 2018 to begin using it. This EHR will more adequately manage confidential medical records and ensure the ability to store and retrieve Records related to mental health program or unit (including behavior management or self-injurious behavior programs).

November 2016 Implementation Panel findings: See 4(a).

v. Use of force documentation and videotapes;

Implementation Panel Assessment: partial compliance

November 2016 SCDC Status Update: An automated Use of Force System has been established to document use of force and provide an electronic storage and accessibility to video recordings of uses of force.

November 2016 Implementation Panel findings: The accuracy of use of force reporting, documentation, and videotaping has not been determined. SCDC does not have a preservation policy for video and audio recordings.

Recommendations: A QI needs to be performed to determine use of force data is accurate and use of force video tapes are maintained. SCDC needs to develop a preservation policy for video and audio recordings.

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

Implementation Panel Assessment: partial compliance

November 2016 SCDC Status Update: An automated Use of Force System has been established to document use of force and provide an electronic storage and accessibility to video recordings of uses of force. Use of Force Reviewers collect and track data to produce reports that will be shared on a quarterly basis. To date, one report has been created and shared with Operations leadership.

November 2016 Implementation Panel findings: SCDC has developed quarterly reports reflecting total use of force incidents against mentally ill and non-mentally ill inmates by institution. The quality of obtained use of force data is questionable due to findings not all use of force incidents are being reported.

Recommendations: A QI needs to be performed to determine the accuracy of use of force reports involving mentally ill and non-mentally ill inmates by institution.

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 Assessment: partial compliance

November 2016 SCDC Status Update: An automated system has been created to document information on inmates in CI. Because this is an electronic system, the ability to store large amounts of data and to retrieve information on an expedited basis has been greatly enhanced. To date, one report has been partially generated but has not been shared with leadership.

November 2016 Implementation Panel findings: See 4(a)(i).

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 Assessment: partial compliance

November 2016 SCDC Status Update: These reports are generated from RIM and provided on a weekly basis. Because they are electronic and created from existing systems, QARM staff are able to analyze the information and save results on a shared folder on SCDC's network. Because of the electronic nature of this information, barriers to storage and accessibility are minimized. Limited reports have been distributed.

November 2016 Implementation Panel findings: See 4(a)(i).

ix. Quality management documents; and

Implementation Panel Assessment: partial compliance

November 2016 SCDC Status Update: These reports are created by QARM staff and are saved on a shared folder on SCDC's network. Because of the electronic nature of this information, barriers to storage and accessibility are minimized. Limited reports have been distributed.

November 2016 Implementation Panel findings: See 4(a)(i).

x. Medical, medication administration, and disciplinary records

Implementation Panel Assessment: partial compliance

November 2016 SCDC Status Update: SCDC currently uses an antiquated system for its automated medical record. We have contracted with a vendor to build an electronic health record (EHR), with a target date of prior to 2018 to begin using it. This EHR will more adequately manage confidential medical records and ensure accuracy in medication administration, while allowing for better retrieval of statistical data.

November 2016 Implementation Panel findings: See 4(a)(i).

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 Assessment: noncompliance

November 2016 SCDC Status Update: SCDC currently uses an antiquated system for its automated medical record. We have contracted with a vendor to build an electronic health record (EHR), with a target date of prior to 2018 to begin using it. This EHR will more adequately manage

confidential medical records and ensure annual review and upgrades in mental health management information system.

November 2016 Implementation Panel findings: See 4(a)(i).

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

a. Improve the quality of MAR documentation;

Implementation Panel Assessment: noncompliance

November 2016 SCDC Status Update: The EHR will more adequately manage confidential medical records and track administration of psychotropic medication. Because of accessibility of information and data, this should allow for immediate feedback to staff regarding MAR documentation. Built-in features should remind staff when information is incomplete, which should further improve documentation.

In a QARM audit of CGCI MARs in September 2016, it was found at least once that a psychotropic medication was reordered without the required periodic review. The report from this audit has not been finalized or shared with the medical and mental health directors at this time.

November 2016 Implementation Panel findings: See SCDC status update.

Recommendations: Work with nursing staff regarding development and implementation of relevant QI studies.

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

Implementation Panel Assessment: noncompliance

November 2016 SCDC Status Update: Because of accessibility of information and data in the EHR, this should allow for immediate feedback to supervisors regarding MAR documentation. Built-in features should remind staff when information is incomplete or orders have not yet been carried out, which should further improve MARs documentation.

November 2016 Implementation Panel findings: See 5(a).

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

Implementation Panel Assessment: noncompliance

November 2016 SCDC Status Update: A pill line schedule has been provided for each institution. Implementation of an electronic health management systems will verity these times for reasonableness as automated time stamps are a part of the EHR system.

November 2016 Implementation Panel findings: See 5(a).

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

Implementation Panel Assessment: noncompliance

November 2016 SCDC Status Update: Institutional nurse supervisors are required to review MARs and report to Central Office administrators, but QARM has not assessed the efficacy of this QM program, internal to Health Services, under which medication administration records are reviewed.

November 2016 Implementation Panel findings: See 5(a).

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

a. Locate all CI cells in a healthcare setting;

Implementation Panel Assessment: noncompliance

November 2016 SCDC Status Update: CI cells at Broad River CSU are located in a healthcare setting. QARM staff are working with operations to identify the location of each CI cell in each institution and determine if it is in a healthcare setting. In cases where this is not the case, staff will determine the proximity of CI cells to the healthcare setting.

November 2016 Implementation Panel findings: The CI cells at the Broad River CI RHU, the R&E (Unit F-1), the PCI RHU, and the Lee CI RHU were not suicide resistant. The Broad River RHU CI cells did not have beds. A QI needs to be performed regarding relevant elements of the suicide prevention program.

Recommendations: See above.

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

Implementation Panel Assessment: noncompliance

November 2016 SCDC Status Update: QARM has drafted a memo suggesting that specific language be included in policy and information relayed in training explicitly prohibiting any use for CI purposes of alternative spaces such as shower stalls, rec cages, holding cells, and interview booths.

November 2016 Implementation Panel findings: A QI needs to be performed re: relevant elements of the suicide prevention program.

Recommendations: See above.

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

Implementation Panel Assessment: partial compliance

November 2016 SCDC Status Update: SCDC Policy HS-19.03 section 6.1 establishes that "when an inmate is referred to CI on an urgent or emergent basis, he or she is to be placed in a safe cell under constant observation until he/she is evaluated by a QMHP. Only inmates already in a segregation cell may be placed in a safe cell within a segregation unit. Whoever makes the urgent or emergent referral will ensure the initiation of constant observation."
QARM has discussed internally and made the recommendation for the development of a CSU policy that should outline who and how often inmate records should be audited for compliance. QARM has also discussed the need to outline and develop a system to alert if an inmate observer is closely approaching or exceeding the five-hour limitation.

In an August 2016 audit of the BRCI CSU Inmate Observers program, it was noted that in 1426 hours of suicide watch of 16 different suicidal inmates, the observers documented 98.88% of the required 15-minute documentations during their watches. There were 15/1426 hours of suicide watches (or 1.12%) during which they failed to document at least one 15-minute note. Of the 16 inmates evaluated, there were 42 times that the inmate observers documented that an employee, usually an MHT, relieved them for a portion of their shift (typically 30 min – 1 hr.). Thirteen of those 42 times (31%) did not have an accompanying "Employee Watch Log" provided to document continuous SP watch by that employee.

In a September 2016 audit of Camille Graham, the QARM auditor was told that the CI cells in the RHU were checked every 15 minutes, and documentation was provided to support that statement. However, no documentation could be provided to show continuous watch of suicidal inmates.

QARM staff have not collected documentation about continuous suicide watches from other institutions at this point.

November 2016 Implementation Panel findings: A QI needs to be performed regarding relevant elements of the suicide prevention program.

Recommendations: See above.

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

Implementation Panel Assessment: partial compliance

November 2016 SCDC Status Update: While it is observed at BRCI CSU that inmates are provided clean, suicide-resistant clothing, blankets, and mattresses, specific documentation has not been requested. The assessment of documentation will be included in all standard CI reviews and audits.

November 2016 Implementation Panel findings: A QI needs to be performed regarding relevant elements of the suicide prevention program.

Recommendations: See above.

e. Increase access to showers for CI inmates;

Implementation Panel Assessment: partial compliance

November 2016 SCDC Status Update: Refer to SCDC Policy HS-19.03

- RHU inmates in CSU will be allowed daily showers if security staffing presence permits. Otherwise, RHU inmates will be allowed to shower a minimum of 3 times per week.
- Non-RHU inmates in CSU will be allowed to shower daily, unless restricted by a psychiatrist or licensed psychologist.
- All non-RHU CSU inmates, unless clinically contradicted, shall have access to out of cell time for 10 hours structured and 10 hours unstructured in a 7 day period.

CSU Inmate Showers from May 12 – July 31, 2016

Total Inmates in the Sample	21
Total # RHU Inmates	14
Total # Non-RHU Inmates	7
Average # days in CSU	11
Total days in CSU for all inmates	227
Averages Showers given/offered	96%
Total showers given/offered	217
Average showers refused	7%
Total showers refused	156
Average showers not offered	28%

QARM staff has not been given quantifiable data from other institutions regarding showers in their RHU's.

November 2016 Implementation Panel findings: A QI needs to be performed regarding relevant elements of the suicide prevention program.

Recommendations: See above.

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

Implementation Panel Assessment: noncompliance

November 2016 SCDC Status Update: No data to verify or substantiate that meetings between CI inmates and mental health counselors, psychiatrists, and psychiatric nurse practitioners were confidential. However, in an August 2016 audit at BRCI CSU, it was observed that individual sessions were held in a confidential setting.

November 2016 Implementation Panel findings: A QI needs to be performed regarding relevant elements of the suicide prevention program.

Recommendations: See above.

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

Implementation Panel Assessment: noncompliance

November 2016 SCDC Status Update: BRCI CSU was audited in August. Observation showed that the CI cells were being cleaned when inmates were taken to their showers, but this was not documented anywhere. Temperatures were not being checked in the cells.

This data has not been provided to the Division QARM from any other institutions.
A cell-side log is being developed that will allow for tracking of cell cleaning and temperatures. Equipment (for checking temperature) has been purchased for GPH, and additional units have been ordered to cover the other segregation areas.

November 2016 Implementation Panel findings: A QI needs to be performed regarding relevant elements of the suicide prevention program.

Recommendations: See above.

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

Implementation Panel Assessment: partial compliance

November 2016 SCDC Status Update: A formal QM program has not been established; however, QARM is drafting a policy to establish an agency CQI policy under which CI practices will be reviewed.

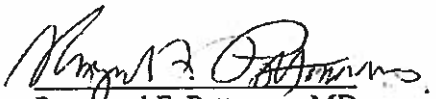
November 2016 Implementation Panel findings: A QI needs to be performed regarding relevant elements of the suicide prevention program.

Recommendations: See above.

Conclusions and Recommendations:

The IP has provided its recommendations on specific items in the Settlement Agreement in this report and while on-site. We have also provided suggestions to SCDC to pursue development of their own internal processes and support systems for an adequate mental health services delivery system and quality management system. We are providing this report initially as a draft report to the parties for any comments they want to make, and we will consider those comments when finalizing this report; however, the report will reflect the IP's findings and recommendations as of November 4, 2016. The IP is hopeful that this report has been informative. We look forward to further development of the mental health services delivery system within the South Carolina Department of Corrections and appreciate the cooperation of all parties in the pursuit of adequate mental health care for inmates living in SCDC. The IP requests any comments regarding this report be provided within fifteen days of the date of this Draft Report.
Sincerely,

Respectfully Submitted,,



Raymond F. Patterson, MD
Lead Monitor
On behalf of:

Emmitt Sparkman
Operations Monitor

Jeffrey Metzner, MD
Subject Matter Expert

Tammie Pope
Implementation Panel Coordinator

FIRST IMPLEMENTATION REPORT OF MEDIATOR

IN RE: **SETTLEMENT AGREEMENT** between T.R., P.R., K.W., AND A.M. on behalf of themselves and others similarly situated,; and Protection and Advocacy for People with Disabilities, Inc., and the South Carolina Department of Corrections (SCDC); et. al.

DATE: JUNE 14, 2016

TO: Stuart M. Andrews, Jr.
Daniel Westbrook
Roy F. Laney

CC: Raymond Patterson, M.D.
Emmitt Sparkman
Jeffrey Metzner, M.D.
Tammie M. Pope

The Implementation Panel conducted its first monitoring visit of the SCDC facilities and operations between May 2nd and May 5th, 2016. At the time of the visit, the terms of the Settlement Agreement between the above parties had been determined, but the written agreement was still in the final stages of being redrafted. Subsequent to the visit, the Agreement was completed and was executed by the parties with an effective date of May 31, 2016. The Settlement Agreement was submitted to the South Carolina Supreme Court for approval by joint motion pursuant to Rule 261 (b), SCACR and Rule 23(c), SCRCP on June 1, 2016. Proceedings for approval are currently pending before the Court.

On June 3, 2016, the Implementation Panel issued the First Report of the Implementation Panel. As explained in the introduction to its report, neither the Settlement Agreement nor the policies and procedures had been finalized at the time of the May 2-5 site visit. Consequently, the Panel determined it would be more helpful to the process for them to focus the first visit on consultation and technical assistance to SCDC and meet with the staff to discuss their

understanding of the process contemplated for implementation of the Settlement Agreement. Consequently, the report issued by the Implementation Panel was descriptive of the facilities they visited and current operations they observed, identifying various issues to be addressed during implementation, but did not attempt to measure the degree of progress by SCDC toward substantial compliance of each component of the Remedial Plan.

Final Court approval of the Settlement Agreement, including the policies underpinning the processes to be implemented pursuant to its terms, is a necessary prerequisite to implementation, and to the ability to evaluate progress toward substantial compliance by the Implementation Panel. The evaluation by the implementation Panel, in turn, informs the undersigned mediator to allow for a determination of the degree of compliance and to identify when SCDC is in substantial compliance with the Remedial Plan set forth in the Agreement.

The next site visit by the Implementation Panel is scheduled for October 31 through November 4, 2016. It is anticipated that Court approval of the Settlement Agreement and finalization of all policies will be accomplished by that time, allowing the Panel to make its initial evaluation of SCDC compliance under the terms of the Settlement. It is also anticipated that the next Implementation Report of the undersigned mediator will summarize the status of the Implementation and the progress towards achievement of the Implementation Goal as required by Section 4(e) of the Settlement Agreement.

Respectfully submitted this 13th day of June, 2016

William L. Forrest

South Carolina Department of Corrections
Site Visit Summary
08.01.16 and 08.02.16
Emmitt L. Sparkman
Implementation Panel Member

Introduction

A site visit was conducted on August 1-2, 2016, to provide the South Carolina Department of Corrections (SCDC) technical assistance in the areas of Use of Force, Restrictive Housing Units and Offender Disciplinary. Meetings were held with the SCDC Compliance Department officials on August 1, 2016 and SCDC Operations officials on August 2, 2016. A joint meeting between SCDC Operations and Compliance officials was held on August 2, 2016, to review technical assistance and establish objectives to be accomplished prior to the scheduled October 31-November 4, 2016, Implementation Panel Site Visit.

Compliance Department August 1, 2016

Meetings were held with the SCDC Compliance Division; Chief Legal & Compliance Officer Salley Elliott and her staff on August 1, 2016. The Use of Force Policy and checklist were reviewed and areas needing revision were discussed in depth. It was determined the Use of Force Policy Review Section was insufficient to support necessary use of force reforms. Decisions were made to strengthen the use of force review section by establishing review time frames, identifying reviewer responsibilities, and ensuring necessary information was available for each reviewer to conduct a thorough and quality review. Use of Force Review Forms will be electronic with the capability to attach all applicable documents/videos. A Use of Force Review Flow Chart was developed with recommendations as follows:

Use of Force Incident Occurs	Use of Force Incident Packet completed by end of shift All staff reports completed by the conclusion of the shift including the medical assessment for the inmate(s) and staff involved in the incident.
	↓
Chief of Security (Major)	Use of Force Incident Packet Review completed in 72 hours
	↓
Warden	Use of Force Incident Packet Review completed within 7 days
	↓
Compliance Use of Force	Use of Force Incident Packet Review completed within 10 days
	↓

Operations Regional Director	Use of Force Incident Packet Review completed within 10 days The Regional Director closes the Use of Force Packet if there are no issues. If issues are identified at any level of the review, the packet is forwarded to the Operations Assistant Deputy Director for review. All closed reviews are forwarded to the Operations Assistant Deputy Director with a copy to the Compliance Department.
	↓
Operations Asst. Deputy Director	Responsible for Use of Force Packet with Issues Review The Assistant Deputy Director reviews Use of Force Packets with any issues and implements actions based on findings and conclusions. He will be responsible for closing investigations with issues and forwarding a copy to the Compliance Department.

The time frames for the use of force review will not begin until the use of force incident packet is received by the reviewer. Times delays for exigent circumstances require written justification from the reviewer. Any reviewer that has a use of force incident packet returned for additional information at any stage in the review process will have the following time requirements:

Shift	Completed and returned the next work day
Chief of Security (Major)	3 days
Warden	3 days
Compliance Use of Force	3 days

SCDC will explore if their Information Technology (IT) Department can develop a program to prompt Management and the employee with a report and/or email when a use of force review is not completed within the required time frame. This will ensure employee accountability in reviewing use of force incidents. The Use of Force Incident Reviewer plans to work with IT to develop a system to utilize the Use of Force Incident Checklist to monitor the quality of the Use of Force reviews at each level and generate reports that can be shared with SCDC officials and the Implementation Panel.

The SCDC does not have a procedure for action if a use of force violation is identified during any of the reviews. The recommendation is to designate the SCDC Inspector General Division and his staff to investigate use of force violations. Referrals to the Inspector General Division during the review process can be made by the Warden, Compliance Use of Force Reviewer, Operations Regional Director or Operations Assistant Deputy Director. A referral to the Inspector General Division will require notification to the Operation Assistant Deputy Director and the Chief Compliance & Legal Officer. The Inspector General's Division would not have a time frame to complete an investigation but will be required to provide the Compliance Department with a 30 day status report for each open investigation.

The SCDC does not have a reliable mechanism to resolve use of force allegations. The SCDC MINS Policy should be revised to include a reporting requirement for use of force allegations. A decision was made to revise the existing Use of Force Policy and develop a section addressing Use of Force allegations. Currently, the Inspector General Division receives grievances regarding use of force allegations and the practice should continue; however, the Inspector General Division should be required to report use of force allegations via MINS and the allegation outcome to the SCDC Compliance Department.

Other proposed enhancements for the Use of Force Policy were;

- Develop Use of Force categories based on severity of injuries; A Category-Injury required off site medical treatment, B Category- Injury required treatment beyond 1st Aid but on-site, C Category-1st Aid only or no injury;
- Develop a severity rating for use of force injuries;
- Photograph all inmates and staff injured for a use of force incident;
- Revise the Use of Force Restraint Form to capture additional information;
- Designate a 2nd Response Security Staff Member to obtain the handheld video camera form Main Control and respond to spontaneous use of force incidents
- Revise the Use of Force Incident Review Form to include: Did you review video? If no, why? If yes, was the video consistent with written reports?

Reports to be requested from the SCDC IT for Operations, Compliance and the Implementation Panel are;

- Use of Force Incident MINS Report on Use of Force Incidents
- Use of Force Incident MINS Report for all Use of Force Allegations
- Use of Force Incident Recommendations for Corrective Action Report
- Use of Force Incident Review Checklist Assessment Report
- Use of Force Incident Closed Report
- Use of Force Incident Open Report
- Use of Force Incident Closed No Action Report
- Use of Force Incident Closed Corrective Action Report
- Use of Force Incident Inspector General Division Referral Report
- Use of Force Allegations Grievance Report
- Use of Force Incident Review Time Frame Exceptions Report

Operations Division August 2, 2016

Meetings were held with the Operations Deputy Director Michael McCall, Assistant Deputy Director Dennis Patterson and the three (3) Operation as Regional Directors on August 2, 2016. A discussion was held with Operations Management on the continued issue of inmates being held in Restrictive Housing Unit (RHU) Disciplinary Detention and Short Term status over sixty (60) days in violation of the SCDC RHU Policy. Operations Management recognized the seriousness and made commitments to immediately resolve the issue. SCDC Assaultive MINS, Use of Force and Assaultive Disciplinary Reports were reviewed in detail. Operations Management was complimented on their continued success maintaining the overall RHU population at less than 900 inmates with the long term Security Detention (SD) and Substantial Security Risk (SSR) population at less than 300 inmates. A discussion was held on the importance of continuing to lower the current number of mentally ill inmates in RHU SD status (53 inmates) and SSR (28 inmates).

The American Correctional Association (ACA) is proposing RHU standards that identify confinement over thirty (30) days as long term isolation. The potential ACA standard change and the National Commission on Correctional Healthcare (NCCHC) position that 15 days or more is long term isolation will impact the existing SCDC RHU Policy that 60 days or more is defined long term.

Operations is establishing a Mental Health Step Down Program (48 beds) at Allendale Correctional Institution to remove mentally ill inmates out of RHU while the Mental Health Behavior Modification Unit (BMU) is being developed and implemented. Allendale Correctional Institution was selected because the correctional facility is one of the few in SCDC that has full staffing. The Allendale Correctional Institution Mental Health Step Down Unit will be operate with general population procedures.

It was emphasized to Operations staff that the SCDC RHU Units Security Detention Step Down Programs and their implementation will be assessed during the next Implementation Panel Site Visit scheduled for October 31-November 4, 2016. Minimal progress has been made moving forward with RHU Step Down Program Implementation. The current SCDC IT RHU Report needs revision to identify the behavior level of each inmate in RHU SD status. Issues continue with providing and documenting the RHU inmate activities and services.

Operations has implemented Inmate Disciplinary procedures establishing inmates cannot accumulate in excess of 360 days loss of privileges. The IT Department provided a *SCDC Disciplinary Sanction Report Inmates with over 60 days* with no inmates identified having loss of privileges over 360 days and the inmate with the highest accumulated loss of privileges was 313 days.

Use of Force recommendations from the Compliance Department meetings were discussed and the Operations Department agreed to review and consider the recommended revisions and changes.

The following IT Reports were requested from the Operations Division to be provided the designated Implementation Panel Member on a monthly basis:

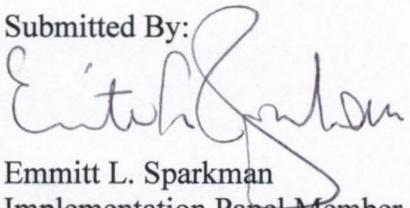
- SCDC Inmate Disciplinary Loss of Privileges Over 60 days Report
- SCDC Average Correctional Facility Population Report (to calculate use of force rates)

Close Out Meeting

A close out meeting was held with Operations Deputy Director McCall and Chief of Legal & Compliance Salley Elliott the afternoon of August 2, 2016. The information from meetings with Compliance and Operations were discussed and reviewed. Operations and Compliance will strive to continue progress and address the identified areas prior to the Implementation Panel Site Visit October 31 through November 4, 2016.

Feel free to contact me if additional information is required or needed.

Submitted By:



Emmitt L. Sparkman
Implementation Panel Member

C: file/SiteVisitSummary 08.01.16-08.02.16

EXHIBIT B
IMPLEMENTATION PANEL REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
1.	**The development of a systematic program for screening and evaluating inmates to more accurately identify those in need of mental health care:**			
	a. Develop and implement screening parameters and modalities that will more accurately diagnose serious mental illness among incoming inmates at R&E with the stated goal of referring inmates to the appropriate treatment programs. Accurately determine and track the percentage of the SCDC population that is mentally ill.	HS 19.10	11/4/16 Partial compliance	
		HS 19.07	11/4/16 Partial compliance	
	b. The implementation of a formal quality management program under which mental health screening practices are reviewed and deficiencies identified and corrected in ongoing SCDC audits of R&E counselors;	HS 19.07	11/4/16 Partial compliance	
	c. Enforcement of SCDC policies relating to the timeliness of assessment and treatment once an incoming inmate at R&E is determined to be mentally ill; and	HS 19.07 HS 19.10	11/4/16 Partial compliance	
	d. Development of a program that regularly assesses inmates within the general population for evidence of developing mental illness and provides timely access to mental health care.	HS 19.07 HS 19.10	11/4/16 Noncompliance	
2.	**The development of a comprehensive mental health treatment program that prohibits inappropriate segregation of inmates in mental health crisis, generally requires improved treatment of mentally ill inmates. and substantially improves/increases mental health care facilities within SCDC:**			
	a. Access to Higher Levels of Care:			

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

EXHIBIT B
IMPLEMENTATION PANEL REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	i. Significantly increase the number of Area Mental Health inmates vis-a-vis outpatient mental health inmates and provide sufficient facilities therefore;	HS 19.04 HS 19.11	11/4/16 Noncompliance	
	ii. Significantly increase the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefore;[2]	HS 19.04, HS 19.07, HS 19.11	11/4/16 Noncompliance	
	iii. Significantly increase the number of male and female inmates receiving inpatient psychiatric services, requiring the substantial renovation and upgrade of Gilliam Psychiatric Hospital, or its demolition for construction of a new facility;	HS 19.04, HS 19.07 HS 19.09	11/4/16 Noncompliance	
		Gilliam Construction Plan	11/4/16 Noncompliance	
	iv. Significantly increase clinical staffing at all levels to provide more mental health services at all levels of care; and	Hiring Plan attached as Exhibit E to the Settlement Agreement	11/4/16 Partial compliance	
	v. The implementation of a formal quality management program under which denial of access to higher levels of mental health care is reviewed.	HS 19.07	11/4/16 Partial compliance	
	b. Segregation:			
	i. Provide access for segregated inmates to group and individual therapy services;			
		OP RHU Policy _22.38 Section 3.23 H.S. 19.04	11/4/16 Noncompliance	
	ii. Provide more out-of-cell time for segregated mentally ill inmates;	HS 19.12 OP RHU Policy 22.38 Section 3.14.4 & Section 3.25	11/4/16 Noncompliance	
	iii. Document timeliness of sessions for segregated inmates with psychiatrists, psychiatric nurse practitioners, and mental health counselors and timely review of such documentation;	HS 19.04 OP RHU Policy 22.38 Section 3.15	11/4/16 Noncompliance	

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

EXHIBIT B
IMPLEMENTATION PANEL REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	iv. Provide access for segregated inmates to higher levels of mental health services when needed;	HS 19.04 HS 19.06	11/4/16 Partial compliance	
	v. The collection of data and issuance of quarterly reports identifying the percentage of mentally ill and non-mentally ill inmates in segregation compared to the percentage of each group in the total prison population with the stated goal of substantially decreasing segregation of mentally ill inmates and substantially decreasing the average length of stay in segregation for mentally ill inmates;	HS 19.07 OP RHU Policy 22.38 Section 1 and Section 2	11/4/16 Substantial compliance	
	vi. Undertake significant, documented improvement in the cleanliness and temperature of segregation cells; and	To be determined	11/4/16 Noncompliance	
	vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.	HS 19.07	11/4/16 Noncompliance	
	c. Use of Force:			
	i. Development and implementation of a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness;	OP 22.01 HS 19.08	11/4/16 Noncompliance	
	ii. The plan will further require that all instruments of force, (e.g., chemical agents and restraint chairs) be employed in a manner fully consistent with manufacturer's instructions, and track such use in a way to enforce such compliance;	OP 22.01 HS 19.08	11/4/16 Partial compliance	
	iii. Prohibit the use of restraints in the crucifix or other positions that do not conform to generally accepted correctional standards and enforce compliance;	OP 22.01 HS 19.08	11/4/16 Noncompliance	
	iv. Prohibit use of restraints for pre-determined periods of time and for longer than necessary to gain control, and track such use to enforce compliance;	OP 22.01 HS 19.08	11/4/16 Partial compliance	
	v. The collection of data and issuance of quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs;	HS 19.07 OP Use of Force 22.01 Section 13	11/4/16 Partial compliance	
	vi. Prohibit the use of force in the absence of a reasonably perceived immediate threat;	OP 22.01 HS 19.08	11/4/16 Noncompliance	
	vii. Prohibit the use of crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions;	OP 22.01 HS 19.08	11/4/16 Noncompliance	

EXHIBIT B
IMPLEMENTATION PANEL REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	viii. Notification to clinical counselors prior to the planned use of force to request assistance in avoiding the necessity of such force and managing the conduct of inmates with mental illness;	OP 22.01 HS 19.08	11/4/16 Partial compliance	
	ix. Develop a mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates;	OP 22.01 ADM 17.01 Employee Training Standards, SCDC Annual Training Plan HS 19.08	11/4/16 Partial compliance	
	x. Collection of data and issuance of quarterly reports concerning the use-of-force incidents against mentally ill and non-mentally ill inmates; and	OP 22.01 HS 19.07	11/4/16 Partial compliance	
	xi. The development of a formal quality management program under which use-of-force incidents involving mentally ill inmates are reviewed.	OP 22.01 HS 19.07	11/4/16 Noncompliance	
3.	**Employment of a sufficient number of trained mental health Professionals:**			
	a. Increase clinical staffing ratios at all levels to be more consistent with guidelines recommended by the American Psychiatric Association, the American Correctional Association, and/or the court-appointed monitor;	Hiring Plan attached as Exhibit E to the Settlement Agreement	11/4/16 Partial compliance	
	b. Increase the involvement of appropriate SCDC mental health clinicians in treatment planning and treatment teams;	HS 19.05	11/4/16 Partial compliance	
	c. Develop a training plan to give SCDC mental health clinicians a thorough understanding of all aspects of the SCDC mental health system, including but not limited to levels of care, mental health classifications, and conditions of confinement for caseload inmates;	Mental Health Training Policy Addendum	11/4/16 Partial compliance	
	d. Develop a plan to decrease vacancy rates of clinical staff positions which may include the hiring of a recruiter, increase in pay grades to more competitive rates, and decreased workloads;	Hiring Plan attached as Exhibit E to the Settlement Agreement	11/4/16 Partial compliance	
	e. Require appropriate credentialing of mental health counselors;	HS 19.04	11/4/16 Partial compliance	
	f. Develop a remedial program with provisions for dismissal of clinical staff who repetitively fail audits; and	HS 19.07	11/4/16 Noncompliance	
	g. Implement a formal quality management program under which clinical staff is reviewed.	HS 19.07	11/4/16 Noncompliance	

EXHIBIT B
IMPLEMENTATION PANEL REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
4.	**Maintenance of accurate, complete, and confidential mental health treatment records:**			
	a. Develop a program that dramatically improves SCDC's ability to store and retrieve, on a reasonably expedited basis:	HS 200.7		
	i. Names and numbers of FTE clinicians who provide mental health services;		11/4/16 Partial compliance	
	ii. Inmates transferred for ICS and inpatient services;		11/4/16 Partial compliance	
	iii. Segregation and crisis intervention logs;		11/4/16 Noncompliance	
	iv. Records related to any mental health program or unit (including behavior management or self-injurious behavior programs);		11/4/16 Noncompliance	
	v. Use of force documentation and videotapes;		11/4/16 Partial compliance	
	vi. Quarterly reports reflecting total use-of-force incidents against mentally ill and non-mentally ill inmates by institution;		11/4/16 Partial compliance	
	vii. Quarterly reports reflecting total and average lengths of stay in segregation and CI for mentally ill and non-mentally ill inmates by segregation status and by institution;		11/4/16 Partial compliance	
	viii. Quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution;		11/4/16 Partial compliance	
	ix. Quality management documents; and		11/4/16 Partial compliance	
	x. Medical, medication administration, and disciplinary records.		11/4/16 Partial compliance	
	b. The development of a formal quality management program under which the mental health management information system is annually reviewed and upgraded as needed.	HS 19.07	11/4/16 Noncompliance	
5.	**Administration of psychotropic medication only with appropriate supervision and periodic evaluation:**			
	a. Improve the quality of MAR documentation;	HS 18.16	11/4/16 Noncompliance	
	b. Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs;	HS 18.16	11/4/16 Noncompliance	

EXHIBIT B
IMPLEMENTATION PANEL REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	c. Review the reasonableness of times scheduled for pill lines; and	HS 18.16	11/4/16 Noncompliance	
	d. Develop a formal quality management program under which medication administration records are reviewed.	HS 18.16	11/4/16 Noncompliance	
6.	**A basic program to identify. treat, and supervise inmates at risk for suicide:**			
	a. Locate all CI cells in a healthcare setting;	HS 19.03 OP RHU 22.38 Section 3.39	11/4/16 Noncompliance	
	b. Prohibit any use for CI purposes of alternative spaces such as shower stalls, rec cages, holding cells, and interview booths;	HS 19.03 OP RHU 22.38 Section 3.39	11/4/16 Noncompliance	
	c. Implement the practice of continuous observation of suicidal inmates;	HS 19.03	11/4/16 Partial compliance	
	d. Provide clean, suicide-resistant clothing, blankets, and mattresses to inmates in CI;	HS 19.03	11/4/16 Partial compliance	
	e. Increase access to showers for CI inmates;	HS 19.03	11/4/16 Partial compliance	
	f. Provide access to confidential meetings with mental health counselors, psychiatrists, and psychiatric nurse practitioners for CI inmates;	HS 19.03	11/4/16 Noncompliance	
	g. Undertake significant, documented improvement in the cleanliness and temperature of CI cells; and	HS 19.03	11/4/16 Noncompliance	
	h. Implement a formal quality management program under which crisis intervention practices are reviewed.	HS 19.03	11/4/16 Partial compliance	

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

Executive Summary

This third report of the Implementation Panel (IP) is provided as stipulated in the Settlement Agreement in the above-referenced matter, and it is based on the third site visit to the South Carolina Department of Corrections facilities and our review and analysis of SCDC's compliance with the Settlement Agreement criteria. The first site visit by the Implementation Panel was from May 2 thru May 5, 2016, the second site visit was October 31 thru November 4, 2016, and this third site visit was from February 27 thru March 3, 2017. We have requested and received a plethora of documents, including policies and procedures and additional reports as noted in this report, however several documents were received during the week prior to the third site visit. We requested that documents be provided to the IP at least two weeks prior to the site visits. In addition, we have had conference calls with the plaintiffs and defendants as well as discussions with SCDC staff, inmates, and plaintiffs, and we reviewed additional documents during the onsite visits. We conducted an Exit Conference on March 3, 2017, which was attended by Deputy Director [redacted] and members of the administrative, operations, and clinical staff of SCDC; plaintiffs' counsel Stuart Andrews; defendant's counsel [redacted] and the mediator, Judge William Howard. During the Exit Conference we provided our preliminary findings based on the two site visits and addressed questions and concerns offered by any of the participants.

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

1. Substantial Compliance – 9 components
2. Partial Compliance – 44 components
3. Noncompliance – 5 components

As discussed during the site visits and during our Exit Conference with the parties, the Implementation Panel's primary concerns regarding SCDC's failure to demonstrate substantial compliance with the Settlement Agreement have to do with the following issues: (1) Staffing, including clinical, operations, administrative, and support staff; (2) Conditions of Confinement including specifically the Restrictive Housing Units (RHU), segregation of any type; (3) prolonged

stays in Reception and Evaluation and the quality and appropriateness of evaluation, referral and treatment components; (4) lack of timely assessments and adequate treatment at the mental health programmatic levels; (5) operations practices and adherence to policies and procedures; (6) access to all higher levels of care, particularly timely hospital level care for male and female inmates; and (7) future planning for adequate numbers of beds and staffing for mental health higher levels of care as the hospital and male CSU and ICS programs will be in need of additional resources.

We recognize that the policies and procedures have been substantially completed. The other necessary components including training staff regarding the policies and procedures, implementation, supervision regarding those policies and procedures, and quality management review via the quality assurance/improvement mechanisms within SCDC are currently incomplete and inadequate and should be of primary focus going forward.

A major achievement has been development of the Quality Assurance Risk Management (QARM). The Implementation Panel continues to be very positively impressed by the efforts of the QARM component, as well as IT and web based information data collection and analysis components, and strongly encourages the continuation and expansion of their efforts at the central levels. The IP reemphasized during our discussions and on-site reviews, the data collection and analysis component of the quality management program must be accomplished at the facility level and relate to policies and procedures, and specific facility parameters and mental health programs, operations, support, and ultimately inmate mental health needs. This has not been fully accomplished but has continued to improve, and the dire need for staffing (as noted in this report) and active on-site and central support for instituting, developing, and/or maintaining adequate services and support functions at the facility level has not been fully achieved. However significant progress is noted in this report.

The Low Intensity Behavioral Management Unit became operational in 2016, and the High Intensity Behavioral Management Unit has begun although not scheduled to open until March 2017. The Crisis Stabilization Unit at Camille Graham is scheduled to open in April 2017.

As noted in our previous reports, the Implementation Panel has continued to provide technical assistance and suggestions regarding how obtaining compliance with the Settlement Agreement criteria and its requirements could be accomplished, and reemphasizes that these processes should be developed within SCDC by the appropriate staff within the SCDC and consultants, if necessary, who are responsible for their implementation, training, and supervision of staff on the actual requirements. SCDC must continue to develop and implement an internal process that supports and assures effective quality management so that the process will be developed and sustained beginning with the Settlement Agreement monitoring process and continuing after the settlement agreement has been satisfied and/or otherwise resolved. The timely development and implementation will also facilitate transition to the anticipated Electronic Health Record (EHR).

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

Correctional Institution, and Allendale Correctional Institution. As reported during our Exit Conference, the Implementation Panel considers the conditions at Lieber Correctional Institution to be at a severe crisis level that requires immediate correction. Not only are the staffing levels for clinicians, as well as operations staff, unacceptably low, preventing the implementation of effective treatment measures, but also based on the operations staffing this facility has experienced frequent lockdowns since at least February 2016 and has been unable to provide adequate recreation or showers. Plaintiffs' counsel have expressed their very serious concerns for the inadequate numbers of operations staffing for SCDC facilities and the resultant harm to their clients, including prolonged lockdowns, extremely limited access to out of cell activities including mental health and medical services, showers, and recreation. The IP is very gravely concerned that the deficiencies in operations staffing, at crisis levels based on our onsite reviews at Lieber and Perry, and reportedly at other facilities, are in need of immediate corrective actions. These severe shortages of operations staff directly impact access to mental health care and services. Without adequate operations staff at all SCDC facilities, it will be extremely difficult if not impossible to meet the requirements of the Settlement Agreement and these conditions of confinement clearly and directly contribute to the harm and dangerous conditions for inmates and staff. These conditions must be corrected immediately, and plans to address the multiple factors contributing to the crisis at Lieber and Perry must be developed and implemented. By contrast, the Low Intensity BMU at Allendale has begun with the support of adequate operations/custody staffing, however the mental health staffing is inadequate. The IP interviewed Character Program Coordinator inmates at Allendale and were very positively impressed by their efforts to assist other inmates and themselves in developing and continuing appropriate behaviors, activities and incentives.

Below are the specific findings followed by the appendices that provide overview information on the system as a whole as well as the individual facilities within the system. As noted, Policies and Procedures are in Partial Compliance.

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 March 2017 Assessment: **partial compliance**

February 2017 SCDC Status Update:

- An R & E Internal Committee was established in November after the site visit by the Implementation Panel (IP). The first meeting was in December.

- The R&E Internal Committee met in December and early February. In the 2/7/17 meeting, we discussed August R&E data at Kirkland and Camille Graham. Preliminary findings were reported by QARM regarding length of times for inmates to access services and to get classified. (See the charts below.) Both Kirkland and Camille Graham were outside of the fourteen days of getting clients to see the QMHP and Psychiatrist for routine referrals. There were very limited referrals that reflected being of an emergent or urgent manner. Staff have been trained how to better document emergent and urgent referrals since August and September data entry; however, October's data were still being analyzed at the time of this report, to determine if improvements have occurred. The R&E Internal Committee will meet on a monthly basis.

- Progress on a web-based system and Automated Medical Record (AMR). –The Division of Resource and Information Management (RIM) has added additional features to the AMR system to better capture types of encounters such as emergent, urgent, and routine referrals. Unique clinical services, such as individual, group, and crisis management services are also able to be identified. Training for medical staff to utilize this system began on 02/17/17. Those developing the electronic health record (EHR) have also been made aware of the need for these features so that they can incorporate them into the EHR. Following are some of the screens that will be used to train medical and mental health staff.
- Interviews for a new QMHP were completed and a final candidate was selected. She later declined the position due to another job offer. A second candidate is being interviewed 02/22/16. The Division is hoping to have this position filled by 03/30/17.
- Custody staff shortages have not improved. This continues to impede our ability to provide care in a timely manner in some cases.
- Psychiatric coverage at R&E continues to average 2 days per week for coverage. SCDC continues to advertise and recruit for a Psychiatrist.
- [The referral] process has been refined to assessing inmates who present with a past suicide history or SCDC MH episode of care within the last three years. QMHP's began using the referral criteria proposed below in December, so the audits done to date do not yet reflect these data coming from the new criteria.
    - Kirkland continues to utilize F1 for observation/crisis cells with the appropriate observation protocols. The CI cells in F1 have been upgraded to safe-cells. Inmates are transferred within 60 hours or sooner depending on level of acuity.

March 2017 Implementation Panel findings: Implementation of the relevant policy and procedure continues to be problematic, especially in meeting the required timeframes as demonstrated by the SCDC status update data. Identified obstacles to achieving compliance with the required timeframes continue to include current custody and mental health staffing shortages.

The over-referrals issue described during the previous site assessment should be significantly improved with the new referral criteria referenced in the SCDC status update section.

Improvement is noted in the context of monitoring the required timeframes and revising the mental health referral criteria.

March 2017 Recommendations:

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

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

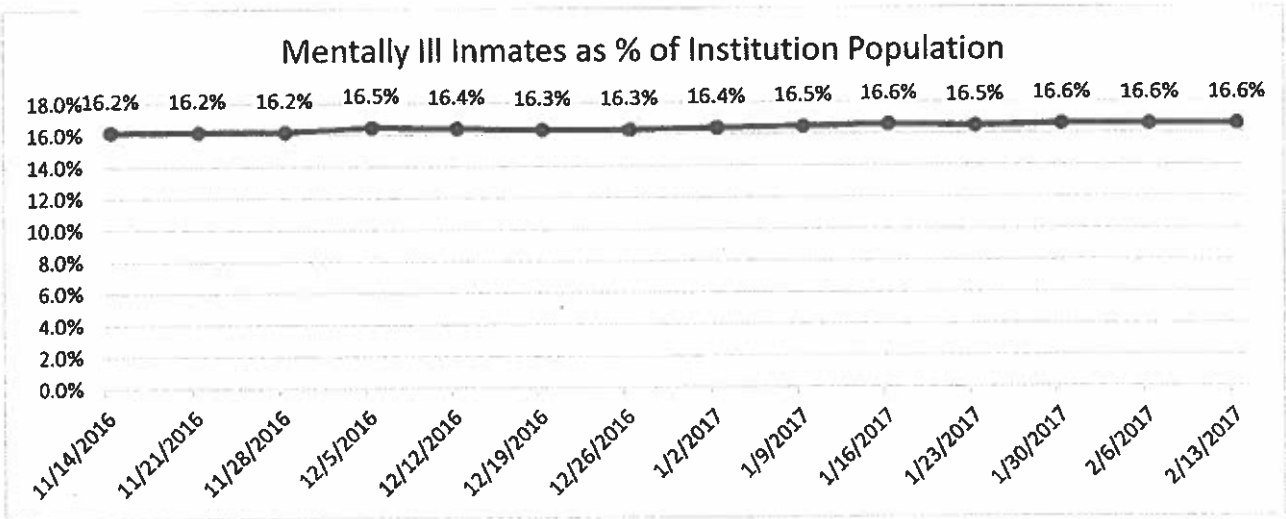
Implementation Panel March 2017 Assessment: **partial compliance**
February 2017 SCDC Status Update:

The Division of Resources and Information Management (RIM) generates a weekly report of Mental Health Classifications for the Mentally Ill Institutional Population. This report includes

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

This information is also provided by institution.

SCDC has demonstrated an increase of 0.6% in the mentally ill population since the November 2016 report.



As of 2/13/17 3,383 inmates of the total SDCD inmate population (16,984) were on the mental healthcare caseload.

March 2017 Implementation Panel findings: As per SCDC status update. It is very likely that the percentage of inmates within SCDC that are on the mental health caseload is underrepresented based on national statistics.

March 2017 Recommendations: As per recommendations summarized in other sections of this report relevant to R&E process and the planned annual mental health screening assessment.

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

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

February 2017 SCDC Status Update:

SCDC MH administration audits, on a monthly basis, 100% of CGCI's monthly intakes and a minimum of 10% of KCI's monthly intakes, to include which counselor evaluated the inmate. Those audits are reviewed by the MH administration and QARM and discussed monthly during the R&E Internal Committee QA meetings. At the time of this report, the MH Division Director has only reviewed one month's worth of data (August), and is aware that data showed that KCI's percentage of inmates who end up on the caseload is very low compared to CGCI. KCI's lead counselor will watch for trends in this area. This auditing and subsequent discussion/review with the counselors and the R&E Internal Committee is the formal process implemented by SCDC. A member of QARM meets with this committee each time.

March 2017 Implementation Panel findings: As per SCDC status update. Issues remain regarding the need for a more accurate and efficient database as described in the prior site assessment to produce quality improvement reports. In general, quality improvement reports should be "stand-alone" documents that include the following subsections:

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

March 2017 Recommendations: Produce QI reports addressing relevant elements of this provision.

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

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

February 2017 SCDC Status Update:

At the recommendation of Dr. Metzner, once the screening has referred the inmate to secondary evaluation (rather than after diagnosis and MH classification assignment), SCDC must enforce the R&E timelines outlined in policy

The following flowchart outlines the process and the timeframes allowed by Policy HS-19.11, for processing inmates through the R&E. [see Appendix 1].
The second chart shows how Camille's and Kirkland R&E's timeframes compared to the allowable time frames from August through October, though not all the statistics were available for October [see Appendix 2].

March 2017 Implementation Panel findings: We made specific recommendations regarding revision of Appendix 1 regarding the timeframes for urgent psychiatric evaluations and clarification regarding the timeframes for routine secondary evaluations. Appendix 2 provides data relevant to the QI specific to mental health timeframes regarding R & E screening and subsequent mental health evaluations.

March 2017 Recommendations: Continue to monitor the relevant timeframes and revise the flow chart.

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

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

February 2017 SCDC Status Update:

Nursing staff continue to provide the mental health screening when an inmate transfers from one institution to another, as explained in the November 2016 report.

The first step in providing the annual assessments discussed above is to identify inmates who have reached the anniversary of their last assessment. Beginning in January, RIM [Resource Information Management] started producing a monthly report (example shown below) for each institution of all inmates not on the mental health (MH) caseload whose intake anniversary is the following month. For example, the January report shows the inmates whose anniversary month is February.

There is no data to show for this to date, other than the number of inmates who were screened. Below is a copy of a roster of inmates who were screened at CGCI on 2/15/17. Results from the screening will be shared with the IP during the February 2017 site visit.

During a 2/17/17 training with mental health clinicians, the Division Director for MH informed staff that the screening process would be phased in next at Level 3 prisons."

March 2017 Implementation Panel findings: Improvement is noted from the perspective of identifying inmates who have reached the anniversary of their last assessment, which will provide a list of inmates to be assessed for their annual screening as previously summarized.

March 2017 Recommendations: Begin the mental health screening process for inmates identified as needing their annual assessment.

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

2.a. Access to Higher Levels of Care

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

Implementation Panel March 2017 Assessment: **noncompliance**

February 2017 SCDC Status Update:

QARM initiated QI studies to assess the appropriateness of levels of care for Inmates with two or more CSU admissions within the past six months and for inmates with two or more GPH admissions within the past six months. The results of those studies are included as attachments 2 & 3. Mental Health Administration and staff reviewed the data analysis completed by QARM and finalized the reports including a writing the assessment summary a plan of action.

CQI Studies

1. GPH Quality Improvement Study
2. CSU Quality Improvement Study

MH Caseload with Disciplinary Convictions: CSU & GPH

As recommended by the IP, as a part of the CQI studies, QARM reviewed inmates with multiple disciplinary infractions and cross-referenced with those who had multiple admissions to GPH or CSU. It was anticipated that these inmates may need to be reclassified to a higher level of mental health care. The results were shared with the Mental Health staff to use for

final analysis, results assessment and plan of action for both GPH and CSU QI studies. For privacy reasons, inmates' names and SCDC numbers have been removed.

March 2017 Implementation Panel findings: The above referenced audits were reviewed. Missing from the studies were narratives of the assessment of the results and planned actions, if any, based on such an assessment. These studies appeared to indicate that at least some of these inmates with multiple admissions to either the CSU or GPH needed a higher level of mental health care.

March 2017 Recommendations: Future QI studies should include the recommended standalone report as described in an earlier section of this report.

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

Implementation Panel March 2017 Assessment: **noncompliance**

February 2017 SCDC Status Update:

In December 2016 because KCI ICS lost 3 QMHP's the program stopped taking additional referrals to the program. Since then, 3 QMHP's have been selected and are currently completing the hiring process. Since SCDC has implemented an expedited hiring process, the goal is to have the additional staff hired and on board within a four-week time period. Until these new staff members are fully trained, ICS is currently accepting emergency admissions only.

Residential Treatment Services as of February 13, 2017

Inmates receiving MH residential treatment services comprise approximately 6.21% of SCDC's mental health population. This is inclusive of all residential treatment services, including Low-Level BMU, ICS, SIB and MR (HAB).

Mental Health Classification	Female	Male	Total	Percent of Mentally Ill Population	Percent of Total Population
No Class. (N/A)	84	404	488	N/A	2.40%
L1	0	83	83	2.45%	0.41%
L2					
BL	*0*	*12*	*12*	*0.36%*	*0.06%*
ICS	*29*	*134*	*163*	*4.82%*	*0.80%*
LC (SIB)	*0*	*14*	*14*	*0.41%*	*0.07%*
MR (HAB)	*4*	*17*	*21*	*0.62%*	*0.10%*
L2 (Total)	33	177	210	6.21%	1.03%
L3	28	162	190	5.62%	0.93%
L4	631	2,188	2,819	83.30%	13.80%
L5	0	81	81	2.39%	0.40%

Month	Total MH	Total L2	Percent of Mentally Ill Population	Percent of Total Population
Nov	3349	212	6%	1%
Dec	3377	219	6%	1%
Jan	3381	224	7%	1%
Feb	3383	210	6%	1%

ICS Renovations

See b). 2.a.iii.

March 2017 Implementation Panel findings: No change from November 2016 site assessment, in part, related to staffing vacancies as previously summarized in the SCDC status update section. During the site visit we did not assess the male ICS services at Kirkland CI.

We did assess the female ICS services at Camille Graham CI during March 2, 2017. Inmates in Section D were interviewed in the community-like setting during the morning of March 2. These inmates reported that they were essentially restricted to their rooms from about 8 AM-3:30 PM on a daily basis except during lunch. They also indicated that they did not have access to their personal TVs during the same period of time. These inmates also indicated that they

were not receiving any programming such as structured therapeutic groups. Poor access to outdoor recreation time was also described by these inmates.

There were no chairs available in the dayroom although benches were present. These ICS inmates indicated that other ICS inmates from Section C had recently been allowed to remove the dayroom chairs from Section D and also periodically would take their cleaning supplies. Many of these inmates appeared to be of a geriatric age group. These ICS inmates also voiced their fears regarding the return of a specific ICS inmate, who was currently in the RHU, who had on two different occasions thrown scalding water on several peers.

Mental health staff confirmed that these inmates recently were not receiving structured therapeutic groups due to the loss of an activity therapist, who was recently promoted to a different position. Correctional officer leadership reported that the information obtained from these inmates regarding essentially being restricted to the rooms for long periods of time was inaccurate.

Key custody staff stated that chairs in the dayroom, which were not bolted to the floor, posed a security risk because several inmates were prone to throw chairs at others. They also indicated that these inmates all had chairs in their rooms, which could be brought to the dayroom space as needed.

We also interviewed about 14 ICS inmates in Section C, which had a count of 27 inmates during the site visit, in a community -like setting. Most of these inmates were either L-3 or L-4, with the minority having an ICS level of care. These inmates also described lack of structured therapeutic programming and poor access to outdoor recreation. They also voiced concerns about being isolated from other general population inmates due to being housed in the "mental health unit." Many of these inmates described access to their mental health counselor ranging from monthly to once every three months.

Inmates in Section C described continuity of medication issues related to both untimely medication renewals and other medications not being available in the pharmacy because of apparent stock supply issues. Staff confirmed the accuracy of these continuity of medication issues.

We observed a treatment team meeting during the afternoon of March 2. We were encouraged by the multidisciplinary discussion and the presence of a psychiatrist, Dr[redacted]

March 2017 Recommendations:

3. Restart the ICS admission process for male inmates as planned.

4. Begin the planning process for more ICS beds.

5. Structured therapeutic programming for the female inmates needs to be restarted. The amount of structured therapeutic programming on a weekly basis offered to the average ICS inmate needs to be tracked as well as the actual number of hours per week actually used by the average inmate.

   Structured therapeutic programming should be treatment plan driven in contrast to "Round Robin" selected groups.

   We discussed in detail with both leadership and line mental health staff issues related to the reported refusal rate demonstrated by ICS inmates. If the refusal rate exceeds 30%, a QI process needs to be initiated to address this issue.

6. Access to outdoor recreation also needs to be tracked and monitored.

7. We also discussed with staff issues related to housing ICS inmates with non-ICS inmates in the same unit. Staff need to identify the involved issues closely and develop solutions.

8. Community meetings on a weekly basis should occur in both ICS housing units, which should be attended by both custody and mental health staff.

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

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

February 2017 SCDC Status Update:

The following chart shows all female admissions to inpatient care over the past six months. To protect the privacy of the inmates, personal identifying information has been removed. Currently 2 females remain in inpatient psychiatric care.
During the previous IP visit, reporting indicated a need to better track the number of inmates being referred to inpatient levels of care. As a result, SCDC is tracking referrals to inpatient levels of care as evident in the chart below.

In a review, QARM analysts cross-referend this report with the AMR for those with the date the inmate was classified as L1 (column 5). When this date was not indicated or if any discrepancies noted, the Division of Mental Health was notified that a review or update may be required. QARM will continue to review this report on at least a quarterly basis.

GEO (Correct Care) Female Admissions and Discharges

August 15, 2016 through February 14, 2017

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

Inmate #	MH Class Prior to Admission	Admission Date	Admission Reason	Classified as L1 on	Discharge Date	Discharged To
Inmate 1	L2	11/15/2016	Mental Health	11/16/2016	12/29/2016	GRAHAM
Inmate 2	L2	8/24/2016	Mental Health		9/7/2016	GRAHAM
Inmate 2	L2	1/26/2017	Mental Health	2/2/2017		
Inmate 3	L2	9/12/2016	Mental Health		11/10/2016	GRAHAM
Inmate 4	L1	12/14/2016	Mental Health	12/14/2016	12/29/2016	GRAHAM
Inmate 5	MH	1/27/2017	Mental Health			

GPH Renovations

The following chart shows progress in renovations and upgrades to GPH to facilities an increase in the number of male and female inmates receiving inpatient psychiatric services:

Kirkland Correctional Institution -- Gilliam Psychiatric Hospital (GPH)	
Administration Area:	Renovations/Upgrades
Four (4) group counseling rooms:	
Renovate two (2) offices for group counseling rooms and two (2) conference rooms.	Offices to group counseling room and conference rooms to group counseling. Complete Larger Glazing view panels. Complete. Cameras Complete Furniture/chairs to be determined
Add cameras (2 ea. per room). Add cameras to view corridor.	
Add larger security glazing view panels in doors.	
Furniture / chairs.	
Existing Nurse's Station in Admin Area – scope of work has not been determined at this time.	

Hospital Housing Unit: *(Note: Must be mindful not to violate the current 87 bed SCDHEC hospital license)*	
The cells and door view panels are adequate at this time.	
Install 5 benches and 2 restraint group tables with stools per wing of the housing unit.	B-Wing - 2 Tables and 5 benches Complete A-Wing - 5 Benches Complete 2 Tables awaiting the removal of the TV Stand
Provide an enclosed nurse's station to include hand sink ("no restroom facilities") to both A & B wings. .	Projected Completion December 1, 2017 Design documents & paperwork are being finalized for submission to SCDHEC – submission Feb 8, 2017, Anticipate 30 days for review & comments. Installation of cameras & construction of showers (drawings are complete) can commence at any time FM crews are ready to start in this area
Install security cameras in hospital cells – 1st floor one wing. 31-1 Form has been entered	
Renovate showers on both wings to include push button valves and an ADA shower with ADA with ligature resistant ADA fixtures	
Install four (4) silent TV's in security cages in the dayroom for both wings.	B- Wing Complete A-Wing Complete
All areas to be painted to accommodate a more therapeutic setting.	Color(s) selected
Kirkland Correctional Institution -- Modular Unit at GPH	
Additional office space:	Complete
Renovate the open area for additional office spaces and add a wall in the existing ICS pill room to make two offices. ICS Pill room must be relocated before the renovations can begin. The new area in the Admin. . Area is ready for the ICS pill room. Awaiting notification of the move.	ICS Pill Room Relocated Complete. 2 cameras have been installed, gate controllers are in progress. 13-1 Forms completed for camera purchase
Add enclosed fence walkway and controlled locking systems at gates to include three (3) cameras. Change: Relocate the entrance to the Modular Office space to include an additional concrete walk way and 2 additional cameras with 2 additional electric locks, to be controlled by the control room in the Gilliam Center	Additional concrete walkway in progress

March 2017 Implementation Panel findings: As per SCDC status update section. Renovations at GPH, with specific reference to the nursing station, are not expected to be completed until December 2017.

Since the November 2016 site assessment, there has been a net gain of 2.0 FTE mental health counselors working at GPH in addition to a recreational therapist supervisor and a 1.0 FTE recreational activities therapist. Other gains in staffing included 2.0 FTE sergeants and a unit

manager. The inmate count during February 27, 2017 was 87 inmates. A waitlist for admissions was started during January 24, 2017 and had 12 inmates on the waitlist during the first day of our site visit.

At the time of our site visit five structured therapeutic groups per week (12 inmates per group) were scheduled in addition to three activity therapy groups per day (12 inmates per group). Inmates received two hours per day of out of cell unstructured time on a daily basis with higher functioning inmates receiving additional hours of unstructured time out of cell during weekend days.

Additional security measures have occurred and/are being planned in response to an inmate assault upon a psychiatrist during late December 2016.

During the morning of February 28, 2017, we observed a GPH treatment team meeting, which was attended by the appropriate staff and conducted in a competent manner. Inmates being staffed during this meeting were interviewed by the treatment team as part of the process.

We also observed two of the renovated group treatment rooms, which included in one room "treatment chairs" and in the other group room "therapy tables." The room with the treatment chairs was organized in a classroom style in contrast to a semicircular configuration that would facilitate the group process. There were significant problems with the "treatment chairs" due to their excessive height, which resulted in the legs of inmates sitting in these chairs becoming numb after about 15-20 minutes.

Data provided prior to the site visit indicated no waiting lists for male or female inmates for access to hospital level care; however, during the site visit, the IP was apprised there had been three referrals for female inmates (one of whom had not been transferred for 2-3 weeks) and occasional waiting lists (including currently) for male inmates. SCDC must track all referrals for inpatient/hospital level care as well as waiting lists and rejections of referrals.

The reasons for the low number of female inmates admitted to an inpatient psychiatric unit via GEO were unclear but appeared to be related to limited beds and contractual issues. During our site visit we interviewed an inmate who was currently housed in the RHU due to the lack of timely access to an inpatient psychiatric bed. This inmate was grossly psychotic and had been in need of inpatient psychiatric care for 2-3 weeks. Staff had apparently misinterpreted a court order relevant to the use of involuntary medications, which had contributed to her decompensated state due to medication noncompliance.

March 2017 Recommendations:

1. Continue to focus on providing more out of cell structured therapeutic and unstructured time to inmates in GPH.
2. Continue to monitor implementation of the scheduled GPH renovations.
3. Fix the "treatment chairs" as well as their configuration.

4. Further explore the reasons for the low admission rate of female inmates to an inpatient psychiatric unit.
5. Explore other options for inpatient psychiatric beds such as the female forensic division of the State Hospital and/or renegotiate the current contract with the vendor that is providing inpatient psychiatric care for women. Timely access to female hospital beds must be available or this requirement will be found in noncompliance.
6. Provide training/supervision to mental health staff regarding court orders relevant to involuntary medications.

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

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

February 2017 SCDC Status Update:

A new recruiter for Health Services was hired on 9/12/16. All SCDC employees received a general increase of 3.25% in July 2016. Increases in pay grades are being considered and their cost and implications reviewed.

Since November 2016, SCDC has launched an aggressive hiring campaign to increase staffing.

- Super Bowl commercial aired on February 5, 2017
- One-day hiring for correctional officers began on July 5, 2016. One-day hiring for nurses and mental health staff began on February 1, 2017. This program reduces the time for interviews and placement by at least 3 months
- Truck and car wrap on SCDC vehicles advertising positions and opportunities effective February 2017
- Beginning October 2016, 13 billboards were placed statewide advertising SCDC positions and opportunities
- November 2016, SCDC began running television spots on local stations in major metropolitan areas advertising positions and opportunities. Television advertisement is expanding to more rural areas
- Mental health positions are being advertised on the "Indeed.com" job site
- SCDC recruiter regularly contacts the South Carolina Department of Labor, Licensing, and Regulation for potential healthcare staff
- Consistent weekly appearances at job fairs hosted by the state Employment Department and college job boards and fairs at universities in Orangeburg, Charleston, Clemson, Columbia as well as technical schools across the state
- Converting SCDC application process to the state website NEO.GOV to allow for streamlined, easier application and notice of positions at SCDC. Full and part-time

positions will be posted for medical and mental health staffing

- Hosted a booth at the South Carolina State Fair manned by employees who spoke with 682 potential applicants
- Recruitment of retirees at military bases
- Position notices in major newspapers and 3 trade journals
- Digital job board banner displayed on WIS-TV website
- Ad hoc appearances at companies that are closing to recruit employees
- Addition of 5 lieutenant recruiters with a plan to add a recruitment captain who has been identified
- Hired 7 retention lieutenants. In the process of hiring 3 additional retention lieutenants. These staff will work with and train new officer staff. The long term plan is to place one retention lieutenant in each institution
- Post actual salary (rather than range) in job postings so that applicants are not disappointed with salary offer
- Provide overtime and shift/weekend differential for nurses
- Creation of a spot bonus program to recognize exemplary performance by employees with a bonus of $250
- Decreasing the time for Correctional Officer step incentives from a five – step program to a two – step program with a higher salary in a shorter period of time (from 2 years to 6 months).
- Overtime for officers being piloted in several institutions
- Conducted a salary survey and will increase salaries to the state average
- HR will post positions with increased salaries to the state average
- Increased officer salary (see example of handout below)

	NEW JOB CLASS/BAND/LVL.	Average Statewide	SCDC Average	Difference
Adm Assist	AA75 4/D	$32,920.00	$31,888.00	($1,032.00)
Risk Mgmt & compliance Mgr I	AF30 8/B	$81,687.00	$80,518.00	($1,169.00)
Adm Coord II - Health Serv Recruiter	**AH15 6/C**	$52,821.00	**$55,000.00**	$2,179.00
Physician Assistant	**EB35 8/C**	$90,558.00	$98,947.00	$8,389.00
Paramedic	**EC20 4/D**	$36,717.00	$38,000.00	$1,283.00
Human Serv Coord I - Activity Therapist	**GA40 4/A**	$33,809.00	**$31,315.00**	($2,494.00)
Human Serv Coord I - Mental Health Tech	**GA50 5/C**	$39,407.00	$36,137.00	($3,270.00)
Human Serv Coord I - CCC IV	**GA50 5/E**	$39,407.00	$43,881.00	$4,474.00
Human Serv Coord II - QA Monitor	**GA60 6/B**	$49,168.00	$47,822.00	($1,346.00)
Clinical Supervisor	GA70	$67,353.00	$61,823.25	($5,529.75)
Psychologist	GA80 8/E	$83,555.00	$83,041.00	($514.00)
Licensed Practical Nurse	**EA10 4/C**	$31,936.00	$31,901.00	($35.00)
Registered Nurse	**EA20 6/A**	$47,512.00	$48,491.00	$979.00
Psychiatrist	UB26	$180,632.00	$215,104.00	$34,472.00
Physician	**UB27**	$145,512.00	$145,551.00	$39.00
		$1,052,401.00	$1,093,300.25	$40,899.25

SCDC hosted a job fair on January 27, 2017 at the SCDC Recruiting and Employment Office. The numbers below reflect the number of applications by discipline:

67 participants
59 applicants
8 did not submit an application

Discipline	Number of Applicants
Nursing -RN	2
Mental Health	3
Non-security	16
Security	38

Additionally, contacts at the SC Stare Fair were:

- Approximately 360 Applications distributed
- Approximately 320 Information Cards received

Information Cards Distribution

Discipline	Number of Information Cards Distributed
Security	284
Medical	32
Administrative	2
Education	1
Food Service	1

The staffing plan was provided in the document drop submitted to the IP on February 13, 2017.

March 2017 Implementation Panel findings: The 40% vacancy rate noted during the November 2016 site assessment is little changed from the current 38% vacancy rate. The department has implemented an aggressive recruiting campaign as previously summarized relevant to hiring of both correctional and mental health staff. The salary for psychiatrists is likely not competitive to psychiatrists' salary in the community in contrast to other state institutions.

Appendix 3 provides a summary of current mental staffing allocations and vacancies.

The expedited hiring process is very encouraging.

March 2017 Recommendations: It is very likely that the salary structure for psychiatrists and psychologists will need to be reconsidered depending on the outcome of the current recruiting/hiring efforts.

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

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

February 2017 SCDC Status Update:

SCDC has created a committee, co-chaired by Dr. [redacted] (psychologist) and Dr. [redacted] (chief psychiatrist) to review all denials to all higher levels of care. This committee has met to determine process flows; however, the formal review process is scheduled to begin March 2017. The following e-mail shows some of the preliminary work of this committee.

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

March 2017 Recommendations: Begin the formal QI process as planned.

2.b. Segregation:

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

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

November 2016 SCDC Status Update: Currently there is no documentation available to track the number of RHU inmates participating in groups. In the CSU group therapy rosters have been provided, but they failed to indicate those inmates participating in groups with a designated segregation status. Although groups are reported as ongoing, this documentation is insufficient to support this requirement.

February 2017 SCDC Status Update:

The Low-Level Behavioral Management Unit (LLBMU) at Allendale CI was opened in December 2016 with a bed capacity of 48 inmates. The first group of inmates have moved into "Phase Two," which provides 4 hours of group therapy per week as well as 30-60 minutes of individual therapy per week. Twelve therapy chairs are currently being utilized for groups.

Therapy chairs have been installed at Lee CI RHU and group assignments have been made; however, as of 2/10/217, groups have not been started. Please see email correspondence below: Due to MH and Medical staffing, the High-Level Behavioral Management Unit (HLBMU) at Kirkland's former SSR is scheduled to open 4/3/17. This also allows staff the opportunity to identify improvements based on lessons learned from the LLBMU.

Staff at both Perry and Lieber are currently evaluating the feasibility of placing therapy chairs in their RHUs.

March 2017 Implementation Panel findings: It is encouraging that the LLBMU has been initiated on a small scale and the HLBMU is scheduled to be implemented during April 2017. These programs are beginning with low numbers of inmates. As the census grows, there will be a need for additional staff and additional programmatic interventions including Cognitive Behavioral and other therapies by trained and credentialed professionals.

We met with five HLBMU designated inmates in a group setting to discuss the beginning of the HLBMU. These inmates expressed concerns about this program but were generally optimistic about their participation. They also described physical discomfort re: the therapy

chairs for reasons previously summarized. They also described their dissatisfaction with the current recreational yards.

We also observed the area that will be used for the new recreational yards to be constructed for the HLBMU. We strongly recommended that these yards include a toilet, mister and pull up bars.

March 2017 Recommendations:

1. Continue with the current implementation schedule relevant to BMU's. Consider changing the names of the two programs to delete reference to the terms "low level" or "high level."
2. Construct the new recreational yards.
3. Fix the "therapy chairs."

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

Implementation Panel March 2017 Assessment: **noncompliance**

February 2017 SCDC Status Update:

The recommendation to provide crank radios as one means to mitigate the conditions of RHU has been implemented. See the e-mail messages below.

Perry: Based on the IP's recommendation that PCI should not house inmates requiring an area mental health services level, all general population inmates at Perry classified as L3, area mental health, were transferred from PCI. All protective custody inmates were transferred to another institution 12-12-16.

Camille Graham R&E: Camille Graham began an activities schedule for R&E inmates, which allows approximately 20 hours out-of-cell time, though it does not differentiate between structured and unstructured. To date this is not being documented by individual inmate cell-side logs, but is documented in the log book.

Beginning on February 20, 2017, CGCI will begin allowing staff to leave R&E cells unlocked for those inmates to receive additional out-of-cell time. In addition, plans are being considered to move PC and other segregated R&E inmates to the RHU side of the building. This will open additional beds for those R&E inmates who don't require segregation but are currently housed in the overflow beds which are on the RHU side of the building.

Kirkland's administration is considering making similar changes to those being implemented and planned at CGCI.

Allendale LLBMU: A spreadsheet capturing the following information has been provided to the IP to demonstrated tracking of structured and unstructured out-of-cell activities in the

LLBMU. This information has not been analyzed at the institutional level and submitted to QARM for reporting; however, QARM is currently analyzing the data and will provide a summary report to the IP during the February 2017 visit.

March 2017 Implementation Panel findings:

Implementation of the activity schedule for the Camille Graham R&E has been delayed for about one week.

Crank radios had been provided to inmates in the LLBMU and at GPH. They have not been provided to inmates in the RHU due to potential issues related to providing crank radios to inmates on the mental health caseload but not to other inmates in the RHU.

Since the November 2016 site assessment, 22 mental health caseload inmates from PCI have been transferred to other prisons with 27 mental health caseload inmates remaining at PCI. Sixteen (16) of the 27 inmates are in the RHU with 12 of these inmates refusing to transfer.

The adjustment unit at PCI, which is designed for vulnerable inmates, remains at this location.

During the morning of February 28, 2017, we observed the mental health rounding process in the RHU at the Kirkland CI. The process essentially involved the mental health worker performing a mini-mental status examination that focused on the presence or absence of suicidal or homicidal ideation and the presence or absence of auditory or visual hallucinations. Related to how the mental health workers are assigned to the mental health rounding process in this RHU, the mental health worker appeared to not be very familiar with these inmates.

During the afternoon of February 28, 2017 we observed the mental health rounding process in the RHU at Broad River CI, which was done in a competent manner. The mental health worker performing the rounds appeared to be very familiar with these inmates. Inmates reported very limited access to the outdoor recreational cages. Broad River CI officials acknowledged that inmates are not being provided access to the outdoor recreation cages due to security staffing shortages.

During the afternoon of March 1, 2017, we observed the mental health rounding process in the RHU at the Leiber CI. The mental health clinician followed a written protocol that included an abbreviated mental health review of systems. For reasons previously summarized, it is our recommendation that the rounds process be modified as previously referenced. Significant issues specific to the RHU conditions of confinement were present that included limited access to yard and showers as well as poor access to clinical interventions being conducted in a confidential setting.

Many, if not all, of the above conditions of confinement issues at the Leiber RHU were directly related to the severe custody and mental health staffing vacancies.

Review of a limited number of randomly selected records of mental healthcare caseload inmates (see Appendix 5) surprisingly demonstrated better than expected frequency of clinical contacts although there were frequent delays due to custody staffing issues. A significant issue was the frequent lack of access to providing clinical interventions/ assessments in a setting that allows for adequate confidentiality.

During the morning of March 2, 2017 we observed the mental health rounding process at Camille Graham CI, which also used a mini-mental status examination approach as previously referenced.

The reported inmate access to showers and outdoor recreation was not consistent with documentation of such activities, which appeared to be a documentation problem. During the morning of March 3, 2017 we observed the rounding process at Allendale CI which also used a mini-mental health status examination approach as previously referenced.

March 2017 Recommendations:

1. Mental health staff need to evaluate the inmates at the PCI refusing to transfer in order to determine whether transfer to a higher level of mental health care is indicated.
2. Standardize the mental health rounding process to have the same mental health clinicians performing rounds on the same inmates for at least six months at a time. The rounding process should not include on a routine basis a mini-mental status examination unless clinically indicated. It would also be useful for these clinicians to be able to provide inmates during the rounds process with written materials such as puzzles or psychoeducational information.
3. The staffing vacancies at the Leiber CI have resulted in very significant problems in the context of the mental health system. A remedy needs to be developed and implemented as soon as possible.
4. Documentation issues specific to access to showers and yard time for RHU inmates at the Camille Graham CI need to be remedied.

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

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

February 2017 SCDC Status Update:

Caseload monitoring sheets have been designed for monitoring inmates being seen by QMHPs and psychiatrists within the timeframes outlined in policy. Because this is a new process, reports have not been compiled for submission to the IP.

Health Services Office Assistants (HSOA's), are being hired to work at the institutional level to collect, compile and report these findings.

The following chart documents the information currently being collected.

March 2017 Implementation Panel findings: Improvement is noted in the context of having developed caseload monitoring sheets as per the SCDC status update section. We made specific references to recommended revisions of the data collected with specific reference to including the dates of the last five psychiatric clinic appointments as well as the last five appointments with the inmate's mental health counselor. In addition, we recommended that the weekly structured therapeutic activity offered and used by an individual inmate be included on the caseload monitoring sheet.

March 2017 Recommendations: as above.

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

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

February 2017 SCDC Status Update:

All SCDC CI cells are scheduled to have been renovated to safe cells prior to the February 2017
IP visit.

The LLBMU was opened in December and is currently operating. Due to MH and Medical staffing, the High-Level Behavioral Management Unit (HLBMU) at Kirkland's former SSR is scheduled to open 4/3/17. This also allows staff the opportunity to identify improvements based on lesson learned from the LLBMU. In additions, the outdoor recreation area for the HLMBU has not been completed and Lexan glass has to be installed in CI cells.

Security staff anticipates 14 new graduates and CIT-trained staff for the HLBMU by March 31. for KCI.

Weekly RHU Rounds are ongoing. During rounding, inmates are briefly assessed for signs/symptoms of decompensation. If any decompensation is noted, the inmate is pulled from the cell and an assessment is made to determine if he/she requires mental health care; or if already a mental health client, a higher level of care. If a higher level of care is indicated, the client is seen by the psychiatrist and a referral to a higher level of care is completed.

Weekly notes to reflect the completed rounds are made in the AMR for all RHU mental health patients. (See samples below.)

Each institution maintains a record of weekly rounding non-mental health inmates. Some institutions are placing a note in the AMR, while others are using weekly RHU paper forms to document weekly rounds. (See the example below.) A request has been submitted to RIM to add a "Weekly Rounds" encounter type to quantify the completed rounds. This request has also been made for the EHR system.

March 2017 Implementation Panel findings: As per SCDC status update. Information relevant to the HLBMU has been provided in a previous section of this report. The LLBMU is operational with 10 inmates (5 in Phase 1, 3 in Phase 2, and 2 in segregation). The programming schedule appears to be adequate, however out of cell time for unstructured activities does not occur after 4pm on weekdays and not at all on weekends. Visitation is also an issue discussed on site and is to be modified.

Based on discussions with custody and mental health staff at Camille Graham CI, it was clear that there is a need for a female Behavioral Management Unit although the size of such a unit would be relatively small. We discussed with key staff potential options for such a unit.

March 2017 Recommendations:

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

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

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

February 2017 SCDC Status Update:

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

The charts below show the percentage of mentally ill and non-mentally ill inmates in RHU, with each number compared to the same group in the total SCDC population. There continues to be a disproportionate number of mentally ill population in SCDC's RHU's.

Summary of SCDC Mentally Ill & Mentally Healthy Inmates as a Percent of RHU and Total Institutional Population November 1, 2016 - February 1, 2017

Month	% of RHU Pop Mentally Ill	% of Total Pop Mentally Ill	% of RHU Pop Non-Mentally Ill	% of Total Pop Non-Mentally Ill
1-Nov-16	36.22%	16.01%	63.78%	83.99%
1-Dec-16	37.70%	16.33%	62.30%	83.67%
1-Jan-17	35.54%	16.46%	64.46%	83.54%
1-Feb-17	34.50%	16.61%	65.50%	83.39%

RIDGELAND	47.5%	34.0%	52.5%	66.0%
TRENTON	21.9%	15.4%	78.1%	84.6%
TURBEVILLE	0.0%	1.0%	100.0%	99.0%
TYGER RIVER	30.0%	12.1%	70.0%	87.9%
WALDEN	18.9%	13.5%	81.1%	86.5%
WATEREE RIVER	0.0%	0.0%	100.0%	100.0%
TOTAL	**37.7%**	**16.3%**	**62.3%**	**83.7%**

SCDC Mentally Ill Inmates as a Percent of RHU and Total Institutional Population on February 1, 2017

Institution	% of RHU Pop Mentally Ill	% of Total Pop Mentally Ill	% of RHU Pop Non-Mentally Ill	% of Total Pop Non-Mentally Ill
ALLENDALE	24.1%	14.9%	75.9%	85.1%
BROAD RIVER	25.0%	20.6%	75.0%	79.4%
CATAWBA	0.0%	0.0%	100.0%	100.0%
EVANS	15.7%	11.0%	84.3%	89.0%
GILLIAM PSY	N/A	90.3%	N/A	9.7%
GRAHAM	N/A	0.0%	N/A	100.0%
GRAHAM R&E	100.0%	43.5%	0.0%	56.5%
KERSHAW	46.9%	26.4%	53.1%	73.6%
KIRKLAND	42.3%	12.4%	57.7%	87.6%
KIRKLAND INFRM	22.6%	17.2%	77.4%	82.8%
KIRKLAND MAX	0.0%	21.4%	100.0%	78.6%
LEATH	100.0%	90.9%	0.0%	9.1%
LEE	83.3%	54.4%	16.7%	45.6%
LIEBER	45.9%	18.7%	54.1%	81.3%

LIVESAY	57.4%	23.4%	42.6%	76.6%
MACDOUGALL	N/A	0.0%	N/A	100.0%
MANNING	N/A	16.2%	N/A	83.8%
MCCORMICK	5.0%	2.3%	95.0%	97.7%
PALMER	27.8%	14.4%	72.2%	85.6%
PERRY	N/A	0.0%	N/A	100.0%
RIDGELAND	55.3%	33.6%	44.7%	66.4%
TRENTON	18.2%	15.4%	81.8%	84.6%
TURBEVILLE	0.0%	0.9%	100.0%	99.1%
TYGER RIVER	42.3%	12.6%	57.7%	87.4%
WALDEN	16.9%	13.9%	83.1%	86.1%
WATEREE RIVER	0.0%	0.0%	100.0%	100.0%
TOTAL	**34.5%**	**16.6%**	**65.5%**	**83.4%**

March 2017 Implementation Panel findings: As per SCDC status update. There has been a 9% overall decrease in the number of inmates on the mental health caseload who are housed in RHU from December 7, 2016 until January 18, 2017. Inmates with L4 MH classification have an average length of stay in segregation of about 507 days compared to 94 days for non-mental health caseload inmates.

March 2017 Recommendations: Attempt to understand the reasons for the significant differences in the context of the length of stays in the RHU as previously referenced.

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

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

February 2017 SCDC Status Update:

On December 19, 2016, SCDC initiated a process requiring that officers conduct temperature and cleanliness checks twice per day in the segregated areas. Thermometers were provided for each RHU. The logs documenting these checks have been uploaded to the SCDC shared drive for staff access.

After site visits to the RHUs QARM noticed that cell checks were not standardized, in that officers were checking temperatures on different focal points within the cell (wall, window, bedframe, through glass, etc.) which may have led to wide variations the final readings. As a result, Operations has refined parameters for temperature and cleanliness checks. (See the e-mails below.)

QARM also reviewed some of the documentation and provided verbal feedback to Operations that when deficiencies are noted, there should be a way to ensure issues are corrected.

Specifically, when the cells has been documented as "Not Clean", the officer should indicate what factors determined uncleanliness and documentation that the problem was corrected.

Currently, no additional studies have been conducted to evaluate the results of the temperature and cleanliness checks. An example of the form used to document the temperature and cell cleanliness is captured below:

March 2017 Implementation Panel findings: As above. It was clarified that a similar procedure needs to be implemented for the Crisis Stabilization Unit cells.

March 2017 Recommendations: As above and QARM continue to perform studies to evaluate the results of cell temperature and cleanliness checks. Operations currently is only conducting temperature and cleanliness checks for random cells. Temperature checks for random cells is acceptable; however, inspections for cleanliness should be conducted daily for all RHU cells.

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

Implementation Panel March 2017 Assessment: **noncompliance**

February 2017 SCDC Status Update:

QARM has drafted a policy to establish and maintain a system of quality assurance to ensure the sustainability of organizational goals and objectives. This policy establishes a Continuous Quality Improvement Review Committee (CQIRC) to review data related to inmate safety and security, analyze operational performance, identify deficiencies, recommend corrective actions, and ensure compliance on an ongoing basis. The policy is currently being placed in draft form through the Office of Policy Development. The target date for implementation of this new policy is April 2017.

QUALITY ASSURANCE
Overview of policy:

SCDC is committed to improving the health of our offenders by providing excellent health care. We foster an atmosphere that promotes comprehensive, compassionate, quality, professional healthcare (physical and mental health) through education, provision of resources, clinical oversight and administrative support.

SCDC will establish standards and strategies to effectively manage operations through systematic analysis, self-audit, and staff accountability. Goals and outcomes of SCDC quality assurance process will include, but will not be limited to:

- Improving inmate and staff safety and security;
- Enhancing operational efficiencies;

- Enhancing feedback for informed decision-making;
- Conducting periodic staffing analyses to be presented to the Deputy Director of Administration for resource allocation;
- Reviewing, and compiling relevant internal and external compliance reports;
- Reviewing corrective action plans and follow-ups;
- Identifying opportunities that support the review, revision, and/or development of protocols, policy, and procedures
- Identifying opportunities to continuously improve the quality of care to inmates by monitoring clinical activity, identifying opportunities to improve clinical outcomes, and identifying educational and training needs of staff
- Quality Improvement studies

March 2017 Implementation Panel findings: Partial compliance will be achieved when the draft policy has been finalized and approved.

March 2017 Recommendations: Finalize and obtain approval regarding the above draft policy. Then begin implementation that initiates with training of staff.

2.c. Use of Force:

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

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

February 2017 SCDC Status Update:

In response to concern regarding a formalized procedure for addressing administrative violations and excessive force identified during electronic use-of-force reviews, SCDC, in conjunction with the IP, developed amendments to the Use-of-Force policy outlining a formalized process. Currently policy dictates that the IG's office is responsible for criminal and administrative investigations; however, this policy is being amended to direct criminal investigations to the IG's office. Administrative matters are directed for investigation by the Agency Director or when deemed necessary to Operations for additional review.

For more thorough reviews, SCDC increased the UOF review staff from one to three reviewers and expanded the duties for these staff. The initial responsibilities included

- reviewing, tracking, and reporting on the UOF videos uploaded to the automated system;
- and commenting on policy infractions

Additional responsibilities now include

- reviewing and tracking:

  - daily UOF MINS,
  - AMR records related to UOF,
  - UOF grievances,
- referring UOF allegations to the IG for criminal and additional administrative investigations.
- contacting institutions about discrepancies or issues in reports/videos/MINS/medical reports/grievances/allegations,
- providing guidance to institutions on the UOF policy and proper exercise of UOF,
- tracking when institutions are delinquent in uploading information about use of force into the automated system

SCDC has also developed and implemented a plan to eliminate the disproportionate use of force against inmates with mental illness through creation of an automated Employee Corrective Action tracking system. This system tracks corrective actions involving staff identified to have violated the UOF policy. A monthly report is forwarded to the Operations for review.

RIM has provided a report in the document drop that details corrective action for employees who have not violated the UOF policy. See example below.

March 2017 Implementation Panel findings: SCDC has revised the OP 22.01 Use of Force Policy and formalized procedures for addressing administrative violations and excessive force. QARM has increased the number of UOF Reviewers from one to three since the November 16 site assessment and increased reviewing and tracking responsibilities for the positions. An automated Employee Corrective Action Tracking System has been developed for employees receiving corrective action for use of force violations. Since the November 16 site assessment, QARM referred 65 potential UOF violations to the Operations Division for review. Information was provided that six (6) of the referrals resulted in employee corrective action. The outcome for the other 59 referrals is pending. The UOF review process has been enhanced to assist eliminate the disproportionate use of force against all inmates including mentally ill inmates. A proposed policy revision is in progress that the Inspector General will no longer routinely conduct administrative investigations. It is anticipated that the use of force incidents will require routine administrative investigation and the policy revision will potentially impact administrative investigations being conducted and completed in a timely manner.

March 2017 Recommendations: Operations and QARM continue to conduct reviews and studies to identify disproportionate use of force against inmates and take the appropriate corrective action when incidents occur to eliminate the practice. Ensure that Operations determines final action on all referrals for potential use of force violations and that required administrative investigations are conducted critical to the elimination of disproportionate use of force against inmates.

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

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

February 2017 SCDC Status Update:

On January 27, 2017 Assistant Deputy Director of Operations, Mr. [redacted] sent an email to all Wardens, Associate Wardens, Training Academy staff and other relevant Security staff indicating revisions to OP 22.01 Use of Force Policy requiring that chemical munitions be employed in a manner fully consistent with manufacturer's instructions during planned uses of force.

The referenced e-mail was sent to the wardens on January 27, 2017, with the disclaimer and the Chemical Munitions Matrix. [see Appendix 4].

March 2017 Implementation Panel findings: SCDC has revised the OP 22.01 Use of Force Policy requiring that chemical munitions be employed in a manner consistent with manufacturer's instructions during use of force incidents. Operations and QARM continue to monitor use of force incidents to ensure all instruments of force are employed in a manner fully consistent with manufacturer's instructions. SCDC has established specific guidelines on the amount of chemical agents that should be deployed for each application. These guidelines have been incorporated in the OP 22.01 Use of Force Policy. Progress has been made in instruments of force being employed in a manner consistent with the manufacturer's instructions. Although there has been progress, primarily with chemical agents, there continue to be too many incidents where excessive amounts and types of munitions are utilized without necessary justification. SCDC is addressing these issues with improved procedures, employee corrective action and limiting of issue of certain types of chemical agents (i.e. MK 9) for certain areas.

March 2017 Recommendations:

1. Finalize Training Lesson Plans on the Use of Force requiring instruments of force are employed in a manner consistent with the manufacturer's instructions;

2. Train Employees on the revised OP 22.01 Use of Force Policy;

3. Operations and QARM continue to review use of force incidents utilizing through the automated system and take appropriate action when violations and/or issues are identified.

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

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

February 2017 SCDC Status Update:

The following language has been drafted by the SCDC and approved by the IP, amending OP-22.01 to strictly prohibit the use of restraints in the crucifix or other positions that do not conform to generally-accepted correctional standards.

> ***5.6 Placement of inmates in the crucifix position or other positions not outlined in this policy is prohibited and subject to formal corrective action up to and including termination.*** (New Section 5.6 added by Change 1 dated December 20, 2016.)

March 2017 Implementation Panel findings: SCDC has revised the OP 22.01 Use of Force Policy. There are formalized procedures for addressing administrative violations and excessive force. Policy now strictly prohibits the use of restraints in the crucifix or other positions that do not conform to generally-accepted correctional standards.

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

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

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

February 2017 SCDC Status Update:

Use of Force Review staff routinely review all uses of force uploaded the Automated Use of Force system including uses of the medical restraint chair. Although use of the medical restraint chair have implications of medical necessary and is used when the patient poses a threat of harm to himself or others, its use involves both medical and security staff; therefore, its uses will continue to be monitored.

From June 1, 2016 through February 13, 2017, there were 8 occurrences of restraint chair use. Of the eight (8), six (6, or 75%) involved inmates with a mental health classification, though one was later added to the case-load.

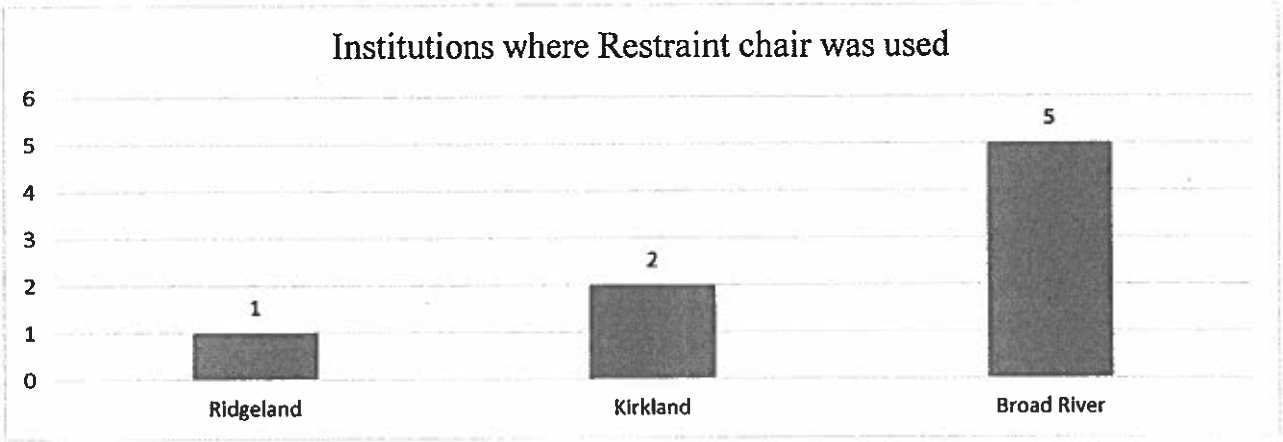
This information was cross-referenced with the Automated Medical Record and Classification Bed Reports.

The following charts and graphs provide details regarding use of the medical restraint chair.

MIN #	Date	Location	Inmate	Mental Health Status	Minutes in Chair
[redacted]	1/18/2017	RIDGELAND	[redacted]	NMH	150
	12/22/2016	KIRKLAND	[redacted]	L1	120
	12/3/2016	KIRKLAND	[redacted]	L1	120
	12/5/2016	BROAD RIVER	[redacted]	L4	56
	11/10/2016	BROAD RIVER	[redacted]	L4	240
	11/11/2016	BROAD RIVER	[redacted]	L4	120
	11/8/2016	BROAD RIVER	[redacted]	NMH	69
	9/27/2016	BROAD RIVER	[redacted]	L3	50

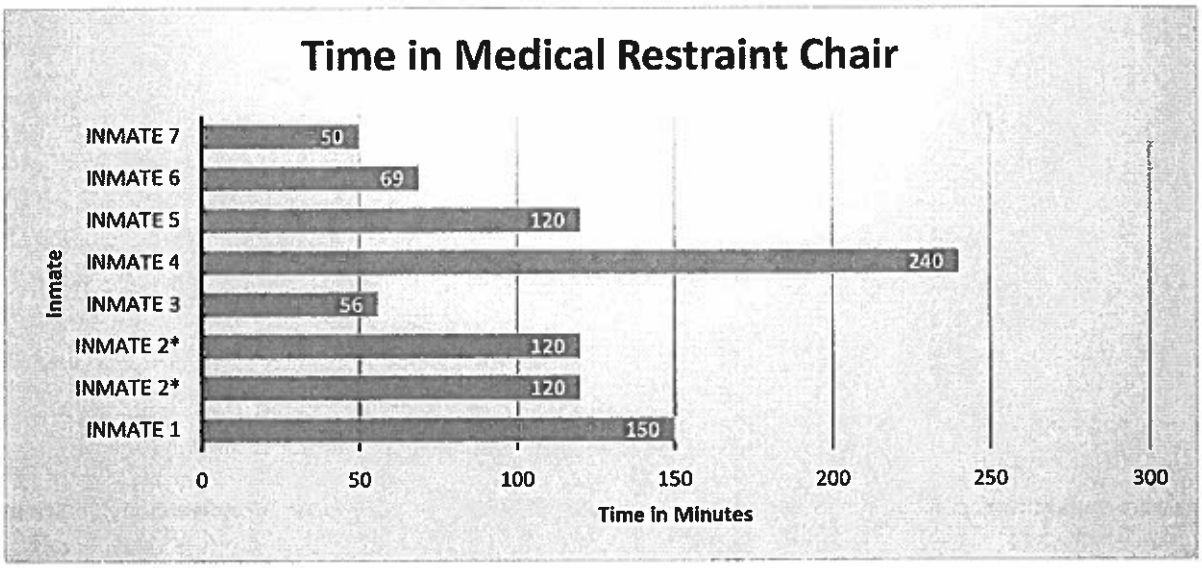
Of those included in the review, six (6, or 75%) of the eight (8) involved inmates with self-injurious behavior, and two (2, or 25%) were restrained for assaultive behavior toward staff.

Of the eight uses, five (5, or 62.5%) were at Broad River CI (BRCI) Crisis Stabilization Unit, two at Kirkland and one Ridgeland.



Data Source-AUOF System Cross Referenced with AMR

The review identified only one inmate who remained in the medical restraint chair for four hours. Documentation supports that his continued disruptive behavior supported the need for the time in the medical restraint chair.



Data Source-AUOF System

See also the E-mail in the response to component 2.c.v., below, as portion of it relates to the issue of "pre-determined" times.

March 2017 Implementation Panel findings: SCDC has made significant progress limiting the amount of time inmates remain in the restraint chair. QARM identified that Operations and Medical Staff have documented different times inmates are removed from restraint chairs. This was analyzed by QARM and perceived to be a procedure flaw that is being addressed. There were no incidents identified for failure to report use of the restraint chair. Reviewed information reveals inmates only remain in the restraint chair as long as necessary to gain control. Medical staff is being informed their orders cannot be that an inmate remain in the restraint chair for a predetermined amount of time.

March 2017 Recommendations: Provide clarification to Medical/Mental Health staff their orders cannot be that an inmate remain in the restraints for a predetermined amount of time. Operations and Medical/Mental Health staff continue to prohibit use of restraints for pre-determined periods of time and for longer than necessary to gain control. QARM continue to track and monitor compliance with use of the restraints.

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

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

February 2017 SCDC Status Update:

As noted above, the following chart shows the length of time and mental health status of inmates in the restraint chair. Please note that only the restraint chair use initiated by Security was on 1/18/17—the remaining uses were ordered by the practitioner or psychiatrist. QARM is now tracking the length of time mentally ill inmates are placed in restraints as captured in the reports above. This information is being shared with institutional leaders. It should be noted that when these uses of force were cross-referenced with the AMR (Automated Medical Record), some discrepancies were noted by QARM staff. The time in and out of the chair are not always documented by nursing staff. QARM analysts reviewed the times actually documented, and if not documented, then the time the encounter was written or signed off, as applicable, for an approximate time in the chair. The following time discrepancies were noted.

Policy OP-22.01, Use of Force and Restraints, section 13.11, states, "the restraint chair is to be used for control purposes only and will not be used for any longer than the condition warrants." This specifically addresses Security-initiated uses of the chair. For medical use of the chair, the physician's order typically indicates a maximum (or "up to") time limit for placement in the restraint chair. However, on three occasions nurses documented telephone orders for a specified number of hours, as opposed to an order recommending "up to" that a maximum number of hours.

Any discrepancies and opportunities for improved documentation were noted and shared with Health Services and the Assistant Director of Operations.

March 2017 Implementation Panel findings: It is encouraging that only seven inmates were placed in restraint chair during this monitoring period and the duration of being placed in restraints was almost always significantly less than four hours. Six of these inmates were placed in restraint chair for mental health reasons.

We discussed the need to concurrently QI the relevant policy and procedure for inmates placed in restraints for mental health purposes.

March 2017 Recommendations: as above.

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

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

February 2017 SCDC Status Update:

SCDC has drafted a proposed amendment to the, OP-22.01 Use of Force, prohibiting use of force in the absence of a reasonably perceived immediate threat. The amendment has been approved by the IP. This prohibition is being incorporated into the use-of-force training curriculum.

March 2017 Implementation Panel findings: OP 22.01 has been revised prohibiting the use of force in the absence of a reasonably perceived immediate threat. The revised Use of Force

Training Lesson Plan is in the development stage.

March 2017 Recommendations:

1. Complete the revision of the Use of Force Training Lesson Plan;
2. Schedule SCDC Staff for training on the revised Use of Force Policy;
3. All Staff complete the training for the revised Use of Force Policy;
4. Operation and QARM continue to monitor use of force incidents to ensure use of force is only when there is a reasonably perceived immediate threat.

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

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

February 2017 SCDC Status Update:

SCDC has drafted proposed amendments to the use-of-force policy, OP-22.01, prohibiting 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. The amendment has been approved by the IP. This prohibition is being incorporated into the use-of-force training curriculum.

QARM UOF reviewers have not seen any violations of this provision since the issuance of the directive on November 14, 2016. In addition, if/when applicable, RIM immediately notifies the Div. Operations if MK-9 is used in the RHU environment.

March 2017 Implementation Panel findings: OP 22.01 has been revised prohibiting 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. The revised Use of Force Training Lesson Plan is in the development stage.

March 2017 Recommendations:

1. Complete the revision of the Use of Force Training Lesson Plan;
2. Schedule SCDC Staff for training on the revised Use of Force Policy;
3. All Staff complete the training for the revised Use of Force Policy;
4. Operation and QARM continue to monitor use of force incidents to ensure crowd control canisters, such as MK-9, are not utilized in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions.

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 March 2017 Assessment: **partial compliance**

February 2017 SCDC Status Update:

The following chart shows that security staff frequently contact medical staff prior to the planned use of force, but documentation does not generally support this contact for the Clinical Counselor. Additional review shows that the counselor was present during two encounters but was not listed in the AUOF system.

These following charts and graphs demonstrate an increase from November through January in the notification of the counselor prior to the execution of a planned use of force.

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

March 2017 Recommendations: Provide training/supervision relevant to documentation specific to notification of the clinical counselors prior to a planned use of force to request assistance and the actual intervention and outcome of the intervention (e.g., was planned use of force required?).

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

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

February 2017 SCDC Status Update:

The mandatory officers training report from October 2016 – January 2017 was provided to the IP in the list of documents provided on February 13, 2017. An example of the completed training report is included below.

On January 24, 2017, a MH Lawsuit Informational Training was presented to provide staff with information on the background of the MH lawsuit and its impact on changes within the agency. 176 staff attended this informative educational session. The training also presented compliance status information and changes in policies regarding our mentally ill inmates. The following graph provides a summary of attendees.

The following graph and chart shows, by institution the number of officers currently trained as Crisis Intervention Team (CIT) Officers.

The following chart provides documentation for both uniform and non-uniform staff receiving required MH training from October 1, 201- January 31, 2017.

March 2017 Implementation Panel findings:
SCDC provides the following training to correctional officer concerning the appropriate methods of managing mentally ill inmates;

Introduction to Mental Health	1.5 hours	Orientation (all new employees)
Mental Health	2.0 hours	Basic Training
Pre-Crisis and Suicide Prevention	3.0 hours	Basic Training
Interpersonal Communications	10.0 hours	Basic Training
Communication Skills/Counseling	1.5 hours	Annual In-Service
Mental Health Lawsuit	4.2 hours	Annual In-Service
Suicide Prevention	4.0 hours	Annual In-Service
Crisis Intervention Training (CIT)	40.0 hours	Annual In-Service (Specialized Employees)

Since the November Site Assessment 1357 of the total 5403 correctional officers have received all or portions of the above training. The identity and number of correctional officers that had not received the required training on methods of managing mentally ill inmates was not provided.

March 2017 Recommendations:

QI studies are needed to identify the correctional officers that have not received the required SCDC training as it pertains to the appropriate managing of mental health offenders. Training Lesson Plans need to be developed and training provided to all correctional officers that will be assigned to the LLBMU and HLBMU Programs.

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; and

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

February 2017 SCDC Status Update:

Use of Force Review staff routinely review all uses of force uploaded the Automated Use of Force system including uses of the medical restraint chair. Although use of the medical restraint chair have implications of medical necessary and is used when the patient poses a threat of harm to himself or others, its use involves both medical and security staff; therefore, its uses will continue to be monitored.

From June 1, 2016 through February 13, 2017, there were 8 occurrences of restraint chair use. Of the eight (8), six (6, or 75%) involved inmates with a mental health classification, though one was later added to the case-load.

This information was cross-referenced with the Automated Medical Record and Classification Bed Reports.

The following charts and graphs provide details regarding use of the medical restraint chair. In addition, QARM UOF Reviewers track and report, on a monthly basis, the number of UOF incidents involving mentally ill vs non-mentally ill inmates. This report is sent to it IP UOF expert, Wardens, and Agency leadership. This report also details:

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

See Use of Force Report at the end of the document.

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

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

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

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

February 2017 SCDC Status Update:

SCDC has developed and implemented a plan to eliminate the disproportionate use of force against inmates with mental illness through creation of an automated Employee Corrective Action tracking system. This system tracks corrective actions involving staff identified to have violated the UOF policy. A monthly report is forwarded to the Operations for review.

In response to concern regarding a formalized procedure for addressing administrative violations and excessive force identified during electronic use-of-force reviews, SCDC, in conjunction with the IP, developed amendments to the Use-of-Force policy outlining a formalized process. Currently policy dictates that the IG's office is responsible for criminal and administrative investigations; however, this policy is being amended to direct criminal investigations to the IG's office. Administrative matters are directed for investigation by the Agency Director or when deemed necessary to Operations for additional review.

For more thorough reviews, SCDC increased the UOF review staff from one to three reviewers and expanded the duties for these staff. The initial responsibilities included

- reviewing, tracking, and reporting on the UOF videos uploaded to the automated system;
- and commenting on policy infractions

Additional responsibilities now include

- reviewing and tracking:
  - daily UOF MINS,
  - AMR records related to UOF,
  - UOF grievances,
- referring UOF allegations to the IG for criminal and additional administrative investigations,
- contacting institutions about discrepancies or issues in reports/videos/MINS/medical reports/grievances/allegations,
- providing guidance to institutions on the UOF policy and proper exercise of UOF,
- tracking when institutions are delinquent in uploading information about use of force into the automated system

SCDC has also developed and implemented a plan to eliminate the disproportionate use of force against inmates with mental illness through creation of an automated Employee Corrective Action tracking system. This system tracks corrective actions involving staff identified to have violated the UOF policy. A monthly report is forwarded to the Operations for review.

RIM has provided a report in the document drop that details corrective action for employees who have not violated the UOF policy.

March 2017 Implementation Panel findings: The Use of Force electronic monitoring and tracking system remains in use to monitor use of force incidents involving inmates including mentally ill inmates. Mental Health staff is electronically forwarded use of force incidents involving mentally ill inmates for review. Formalized procedures on how the use of force incidents involving mentally ill inmates are reviewed have not been completely developed. SCDC has revised the OP 22.01 Use of Force Policy and formalized procedures for addressing administrative violations and excessive force. The UOF review process has been enhanced to assist eliminate the disproportionate use of force against all inmates including mentally ill inmates. A proposed policy revision is in progress that the Inspector General will no longer routinely conduct administrative investigations. It is anticipated that the use of force incidents will require routine administrative investigation and the policy revision will potentially impact administrative investigations being conducted and completed in a timely manner.

March 2017 Recommendations:

1. Formalize the procedures for how Mental Health staff will review use of force incidents involving mentally ill inmates;

2. Ensure procedures addressing how routine administrative use of force investigations will be assigned and conducted are in place.

3. <u>Employment of a sufficient number of trained mental health professionals:</u>

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

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

February 2017 SCDC Status Update:

SCDC HR conducted a survey of average state salaries, the result of which is outlined below.

	NEW JOB CLASS/BAND/LVL.	Average Statewide	SCDC Average	Difference
Adm Assist	AA75 4/D	$32,920.00	$31,888.00	($1,032.00)
Risk Mgmt & compliance Mgr I	AF30 8/B	$81,687.00	$80,518.00	($1,169.00)
Adm Coord II - Health Serv Recruiter	**AH15 6/C**	$52,821.00	**$55,000.00**	$2,179.00
Physician Assistant	**EB35 8/C**	$90,558.00	$98,947.00	$8,389.00
Paramedic	**EC20 4/D**	$36,717.00	$38,000.00	$1,283.00
Human Serv Coord I - Activity Therapist	**GA40 4/A**	$33,809.00	**$31,315.00**	($2,494.00)
Human Serv Coord I - Mental Health Tech	**GA50 5/C**	$39,407.00	$36,137.00	($3,270.00)
Human Serv Coord I - CCC IV	**GA50 5/E**	$39,407.00	$43,881.00	$4,474.00
Human Serv Coord II - QA Monitor	**GA60 6/B**	$49,168.00	$47,822.00	($1,346.00)
Clinical Supervisor	GA70	$67,353.00	$61,823.25	($5,529.75)
Psychologist	GA80 8/E	$83,555.00	$83,041.00	($514.00)
Licensed Practical Nurse	**EA10 4/C**	$31,936.00	$31,901.00	($35.00)
Registered Nurse	**EA20 6/A**	$47,512.00	$48,491.00	$979.00
Psychiatrist	UB26	$180,632.00	$215,104.00	$34,472.00
Physician	**UB27**	$145,512.00	$145,551.00	$39.00
		$1,052,401.00	$1,093,300.25	$40,899.25

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

March 2017 Recommendations: See 2.a.iv.

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

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

February 2017 SCDC Status Update:

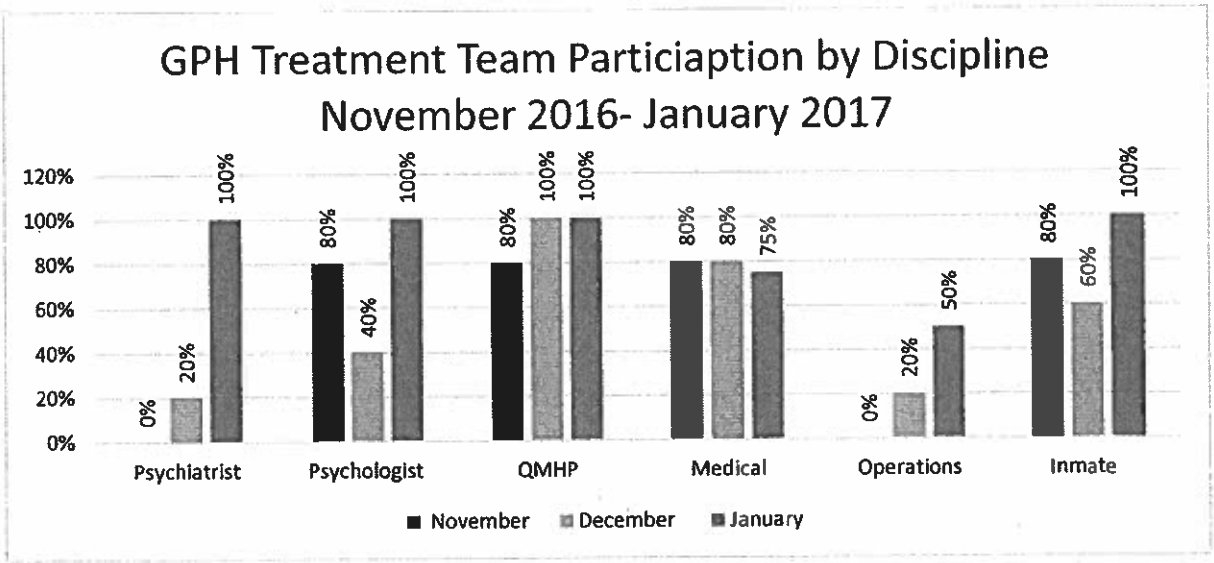
Weekly participation rates could not be calculated, as the number of expected participant could not be determined based on documentation provided (below). As a result, the rates of participation by month, by discipline is calculated based on any level of participation by discipline. A graph will be provided during the IP visit in February.

Lee CI- Dr. [redacted] attends Psychiatrist x 2 month since 1/27/11. Dr. [redacted] has signed Treatment Plans and Treatment Team Logs. The Treatment Team Tracking form is utilized.

Camille CI- Dr. [redacted] attends Treatment Team weekly since 1/26/17. Dr. [redacted] has signed Tx. Logs. Dr. [redacted] has not signed Tx. Plans. This will be corrected. The Treatment Tracking form is utilized. Treatment Team meetings change to Thursdays.

GPH- Treatment Teams are held x2 weekly. Dr. [redacted] attends on Wednesdays and Dr [redacted] attends on Thursdays. The Tx. Plans and Tx. Team Log Sheets are signed. The Treatment Plan Tracking Sheet is utilized.
ICS- Dr. [redacted] attends Treatment Team weekly. Treatment Plans, Treatment Logs are signed. The Treatment Plan Tracking sheets are being utilized.
SIB- Treatment teams are held weekly since 7/13/14 and Dr. [redacted] is present. Tx. Plan and Logs are signed.
CSU- Treatment teams are held weekly since 3/22/16 with a Psychologist. No Psychiatrist is present. Dr. [redacted] is developing a plan for Psychiatry to be present.
LLMBU- Treatment teams are held weekly since the inception of the program in December 2016 with a Psychiatrist present.

Summary:
Treatment Teams have been initiated with Psychiatry present with exception of CSU. The Treatment Team Logs, Treatment Plans and Treatment Tracking form are being utilized.



March 2017 Implementation Panel findings: Significant improvement has occurred relative to the participation of psychiatrists in the treatment team process for the higher levels of mental healthcare. Issues clearly remain due to the significant psychiatrists vacancies (e.g., psychiatrists attending treatment team meetings and/or signing treatment team plans for inmates who are not under their direct care although such a practice is better than having no psychiatric involvement).

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

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

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

February 2017 SCDC Status Update:

SCDC has completed the training module for the General Provisions MH policy explaining the different MH levels of care. This online training will be required of all clinical staff. This training is scheduled to begin March 2017. The following screenshots capture a sample of the content to be covered during the Mental Health General Provisions training.

All MH staff are required to complete one week of orientation at the Training Academy and full time staff complete 4 week BASIC.

March 2017 Implementation Panel findings: The newly completed training module is online training that takes about two hours to complete. The percentage of mental health staff that have completed the four week module was reported to be 51%

March 2017 Recommendations: Provide the required training for mental health staff that have not completed the training.

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

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

February 2017 SCDC Status Update:

SCDC hired a recruiter for Health Services on 9/12/16. HR conducted a survey of average state salaries with results outlined below. Based on the results of the study, HR will post positions with increased salaries to those of the state averages.

Discipline	Vacancy Rate
Nursing -RN	
Mental Health	38%
Non-security	
Security	

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

March 2017 Recommendations: See 2.a.iv.

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

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

February 2017 SCDC Status Update:

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

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

The following document outlines current licensure prior to 2013, new staff with licensure hired as of 2013, existing staff with licensure obtained since 2015 and the percentage of licensed staff. Based on the provisions outlined in policy, 39/41 or 95% are appropriately licensed.

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

March 2017 Recommendations: Continue to monitor.

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

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

February 2017 SCDC Status Update:

According to Policy 3.3.10 Improvement Action Plan: The CQM Director and the reestablishment of the internal role of the Mental Health Services Quality Management will allow Individual and System Improvement Action Plans to occur. No corrective action plans were reported for 2016.

No Internal Audits MH audits have been conducted from November 2016- February 2017.

In the absence of a Divisional Quality Assurance Manager, this task has been delegated to Clinical Supervisors.

Lee CI- Reported one staff failed 90 Day Review last year. Staff was given counseling and corrective action plan with progression to one-day Suspension with review from Human Resources. Follow up review is scheduled within six months.
Camille CI- No 90 Day New Hire Reviews Reported. One formal Audit in 12/2017. Staff will be trained on how to conduct these reviews and documentation that is required.
GPH -No 90 Day Hire Reports. Staff will be trained on how to conduct these reviews and documentation that is required.
ICS- No 90 Day Hire Reports. Staff will be trained on how to conduct these reviews and documentation that is required.
SIB- No new hires for 2016.
CSU- No 90 Day New Hire Reviews completed. Staff will be trained on how to conduct these reviews and documentation that is required.

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

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

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

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

February 2017 SCDC Status Update:

The Role of the Mental Health Services Quality Management will be reestablished within the Division of Mental Health with the hiring of an internal QA manager to provide more direct Mental Health internal audits and feedback. Once filled, this position will enable the Division to properly conduct internal audits.

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

March 2017 Recommendations: As above.

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

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

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

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

February 2017 SCDC Status Update:

This "Medical Personnel Report" is produced weekly by RIM [redacted]. The detailed report was provided in the document drop for Dr. Patterson in folders 7 and 8. The following screenshot provides a snapshot of the detailed report included in the aforementioned folders.

March 2017 Implementation Panel findings: as above

March 2017 Recommendations: Provide detailed RIM reports prior to each site visit.

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

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

February 2017 SCDC Status Update:

Each QMHP maintains a list of inmates on their caseloads transferred to inpatient care. Information tracked in these databases include:

- NAME
- SCDC#
- Max Out Date
- Mental Health Class
- Diagnosis
- Last Session Held Date
- Next Session Due Date
- Last Psych Clinic Date (Write next due date on calendar)
- Current Psych Medications
- Current Psych Medications
- Current Psych Medications
- Current Psych Medications
- Current Psych Medications
- If TX Plan (hard copy in Medical Record)
- Next Tx. Plan Due Date
- If enrolled in Structured Activity Specify work or name of group(s)
- Current Psychiatrist
- Assigned QMHP
- Additional Psych Medications

RIM generates a weekly Mental Health Caseload list to include

- Mental Health Classification
- Institution
- Dorm
- Inmate Name
- SCDC Number
- Cell
- Bunk

The Mental Health Caseload in February 6, 2017 included 3,372 inmates, with MH classifications:

- BL
- L1
- L2
- L3
- L4
- L5
- LC
- MR

March 2017 Implementation Panel findings: SCDC was able to produce reports consistent with this provision relevant to male ICS inmates but not to inmates transferred to GPH or contractual provider.

March 2017 Recommendations: develop and demonstrate the capacity to track the number and timeliness of inmates being transferred to GPH, contractual providers and ICS programs.

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

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

February 2017 SCDC Status Update:

Cell checks and segregation logs are collected and maintained onsite per SCDC's Agency Records Management Policy, OP 21.10

QARM Analysts conducts audits of the cell-check logs during RHU Audits including audits of irregular cell checks at no more than 30- and 15- minute intervals

March 2017 Implementation Panel findings: As above.

March 2017 Recommendations: continue to monitor.

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

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

February 2017 SCDC Status Update:

- Clinical encounter data is available in the AMR (with additional information in the paper chart at GPH). New encounter types have been created that will better account for the type of care provided in each encounter. Staff is currently scheduled for training on the new encounters.
- The new Electronic Medical Record (EMR) is scheduled to go live at the two women's institutions at the end of March, 2017, and at the men's institutions by the end of August, 2017.
- Activity and cell check logs remain on paper and are addressed in 4.a.iii., but RIM is working to create an automated system.

March 2017 Implementation Panel findings: The EHR and the planned web based management information system should facilitate compliance with this provision. During the afternoon of March 2, 2017 we were provided with a demonstration of the web based management information system. We were extremely impressed with the improvements made in the system and type of data that can be mined from it.

March 2017 Recommendations: Continue to improve the web based management information system and implement the EMR as planned.

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

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

February 2017 SCDC Status Update:

Use of Force web application;

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

March 2017 Implementation Panel findings: No issues were identified with the use of force data since the November 16 site assessment. SCDC Policy OP 22.01 addresses the retention of recordings.

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

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

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

February 2017 SCDC Status Update:

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

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

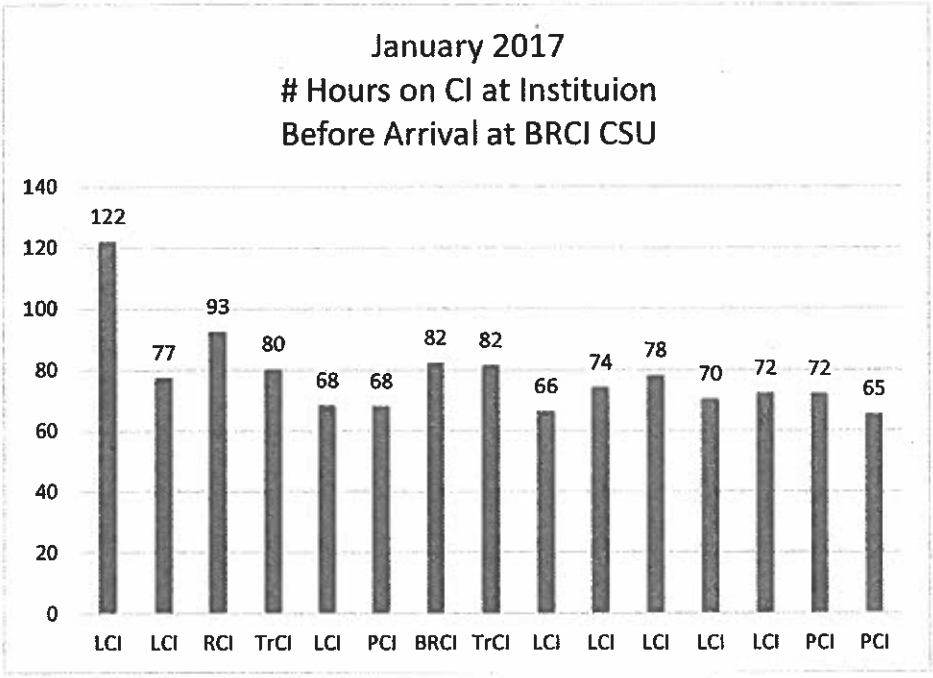
March 2017 Recommendations: Continue to produce and disseminate the monthly UOF Mentally Ill vs. Non-Mentally Ill Report.

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

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

February 2017 SCDC Status Update:

- "CY CISP Admissions" report produced quarterly by RIM [redacted] shows if an inmate stays in a CI cell in an outlying institution longer than the 60 hours allowed to have him transferred to BRCI CSU.



- RIM produces and distributes the weekly report, "Total length of stay in Segregation".

March 2017 Implementation Panel findings: SCDC was able to produce reports consistent with this provision.

March 2017 Recommendations: none

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

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

February 2017 SCDC Status Update:

- "Weekly Lockup by Custody and Mental Health Classification" produced weekly by RIM (Erin Ferencik).
- QARM Analyst provide a detailed report on inmates in segregation by institution, custody and mental health classification. This monthly report is shared with institutional and agency leaders.
- A Summary of the report can be accessed in attachment one.

March 2017 Implementation Panel findings: As per SCDC update.

March 2017 Recommendations: none

4.a.ix. Quality management documents; and

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

February 2017 SCDC Status Update:

- Quality management documents, including reports, audit tools, audits, and other forms of documentation are currently available in shared network folders. Access to each folder is managed by system administrators through the IT Access Request menu. This allows for central storage of documentation for access across divisions and institutions.
- Other documents will be readily available when the EHR is implemented.

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

March 2017 Recommendations: Continue to develop the QI process.

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

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

February 2017 SCDC Status Update:

- Medical records stored in AMR, paper record, or both (see 4.a.iv.). Transition to new EMR is ongoing. See below:

SCDC Electronic Medical Record Implementation – UPDATE
Preparation and planning for end user training is currently underway. Training for our pilot site end users is scheduled to begin 2/27/17 with a pilot site go-live date of 3/28/17 at our two female institutions. Training for remaining end users is scheduled to take place throughout May and June, 2017 with staggered go-lives scheduled at the 20 remaining institutions in June/July/August of 2017.

Please consult the project plan timeline summary below for more information.

Complete

Task:	Date(s) Completed
Project Plan approved	8/12/16
Configuration of secure VPN for encrypted network connection	7/29/16
Provisioning of hosted application and database server farms; All software installed	8/12/16
System Configuration Training	8/30/16-9/1/16

Site Visit Observations and Gap Analysis	8/23-25/16 and 9/20-21/16

Remaining Timeline

Task:	Start	End
Interface Build and Testing	8/26/16	3/17/17
Template and Report Design	10/3/16	2/24/17
Design of Training Plans and Preparing Database for Training	1/25/17	2/17/17
Pilot End User Training	2/27/17	3/17/17
Pilot Go Live	3/28/17	--
Rollout End User Training	5/8/17	6/9/17
Rollout Go Live (specific schedule of facilities TBD)	6/27/17	8/11/17

- Medication administration records currently on paper and quality improvement is currently being addressed by component number 5. Medication administration records will become electronic when transitioned to the new EMR.
- Disciplinary records are stored and accessible for review and reporting on our mainframe Offender Management System.

March 2017 Implementation Panel findings: The EHR and the planned web based management information system should facilitate compliance with this provision.

March 2017 Recommendations: Implement EHR and continue to improve the web based management information system.

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

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

February 2017 SCDC Status Update:

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

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

March 2017 Recommendations: Implement the EMR as planned.

5. <u>Administration of psychotropic medication only with appropriate supervision and periodic evaluation:</u>

5.a. Improve the quality of MAR documentation;

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

February 2017 SCDC Status Update:

1. The pill line nurse will document that an ordered medication has been administered at the time of the delivery.
2. The pill line nurse will review each MAR to ensure that all documentation has been completed, to include appropriate documentation for any inmate that filed to show up for their scheduled dose.
3. The HCA will monitor to ensure that order transcription is completed correctly and MAR documentation is correct.
4. The HCA will ensure that all new staff are trained and demonstrate comprehension in the MAR documentation procedure and annual reviews are completed.
5. The HCA will complete weekly MAR audits to ensure that staff are documenting appropriately.
6. The HCA will address any deficiencies with the nursing staff involved and take corrective action when necessary.

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

March 2017 Recommendations: Provide QI reports regarding the above referenced orders for the next site assessment.

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

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

February 2017 SCDC Status Update:

1. Nursing will complete weekly MAR reviews to monitor the compliance of the inmate, and report any concerns to the Mental Health/Medical Provider.
2. The Mental Health Provider will review the MAR(s) of each inmate when seen in the provider's clinic or when a medication concern is addressed.
3. The Regional Mental Health Supervisor will review monitoring documentation and will address any deficiencies and take/recommend corrective action when necessary.

4. The QMHP or Provider will review any nursing concerns with the HCA when necessary.

March 2017 Implementation Panel findings: See 5.a.

March 2017 Recommendations: See 5.a.

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

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

February 2017 SCDC Status Update:

1. This will be a difficult to establish an "agency wide" pill line time as each institution is unique and have different control movement schedules.
2. An "agency wide" pill line times would be a decision that would need to involve the Director of Operations as any set pill line time would require the cooperation of the institutional Warden and security staff.
3. If a four time a day pill line is required then inmates that require medication after daily nursing hours will need to be assigned to a 24 hour medical unit. This will require more staff to complete the pill line passes. This would double the current pill line times so the pill line staff would need to double to accommodate the increase.

1a. Mental Health Providers will review each inmate care plan and only order TID, QID and HS medication when absolutely necessary to achieve treatment goal.
2a. The HCA will schedule appropriate staff to cover pill lines as directed.
3a. Wardens will ensure that the nursing staff have the appropriate security escorts and all housing units are secured during pill pass times and security presents will be provided outside each pill line at the scheduled time and remain until pill line/pass is completed.

March 2017 Implementation Panel findings: As per SCDC status update, which indicates the timing of the pill call lines have been reviewed by institution.

March 2017 Recommendations: We discussed with staff issues specific to the timing of HS medications, which needs to be administered after 8 PM. Implement this recommendation.

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

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

February 2017 SCDC Status Update:

1. The HCA will complete weekly MAR audits and review concerns with nursing staff.
2. Nursing will complete weekly MAR reviews and review compliance with the Provider.

3. The Mental Health Provider will complete MAR reviews during the inmates clinic visit and review compliance with the inmate.
4. The Regional Mental health Supervisor will review monitoring documentation at least quarterly.
5. The regional Nurse Manager will complete MAR audits at least quarterly and review with the HCA.
6. Corrective action will be taken by the appropriate authority when necessary.
7. MAR audits will be completed: Weekly by the Institution Supervising Staff and Quarterly by the Regional Management Staff.
8. A standardized audit tool will be used to ensure all requirements are reviewed.

March 2017 Implementation Panel findings: See 5.a.

March 2017 Recommendations: See 5.a.

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

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

Implementation Panel March 2017 Assessment: partial compliance

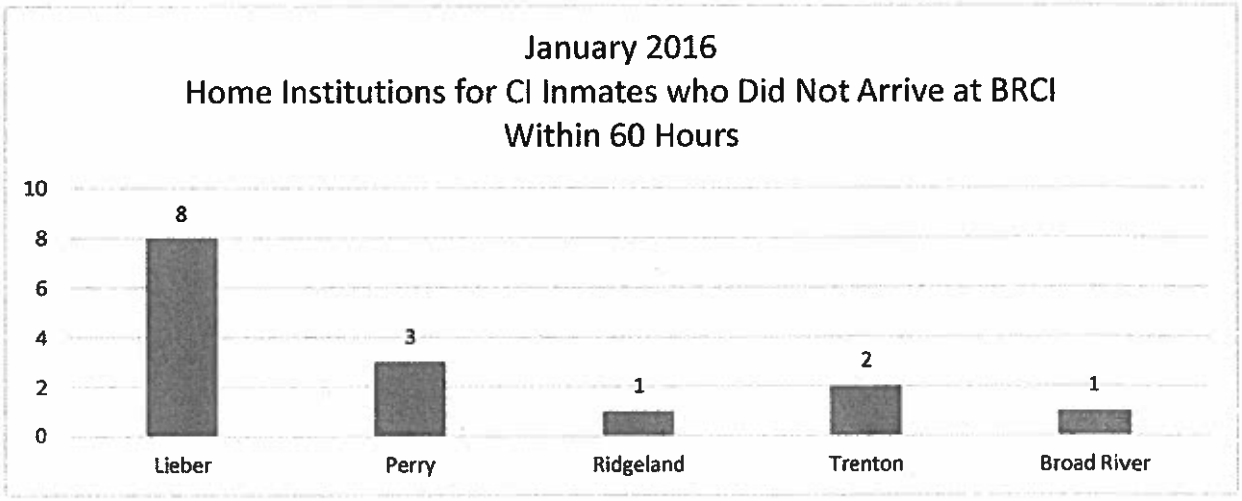
February 2017 SCDC Status Update:

This is a response to the IP's findings as follows from the subcomponent: Provide access for segregated inmates to higher levels of mental health services when needed;

"The "60-hours holding crisis" cells in the Broad River CI RHU, the R&E (Unit F-1), the Perry CI RHU, and the Lee CI RHU were not suicide resistant. The crisis cells at the Broad River RHU did not have beds. It was our understanding that the CSU at the Broad River CI will no longer be a pilot project beginning November 7, 2016."

Renovations have been completed for CI cells at Broad River Correctional Institution, Kirkland Corrections F-1 dorm and BMU. Additional renovations have been made on other Crisis cells and are outlined below.

RIM began a report of all inmates on CI/SP to monitor if it took longer than 60 hours to be transferred to BRCI CSU. The report is sent to the Div. Dir. of Mental Health Services. In January there were 14 cases where an inmate remained at an institution beyond the limit. The following graphs reflect the number of hours on CI at the outlying institutions before arrival at CSU and a comparison of which institutions held the CI inmates beyond the 60-hour limit.



Crisis Intervention Cells		Updates
Institutions	# of Cells	Location
Allendale Correctional Institution	4	RHU three cells complete awaiting one cell door
Broad River Correctional Institution	4	Complete
Camille Graham Correctional Institution	4	CRU 4 Cells need beds replaced with crisis safe beds
Evans Correctional Institution	3	Infirmary & RHU Complete awaiting sprinkler heads which are on order
Kershaw	4	RHU & Medical Complete awaiting sprinkler heads which are on order
Kirkland Correctional Institution	19	F-1 & BMU Complete
Leath Correctional Institution	4	Phoenix – A Side Complete awaiting Sprinkler heads which are on order
Lee Correctional Institution	4	RHU – North Door hinge covers are being modified and sprinkler heads are on order.
Lieber Correctional Institution	4	RHU Cell doors have been sent to the Sheet Medal Shop for modifications. Sprinkler heads need to be replaced which are on order
McCormick Correctional Institution	2	RHU – B Wing Complete awaiting sprinkler heads which are on order
Perry Correctional Institution	6	RHU – B Dorm, Z Wing cells need painting and sprinkler heads replaced Painting should be complete by Friday February 10, 2017. Sprinkler heads ordered
Ridgeland Correctional Institution	2	RHU – South cell doors to be sent to the Sheet Metal Shop for renovations. Sprinkler heads to be replaced which are on order

Trenton Correctional Institution	1	RHU Complete waiting on sprinkler heads which are on order
Tuberville Correctional Institution	4	RHU – Murray 3 cell doors being modified,(2) complete at the sheet metal shop awaiting pick up. Sprinkler heads ordered
Tyger River Correctional Institution	2	RHU – East awaiting beds and sprinkler heads
Wateree River Correctional Institution	2	RHU Complete awaiting sprinkler heads which are on order

March 2017 Implementation Panel findings: CI cells in several institutions had not been approved by mental health and/or were not suicide resistant as discussed on site. All CSU CI cells are now located in a healthcare setting. However the CGCI CSU will not open until April 2017.

March 2017 Recommendations: Complete the above referenced renovations.

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

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

A QI needs to be performed re: relevant elements of the suicide prevention program.

February 2017 SCDC Status Update:

SCDC Policy OP-22.38 states:

> **14.1** Inmates will be housed in an appropriate RHU cell. SCDC prohibits the use of alternative space such as shower stalls, recreation cages, holding cells and interview booths for any purpose other than what they have created for. Inmates placed in Crisis Intervention status will be placed in a cell designated to house inmates in this status.

In all the CI cell check logs audited by QARM from Allendale, Evans, Kershaw, Lieber, Lee, Camille, Manning, Broad River, and Tyger River, only one (1) of the Fifteen-Minute Observation Logs provided to the auditors listed the inmate as being in a holding cell. In this case, the inmate was in the holding cell at Lieber for 15 hours. This was reported in January by QARM to the Warden, Regional Directors, Assistant Deputy Director, and Deputy Director for Operations. During that 15 hours in the holding cell, there was one 150- and one 180-minute period with no documentation of the inmate being checked on. And according to officials at Lieber, none of the CI inmates had continuous observation.

The following is a sample of the audit tool used by QARM to review the 15-minute observation log on the inmate who was in the holding cell.

March 2017 Implementation Panel findings: As per SCDC status update. Partial compliance was found due to the combination of the use of two holding cells for suicide watch purposes at CGCI and Lieber CI and noncompliance with the documentation that the inmates were being checked on as required by policy and procedure.

March 2017 Recommendations: continue to monitor and train staff.

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

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

February 2017 SCDC Status Update:

QARM has conducted reviews of the cell check logs at Allendale, Evans, Kershaw, Lieber, Lee, Camille, Manning, and Tyger River RHU's, and Broad River CSU.

At BRCI CSU, the practice of continuous observation continues.

Allendale's security staff has stated that they have been performing continuous observation from the time the crisis is identified until the inmate is seen by the QMHP. However, their documentation did not differentiate continuous and the non-continuous 15-minute cell checks.

At KCI's SIB unit, QARM staff was told that continuous observation is practiced, but no audit of documentation has been completed at this time. In KCI's F1 unit, QARM staff saw an officer was performing continuous observation. However, the form he used was the same form as the Security staff use for the irregular 15-minute cell checks, and no distinction was made to differentiate continuous vs the non-continuous 15-minute cell checks.

The other institutions admitted they were not performing continuous watch—only documenting 15-minute cell checks. The audits of these cell check logs failed compliance at all institutions.

On January 24, 2016, about 175 wardens and other institutional managers, both security and mental health, medical, and other non-security staff, attended training that included the need and procedures for continuous observation. Since then, the number of inmates transferred to CSU has increased dramatically, based on staffing patterns in the outlying institutions.

In early February, new forms were created by the Div. of Operations to document the continuous watch by employees and by inmate watchers. This distinguishes that type of watch from the irregular security checks at no more than 15-minute intervals.

[redacted] Deputy Director for Operations recently met with QARM on February 6 and 13, 2016, and reviewed some of the deficiencies found with the cell check logs. He has requested that Resource and Information Management (RIM), SCDC's IT department make the developing of an electronic system a priority. This e-mail updates the response from the Division Director for RIM.

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

March 2017 Recommendations: Continue to monitor, supervise and train staff relevant to the specific suicide prevention policy.

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

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

February 2017 SCDC Status Update: QARM audits show that this is the general practice; however, there is no quantifiable documentation provided. This is frequently documented in the AMR notes, as in these examples.

At McCormick, the officers have been using the following form to document the issuing and cleaning of CI blankets, but this is not done state-wide.

QARM staff asked if the web application for automating cell checks, mentioned in the e-mail in component c. above, will be capable of including the issuing of clean linens, CI smocks, and mattresses. The reply was that this is a possibility.

March 2017 Implementation Panel findings: As per SCDC status update. We discussed with staff various ways of auditing this provision that included obtaining information directly from inmates as well as inspecting the storage rooms that contain suicide resistant clothing, blankets and mattresses for inmates in CI.

March 2017 Recommendations: As above.

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

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

November 2016 Implementation Panel findings: A QI needs to be performed regarding relevant elements of the suicide prevention program.

February 2017 SCDC Status Update:

A report of showers will be provided during the IP visit.

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

March 2017 Recommendations: Correct the above.

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

Implementation Panel March 2017 Assessment: **noncompliance**

February 2017 SCDC Status Update:

This is in practice at BRCI CSU, although challenges still exist with the number of security staff needed to support the activities required. (See the e-mail below from Dr. [redacted]) Until staffing improves so that inmates can be transferred from their cells to a confidential area, many CI assessments continue to be cell-front.

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

March 2017 Recommendations: remedy the above.

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

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

February 2017 SCDC Status Update:

On December 19, 2016, SCDC initiated a process requiring that officers conduct temperature and cleanliness checks twice per day in the segregated areas. Thermometers were provided for each RHU. The logs documenting these checks have been uploaded to the SCDC shared drive for staff access.

After site visits to the RHUs QARM noticed that cell checks were not standardized, in that officers were checking temperatures on different focal points within the cell (wall, window, bedframe, through glass, etc.) which may have led to wide variations the final readings. As a result, Operations has refined parameters for temperature and cleanliness checks. (See the e-mails below.)

QARM also reviewed some of the documentation and provided verbal feedback to Operations that when deficiencies are noted, there should be a way to ensure issues are corrected. Specifically,

when the cells has been documented as "Not Clean", the officer should indicate what factors determined uncleanliness and documentation that the problem was corrected.

Currently, no additional studies have been conducted to evaluate the results of the temperature and cleanliness checks. An example of the form used to document the temperature and cell cleanliness is captured below.

March 2017 Implementation Panel findings: The above process specific to RHU will be implemented in the CSU.

March 2017 Recommendations: As above.

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

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

February 2017 SCDC Status Update:

QARM has drafted a policy to establish and maintain a system of quality assurance to ensure the sustainability of organizational goals and objectives. This policy establishes a Continuous Quality Improvement Review Committee (CQIRC) to review data related to inmate safety and security, analyze operational performance, identify deficiencies, recommend corrective actions, and ensure compliance on an ongoing basis. The policy is currently being placed in draft form through the Office of Policy Development. The target date for implementation of this new policy is April 2017.

March 2017 Implementation Panel findings:

During the afternoon of February 28, 2017, we observed a treatment team meeting at the Broad River CSU, which was attended by the treatment team except for a psychiatrist. Most of the psychiatric time is provided by several tele-psychiatrists with onsite psychiatry being provided by a psychiatrist on weekends. Female psychiatrists at Broad River have not provided onsite coverage to the CSU due to their safety concerns about walking through the yards to the CSU.
Staff confirmed difficulties in seeing inmates in a confidential setting primarily related to custody staffing issues.

Some of the inmates reviewed during the treatment team meeting were interviewed as part of the treatment planning process.

March 2017 Recommendations:

1. Psychiatric coverage predominantly by telepsychiatry is better than no psychiatric coverage, but is very problematic. It can be, in part, remedied by working with custody staff to make it safe for female psychiatrists to walk or ride to the CSU.
2. Clinical interventions/assessments conducted in a non-confidential setting is not adequate. This issue needs to be remedied.
3. A QI needs to be performed regarding relevant elements of the suicide prevention program.

Conclusions and Recommendations:

The IP has provided its recommendations on specific items in the Settlement Agreement in this report and while on-site. We have also provided suggestions to SCDC to continue in their pursuit of development of their own internal processes and support systems for an adequate mental health services delivery system and quality management system. This report reflects the IP's findings and recommendations as of March 3, 2017. The IP is hopeful that this report has been informative. We look forward to further development of the mental health services delivery system within the South Carolina Department of Corrections and appreciate the cooperation of all parties in the pursuit of adequate mental health care for inmates living in SCDC.

Sincerely,

Raymond F. Patterson, MD
Implementation Panel Member

On behalf of himself and:

Emmitt Sparkman
Implementation Panel Member

Jeffrey Metzner, MD
Subject Matter Expert

Tammie M. Pope
Implementation Panel Coordinator

MEDIATOR REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES
MARCH 2017 IP ASSESSMENT

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
1.	**The development of a systematic program for screening and evaluating inmates to more accurately identify those in need of mental health care:**			
	a. Develop and implement screening parameters and modalities that will more accurately diagnose serious mental illness among incoming inmates at R&E with the stated goal of referring inmates to the appropriate treatment programs. Accurately determine and track the percentage of the SCDC population that is mentally ill.	HS 19.10	3/3/17 Partial compliance	3/3/17 Partial Compliance
		HS 19.07	3/3/17 Partial compliance	3/3/17 Partial Compliance
	b. The implementation of a formal quality management program under which mental health screening practices are reviewed and deficiencies identified and corrected in ongoing SCDC audits of R&E counselors;	HS 19.07	3/3/17 Partial compliance	3/3/17 Partial Compliance
	c. Enforcement of SCDC policies relating to the timeliness of assessment and treatment once an incoming inmate at R&E is determined to be mentally ill; and	HS 19.07 HS 19.10	3/3/17 Partial compliance	3/3/17 Partial Compliance
	d. Development of a program that regularly assesses inmates within the general population for evidence of developing mental illness and provides timely access to mental health care.	HS 19.07 HS 19.10	3/3/17 Partial compliance	3/3/17 Partial Compliance

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

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
2.	**The development of a comprehensive mental health treatment program that prohibits inappropriate segregation of inmates in mental health crisis, generally requires improved treatment of mentally ill inmates. and substantially improves/increases mental health care facilities within SCDC:**			
	a. Access to Higher Levels of Care:			
	i. Significantly increase the number of Area Mental Health inmates vis-a-vis outpatient mental health inmates and provide sufficient facilities therefore;	HS 19.04 HS 19.11	3/3/17 Noncompliance	3/3/17 Noncompliance
	ii. Significantly increase the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefore;[2]	HS 19.04, HS 19.07, HS 19.11	3/3/17 Noncompliance	3/3/17 Noncompliance
	iii. Significantly increase the number of male and female inmates receiving inpatient psychiatric services, requiring the substantial renovation and upgrade of Gilliam Psychiatric Hospital, or its demolition for construction of a new facility;	HS 19.04, HS 19.07 HS 19.09	3/3/17 Partial compliance	3/3/17 Partial Compliance
		Gilliam Construction Plan	3/3/17 Partial compliance	3/3/17 Partial Compliance
	iv. Significantly increase clinical staffing at all levels to provide more mental health services at all levels of care; and	Hiring Plan attached as Exhibit E to the Settlement Agreement	3/3/17 Partial compliance	3/3/17 Partial Compliance
	v. The implementation of a formal quality management program under which denial of access to higher levels of mental health care is reviewed.	HS 19.07	3/3/17 Partial compliance	3/3/17 Partial Compliance
	b. Segregation:			
	i. Provide access for segregated inmates to group and individual			

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

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	therapy services;			
		OP RHU Policy _22.38 Section 3.23 H.S. 19.04	3/3/17 Partial compliance	3/3/17 Partial Compliance
	ii. Provide more out-of-cell time for segregated mentally ill inmates;	HS 19.12 OP RHU Policy 22.38 Section 3.14.4 & Section 3.25	3/3/17 Noncompliance	3/3/17 Noncompliance
	iii. Document timeliness of sessions for segregated inmates with psychiatrists, psychiatric nurse practitioners, and mental health counselors and timely review of such documentation;	HS 19.04 OP RHU Policy 22.38 Section 3.15	3/3/17 Partial compliance	3/3/17 Partial Compliance
	iv. Provide access for segregated inmates to higher levels of mental health services when needed;	HS 19.04 HS 19.06	3/3/17 Partial compliance	3/3/17 Partial Compliance
	v. The collection of data and issuance of quarterly reports identifying the percentage of mentally ill and non-mentally ill inmates in segregation compared to the percentage of each group in the total prison population with the stated goal of substantially decreasing segregation of mentally ill inmates and substantially decreasing the average length of stay in segregation for mentally ill inmates;	HS 19.07 OP RHU Policy 22.38 Section 1 and Section 2	3/3/17 Substantial compliance (11/16)	3/3/17 Substantial compliance (11/16)
	vi. Undertake significant, documented improvement in the cleanliness and temperature of segregation cells; and	To be determined	3/3/17 Partial compliance	3/3/17 Partial Compliance
	vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.	HS 19.07	3/3/17 Noncompliance	3/3/17 Noncompliance
	c. Use of Force:			
	i. Development and implementation of a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness;	OP 22.01 HS 19.08	3/3/17 Partial compliance	3/3/17 Partial Compliance
	ii. The plan will further require that all instruments of force, (e.g., chemical agents and restraint chairs) be employed in a manner fully consistent with manufacturer's instructions, and track such use in a way to enforce such compliance;	OP 22.01 HS 19.08	3/3/17 Partial compliance	3/3/17 Partial Compliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	iii. Prohibit the use of restraints in the crucifix or other positions that do not conform to generally accepted correctional standards and enforce compliance;	OP 22.01 HS 19.08	3/3/17 Substantial compliance	3/3/17 Substantial compliance
	iv. Prohibit use of restraints for pre-determined periods of time and for longer than necessary to gain control, and track such use to enforce compliance;	OP 22.01 HS 19.08	3/3/17 Partial compliance	3/3/173/3/17 Partial compliance
	v. The collection of data and issuance of quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs;	HS 19.07 OP Use of Force 22.01 Section 13	3/3/17 Partial compliance	3/3/17 Partial Compliance
	vi. Prohibit the use of force in the absence of a reasonably perceived immediate threat;	OP 22.01 HS 19.08	3/3/17 Partial compliance	3/3/17 Partial Compliance
	vii. Prohibit the use of crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions;	OP 22.01 HS 19.08	3/3/17 Partial compliance	3/3/17 Partial Compliance
	viii. Notification to clinical counselors prior to the planned use of force to request assistance in avoiding the necessity of such force and managing the conduct of inmates with mental illness;	OP 22.01 HS 19.08	3/3/17 Partial compliance	3/3/17 Partial Compliance
	ix. Develop a mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates;	OP 22.01 ADM 17.01 Employee Training Standards, SCDC Annual Training Plan HS 19.08	3/3/17 Partial compliance	3/3/17 Partial Compliance
	x. Collection of data and issuance of quarterly reports concerning the use-of-force incidents against mentally ill and non-mentally ill inmates; and	OP 22.01 HS 19.07	3/3/17 Substantial compliance	3/3/17 Substantial compliance
	xi. The development of a formal quality management program under which use-of-force incidents involving mentally ill inmates are reviewed.	OP 22.01 HS 19.07	3/3/17 Partial compliance	3/3/17 Partial Compliance
3.	**Employment of a sufficient number of trained mental health Professionals:**			

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	a. Increase clinical staffing ratios at all levels to be more consistent with guidelines recommended by the American Psychiatric Association, the American Correctional Association, and/or the court-appointed monitor;	Hiring Plan attached as Exhibit E to the Settlement Agreement	3/3/17 Partial compliance	3/3/17 Partial Compliance
	b. Increase the involvement of appropriate SCDC mental health clinicians in treatment planning and treatment teams;	HS 19.05	3/3/17 Partial compliance	3/3/17 Partial Compliance
	c. Develop a training plan to give SCDC mental health clinicians a thorough understanding of all aspects of the SCDC mental health system, including but not limited to levels of care, mental health classifications, and conditions of confinement for caseload inmates;	Mental Health Training Policy Addendum	3/3/17 Partial compliance	3/3/17 Partial Compliance
	d. Develop a plan to decrease vacancy rates of clinical staff positions which may include the hiring of a recruiter, increase in pay grades to more competitive rates, and decreased workloads;	Hiring Plan attached as Exhibit E to the Settlement Agreement	3/3/17 Partial compliance	3/3/17 Partial Compliance
	e. Require appropriate credentialing of mental health counselors;	HS 19.04	3/3/17 Substantial compliance	3/3/17 Substantial compliance
	f. Develop a remedial program with provisions for dismissal of clinical staff who repetitively fail audits; and	HS 19.07	3/3/17 Partial compliance	3/3/17 Partial Compliance
	g. Implement a formal quality management program under which clinical staff is reviewed.	HS 19.07	3/3/17 Partial compliance	3/3/17 Partial Compliance
4.	**Maintenance of accurate, complete, and confidential mental health treatment records:**			
	a. Develop a program that dramatically improves SCDC's ability to store and retrieve, on a reasonably expedited basis:	HS 200.7		
	i. Names and numbers of FTE clinicians who provide mental health services;		3/3/17 Substantial compliance	3/3/17 Substantial compliance
	ii. Inmates transferred for ICS and inpatient services;		3/3/17 Partial compliance	3/3/17 Partial Compliance
	iii. Segregation and crisis intervention logs;		3/3/17 Partial compliance	3/3/17 Partial Compliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	iv. Records related to any mental health program or unit (including behavior management or self-injurious behavior programs);		3/3/17 Partial compliance	3/3/17 Partial Compliance
	v. Use of force documentation and videotapes;		3/3/17 Substantial compliance	3/3/17 Substantial compliance
	vi. Quarterly reports reflecting total use-of-force incidents against mentally ill and non-mentally ill inmates by institution;		3/3/17 Substantial compliance	3/3/17 Substantial compliance
	vii. Quarterly reports reflecting total and average lengths of stay in segregation and CI for mentally ill and non-mentally ill inmates by segregation status and by institution;		3/3/17 Substantial compliance	3/3/17 Substantial compliance
	viii. Quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution;		3/3/17 Substantial compliance	3/3/17 Substantial compliance
	ix. Quality management documents; and		3/3/17 Partial compliance	3/3/17 Partial Compliance
	x. Medical, medication administration, and disciplinary records.		3/3/17 Partial compliance	3/3/17 Partial Compliance
	b. The development of a formal quality management program under which the mental health management information system is annually reviewed and upgraded as needed.	HS 19.07	3/3/17 Partial compliance	3/3/17 Partial Compliance
5.	**Administration of psychotropic medication only with appropriate supervision and periodic evaluation:**			
	a. Improve the quality of MAR documentation;	HS 18.16	3/3/17 Partial compliance	3/3/17 Partial Compliance
	b. Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs;	HS 18.16	3/3/17 Partial compliance	3/3/17 Partial Compliance
	c. Review the reasonableness of times scheduled for pill lines; and	HS 18.16	3/3/17 Partial compliance	3/3/17 Partial Compliance
	d. Develop a formal quality management program under which medication administration records are reviewed.	HS 18.16	3/3/17 Partial compliance	3/3/17 Partial Compliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
6.	**A basic program to identify. treat, and supervise inmates at risk for suicide:**			
	a. Locate all CI cells in a healthcare setting;	HS 19.03 OP RHU 22.38 Section 3.39	3/3/17 Partial compliance	3/3/17 Partial Compliance
	b. Prohibit any use for CI purposes of alternative spaces such as shower stalls, rec cages, holding cells, and interview booths;	HS 19.03 OP RHU 22.38 Section 3.39	3/3/17 Partial compliance	3/3/17 Partial Compliance
	c. Implement the practice of continuous observation of suicidal inmates;	HS 19.03	3/3/17 Partial compliance	3/3/17 Partial Compliance
	d. Provide clean, suicide-resistant clothing, blankets, and mattresses to inmates in CI;	HS 19.03	3/3/17 Partial compliance	3/3/17 Partial Compliance
	e. Increase access to showers for CI inmates;	HS 19.03	3/3/17 Partial compliance	3/3/17 Partial Compliance
	f. Provide access to confidential meetings with mental health counselors, psychiatrists, and psychiatric nurse practitioners for CI inmates;	HS 19.03	3/3/17 Noncompliance	3/3/17 Noncompliance
	g. Undertake significant, documented improvement in the cleanliness and temperature of CI cells; and	HS 19.03	3/3/17 Partial compliance	3/3/17 Partial Compliance
	h. Implement a formal quality management program under which crisis intervention practices are reviewed.	HS 19.03	3/3/17 Partial compliance	3/3/17 Partial Compliance

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

Executive Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

June 2017 SCDC Status Update:

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

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

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

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

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

The data below reflect the impact of screenings.

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

Anniversary Mental Health Screening Schedule

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

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

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

July 2017 Recommendations:

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

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

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

June 2017 SCDC Status Update:

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

- Types of referrals:

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

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

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

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

July 2017 Implementation Panel findings: As per SCDC update.

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

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

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

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

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

June 2017 SCDC Status Update:

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

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

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

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

July 2017 Recommendations:

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

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

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

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

June 2017 SCDC Status Update:

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

July 2017 Implementation Panel findings: As per 1A.

July 2017 Recommendations: As per 1A.

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

2.a. Access to Higher Levels of Care

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

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

June 2017 SCDC Status Update: NONE

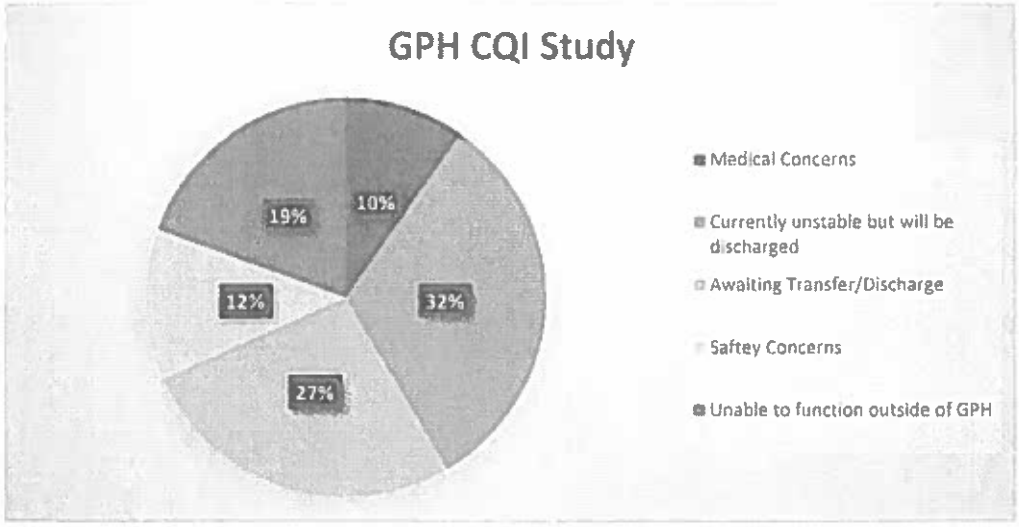
During the November 2016 site visit, the Implementation Panel recommended CQI studies. The studies should be conducted by MH program staff, in conjunction with QIRM, to include narratives of their process, analysis, and improvement plan. QI studies will serve as mechanisms to assure that SCDC Mental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

The full report is available as APPENDIX 3.

Assessment of the Results

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

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



Planned Actions

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

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

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

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

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

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

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

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

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

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

June 2017 SCDC Status Update

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

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

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

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

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

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

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

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

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

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

CAMILLE Group Calendar JUNE 2017

All Groups in ICS unless otherwise noted.

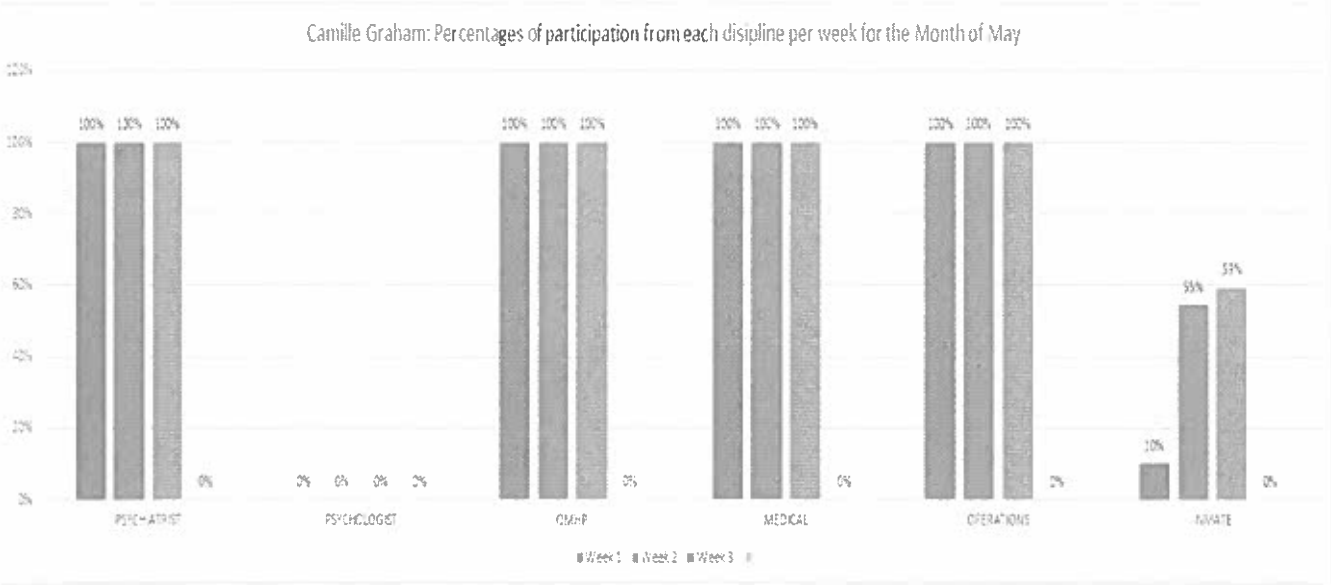
Structured therapeutic groups per week and inmate participation are outlined below:
The inmate participation and average out of cell hours by recent weeks (women housed in Blue Ridge)

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

*activity therapy and one group was canceled this week

Treatment Team Participation CGCI

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



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

KCI ICS

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

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

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

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

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

CGCI

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

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

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

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

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

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

July 2017 Recommendations:

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

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

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

June 2017 SCDC Status Update

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

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

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

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

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

Female inpatient/hospital level care

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

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

GPH Staffing

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

Renovation and upgrades of Gilliam Psychiatric Hospital GPH Renovations

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

Male and female inmates receiving inpatient psychiatric services

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

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

As per SCDC status update.

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

July 2017 Recommendations:

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

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

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

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

June 2017 SCDC Status Update

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

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

Mental Health Staffing Summary

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

(Position Summary – as of 06/20/2017)

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

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

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

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

H.3720 (2017-2018 Appropriations Bill)

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

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

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

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

Recruitment Efforts (Click here to return to 3d)

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

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

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

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

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

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

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

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

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

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

PROPOSED
CRITICAL INCIDENT STRESS MANAGEMENT (CISM)
WITHIN SCDC

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

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

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

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

July 2017 Recommendations: As above.

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

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

June 2017 SCDC Status Update

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

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

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

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

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

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

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

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

July 2017 Recommendations:

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

2.b. Segregation:

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

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

June 2017 SCDC Status Update

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

Data re: the LLBMU provided was as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

July 2017 Recommendations:

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

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

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

Implementation Panel July 2017 Assessment: **noncompliance**

June 2017 SCDC Status Update

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

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

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

- RHU Rounds

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

July 2017 Recommendations:

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

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

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

June 2017 SCDC Status Update

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

Percentages of Levels of Care that have 4 previous QMHP Dates

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

Percentages of Levels of Care that have 3 previous QMHP Dates

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

Percentages of Levels of Care that have 2 previous QMHP Dates

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

Percentages of Levels of Care that have a previous QMHP Date

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

Percentages of Levels of Care that have 4 previous Psych Dates

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

Percentages of Levels of Care that have 3 previous Psych Dates

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

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

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

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

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

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

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

June 2017 SCDC Status Update

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

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

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

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

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

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

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

June 2017 SCDC Update

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

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

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

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

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

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

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

** Percentages are subjected to change daily**

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

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

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

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

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

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

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

June 2017 SCDC Status Update

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

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

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

July 2017 Recommendations:

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

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

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

June 2017 SCDC Update

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

Training Institutional Staff on CQI Policy

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

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

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

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

2.c. Use of Force:

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

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

June 2017 SCDC Update

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

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

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

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

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

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

July 2017 Recommendations:

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

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

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

June 2017 SCDC Status Update

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

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

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

July 2017 Recommendations:

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

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

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

June 2017 SCDC Status Update

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

July 2017 Implementation Panel findings: SCDC remains in compliance.

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

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

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

June 2017 SCDC Status Update

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

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

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

July 2017 Recommendations:

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

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

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

June 2017 SCDC Status Update

Same as in update for 2.c.iv.

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

July 2017 Recommendations:

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

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

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

June 2017 SCDC Status Update

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

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

July 2017 Implementation Panel findings: As per SCDC Update.

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

July 2017 Recommendations:

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

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

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

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

June 2017 SCDC Status Update

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

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

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

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

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

July 2017 Recommendations:

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

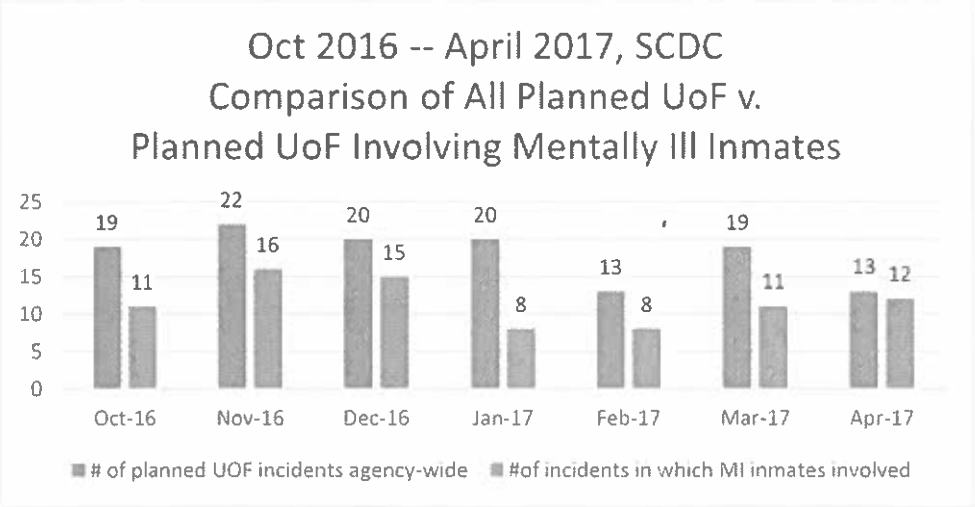
2.c.viii. Notification to clinical counselors prior to the planned use of force to request assistance in avoiding the necessity of such force and managing the conduct of inmates with mental illness;

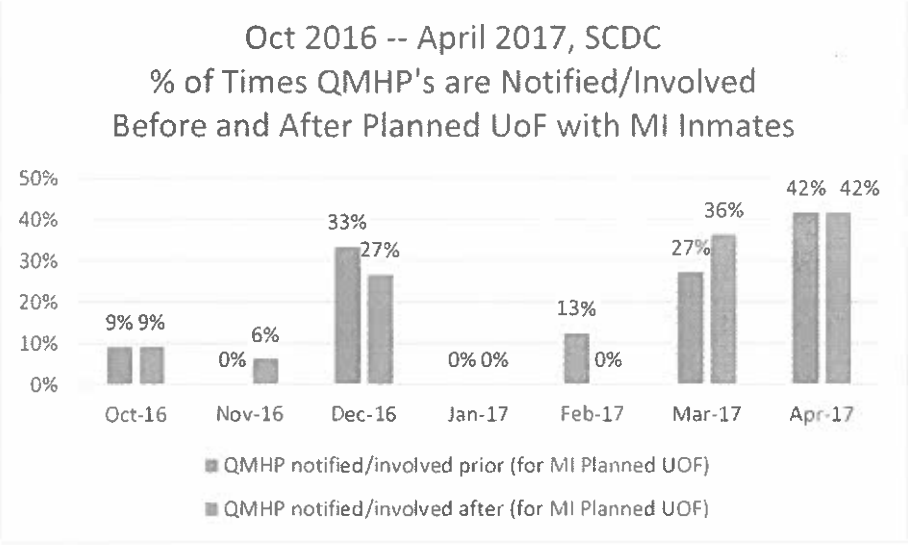
Implementation Panel July 2017 Assessment: **partial compliance**

June 2017 SCDC Status Update

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

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





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

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

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

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

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

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

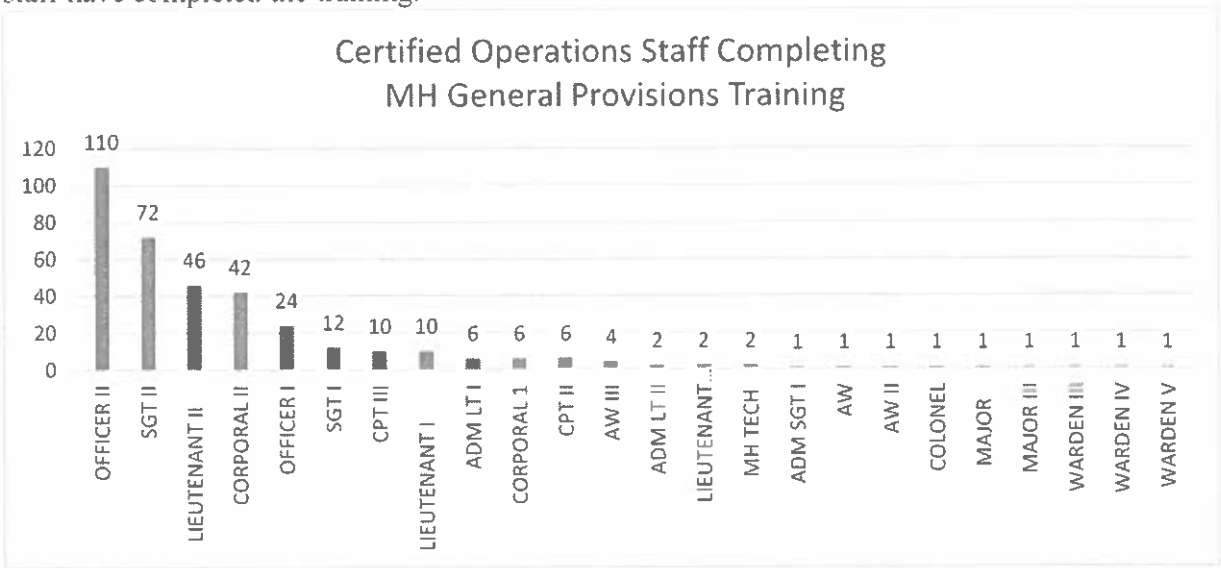
July 2017 Recommendations: Provide additional training to Operations Supervisory and Mental Health Staff on their duties and responsibilities in a planned use of force.

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

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

June 2017 SCDC Status Update

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



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

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

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

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

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

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

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

June 2017 SCDC Status Update

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

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

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

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

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

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

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

June 2017 SCDC Status Update

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

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

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

1. Employment of enough trained mental health professionals:

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

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

June 2017 SCDC Status Update

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

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

July 2017 Recommendations: See 2.a.iv.

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

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

June 2017 SCDC Status Update

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

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

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

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

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

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

June 2017 SCDC Status Update:

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

July 2017 Implementation Panel findings:

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

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

July 2017 Recommendations:

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

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

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

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

June 2017 SCDC Status Update:

Recruitment Efforts (Click here)

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

July 2017 Recommendations: As per SCDC status update section.

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

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

June 2017 SCDC Status Update

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

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

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

July 2017 Implementation Panel findings: Compliance continues.

July 2017 Recommendations: Continue to monitor.

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

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

June 2017 SCDC Status Update

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

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

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

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

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

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

June 2017 SCDC Status Update

See response in 3f (click here)

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

July 2017 Recommendations: See above.

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

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

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

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

June 2017 SCDC Status Update

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

July 2017 Implementation Panel findings: Compliance continues.

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

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

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

June 2017 SCDC Status Update

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

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

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

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

GEO Female Admissions
February 2017 through May 2017

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

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

July 2017 Implementation Panel findings: As per SCDC status.

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

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

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

June 2017 SCDC Status Update

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

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

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

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

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

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

June 2017 SCDC Status Update

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

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

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

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

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

June 2017 SCDC Status Update

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

July 2017 Implementation Panel findings: Remains in compliance.

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

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

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

June 2017 SCDC Status Update

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

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

July 2017 Implementation Panel findings: As per SCDC update.

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

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

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

June 2017 SCDC Status Update:

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

July 2017 Implementation Panel findings: Compliance continues.

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

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

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

June 2017 SCDC Status Update:

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

July 2017 Implementation Panel findings: Compliance continues.

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

4.a.ix. Quality management documents; and

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

June 2017 SCDC Status Update:

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

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

July 2017 Recommendations: Continue to develop the QI process.

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

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

June 2017 SCDC Status Update

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

Complete

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

Remaining Timeline

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

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

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

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

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

July 2017 Recommendations:

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

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

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

June 2017 SCDC Status Update

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

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

July 2017 Recommendations: Implement the EHR as planned.

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

5.a. Improve the quality of MAR documentation;

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

June 2017 SCDC Status Update

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

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

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

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

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

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

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

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

June 2017 SCDC Status Update

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

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

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

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

Implementation Panel July 2017 Assessment: **noncompliance**

June 2017 SCDC Status Update

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

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

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

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

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

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

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

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

June 2017 SCDC Status Update

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

A template has been developed to capture the below information.

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

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

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

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

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

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

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

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

June 2017 SCDC Status Update

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

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

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

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

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

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

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

June 2017 SCDC Status Update

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

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

July 2017 Recommendations: Remedy the above.

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

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

June 2017 SCDC Status Update

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

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

July 2017 Recommendations: Remedy the above.

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

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

June 2017 SCDC Status Update

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

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

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

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

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

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

Implementation Panel July 2017 Assessment: **noncompliance**

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

March 2017 Recommendations: Correct the above.

June 2017 SCDC Status Update

No update provided

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

July 2017 Recommendations: As per the March 2017 recommendation.

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

Implementation Panel July 2017 Assessment: **noncompliance**

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

March 2017 Recommendations: remedy the above.

June 2017 SCDC Status Update

All institutions

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

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

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

In addition, the sample size is too small.

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

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

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

June 2017 SCDC Status Update

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

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

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

July 2017 Recommendations: Remedy the identified issues.

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

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

June 2017 SCDC Status Update

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

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

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

Conclusions and Recommendations:

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

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

Respectfully submitted,

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

MEDIATOR REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES
JULY 2017 IP ASSESSMENT

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
1.	**The development of a systematic program for screening and evaluating inmates to more accurately identify those in need of mental health care:**			
	a. Develop and implement screening parameters and modalities that will more accurately diagnose serious mental illness among incoming inmates at R&E with the stated goal of referring inmates to the appropriate treatment programs. Accurately determine and track the percentage of the SCDC population that is mentally ill.	HS 19.10	7/14/17 Partial compliance	3/3/17 Partial Compliance
		HS 19.07	7/14/17 Partial compliance	3/3/17 Partial Compliance
	b. The implementation of a formal quality management program under which mental health screening practices are reviewed and deficiencies identified and corrected in ongoing SCDC audits of R&E counselors;	HS 19.07	7/14/17 Partial compliance	3/3/17 Partial Compliance
	c. Enforcement of SCDC policies relating to the timeliness of assessment and treatment once an incoming inmate at R&E is determined to be mentally ill; and	HS 19.07 HS 19.10	7/14/17 Partial compliance	3/3/17 Partial Compliance
	d. Development of a program that regularly assesses inmates within the general population for evidence of developing mental illness and provides timely access to mental health care.	HS 19.07 HS 19.10	7/14/17 Partial compliance	3/3/17 Partial Compliance

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

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
2.	**The development of a comprehensive mental health treatment program that prohibits inappropriate segregation of inmates in mental health crisis, generally requires improved treatment of mentally ill inmates. and substantially improves/increases mental health care facilities within SCDC:**			
	a. Access to Higher Levels of Care:			
	i. Significantly increase the number of Area Mental Health inmates vis-a-vis outpatient mental health inmates and provide sufficient facilities therefore;	HS 19.04 HS 19.11	7/14/17 Partial compliance	3/3/17 Noncompliance
	ii. Significantly increase the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefore;[2]	HS 19.04, HS 19.07, HS 19.11	7/14/17 Partial compliance	3/3/17 Noncompliance
	iii. Significantly increase the number of male and female inmates receiving inpatient psychiatric services, requiring the substantial renovation and upgrade of Gilliam Psychiatric Hospital, or its demolition for construction of a new facility;	HS 19.04, HS 19.07 HS 19.09	7/14/17 Partial compliance	3/3/17 Partial Compliance
		Gilliam Construction Plan	7/14/17 Partial compliance	3/3/17 Partial Compliance
	iv. Significantly increase clinical staffing at all levels to provide more mental health services at all levels of care; and	Hiring Plan attached as Exhibit E to the Settlement Agreement	7/14/17 Partial compliance	3/3/17 Partial Compliance
	v. The implementation of a formal quality management program under which denial of access to higher levels of mental health care is reviewed.	HS 19.07	7/14/17 Substantial compliance	3/3/17 Partial Compliance
	b. Segregation:			
	i. Provide access for segregated inmates to group and individual			

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

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	therapy services;			
		OP RHU Policy_22.38 Section 3.23 H.S. 19.04	7/14/17 Partial compliance	3/3/17 Partial Compliance
	ii. Provide more out-of-cell time for segregated mentally ill inmates;	HS 19.12 OP RHU Policy 22.38 Section 3.14.4 & Section 3.25	7/14/17 Noncompliance	3/3/17 Noncompliance
	iii. Document timeliness of sessions for segregated inmates with psychiatrists, psychiatric nurse practitioners, and mental health counselors and timely review of such documentation;	HS 19.04 OP RHU Policy 22.38 Section 3.15	7/14/17 Partial compliance	3/3/17 Partial Compliance
	iv. Provide access for segregated inmates to higher levels of mental health services when needed;	HS 19.04 HS 19.06	7/14/17 Partial compliance	3/3/17 Partial Compliance
	v. The collection of data and issuance of quarterly reports identifying the percentage of mentally ill and non-mentally ill inmates in segregation compared to the percentage of each group in the total prison population with the stated goal of substantially decreasing segregation of mentally ill inmates and substantially decreasing the average length of stay in segregation for mentally ill inmates;	HS 19.07 OP RHU Policy 22.38 Section 1 and Section 2	7/14/17 Substantial compliance (11/16)	3/3/17 Substantial compliance (11/16)
	vi. Undertake significant, documented improvement in the cleanliness and temperature of segregation cells; and	To be determined	7/14/17 Partial compliance	3/3/17 Partial Compliance
	vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.	HS 19.07	7/14/17 Partial compliance	3/3/17 Noncompliance
	c. Use of Force:			
	i. Development and implementation of a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness;	OP 22.01 HS 19.08	7/14/17 Partial compliance	3/3/17 Partial Compliance
	ii. The plan will further require that all instruments of force, (e.g., chemical agents and restraint chairs) be employed in a manner fully consistent with manufacturer's instructions, and track such use in a way to enforce such compliance;	OP 22.01 HS 19.08	7/14/17 Partial compliance	3/3/17 Partial Compliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	iii. Prohibit the use of restraints in the crucifix or other positions that do not conform to generally accepted correctional standards and enforce compliance;	OP 22.01 HS 19.08	7/14/17 Substantial compliance	3/3/17 Substantial compliance
	iv. Prohibit use of restraints for pre-determined periods of time and for longer than necessary to gain control, and track such use to enforce compliance;	OP 22.01 HS 19.08	7/14/17 Partial compliance	3/3/173/3/17 Partial compliance
	v. The collection of data and issuance of quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs;	HS 19.07 OP Use of Force 22.01 Section 13	7/14/17 Partial compliance	3/3/17 Partial Compliance
	vi. Prohibit the use of force in the absence of a reasonably perceived immediate threat;	OP 22.01 HS 19.08	7/14/17 Partial compliance	3/3/17 Partial Compliance
	vii. Prohibit the use of crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions;	OP 22.01 HS 19.08	7/14/17 Partial compliance	3/3/17 Partial Compliance
	viii. Notification to clinical counselors prior to the planned use of force to request assistance in avoiding the necessity of such force and managing the conduct of inmates with mental illness;	OP 22.01 HS 19.08	7/14/17 Partial compliance	3/3/17 Partial Compliance
	ix. Develop a mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates;	OP 22.01 ADM 17.01 Employee Training Standards, SCDC Annual Training Plan HS 19.08	7/14/17 Partial compliance	3/3/17 Partial Compliance
	x. Collection of data and issuance of quarterly reports concerning the use-of-force incidents against mentally ill and non-mentally ill inmates; and	OP 22.01 HS 19.07	7/14/17 Substantial compliance (3/3/17)	3/3/17 Substantial compliance
	xi. The development of a formal quality management program under which use-of-force incidents involving mentally ill inmates are reviewed.	OP 22.01 HS 19.07	7/14/17 Partial compliance	3/3/17 Partial Compliance
3.	**Employment of a sufficient number of trained mental health Professionals:**			

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	a. Increase clinical staffing ratios at all levels to be more consistent with guidelines recommended by the American Psychiatric Association, the American Correctional Association, and/or the court-appointed monitor;	Hiring Plan attached as Exhibit E to the Settlement Agreement	7/14/17 Partial compliance	3/3/17 Partial Compliance
	b. Increase the involvement of appropriate SCDC mental health clinicians in treatment planning and treatment teams;	HS 19.05	7/14/17 Partial compliance	3/3/17 Partial Compliance
	c. Develop a training plan to give SCDC mental health clinicians a thorough understanding of all aspects of the SCDC mental health system, including but not limited to levels of care, mental health classifications, and conditions of confinement for caseload inmates;	Mental Health Training Policy Addendum	7/14/17 Partial compliance	3/3/17 Partial Compliance
	d. Develop a plan to decrease vacancy rates of clinical staff positions which may include the hiring of a recruiter, increase in pay grades to more competitive rates, and decreased workloads;	Hiring Plan attached as Exhibit E to the Settlement Agreement	7/14/17 Partial compliance	3/3/17 Partial Compliance
	e. Require appropriate credentialing of mental health counselors;	HS 19.04	7/14/17 Substantial compliance (3/3/17)	3/3/17 Substantial compliance
	f. Develop a remedial program with provisions for dismissal of clinical staff who repetitively fail audits; and	HS 19.07	7/14/17 Partial compliance	3/3/17 Partial Compliance
	g. Implement a formal quality management program under which clinical staff is reviewed.	HS 19.07	7/14/17 Partial compliance	3/3/17 Partial Compliance
4.	**Maintenance of accurate, complete, and confidential mental health treatment records:**			
	a. Develop a program that dramatically improves SCDC's ability to store and retrieve, on a reasonably expedited basis:	HS 200.7		
	i. Names and numbers of FTE clinicians who provide mental health services;		7/14/17 Substantial compliance (3/3/17)	3/3/17 Substantial compliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	ii. Inmates transferred for ICS and inpatient services;		7/14/17 Substantial Compliance	3/3/17 Partial Compliance
	iii. Segregation and crisis intervention logs;		7/14/17 Partial compliance	3/3/17 Partial Compliance
	iv. Records related to any mental health program or unit (including behavior management or self-injurious behavior programs);		7/14/17 Partial compliance	3/3/17 Partial Compliance
	v. Use of force documentation and videotapes;		7/14/17 Substantial compliance (3/3/17)	3/3/17 Substantial compliance
	vi. Quarterly reports reflecting total use-of-force incidents against mentally ill and non-mentally ill inmates by institution;		7/14/17 Substantial compliance (3/3/17)	3/3/17 Substantial compliance
	vii. Quarterly reports reflecting total and average lengths of stay in segregation and CI for mentally ill and non-mentally ill inmates by segregation status and by institution;		7/14/17 Substantial compliance (3/3/17)	3/3/17 Substantial compliance
	viii. Quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution;		7/14/17 Substantial compliance (3/3/17)	3/3/17 Substantial compliance
	ix. Quality management documents; and		7/14/17 Partial compliance	3/3/17 Partial Compliance
	x. Medical, medication administration, and disciplinary records.		7/14/17 Partial compliance	3/3/17 Partial Compliance
	b. The development of a formal quality management program under which the mental health management information system is annually reviewed and upgraded as needed.	HS 19.07	7/14/17 Partial compliance	3/3/17 Partial Compliance
5.	**Administration of psychotropic medication only with appropriate supervision and periodic evaluation:**			
	a. Improve the quality of MAR documentation;	HS 18.16	7/14/17 Partial compliance	3/3/17 Partial Compliance
	b. Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs;	HS 18.16	7/14/17 Partial compliance	3/3/17 Partial Compliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	c. Review the reasonableness of times scheduled for pill lines; and	HS 18.16	7/14/17 Noncompliance	3/3/17 Partial Compliance
	d. Develop a formal quality management program under which medication administration records are reviewed.	HS 18.16	7/14/17 Partial compliance	3/3/17 Partial Compliance
6.	**A basic program to identify. treat, and supervise inmates at risk for suicide:**			
	a. Locate all CI cells in a healthcare setting;	HS 19.03 OP RHU 22.38 Section 3.39	7/14/17 Partial compliance	3/3/17 Partial Compliance
	b. Prohibit any use for CI purposes of alternative spaces such as shower stalls, rec cages, holding cells, and interview booths;	HS 19.03 OP RHU 22.38 Section 3.39	7/14/17 Partial compliance	3/3/17 Partial Compliance
	c. Implement the practice of continuous observation of suicidal inmates;	HS 19.03	7/14/17 Partial compliance	3/3/17 Partial Compliance
	d. Provide clean, suicide-resistant clothing, blankets, and mattresses to inmates in CI;	HS 19.03	7/14/17 Partial compliance	3/3/17 Partial Compliance
	e. Increase access to showers for CI inmates;	HS 19.03	7/14/17 Noncompliance	3/3/17 Partial Compliance
	f. Provide access to confidential meetings with mental health counselors, psychiatrists, and psychiatric nurse practitioners for CI inmates;	HS 19.03	7/14/17 Noncompliance	3/3/17 Noncompliance
	g. Undertake significant, documented improvement in the cleanliness and temperature of CI cells; and	HS 19.03	7/14/17 Partial compliance	3/3/17 Partial Compliance
	h. Implement a formal quality management program under which crisis intervention practices are reviewed.	HS 19.03	7/14/17 Partial compliance	3/3/17 Partial Compliance

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

Executive Summary

This fifth report of the Implementation Panel (IP) is provided as stipulated in the Settlement Agreement in the above referenced matter, and it is based on the fifth site visit to the South Carolina Department of Corrections (SCDC) facilities and our review and analysis of SCDC's compliance with the settlement agreement criteria. To date the IP has conducted site visits to SCDC on May 2-5, 2016; October 31-November 4, 2016; February 27-March 3, 2017; July 10-14; and December 4-8, 2017. Despite the IP's request that important documents needed to assess compliance/non-compliance with the Settlement Criteria be provided two weeks prior to each site visit, we did not receive all of the requested documents within that time frame. The IP has been asked to consider documents/information provided to us during the site visits and up to the Exit Conference on the last day of the site visits. The IP visits are scheduled and requests for documents have been consistently provided well in advance of the visits; however, our requirement for documents has never been met by SCDC. Regardless of the lateness of receipt of those documents, the IP has considered the information provided prior to and during the site visits in our assessment of compliance/non-compliance with the Settlement Agreement Criteria. The IP has also participated in conference calls at the requests of both plaintiffs and defendants, and held meetings during this visit with Mr. Westbrook and Director Stirling. Deputy Director [redacted] Assistant Director [redacted], and SCDC administrative staff have attended site visits and provided very valuable input to the discussions. Finally, the wardens of each institution site visited as well as the Regional Directors have assisted this process and provided their input. Dr. Sally Johnson and Ms. Terre Marshall, consultants to SCDC, accompanied the IP to the facilities during this site visit. On December 8, 2017 the IP held an Exit Briefing attended by Director Stirling, attorney Roy Laney and SCDC staff, and plaintiff's counsel Daniel Westbrook to apprise the parties of our preliminary findings and encouraged feedback and discussion. Judge William Howard was not able to attend but was apprised of the IP's preliminary findings.

This Executive Summary presents an overview of the SCDC analysis and the Implementation Panel's findings regarding SCDC's compliance with the Settlement Agreement. During each site visit, the IP has provided onsite technical assistance, presented its findings, and when indicated have acknowledged the positive efforts and findings made in specific programs and/or facilities.

The IP review has focused on the Settlement Agreement criteria components and SCDC's own findings and analyses as presented to the IP. The Settlement Agreement compliance levels are reported as "noncompliance", "partial compliance", or "substantial compliance" in each of the elements which are provided along with the basis for the particular/specific findings and recommendations. The IP provided direct feedback during the Exit Briefings at each facility and with SCDC central office staff. The IP also included in this report additional information related to each facility visited during this tour to illustrate both positive and negative aspects of their performance that impacted compliance, partial compliance, or noncompliance.

Included in this report is Exhibit B, and appended are Attachments 1-5. Exhibit B is the summary of the IP's assessment of compliance with the remedial guidelines. The IP acknowledges the work of SCDC in the development and revision of policies and procedures, as well as the development of a preliminary "Master Plan" for mental health services to address the mental health needs of inmates living in the SCDC and to meet the requirements of the Settlement Agreement. As Exhibit B illustrates, the Implementation Panel determined the following levels of compliance:

1. Substantial Compliance--- 14 components

2. Partial Compliance--- 38 components

3. Noncompliance--- 6 components

While the Implementation Panel acknowledges the efforts by SCDC to improve mental health care, particularly considering the conditions at the time of the inception of the Settlement Agreement, SCDC continues to struggle mightily in their attempts to achieve compliance with the necessary requirements of the Settlement Agreement in various programs and facilities. The IP has identified multiple factors of serious concern from past site visits and noted in previous reports, including the following:

1. Staffing - including clinical (mental health, medical and nursing), operations, administration and support staff.

2. Conditions of confinement - including Restrictive Housing Units (RHU), and segregation of any type. The IP was made aware that SCDC administrative staff "reinterpreted" the policy on Suicide Prevention and Management to allow for up to 120 hours for transfer to the Crisis Stabilization Unit from safety cells in other facilities. Further, the safety cells at Gilliam Psychiatric Hospital were found to be less suicide resistant than in the past, which requires immediate attention.

3. Prolonged stays in Reception and Evaluation at both Kirkland C.I. and Graham C.I. with very minimal mental health services and structured and unstructured out of cell time and activities. The timeliness of assessments, referrals and treatment continue to impede these processes, largely impacted by staffing deficiencies.

4. Lack of timely assessments by multidisciplinary treatment teams at the mental health programmatic levels.

5. Operations and clinical staff adherence to policies and procedures and lack of appropriate supervision.

6. Access to all higher levels of care for male and female inmates - The CSU has not yet operationalized its role in the overall mental health system to determine both level of care needs and assistance to operations for management of inmates who require alternative

treatment and housing. The BMU's are not functioning at their planned levels. GPH is basically a lockdown program with very limited programming. A noted positive improvement is the pending contract for hospital level services for women.

7. Future planning for a comprehensive mental health services delivery system including staffing, beds and programs. The current Master Plan is largely a plan to develop a plan.

8. Medication management, particularly at Graham CI and Leath CI with reported audits that do not appear to adequately address medication administration and documentation. Of critical concern is the practice at several male facilities to administer medications by staff placing the medications on the food slot and/or sliding medications under the cell door which are both major clinical and security risks;

9. Substantial progress in the Quality Management Program, specifically by the development and efforts by the Quality Improvement Risk Management Program (QIRM) including necessary increases in staffing, training, audits and review of documents/information. Additional support has been suggested via the Behavioral Health Division and the developing electronic medical record; however, the interface will require improvements in collaboration, methodology, reliability, and timeliness of reporting information. The IP has repeatedly emphasized the necessity to provide pre-site visit information as requested, and SCDC has yet to provide information in a timely manner;

10. The implementation of the EHR, including eZmar, and interface with the pharmacy system (CIPS) continues to be piloted at Graham C.I. and Leath C.I. with extension of the timeframe for implementation system-wide as difficulties have been identified. More available mining of information/data and utilization of this process should facilitate and support systems development provided the methodologies and reliability of the information is sound.

In addition, the following issues regarding custody operations should be addressed and recommendations for addressing them follow each area of concern:

1. Inmates held in Short Term and Disciplinary Detention Status

Assessment: A high number of inmates are being held in Short Term and Disciplinary Detention Status over 60 days (per the provided SCDC Weekly Report Listing of Inmates by Institution in SD, DD, MX, ST, and AP Status). Over 80 inmates were identified in RHU over 60 days in Short Term, Disciplinary Detention and Awaiting Placement Status in the December 7, 2017, Weekly Report.

Recommendation: SCDC needs to develop a corrective action plan within 30 days to prevent inmates in ST, DD and AP Status from exceeding 60 days in RHU.

2. Inmate Disciplinary

Assessment: SCDC OP 22.14 only allows visitation and telephone restrictions to be imposed up to 20 days if an inmate does not have a MH classification regardless of the disciplinary offense. If an inmate has a MH classification, visitation and telephone restrictions can be imposed only if the charge involved visitation or telephone disciplinary offenses. A review of SCDC-produced records for the IP December 2017 Site visit revealed inmates without a MH classification receive restrictions of greater than 20 days for disciplinary offenses and inmates with a MH classification are receiving visitation and telephone restrictions for disciplinary offenses that are not visitation or telephone offenses.

Recommendation: SCDC needs to provide additional training to staff responsible for OP 22.14 to ensure:

- Visitation and telephone restrictions imposed do not exceed 20 days if an inmate does not have a MH classification regardless of the disciplinary offense.
- If an inmate has a MH classification, visitation and telephone restrictions are imposed only if the charge involved visitation or telephone disciplinary offenses.

SCDC officials should review both inmates without a MH designation and those with a MH designation with existing visitation and telephone restrictions and modify any restrictions that do not comply with OP 22.14 and provide the IP documentation of compliance as soon as possible.

3. RHU Population

Assessment: Per SCDC officials a high number inmates are being held in RHU because the inmate has a safety concern and refuses to return to the general population (possibly 20 or more inmates per institution with an RHU). Inmates being held in RHU for safety concerns limits cells for inmates that are identified as a risk to harm staff and/or inmates. An inmate eligible for time credits while in RHU cannot earn the credits to reduce the length of their prison sentence. Inmates held in RHU for safety concerns and eligible to earn time credits are most likely serving longer prison sentences draining valuable resources and increasing the SCDC budget.

Recommendation: SCDC should expand existing RHU alternatives to significantly reduce the number of inmates held in RHU for safety concerns.

4. RHU Behavior Levels for ST, DD, and SD

Assessment: SCDC has not fully implemented the RHU Behavior Levels for inmates in ST, DD, and SD status. OP 22.38 B Intensive Management and Restrictive Management Step Down Programs for High Risk Inmates was finalized and signed by the Director in November 2017. A review of the existing OP 22.38 Restrictive Housing Units (RHU) identified policy inconsistencies with intended SCDC Behavior Level practices.

Recommendation: SCDC Operations should review the OP 22.38 RHU and identify any inconsistencies and request revisions to the policy where necessary to the IP and Plaintiffs. QIRM should begin conducting QI studies regarding progress to implement the OP 22.28 RHU Behavior Levels and OP 22.38B Intensive Management and Restrictive Management Step Down Programs for High Risk Inmates.

5. **Tablets to Electronically Record Inmate Activities in RHU and CSU**

Assessments: SCDC Operations is pilot testing correctional officers utilizing computer tablets to record inmate activities (shower, welfare checks, and recreation, etc.) in RHU and CSU. Broad River CI CSU was selected as the site for the pilot. SCDC Operations and IT officials provided a demonstration of the new program to an IP Member at Broad River CI CSU the afternoon of December 5, 2017. It appears electronically recording inmate activities in RHU and CSU has promise to enhance recording quality and staff efficiency.

Recommendation: Continue the Broad River CI CSU Pilot electronically recording Institution RHUs.

Below are summaries of the IP's visits at each of the institutions during the week of December 4-8, 2017:

Kirkland Correctional Institution

During December 4 and 5, 2017, we site visited Kirkland CI. The inmate count on November 27, 2017 was 1523 inmates which included 270 inmates on the mental health caseload including approximately 80 Level 1 inmates (GPH), 139 Level 2 inmates (ICS), 14 Level 3 inmates (Area Mental Health), 96 Level 4 inmates (Outpatients) and 2 Level 5 inmates (stable and monitored). The mental health staffing allocations and filled positions were as follows based on pre-site information provided:

QMHPs:	25 FTEs allocated
	10 FTEs vacant
GPH Bay Area Staff:	7 FTEs allocated
	0 FTEs vacant
MH Techs:	17 FTEs allocated
	5 FTEs vacant
Activity Therapists:	3.5 FTEs allocated
	1.0 FTEs vacant

We conducted a community meeting of approximately 25 inmates who described minimal programmatic activities and out of cell time at GPH. Only 3 of 25 inmates reported attending 3 groups per week. The newly installed spider table for group therapies had not been used. Discussions with staff indicated requests for additional staff, however implementation of therapeutic activities could not occur without increases. Tours of the units indicated the nurses stations are near completion, however serious nursing shortages, and the majority of staff vacancies are covered by registry nurses. Further, the suicide resistant cells are no longer suicide resistant and are in need of repairs.

We toured the ICS programs, attended a treatment team meeting and held a Community meeting with inmates. The IP was favorably impressed by the team meeting, including participation by inmates and the inmates reported significant out of cell time for structured therapy groups.
We toured the HLBMU and met with inmates. While the inmates reported efforts by staff to have programmatic activities, their impressions, consistent with staff reports, are that there is insufficient staff for programs, out of cell time on weekends, and family visits.

Broad River Correctional Institution

The IP site visited Broad River CI on December 5, 2017. Broad River continues to experience staff shortages that impede the implementation of the CSU and HLBMU programs. The CSU has only limited telepsychiatry services and no psychiatric participation at treatment team meetings. The CSU is the central receiving for inmates from other facilities who have reported or demonstrated increased risk of self-harm and/or suicide. There is limited participation by psychology, and no presence of classification at the treatment team meetings, where recommendations and decisions are made regarding inmate placement in mental health programs. The role of the CSU in the overall system should be reviewed in this context. We were provided with two psychological autopsies of inmates who died by suicide, and both had multiple admissions to the CSU. The autopsies were incomplete and while on site, the IP recommended the outsourcing of psychological autopsies to clinicians more experienced with the appropriate process.
The HLBMU remains at KCI based on lack of staffing resources.
Of critical concern is the decision and movement of Level 3 inmates (Area Mental Health/Enhanced Outpatient) to the Marion dorm at BRCI. This movement did not go smoothly and our Community meeting with these inmates revealed their very serious concerns regarding treatment, medication administration, safety and property issues, as well as extended lockdown of the units for inmates who had been involved in active programming prior to the moves. The mental health staff indicated they are in the process of reviewing and reclassification of these inmates, reporting 14 of 22 inmates had been reclassified to Level 4 AFTER transfer to BRCI as Level 3. There was [redacted] by an inmate on this unit during the site visit.

Lieber Correctional Institution

During December 6, 2017, we site visited the Lieber CI. The inmate count at the Lieber CI during December 4, 2017 was 1092 inmates, which included 233 inmates on the mental health caseload (12 L3 inmates and 221 L4 inmates).
Lieber CI averages ~ 14 hours per week of coverage by a psychiatrist. Additional mental health staff included the following:

QMHPs: 4.0 FTE allocated positions
2.0 FTE vacancies
4.0 FTE positions designated in the staffing plan
MHTs: 2.0 FTE allocated positions
1.0 FTE vacancies

Nursing staff: 13.0 FTE positions filled
32.0 FTE positions designated in the staffing plan

We observed an outpatient treatment team meeting during the afternoon of December 6, 2017, where we observed the treatment team planning process for four inmates.
There were four safety cells in the RHU at the Lieber CI, which still needed further renovations in order to be suicide resistant.
We discussed transfer timeframes specific to inmates placed on either suicide watch or on observation status. There appeared to have been a misunderstanding among the mental health staff in the context of the policy and procedures specific to suicide watch and observational status. We clarified that regardless of which status applied to a given inmate, the 60 hours principle still applied.
We met with 11 general population mental health caseload inmates in a group setting. These inmates indicated that their housing units were, more often than not, locked down due to a variety of reasons, including custody staff shortages and/or disruptive behaviors by one of more inmates on the unit. They stated that the whole housing unit would be locked down if one or more inmates were disruptive. When a housing unit was on lockdown status for any reason, medications would be delivered under the cell door if there was not a food port. Cell doors in general population housing units did not have food ports. It was not uncommon for correctional officers to assist in this process of medication administration. This method of medication administration was confirmed by nursing staff.
These inmates indicated that they generally met with the psychiatrist on an every 90 day basis. However, these sessions were not confidential because the door was left open with a correctional officer within hearing distance. Custody staff stated that the door was left open at the request of the psychiatrist. In general, sessions with their mental health counselors generally occur every 90 days with similar issues relevant to lack of privacy from a sound perspective. None of the inmates interviewed were aware of the recent initiation of two group therapies (anger management classes) being offered to general population inmates. Staff reported there was a waiting list for these four-week groups.

Inmates described the shower stalls within the mental health housing unit to be filthy and fecal stained. Observation of these shower stalls by the monitors was consistent with the inmates' descriptions.
The inmates interviewed were aware of treatment plans with a minority of them indicating that they found knowledge of their treatment plans to be useful to them. None of these inmates remembered attending a treatment team meeting specific to development of the treatment plans. We observed a treatment plan meeting that involved reviewing treatment plans of four inmates, which was attended by two QMHP's and one nurse. The treatment planning meeting process was very brief.

Assessment: The mental health staff and custody staff shortages clearly have a negative impact on the delivery of outpatient mental health services to inmates. The manner of medication administration in housing units that are locked down for any reason is unacceptable and below the standard of correctional mental health care. Individual sessions with a QMHP and/or a psychiatrist lacked adequate privacy from a sound perspective. The treatment planning process, in part related to the minimal staffing resources, does not currently appear to be very meaningful. The excessive lockdown of general population housing units, which is certainly reflective of significant staff shortages, remains very problematic for many different reasons. The shower stalls are hygienically very problematic. The method of food delivery results in food being too cold upon delivery to the inmate.

Recommendations:

1. As summarized in an earlier subsection, remedy the staffing issues.
2. Medications need to be administered in a clinically appropriate manner and not under the cell door.
3. Clinical contact with the psychiatrist and primary mental health clinician should be done in an office setting that allows for adequate sound confidentiality and safety.
4. Once staffing allocations/vacancy issues have been improved, staff should become more focused on treatment plans and treatment team meetings for treatment planning purposes.
5. The shower stall areas should be cleaned on a regular basis.
6. The practice of group punishment related to disruptive behavior by one of more inmates needs to be changed.
7. The food delivery system needs to be revised in order to serve food at an appropriate temperature.

Kershaw Correctional Institution

During the morning of December 7, 2017, we site visited Kershaw CI. The inmate count was 1361, which included 214 inmates on the mental health caseload (2 L3, 204 L4, and 8 L5 level of care mental health inmates). Of the approximate 80 RHU inmates, a total of 41 inmates were on the mental health caseload (27 SD, 10 ST and 4 inmates awaiting placement).

Staffing data was as follows:

Kershaw CI averages about eight hours per week of coverage by psychiatrist either on-site or via telepsychiatry.

1.0 FTE QMHP positions were filled with a 1.0 FTE vacancy being present.

1.0 FTE lead QMHP position was vacant.

1.0 FTE MHT position was filled.

6.0 FTE nursing positions of the 10. FTE allocated positions were filled with the staffing plan designating 15.67 FTE positions.

The correctional officer staff vacancy rate was 46.5%.

We observed 3 inmates receiving an assessment by the psychiatrist via telepsychiatry, which was performed in a very competent manner.

We interviewed 9 mental health caseload inmates in a group setting. They indicated significant medication administration problems related to the medications being administered to them in a small envelope under their cell door, which reportedly contributed to them not receiving their medications or receiving the wrong medications. The last "pill call" was at 2:30 pm. General population housing units were very often locked down related to correctional officer shortages and various disturbances.

These inmates reported generally seeing their psychiatrist every 3 months. Very few of these inmates reported meeting with their primary mental health clinician on a regular basis. When available, individual treatment was often not done in a confidential setting. Group therapy was not available to these inmates. In general, they reported much dissatisfaction with access to mental

health treatment.
Assessment: Related in large part to the mental health staffing vacancies, significant problems existed in mental health caseload inmates accessing adequate mental health services. Medication administration issues were present as summarized above.

Lee Correctional Institution

During the afternoon of December 7, 2017, we site visited the Lee Correctional Institution. The inmate count was 1510 inmates, which included 309 mental health caseload inmates (20.5% of the total inmate population). There were 239 L4, 28 L3, and 42 L5 mental health level of care inmates. 75 inmates were in the RHU which included 42 mental health caseload inmates (5 DD, 22 SD and 13 ST).
The step-down unit previously located at the McCormick CI moved several months ago to Lee CI. The current count was 46 inmates with 22 inmates in the RHU track and 24 inmates in the IMU track.
A Better Living Incentive Community (BLIC) has been established in at least two different housing units with one of the housing units being designated for mental health caseload inmates.
Staffing data was as follows:

5.0 allocated QMHP positions with 2.0 vacancies. 1.0 FTE QMHP was on medical leave with coverage being provided on a 3 day per week basis for this person.

13 hours per week psychiatric coverage is provided by three providers with a minority of these hours being provided via telepsychiatry.

2.0 FTE MHT positions allocated with both positions being vacant.

14 FTE nursing positions were filled out of the 36 FTE positions allocated. Registry nurses are also used to mitigate the vacancies.

We interviewed 11 mental health caseload inmates from the BLIC in a group setting. Medication continuity issues were not common. Lockdowns in general population housing units related to systemwide lockdowns were reported to not be uncommon. Medication administration during such lockdowns occurs under the cell door. Reasonable access to the psychiatrist appeared to be present. Inmates described mixed perceptions concerning access to their mental health counselors. However, all the inmates in the BLIC participate in at least two classes per week. In general, these inmates were very complementary of the BLIC.

Assessment: As compared to other SCDC correctional institutions we have assessed, the satisfaction regarding mental health services on an outpatient basis described by mental health caseload inmates was significantly higher, which is likely related to the programming and therapeutic milieu established in the BLIC. We did not interview mental health caseload inmates who were not in the BLIC. Medication administration issues remain very problematic during lockdowns.
Accordingly, the following description and appendices are reflective of the Implementation Panel's findings based on the specific facilities inspected during this site visit, namely Kirkland CI, Broad River CI, Lieber CI, Lee CI, Kershaw CI and Graham CI. As noted previously, Policies and Procedures are in partial compliance and the Implementation Panel has very strongly recommended

further review of the Policies and Procedures, as well as the Master Plan given changes within the system and the critical needs for staffing and other resources.

Camille Graham Correctional Institution

The IP visited Camille Graham CI on December 8, 2017. The IP was very positively impressed by the efforts demonstrated at CGCI during the last site visits, despite continuing staff shortages. We also identified concerns at both CGCI and Leath CI regarding the piloting of the EHR, particularly concerning medication administration. We were assured by staff that there had been significant improvement with only 4% refusals based on audits done by IT and nursing; however we were subsequently informed there were an additional 7% of "missed" doses, and the audit only looked at a sample of inmate records from the ICS and RHU programs. We were also told of multiple groups for caseload inmates in ICS, RHU and outpatients, as well as 6-8 hrs. of out of cell time for women in R & E.
We held two Community meetings in the ICS programs and toured R & E and RHU; the feedback we received from inmates, as well as ongoing concerns by psychiatry and nursing, indicate the information we were provided was inconsistent, at best. CGCI continues to not meet the requirements of the Settlement Agreement largely based on inadequate staffing. It is essential that the information and methodologies for collection and analysis be clear and accurately presented.

Below are the specific findings followed by the attachments that provide overview information on the system as a whole as well as the individual facilities within the system.

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 December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update:
A QI study was completed 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. In contrast to previous tracking results, during this study, R&E staff at Camille Graham differentiated between level urgency of assessment needed, identifying 41 inmates in need of urgent evaluations and 17 in need of emergent evaluations. Kirkland R&E staff identified 19 urgent referrals but no emergent referrals. Both programs continue to face challenges in completing required screenings and follow up evaluations within the timeframes outline in policy though, Kirkland QMHPs showed major improvement assessing routine referrals within the required timeframe for the months of August and September. Both institutions continue to struggle with completing psychiatric follow ups within the required timeframe, but stabilization of QMHP staffing at Kirkland has improved compliance with the meeting the secondary evaluation deadline.

The results are below:

Camille Graham

July	August	September
MH screening (n=28) Percentage completed within mandated timeframe= 71% Average # of days from intake to screening =3.04	**MH screening** (n=29) Percentage completed within mandated timeframe = 69% Average # of days from intake to screening = 2.6	**MH screening** (n=36) Percentage completed within mandated timeframe = 69% Average # of days from intake to screening = 2.74
Routine referrals completed within mandated timeframe QMHP= 66% (n=15) Psychiatry= 36% (n=11)	**Routine referrals** completed within mandated timeframe QMHP= 96% (n=27) Psychiatry= 0% (n=19)	**Routine referrals** completed within mandated timeframe QMHP-31% (n=13) Psychiatry= 0% (n=10)
Urgent referrals completed within mandated timeframe QMHP=0% (n=9) Psychiatry= 0% (n=8)	**Urgent referrals** completed within mandated timeframe QMHP=6% (n=17) Psychiatry= 0% (n=17)	**Urgent referrals** completed within mandated timeframe QMHP= 0% (n=15) Psychiatry= 0% (n=15)
Emergent referrals completed within mandated timeframe QMHP= 0% (n=4) Psychiatry=0% (n=4)	**Emergent referrals** completed within mandated timeframe QMHP= 0% (n=5) Psychiatry=0% (n=5)	**Emergent referrals** completed within mandated timeframe QMHP= 0% (n=8) Psychiatry=0% (n=8)

Kirkland

July	August	September
MH screening (n=46) Percentage completed within mandated timeframe = 76% Average # of days from intake to screening =3.46	**MH screening** (n=54) Percentage completed within mandated timeframe = 80% Average # of days from intake to screening = 3.9	**MH screening** (n=43) Percentage completed within mandated timeframe = 65% Average # of days from intake to screening = 3.37
Routine referrals completed within mandated timeframe QMHP= 80% (n=41) Psychiatry= 68% (n=31)	**Routine referrals** completed within mandated timeframe QMHP= 84% (n=51) Psychiatry= 27% (n=26)	**Routine referrals** completed within mandated timeframe QMHP=91% (n=32) Psychiatry=47% (n=15)
Urgent referrals completed within mandated timeframe QMHP=100% (n=5) Psychiatry= 20% (n=5)	**Urgent referrals** completed within mandated timeframe QMHP=33% (n=3) Psychiatry= 33% (n=3)	**Urgent referrals** completed within mandated timeframe QMHP=82% (n=11) Psychiatry= 27% (n=11)
Emergent referrals completed within mandated timeframe No emergent referrals.	**Emergent referrals** completed within mandated timeframe No emergent referrals.	**Emergent referrals** completed within mandated timeframe No emergent referrals.

The full QI study with planned actions is included as Appendix A.

December 2017 Implementation Panel findings: As per SCDC status update section. Improvement is noted with meeting policy and procedures' timeframes as compared to the prior site visit. As with previous site assessments, it appeared that the partial compliance was related to inadequate mental health and custodial staffing allocations, which are exacerbated by lockdowns and staff being pulled elsewhere.

Average length of stays in the R&E units were as follows:

Removals from Kirkland R&E (Average Time to Assignment, excludes releases from R&E):
Jul17 removals average days in R&E: 72 days
Aug17 removals average days in R&E: 66 days
Sep17 removals average days in R&E: 69 days

Removals from Graham R&E (Average Time to Assignment, excludes releases from R&E):
Jul17 removals average days in R&E: 39 days
Aug17 removals average days in R&E: 47 days
Sep17 removals average days in R&E: 43 days

Staff at Camille Griffin Graham CI reported that newly admitted R&E inmates were offered a coping skills group during the first week following admission and a character building group during the second week until they were transferred from the R&E unit. They estimated that such inmates also received out of cell dayroom time as well. However, information obtained from inmates in the R & E indicated that they were not receiving out of cell time.

It was also brought to our attention, and confirmed by staff, that R&E inmates, who are placed on the mental health caseload as a result of the screening process, are not assigned a mental health clinician regardless of their length of stay in R&E. An inmate complained that she was notified that her mother had died during the second month of her stay in R&E and was unable to meet with a mental health counselor to discuss relevant issues until she was transferred to Blue Ridge C Wing about 68 days later.

December 2017 Recommendations:

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

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

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

November 2017 SCDC Status Update:
To track the percentage of mentally ill inmates, the Division of Resources and Information Management (RIM) generates s report entitled *Mental Health Classifications for the Mentally Ill Institutional Population*. This report includes

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

An important part of our ongoing effort to accurately identify and track inmates within the SCDC population that are mentally is through annual screenings.

As of October 2, 2017, the following institutions have implemented this annual screening process:

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

The full QI study with planned actions and protocols for screenings are attached as Appendix B. and Appendix B1, respectively. Assessment of the results was as follows:

In this data set, 68.8% of inmates eligible for their annual mental health screening were actually screened. Only 1.5% of those eligible for screening actually ended up added to the mental health caseload. This low number seems to be largely due to two factors. First, inmates who are eligible to be screened and receive an Order to Report for the screening do not always show up. Second, follow up evaluations must be completed before an inmate is actually placed on the mental health caseload and these are not being completed within policy timeframes. Thus, it is possible that some inmates in this data set who did receive their annual screening were eventually added to the mental health caseload but their addition is not reflected in this data because it happened after the data for this study was gathered.

Planned actions:
On October 2, 2017, The Division of BMHSAS implemented a new statewide protocol (see attachment) following the guidance provided by the IP during their last site visit. This protocol requires that the wellness checks account for all inmates eligible for them in any given month. In order to accomplish this, mental health staff will seek out inmates who fail to report for their

appointments for face to face contact. Additionally, mental health staff will follow up on inmates who refuse to attend their appointment by completing a records review (AMR and medical chart) and talking with security staff. No inmate will be noted to have "refused services" until all of this has been done. Supervisory staff were trained on this protocol in October. Continued monitoring and oversight will occur to determine if current procedures are adequate based on time/effort built into the process. Since the completion of this study, Camille Griffin Graham CI's Psychiatry hours have doubled. They increased by 32 hours per month and now have 64 hours per month between three part time psychiatrists.

December 2017 Implementation Panel findings: As per SCDC update.

December 2017 Recommendations: Implement and QI the above referenced plan.

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 December 2017 Assessment: **partial compliance**

November 2017 Update:
The Division of BMHSAS conducted a QI study to review triage decisions made by Qualified Mental Health professionals (QMHPs) to determine if screening/assessment practices are accurate for the diagnosing of inmates with serious mental illness for referral to appropriate treatment programs.

The full study is attached as Appendix C. Results were as follows:

Assessment of Results
As noted in previous studies, staff meeting timeframes for triaging referrals continue to be outside of policy guidelines. The data entry of medclass information after inmates have seen the QMHP and Psychiatrist also appears to be an issue.

Plan Actions
1. Psychiatry time for both programs has increased to address timely follow-up of referrals. Camille Graham has approximately 64 Psychiatry hours a month between three part time psychiatrists. In October 2017, Kirkland began Saturday Psych clinics, which will increase their psychiatry coverage by an additional 12 hours a month.
2. Camille's Mental Health Supervisor will provide additional oversight and coordination to subordinate staff to improve compliance percentages for routine, urgent, and emergent referrals to the QMHP.
3. Pursue the hiring of a pink-slip/temporary position to assist with data entry requirements at Kirkland R&E.

December 2017 Implementation Panel findings: The QI referenced in the status update focused on compliance with relevant timeframes in contrast to assessing the accuracy of the mental health screening and/or assessment processes.

December 2017 Recommendations:

Perform a QI specific to assessing the quality of the mental health screening/assessment processes. Target populations can include an appropriate sample of inmates admitted to SCDC within the past six months with negative R&E assessments from a mental health perspective who were subsequently placed on the mental health caseload within six months of admission to the SCDC. Another QI could focus on a sample of R&E mental health screening/assessments performed by a QMHP and reviewed by a supervisor to determine percentage of agreement or disagreement with the QMHP assessments.

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 December 2017 Assessment: **partial compliance**

November 2017 Update:

The R&E Committee established in November 2016 continues to meet and discusses R&E data for Kirkland and Camille Correctional Institutions. The July 2017 meeting was cancelled due to scheduling conflicts. The August 2017 meeting focused on completion of mental health evaluations and ensuring that MEDCLASS and mental health evaluation were reviewed. Detailed minutes for August and September are included as Appendix D.

1. To ensure that policies relating to the timeliness of assessment and treatment for incoming inmates are enforced:
2. Psychiatry coverage at R&E for Kirkland and Camille Graham has increased to address timely follow-up of referrals.
    a. Camille Graham has approximately 64 psychiatry hours per month from three part-time psychiatrists. This has increased from 36 hours per month
    b. In October 2017, Kirkland initiated Saturday psychiatric clinics, which has increased their psychiatry coverage by an additional 12 hours per month.
3. Camille Graham's Mental Health Supervisor will provide additional oversight and coordination to subordinate staff to improve compliance percentages for routine, urgent, and emergent referrals to the QMHP. A part of the problem has been coordination and supervision. Therefore, the MH Supervisor will be more directly involved with monitoring the data regarding timeframes and ensuring that staff are productive. Coordination has also been worked out with Dr[redacted] to ensure Camille and Kirkland staff will have access to a Psychiatric provider daily to handle urgent/emergent referrals.
4. Health Services has identified that a temporary pink slip position will be filled to ensure mental MEDCLASS data is entered timely.

December 2017 Implementation Panel findings: As per status update section. The increased staffing allocations described in the status update section are encouraging, which should facilitate better compliance with relevant timeframes.

This provision has not yet been directly monitored specific to timeliness of inmates receiving treatment once they have been placed on the mental health caseload. However, based on data relevant to other provisions, many inmates are not receiving timely treatment related to custody and mental health staff allocations and/or vacancy issues.

December 2017 Recommendations: continue to closely monitor via QI.

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 December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update:
See report and QI study for 1a.i..

The South Carolina Department of Corrections (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. If this 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. The purpose of this study was 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.

December 2017 Implementation Panel findings: As per 1a.i.

December 2017 Recommendations: As per 1a.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 December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update:
The Division of BMHSAS completed a QI study to review and assess processes that may contribute to an increase in number of male and female inmates receiving Area Mental Health care services.

The goal of the study was to measure whether SCDC had more accurately identified inmates needing a higher level of outpatient mental health care.

Results of the study revealed an increased number of inmates added to the L3 classification from April to May followed by a slight decrease in June. In comparison, there was a significant increase in the numbers for July; however, August and September numbers present a decline with September having the lowest of all 6 months.

The CQI study is attached as Appendix E

Mental Health's Plans for Area Mental Health

1. The decision has been made to create an area mental health unit to centralize delivery of area mental health services to higher security inmates currently house at Lee, Lieber, and Perry. Approximately 239 area mental health inmates will be relocated to designated Mental Health dorms at to BRCI;
2. The Area Mental Health (L3 classified) inmates will be housed in Marion dorm as current non-mental health inmates housed at Marion will be moved:
3. The move will be complete by December 1;
4. 2 QMHPs and 1 mental health tech will have offices at Marion;
5. 2 group rooms will be used on each side of the Marion dorm for a total of 4 rooms;
6. 2 QMHPs will be on the yard and 1 supervisor will be located at Moultrie
7. 1 MH tech will be located at RHU.
8. Adequate supplies will be obtained.
9. Repairs to the dorm will be completed;
10. The mental health counselor requested CIT officers and wants to use the positive experiences at CSU to model Area Mental Health program and services.
11. A unit manager has been assigned to the new area mental health dorm.

December 2017 Implementation Panel findings: See SCDC status update section.

During the afternoon of December 5, 2017, we interviewed inmates in a community - like setting in one of the Marion housing unit wings at the Broad River Correctional Institution that was occupied by inmates with an L3 mental health classification. These inmates were very upset, angry and vocal regarding their dissatisfaction with the transfer process from their home institutions to the Marion housing unit at BRCI. There complaints included the following:

1. Significant problems with the medication administration process such as nursing staff administering the medicines under the cell door, leaving medications on the food port, not delivering medications and/or administering medications to the wrong inmate.
2. Poor access to the mental health counselor due to the large caseload of the assigned mental health counselor to the housing unit.
3. Inadequate access to commissary.
4. Not obtaining property from the sending institution.
5. Lack of access to the law library.
6. Inadequate access to religious services.
7. Lack of access to educational activities, jobs and/or other programs.
8. Lack of access to outdoor yard.
9. Significant laundry issues.
10. Essentially being locked down for the first four weeks following transfer to this unit.

After talking with key administrative clinical and custody staff, it was apparent that many of the above allegations were at least partially, if not completely, accurate. We met with key leadership staff to discuss recommended interventions such as frequent community meetings with custodial decision-makers to address these issues until they were adequately resolved. Leadership staff had made a decision to transfer these L3 classified inmates in the near future to the Murray housing unit due to its better physical plant. Leadership staff appeared to be very open to our recommendations. Lessons learned from the above transfer of inmates process were also discussed with key staff.

We had been informed by mental health staff that these inmates were receiving mental health screenings with a significant number of such inmates having their mental health classification changed from a L3 to L4 designation. We recommended that mental health staff stop this screening process at the present time and focus on crisis management and supportive therapy interventions.

[redacted]

December 2017 Recommendations:

1. Implement the above recommendations.
2. There remain L3 inmates in other CI's that have not yet been transferred to the BRCI. We recommend that these inmates be screened at the sending institution as part of the decision whether to transfer the inmate to BRCI. Some of the L3 inmates' mental health level of care may no longer require an L3 LOC and for some it may be beneficial to not be transferred based on their level of functioning and programming, especially those inmates housed in various character dorms.

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

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

November 2017 SCDC Status Update:
The Division of BMHSAS completed a QI study to review and assess processes that may contribute to an increase in number of male and female inmates receiving intermediate care services.

A CQI study was completed to measure whether SCDC had more accurately identified inmates needing this level of care.

The results of the study revealed that the number of MEDCLASS changes to L2 from lower levels of care were low. However, 22 referrals were made to the ICS program, staffed by the treatment team, which were ultimately not deemed appropriate for ICS. Reasons for the denials included: not suitable due to behavioral issues, does not have SMI warranting L2 services, no treatable psychiatric disorder, not suitable due to manipulative behavior, and not suitable due to extensive disciplinary history. All but one of those denials were upheld in the review phase. This indicates that the QMHPs making the initial referrals to the L2/ICS level of care are not referring the appropriate inmates.

The CQI study is attached as Appendix F.

Community Meetings

- The Program Manager reported that Community Meetings are held on Fridays in the Blue Ridge Unit (C & D). Source documentation (signed attendance rosters) were received which indicates the following:
- Three community meetings were held in July 2017; July 7, 14, and 21, 2017.
- The meeting scheduled for the 28th was cancelled due to agency cleaning day.
- Four community meeting were held in August 2017; August 4, 11, 18 and 25 2017.
- Four community meeting were held in September; September 1, 8, 15, 22 & 29, 2017.
- Due to a late submission of documentation, the sing-in sheets are out of order in the appendix references; however, the sign-in sheets are attached as Appendix R.

MAR-specific considerations:

- After the July 2017 IP visit, more consistent collaboration began between RIM, nursing, MH and pharmacy staff to address any medication issues. Several enhancements have been added to the system:
- The external vendor/Medicalistics has activated the capability for eZmar to automatically send notifications to the prescribing provider when an inmate misses three consecutive doses. This capability was not functional until recently. The provider should have the ability to address the medication non-compliance issues of the inmates in a timely manner.
- Due to the continuing issue of psychiatry coverage at the two female facilities, nursing and MH staff have been proactive in addressing medications that are due to expire. They have been contacting the prescribing psychiatrist and SCDC full-time psychiatrists by email in order to call attention to those medications and receive the renewals that are needed.
- We have had our software vendor amend coding in the eZmar system to allow for improved medication check-in processes.
- Some of the issues with eZmar functionality still exist due to workflow tasks not being completed appropriately by the medical staff. SCDC has coordinated an extra week of

training time with our software vendors. Those re-training classes are scheduled for December 12-14. Correcting these issues will allow staff to request medication refills through eZmar, whereas the current lack of completing workflow tasks are preventing them from being able to request electronically.

- The classes will focus primarily on:
- Consistently checking the "Map Meds" screen to appropriately map new prescriptions to the pill calls.
- Enhanced technology and the ability to electronically check in medications upon arrival from the pharmacy.
- Electronically checking in medications when they arrive from the pharmacy.
- Appropriately selecting "Start New Package" when one is available during a pill call.
- Reviewing the "Medication Change" tasks in the Inbox before preparing medications for an upcoming call to ensure discontinued meds are removed and dose changes are taken into account.
- Preparing the pill calls according to the pill call created in eZmar rather than preparing a pill call based on what the medication bags say for each inmate. The medication information in eZmar will always be more current and accurate than what is shown on a pharmacy label that has perhaps not yet been updated and delivered.

Refresher material has also been made available to all the prescribing providers at Graham and Leath for physicians to prescribe in a manner that reduces the burden of work put on the nursing staff.

December 2017 Implementation Panel findings:

Kirkland Correctional Institution

Nursing staff continues to not be housed within the male ICS unit related to safety issues. Very little has changed from a custody staffing perspective in the male ICS since the April 2017 homicides other than assigning a unit manager and correctional counselor to the male ICS unit. Following the homicides, the male ICS unit was reorganized as follows: Unit F1, which is a 64 bed ICS housing unit, was established for ICS inmates who were considered a high risk of harming vulnerable inmates from the perspective of their functioning level. Unit F2, which is a 128-room ICS housing unit with a capacity of 256 inmates, was designated to treat inmates with a lower level of functioning as compared to F1 inmates. The count during the site visit of unit F2 was 97 inmates as compared to the count of 40 inmates in Unit F1.

At the time of the site visit the total male ICS count was 137 inmates.

The lack of medication administration at KCI being available on a HS basis (i.e., at night) continues to be very problematic. Long acting injectable medications are available but are administered off the housing unit because nursing staff have been removed from ICS related to perceived safety issues.

During the morning of December 5, 2017, we observed a treatment team meeting in the male ICS at KCI. The appropriate staff were present, inmates were interviewed by the team and a reasonable multidisciplinary discussion occurred during the meeting. Specific inmate referrals to the ICS were reviewed during the treatment team meeting. It appeared that acceptance or rejection of such referrals was a team decision, which is problematic from a number of perspectives.

We also met with ICS inmates in one of the F2 wings in a community-like setting. These inmates described satisfaction with the ICS program. Most inmates reported receiving 3 to 5 groups per week, which they described as being very helpful. They were complimentary towards both the custody and mental health staffs. Medication continuity issues were not present. Reasonable access to both individual counseling and the psychiatrist was described. A therapeutic milieu was clearly present on this unit. Suggestions for improvement in the program included access to more therapeutic groups and a wider variety of such groups.

We also met with ICS inmates in housing unit F1 in a community - like setting. These inmates were described as "higher functioning" as compared to ICS inmates in housing unit F2. A therapeutic environment also had been established in this unit. A larger number of inmates, but still a significant minority of inmates, expressed dissatisfaction with certain aspects of this program. Most inmates reported access to 3-4 groups per week, which were generally described as being helpful. Medication continuity issues were not present. Reasonable access to a psychiatrist and assigned mental health clinicians was described.

Assessment: We were very encouraged by the therapeutic milieu established in the ICS units at Kirkland CI. We remain very concerned regarding safety issues, which have resulted in the lack of nursing staff having a significant presence within the ICS. Increased out of cell structured therapeutic activities need to be implemented and tracked.

We do not think that acceptance or rejection of inmates referred to the ICS should be a team decision, although in many cases it may be appropriate for the decision-maker to seek input from the treatment team.

Recommendations:

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

Camille Griffin Graham Correctional Institution

The inmate count during November 27, 2017 was 719 inmates. During December 8, 2017 there were 380 mental health caseload inmates (~59% of the population), which included 23 L2, 55 L3, 204 L4, and 25 L5 mental health caseload inmates.

The RHU count was 18 inmates, which included 13 mental health caseload inmates.

There were 12 CSU beds and 4 safety cells in RHU. The number of inmates on CI status generally ranged from 0-3 per day with length of stay less than 10 days. The 4 safety cells in the RHU were not suicide resistant.

The female ICS count was 23 inmates with three ICS level of care female inmates in the RHU and one ICS female inmate on security detention status.

Staffing data included the following:

> Psychiatric coverage is provided by three psychiatrists that involves up to 16 hours per week, which included 4 hours of telepsychiatry. Additional psychiatric coverage was available on an as needed basis during weekends.
>
> A psychologist provides on-site coverage two days per week for an average of 15 hours per week.
>
> 7.0 FTE QMHP positions are allocated with 6.0 FTE positions filled.
> 4.0 FTE MHT positions are allocated with 3.0 FTE positions filled.
>
> 20.0 FTE nursing staff positions are allocated with 2.0 FTE RN FTE positions filled and 5.0 FTE LPN positions being filled. Registry nurses provided the equivalent of 2.5 FTE nursing positions.

Staff reported that the number of groups being offered to inmates had increased related to the collaborative training project and decreased staffing vacancies.

We observed a treatment team meeting during the afternoon of December 8, 2017. We were again impressed by the multidisciplinary discussion and the presence of a psychiatrist, Dr. [redacted]

ICS

Staff reported that ICS inmates in D Wing were being offered group therapies on a weekly basis although they could not quantify the number of hours of out of cell structured therapeutic activity, on average, being offered to these inmates. A lesser number of group therapies were being offered to mental health caseload inmates who were housed in C Wing. Fifteen group therapies were being offered in the general population mental health caseload inmates, which included those inmates

housed in C Wing. L2 inmates housed in C Wing were offered group therapies being provided to D Wing ICS inmates.

Fourteen ICS inmates in D Wing were interviewed following our observation of a community meeting, which was conducted in a very reasonable manner. The majority of the inmates interviewed indicated that they participated in less than two groups per week with a high refusal rate noted re: other groups offered to them.

We also observed part of a community meeting in C Wing, which was attended by many inmates who had many medication management complaints as referenced in the next subsection. These inmates also complained that until very recently a significant number of non-mental health caseload inmates were housed in this dorm, which caused numerous problems including acting out behaviors by some of those inmates. Several inmates also expressed concern about an inmate in the general population who they described as being psychotic and eating poorly.

Medication Management

Staff reported minimal continuity of medication issues based on an audit that used a sample population of ICS and RHU inmates. However, information obtained from many inmates in the ICS directly contradicted the reported audit results. Medication management issues described by many inmates included the following:

1. Waits up to one hour for the morning medication pass, which involves going to a general population pill call line beginning around 4:45 AM
2. The pharmacy running out of certain prescribed medications, which resulted in significant delay in receiving prescribed medications despite the staff's report that many medications were available via a stock supply.
3. About 4-6 weeks ago, the medication administration process changed from a three per day to a two per day pill call line process due to nursing staff shortages. Nursing staff reported that a psychiatrist had adjusted patients prescribed medications on a t.i.d. scheduled basis to a b.i.d. schedule as a result but many inmates denied that their medications had been changed in that fashion.
4. The lack of medication administration not being available on a HS basis (i.e., at night) continues to be problematic.

R&E

Staff also reported that newly admitted R&E inmates were offered a coping skills group during the first week following admission and a character building group during the second week until they were transferred from R&E. They estimated that such inmates also received out of cell dayroom time as well. However, information obtained from inmates in the R & E indicated that they were not receiving out of cell time.

It was also brought to our attention, and confirmed by staff, that R&E inmates, who are placed on the mental health caseload as result of the screening process, are not assigned a mental health

clinician despite the length of stay in R&E. An inmate complained that she was notified that her mother had died during the second month of her stay in R&E and was unable to meet with a mental health counselor to discuss relevant issues until she was transferred to C Wing about 68 days later.

Assessment: We clearly expressed our dismay regarding the discrepancies in information obtained from staff as compared to inmates specific to medication management issues, participation in out of cell structured therapeutic activities, and the amount of out of cell time offered to inmates in R & E.

Recommendations:

1. The medication management issues need to be remedied and studied via a QI process.
2. Adequate tracking of the out of cell structured therapeutic hours and unstructured out of cell time offered to each mental health caseload inmate, on average, each week as well as the actual number of hours participated in such activities by each inmate, on average, each week needs to occur. This tracking should differentiate between out of cell structured therapeutic time and out of cell unstructured time. This tracking process should occur for mental health caseload inmates in the RHU and for mental health caseload inmates in the R & E.
3. A similar tracking process should occur for ICS inmates.

December 2017 Recommendations:
See Attachment 1. Although the accuracy of the data summarized in Attachment 1 was questionable, there was no disagreement that both male and female ICS inmates were not receiving minimal out of cell structured therapeutic activities. This issue was described as being predominantly related to staffing allocation and/or vacancy issues.

Refer to the previous assessment and recommendations section specific to Kirkland CI and Camille Griffin Graham CI for specific assessments and opinions relevant to each program.

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 December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update:
Status of GPH Renovations as of 10/30/2017
The renovations to turn two cells on each wing of the GPH housing unit to a nurse station is on-going. Most of the renovation is complete except for the electrical upgrades, security camera system, patching of walls/ceilings and painting.

Substantial Completion is anticipated by December 31, 2017. SCDC will then request inspection by SC DHEC for operational permit.

Inpatient psychiatric beds

To increase access to inpatient housing for female inmates, SCDC has successfully executed an amended contract with Correct Care for 10 beds dedicated to SCDC use. This separate unit for SCDC is currently undergoing renovations with an anticipated completion by February 1, 2018. The amended contract has been signed by both parties. A copy has been provided to the Implementation Panel.

Gilliam Psychiatric Hospital (GPH) is the inpatient facility for all males requiring this level of care. During the months of July-October 2017, GPH averaged a census of 79 mentally inmates.

During the months of July – October 2017 there was one (1) female inpatient at Correct Care. She was there for 3 weeks during the month of October.

GPH Treatment Chairs

- Treatment chairs have been removed and replaced with a spider table that can sit six inmates comfortably.
- Provide training/supervision to mental health staff regarding court orders relevant to involuntary medications.

GPH Low Admissions Rate

- Camille Graham has increased Psychiatry at Camille Graham to provide psychiatric care, medication assessment and management.
- Camille is averaging approximately 64 hours of psychiatry services monthly which allows appropriate interventions, preventing hospitalizations.
- **Training on court-ordered involuntary medications**
- On October 25, 2017, a training on Involuntary Medications was taught by the Division Director and Assistant Division Director of BMHSAS. This training was attended by twenty-nine MH staff. The content of this training is attached as Appendix G.
- **Supervision of mental health staff for court-ordered involuntary medications**
- Supervision will be provided by keeping a database of all inmates with court orders for involuntary medications. Clinical Supervisors will be required to review all cases quarterly with subordinate staff to ensure continuity of mental health care.

- Attachment 1 summarize at a cell time offered to GPH inmates.

December 2017 Implementation Panel findings:

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

Renovations at GPH are not yet completed with specific reference to the nursing stations although significant progress has been made as summarized in the SCDC status update section.

Since the last site visit, training has been provided to mental health staff regarding court orders relevant to involuntary medication. In addition, the "treatment" chairs have been replaced by a spider table in one of the group therapy rooms.

Clinical staffing for GPH was reported as follows:

Psychiatrists: 2.1 FTE positions filled with 4.0 FTE positions designated in the staffing plan.

Psychologist: .60 FTE position filled with 1.50 FTE positions designated in the staffing plan.

QMHPs: 4.0 FTE positions filled out of the 8.0 FTE allocated positions with 9.0 FTE positions designated in the staffing plan.

MHTs: 15.0 FTE positions filled out of the 16.0 designated positions in the staffing plan.
Nursing (R.N./LPN): 7.0 FTE positions were filled out of the 22 FTE allocated positions with 27.0 FTE positions designated in the staffing plan. Registry nurses are used to cover many of the vacant positions.

Activity therapists: .42 FTE positions were filled out of the 1.0 FTE positions designated in the staffing plan.

During the afternoon of December 4, 2017, we met with 22 inmates at GPH in a community meeting like-setting. The inmates were attentive and generally socially appropriate throughout the 30-40 minute meeting. Inmates reported that they received 0-2 hours per day of out of cell activity, which was mainly unstructured recreational activity in either the dayroom or outdoor recreational cages. Very few inmates were offered out of cell structured therapeutic activities in a group setting. Individual out of cell counseling was offered to many inmates but on an infrequent basis. These inmates described the housing unit at GPH to essentially be a locked down housing unit. Inmates who had been at GPH many years ago described the current conditions of confinement initiated to have improved. Inmates also reported that the groups offered to them were helpful but too few in numbers.

Several inmates reported that they had witnessed inappropriate use of force by staff against inmates.

We discussed with staff issues relevant to the minimal out of cell time offered to inmates in GPH. We were informed that medication administration generally occurs around the time that meals are being delivered, which meant that on a daily basis there was only about a five-hour window of opportunity for GPH inmates to be out of their cell. The default principal for GPH inmates is that they are locked in their cell unless there is a specific reason for them to come out of their cells.

December 2017 Recommendations:

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

2. Further explore the reasons for the low admission rate of female inmates to an inpatient psychiatric unit.

3. Complete the renovations.

4. Fill the mental health staffing vacancies and perform a needs analysis for custody staffing in GPH.

5. Provide information relevant to the number of hours received, on average, to each GPH inmate on a weekly basis both in terms of out of cell structured therapeutic time and out of cell unstructured time. Please provide this data as part of the pre-site document requests prior to our March 2018 site assessment.

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

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

November 2017 SCDC Status Update:
The strategies summarized in Attachment 1 outline SCDC's plan to decrease vacancy rates of clinical positions. This plan includes salary increases to a more competitive rate, hiring additional staff to decrease workloads and developing a plan to consolidate and centralize some of the mental health services.

New mental health staffing allocations have been approved as follows:

NEW POSITIONS REQUESTED				
Position	**# of FTE's**	**Base pay**	**Total**	**Total W/Benefits**
QMHP	9	$ 50,000.00	$ 450,000.00	$ 653,535.0000
MH Techs	6	$ 37,000.00	$ 222,000.00	$ 322,410.6000
Psychiatrist	2	$ 206,000.00	$ 412,000.00	$ 598,347.6000
Psychologist	2	$ 90,000.00	$ 180,000.00	$ 261,414.0000

Total	**19**	**$ 383,000.00**	**$ 1,264,000.00**	**$ 1,835,707.20**

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

Our July 2017 recommendations included the following:

> A staffing needs analysis for all aspects of the mental health system throughout the SCDC, which should include both mental health and custodial staff, is needed. This analysis should be completed in a timeframe that would permit the Director to request additional FTE positions, if needed, for the next fiscal year.
>
> In addition, a salary analysis should be completed specific to mental health staff positions to determine the level of salary that is needed to be competitive for hiring purposes.

The salary analysis was completed, which has contributed to restructuring the salaries for various mental health disciplines as summarized in Attachment 2. An aggressive hiring recruitment plan was developed and implemented as summarized in that attachment, which is beginning to demonstrate positive results.

A staffing needs analysis has not yet occurred although it is clearly recognized that more staffing allocations are needed as evidenced by new positions being requested by the Director as summarized in the SCDC status update section. It is encouraging that an outside correctional consultant is doing a staffing analysis for SCDC in the context of correctional officers. It is expected that a report will be finalized in March 2018.

The current mental health staffing vacancy rate is 26.78%, which is a significant improvement as compared to the 37% to 40% mental health staffing vacancy rates noted during site visits since November 2016.

December 2017 Recommendations: Continue to implement the recruitment and retention plan as outlined in attachment 2.

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 December 2017 Assessment: **compliance (07/17)**

November 2017 SCDC Status Update:

LLBMU Denials

Mental Health continues to review denials to the BMU programs. Training was provided to staff on the BMU policy on 10/25/17; therefore, the decrease in denials cannot be directly attributed to the

training. The staffing pattern for LLBMU has remained consistent throughout last reporting period. The training content is included as Appendix I.

Inmates not accepted were reviewed by Dr. [redacted] committee and if overturned are currently awaiting to transfer in to the program. Inmates remain in RHU until transferred to either LLBMU or HLBMU. LLBMU has capacity for 24 inmates based on current staffing.

December 2017 Implementation Panel findings:

During our prior site visit, SCDC provided a description of the QI committee that meets to review denials of referrals of inmates to higher levels of care. The description included the following:

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

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

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

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

This review process has continued.

Some issues described during the prior site visit relevant to denials specific to the HLBMU appeared to have been adequately addressed via this review process.

As summarized in the SCDC status update section, training has been provided to mental health staff relevant to criteria for referral to the BMUs.

December 2017 Recommendations: Continue with the described review process.

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

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

November 2017 SCDC Status Update:

HLBMU

The attachment at Appendix J outlines progression of inmates through the three phases of the HLMBU from July- September 2017. The mission of the HLBMU is to provide programming, treatment and structure to inmates whose mental health needs likely contribute to their segregation status.

The HLBMU's serves as an alternative to long-term placement in restrictive housing. For some inmates, the program will facilitate reentry to the community at the completion of their sentence. HLBMU services include: crisis intervention, individual & group treatment, and daily rounds.

The program is designed to provide inmates ten (10) hours of out-of-cell activities structured by their mental health treatment plans, including group activities, and ten (10) hours of unstructured, out-of-cell activities time each week.

HLBMU has not moved from KCI to Broad River due to staffing and the relocation of Death Row to the SSR building at KCI. Timelines and program expansion dates are outlined and explained in the Master Plan.

The SDP program Managers are actively involved in the selection of officers assigned to the SDP.

The SDP policy addressing inmates released from Security Detention has been written and in the signature stage.

HLBMU Staffing & Program Capacity

Staffing

Position	Positions Allotted	Positions Filled	Current Vacancies
Program Manager	1	1	0
QMHP	4	1	3
Mental Health Techs	4	1*	3

*1 Mental Health Tech was hired for this area but had to be reassigned to GPH as a Bay Counselor as a result of failing the required officer certification.

Program Capacity

Program Capacity	24	
Number of Admissions	3	
Number served this quarter (July- September 2017)	18	
Number dismissed	4^	

^ Inmates dismissed due to staff assault & building destruction

December 2017 Implementation Panel findings:

During the afternoon of December 4, 2017, we interviewed level 2 and level 3 HLBMU inmates in the HLBMU at the KCI. The inmate census in this unit was 19 with a current capacity of 24. The planned expansion and move of the HLBMU at KCI to the Broad River CI did not occur for reasons summarized in the SCDC status update section. Our prior site assessment report included the following:

> The HLBMU program has essentially never been appropriately implemented due to the custody staffing shortages (average about two officers per day with only one officer assigned at times) and inadequate mental health staffing (1.0 FTE QMHP and 1.0 FTE mental health technician, both of whom provide coverage to the SSR) within the unit.

For somewhat different reasons as referenced in the SCDC status update section, the mental health and custody staffing shortages have persisted. Level 2 inmates remained very upset that their visitations did not include weekend visits. HLBMU inmates continued to complain about lack of structured programming within the HLBMU and inconsistency among correctional staff due to regularly assigned staff being frequently pulled to other units. Our prior site assessment report included the following:

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

Our opinion is essentially unchanged.

Inmates also complained about work orders not being completed in a timely fashion in the context of a broken phone within the unit and various plumbing issues.

We did not evaluate the LLBMU during this site assessment.

December 2017 Recommendations:

We discussed with key clinical and administrative staff various ways of mitigating the lack of programming, with an emphasis on increasing out of cell time and providing, at least intermittently, access to weekend visitation. It appeared that weekend visitation on a monthly basis for these inmates would be implemented in the very near future.

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

Implementation Panel December 2017 Assessment: **noncompliance**

November 2017 SCDC Status Update:

To determine the average number of SCDC Mentally Ill Inmates in RHU and Total Institutional Population for the months of July, August and September of 2017 the RIM reports provided were utilized. The RIM reports would provide the institution's RHU census for each Thursday of the week. Each week was then utilized to determine the average. Refer to attachment 3 for a summary of the RHU population from a mental health classification perspective.

Suring September 14, 2017, QIRM hosted the first of four-learning session of the Mental Health Care Improvement Collaborative. This purpose of the collaborative was to work with seven institutions selected jointly by Mental Health and Operations leaders to individually test system changes focused on improving the care provided to their mental health inmates.

This Breakthrough Series (BTS) Collaborative is a systematic approach to healthcare quality improvement in which organizations and providers test and measure practice innovations and then share their experiences to accelerate learning and widespread implementation of best practices.

The objectives of the collaborative were:

- to increase collaboration among institutions to address components of the Mental Health Lawsuit.
- provide evidence-based information on mental health subject matter, application of that subject matter, and methods for measurement and process improvement, both during and between collaborative learning sessions.
- provide coaching and training to teams on continuous quality improvement.

- During the learning sessions participating institutions, through plenary sessions, small group discussions, and team meetings, attendees have the opportunity to:
- Learn from content experts and colleagues;
- Receive individual coaching;
- Gather knowledge on clinical topics and on process improvement;
- Share experiences and collaborate on improvement plans; and
- Problem-solve barriers to improve care.

Action periods are the times between learning sessions. During action periods, teams work within their institutions to test and implement changes using small tests of change know as Plan-Do-Study-Act or PDSA cycles. Teams share the results of their improvement efforts in monthly senior leader reports and also participate in shared learning through an electronic mailing list and scheduled conference calls.

A major focus of the Collaborative encouraged institutions to closely assess out-of-cell time for segregated mentally ill inmates. A measure was created that required teams to evaluate the time mentally ill inmates in segregation spend out of their cells. The mental health settlement agreement requires 10 OOC hours structured by the inmate's MH treatment plan and 10 unstructured OOC hours.

There continues to be limited data on the amount of out-of-cell structured and unstructured time for segregated mentally ill inmates; however, institutions have identified this as problematic and are currently taking some steps to identified opportunities for improvement.

As a part of the collaborative, seven team were encouraged to selected one area to focus on improving upon return to their institutions. Camille Graham, Broad River, McCormick, Leath and Lee CIs focused on increasing OOC time for inmates in RHUs. Perry and Broad River focused on increasing the percentage of inmates on CI seen in a confidential setting.

A summary of reported barriers, successes, and lessons learned as reported by each team is outlined in the CQI update attached as Appendix K.

December 2017 Implementation Panel findings: Data relevant to structured and unstructured out-of-cell time for institutions participating in the learning collaborative was presented and reviewed by the IP. Based on the data presented, it was clear that inmates with mental illness in the RHUs received very little, if any, out of cell therapeutic activities on a monthly basis.

Medication administration in all the RHU's we reviewed, except for the Camille Griffin Graham CI, involved administering the medications under the cell door.

Broad River Correctional Institution

During the afternoon of December 5, 2107, we obtained information relevant to the RHU at the Broad River CI. Thirty-nine (39) of the 65 RHU inmates were on the mental health caseload. Staff confirmed that prior to August 2017 inmates were not receiving out of cell recreational time. They have been receiving minimal out of cell time since that time but the frequency was nowhere close to occurring on a daily basis. There were at least one or two inmates in the RHU that were reported to be extremely disruptive, which caused significant problems in the operation of the RHU. The conditions of confinement within the RHU, based on information obtained from staff, appeared to have changed little since our last site visit.

Lieber Correctional Institution

The RHU count at the Lieber CI during December 6, 2017 was 66 inmates. Forty of these inmates were on the mental health caseload (14 (L3) and 26 (L4)). We observed the mental health rounding process in the RHU during the morning of December 6, 2017, which was done in a competent manner. Recently, RHU inmates were being offered access to the recreational cages, reportedly on a three times per week basis in the mornings. Showers were reportedly offered on a three times per

week basis. Inmates described being offered access to the yard cages 1-3 times per week. Many inmates complained about the filthy conditions of confinement within the RHU.

A group therapy, in the visitation room, has just been initiated for a small number of RHU inmates. "Therapy" chairs were to be installed on December 7, 2017 and will be used for group therapy purposes for some RHU inmates.

Four safety cells in the RHU were not suicide resistant.

Kershaw Correctional Institution

During the morning of December 7, 2017, we site visited Kershaw CI. Of the approximately 80 RHU inmates, a total of 41 inmates were on the mental health caseload (27 SD, 10 ST and 4 inmates awaiting placement). The two safety cells located in the RHU were suicide resistant. Related in large part to the 46.5% correctional officer vacancy rate, RHU inmates for the past month had access to the outdoor recreational cages on only one day. Inmates were reported to have access to showers on a three times per week basis.

We observed the mental health rounding process in the RHU, which was performed by the MHT in a competent manner.

Not surprisingly, many inmates had numerous complaints regarding the conditions of confinement within the RHU.

We observed cell searches occurring while inmates were in the shower. Correctional officers, which included the captain, were involved in the cell search which resulted in some inmates' property being thrown out of the cell into the dayroom in a disrespectful manner while the inmates were watching, for reasons that included having more socks and/or boxer shorts than was allowed by policy. Family pictures and a Christmas card were also removed from an inmate's cell walls due to violation of policy. Inmates observing these cell searches became understandably agitated.

Lee Correctional Institution

During the afternoon of December 7, 2017, we site visited the Lee Correctional Institution. Seventy-five inmates were in the RHU, which included 42 mental health caseload inmates (5 DD, 22 SD and 13 ST). RHU inmates were reported to be out of their cells for at least 10 hours per week for purposes of showers, outdoor recreation, various medical and mental health appointments, etc. In addition, a program has recently been initiated to provide out of cell structured therapeutic activities for two or three RHU caseload mental health inmates. The increased out of cell time for all RHU inmates was initiated by staff as a result of the recent mental health collaborative training project.

Despite the presence of a large number of central office staff, monitors, and "brass" from Lee CI, RHU inmates remained quiet and respectful throughout the review process. Inmates confirmed their access to increased out of cell time although they indicated they generally had to choose on a daily

basis between access to a shower or access to the outdoor recreational cages. They also complained that they did not have access to warm outerwear (i.e., jackets) during their time in the outdoor recreational cages.

Camille Griffin Graham RHU

Staff reported that 5 RHU groups per week were provided to mental health caseload inmates in the RHU. These groups were started as result of the collaborative training project. Staff estimated that RHU caseload inmates were being offered 6 to 8 hours per week of out of cell time. However, we were unable to confirm this report due to lack of time, which resulted in us being unable to interview inmates in the RHU.

December 2017 Recommendations:

1. The manner of medication administration within the RHU's is unacceptable and below the standard of healthcare. This needs to be remedied immediately.

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

3. The conditions of confinement at the Lieber CI RHU are also very problematic from a physical plant perspective and are exacerbated by the very limited out of cell time offered to RHU inmates. The conditions of confinement should be changed to include at least one hour per day of out of cell recreational time in addition to access to showers on a three times per week basis.

4. The conditions of confinement at the Kershaw CI RHU are very problematic from a physical plant perspective and are exacerbated by the lack of out of cell time offered to RHU inmates and the selective enforcement of policies. Specifically, policies and procedures specific to inmates such as property restrictions appear to be enforced in contrast to policies and procedures specific to inmates' access to outdoor recreation. The conditions of confinement should be changed to include at least one hour per day of out of cell recreational time in addition to access to showers on a three times per week basis.

5. The conditions of confinement in the Lee CI RHU were impressive in the context of any other male RHU we have visited within the SCDC. Specifically, correctional staff make extra efforts to provide inmates with what is due to them (e.g., property, (especially out of cell time) and clearly demonstrated a respectful attitude towards inmates.

   It should be noted that the Lee CI RHU appears to be a model RHU within SCDC due to the abysmal conditions of confinement and other RHU's within SCDC that we have site visited. In that context, other wardens and RHU captains could benefit from visiting this RHU. However, compared to many RHU's in other prison systems across the country, the Lee RHU would be far from a model and would be considered very problematic. However, the

progress made at Lee CI in improving the RHU and the vision demonstrated by Lee CI leadership staff should facilitate continued progress toward more acceptable conditions of confinement.

Inmates should have access to jackets while in the outdoor recreational cages.

6. The safety cells in the Camille Griffin Graham CI RHU need to meet criteria for being a safety cell. We assume that RHU safety cells are not used unless there were no vacant CSU cells.

7. The safety cells in the Lieber CI RHU need to be made suicide resistant.

8. As part of our pre-site document request, please provide data relevant to the number of hours of outdoor recreational cage time, on average, offered to each RHU inmate at each institution on a weekly basis as well as the number of showers, on average, offered to each inmate on a weekly basis by institution.

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

   Access to tablets (e.g. iPads) have been successfully implemented by other correctional systems in RHU environments. It was our understanding that crank radios will be increasingly available to RHU inmates as will TVs in the dayroom-like areas. Ensuring that inmates receive timely laundry exchanges and that shower areas are kept clean are other common sense interventions.

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

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

November 2017 SCDC Status Update:

See below:

	% Timeliness of QMHP Sessions		% Timeliness of Psychiatry Sessions	
RHU	Median	Range	Median	Range
Allendale	66.7	62.5 - 100	33.3	25 - 66.7
Camille Graham	62.5	62.5 - 70	20	12.5 - 50
Evans	60	53.8 - 61.5	53.8	46.7 - 53.8
Broad River	64.7	52.4 - 82.4	61.9	56.3 - 70.6
Kershaw	72	50 - 84	50	44 - 56

Kirkland	94.1	81.8 -100	72.7	70.6 - 78.6
Kirkland GPH	88.9	77.8 - 88.9	100	77.8 - 100
Leath	70	40 - 100	47	27.3 - 66.7
Lee	80	76.7 - 87.5	63.3	60 - 68.8
Lieber	65.2	57.1 - 71.4	53.6	52.2 - 66.7
McCormick	77.8	68.8 - 96.0	68	44.4 - 68.75
Perry	53.8	50 - 58.8	53.1*	20.5* - 85.7
Ridgeland	90	66.7 - 100	50	25 - 50
Turbeville	90.9	80 - 100	45.5	20 - 75
Tyger River	31.3	30 - 33.3	61.1	60 - 75
Agency Wide	70	30 - 100	56.2*	12.5* - 100

December 2017 Implementation Panel findings: See SCDC status update section. Partial compliance was due to a combination of custody and mental health staffing allocation/vacancies.

December 2017 Recommendations: Remedy the above .

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

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

November 2017 SCDC Status Update:
See response provided at 2.a.v. (click here)

December 2017 Implementation Panel findings: See 2.b.i.

December 2017 Recommendations: See 2.b.i.

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

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

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

November 2017 SCDC Status Update:
RIM compiles and distributes the report, *Weekly Mentally ill Report for Institutional and Female GEO Care Population.* This report includes by institution:

- Total number of inmates
- Total number of mentally ill inmates

- Total number of mentally ill inmates by mental health classification*
- Mentally ill inmates as a percent of:
- The location's population
- Total mentally ill population
- Total SCDC population

The following is an example of this weekly report.

Mental Health Classifications for Mentally Ill Institutional and Female GEO Care Population on September 25, 2017

SCDC Institutional and Female GEO Care Population = 20,109

SCDC Mentally Ill Population = 3,524

Mental Health Classification	Female	Male	Total	Percent of Mentally Ill Population	Percent of Total Population
Missing	82	492	574	N/A	2.85%
BL	0	14	14	.397%	.070%
BU	0	19	19	.539%	.094%
L1	0	81	81	2.30%	.403%
L2	27	148	175	4.97%	.870%
L3	61	227	288	8.17%	1.43%
L4	631	2,190	2,821	80.1%	14.0%
L5	2	101	103	2.92%	.512%
LC	0	1	1	.028%	.005%
MR	1	21	22	.624%	.109%

Explanation of Mental Health Classifications

(Code table pulled in directly from system and includes Non-Mentally Ill and retired codes. When an inmate returns, their previous Mental Health Classification is used until a new review is performed.)

CODE	DESCRIPTION
BL	BL (BEHAV MANAGEMENT LOWE
BU	BU (BEHAV MANAGEMENT UPPE
L1	MH-1 (HOSPITALIZATION)
L2	MH-2 (INTERMEDIATE CARE S
L3	MH-3 (AREA MENTAL HEALTH)
L4	MH-4 (OUTPATIENT)
L5	MH-5 (STABLE)
LC	SELF-INJURIOUS BEHAVIOR
MH	NMH (NO MENTAL HEALTH TRE
MI	MH-I (MENTALLY ILL)
MR	MH-R (DEVELOPMENTALLY DIS
OK	MH-S (MENTALLY STABLE)
RA	RA (REFUSED ASSESSMENT)
RT	RT (REFUSED TREATMENT)
SA	SUBSTANCE ABUSE TREATMENT

Distribution by Location

												Location Counts		Mentally Ill Inmates as Percent of		
Location	L1	L2	L3	L4	L5	LC	BL	BU	RT	MI	MR	Mentally Ill Inmates	Loc Total	Loc's Pop.	Total Mentally Ill Pop.	Total Pop.
ALLENDALE	0	0	2	159	5	0	14	0	0	0	0	180	1,048	17.2%	5.11%	.895%
BROAD RIVER	0	2	5	284	8	1	0	2	0	0	20	322	1,380	23.3%	9.14%	1.60%
CATAWBA	0	0	0	0	0	0	0	0	0	0	0	0	125	.000%	.000%	.000%
EVANS	0	1	0	115	18	0	0	0	0	0	0	134	1,322	10.1%	3.80%	.666%
GILLIAM PSY	78	2	0	1	0	0	0	1	0	0	0	82	90	91.1%	2.33%	.408%
GOODMAN	0	0	0	0	0	0	0	0	0	0	0	0	522	.000%	.000%	.000%
GRAHAM	0	22	50	229	2	0	0	0	0	0	1	304	596	51.0%	8.63%	1.51%
GRAHAM R&E	0	5	11	37	0	0	0	0	0	0	0	53	187	28.3%	1.50%	.264%
KERSHAW	0	0	2	196	8	0	0	0	0	0	0	206	1,293	15.9%	5.85%	1.02%
KIRKLAND	3	142	6	125	1	0	0	12	0	0	1	290	1,814	16.0%	8.23%	1.44%
KIRKLAND INFRM	0	0	0	0	0	0	0	0	0	0	0	0	18	.000%	.000%	.000%
KIRKLAND MAX	0	0	2	2	0	0	0	1	0	0	0	5	5	100%	.142%	.025%
LEATH	0	0	0	365	0	0	0	0	0	0	0	365	680	53.7%	10.4%	1.82%
LEE	0	0	81	174	41	0	0	1	0	0	0	297	1,332	22.3%	8.43%	1.48%
LIEBER	0	1	86	189	4	0	0	2	0	0	0	282	1,167	24.2%	8.00%	1.40%
LIVESAY	0	0	0	0	0	0	0	0	0	0	0	0	497	.000%	.000%	.000%
MACDOUGALL	0	0	0	120	1	0	0	0	0	0	0	121	669	18.1%	3.43%	.602%
MANNING	0	0	0	8	0	0	0	0	0	0	0	8	554	1.44%	.227%	.040%
MCCORMICK	0	0	0	176	5	0	0	0	0	0	0	181	1,085	16.7%	5.14%	.900%
PALMER	0	0	0	0	0	0	0	0	0	0	0	0	232	.000%	.000%	.000%
PERRY	0	0	41	229	4	0	0	0	0	0	0	274	855	32.0%	7.78%	1.36%
RIDGELAND	0	0	0	114	0	0	0	0	0	0	0	114	988	11.5%	3.23%	.567%
TRENTON	0	0	0	6	0	0	0	0	0	0	0	6	558	1.08%	.170%	.030%
TURBEVILLE	0	0	1	100	4	0	0	0	0	0	0	105	1,030	10.2%	2.98%	.522%
TYGER RIVER	0	0	1	191	2	0	0	0	0	0	0	194	1,251	15.5%	5.51%	.965%
WATEREE RIVER	0	0	0	1	0	0	0	0	0	0	0	1	811	.123%	.028%	.005%
TOTAL	**81**	**175**	**288**	**2,821**	**103**	**1**	**14**	**19**	**0**	**0**	**22**	**3,524**	**20,109**	**17.5%**	**100%**	**17.5%**

December 2017 Implementation Panel findings: As per SCDC status update section. Average lengths of stay in RHU were as follows:

Length of Stay (in days) for Inmates in
Short Term RHU Custody (DD and ST) on Dec. 6, 2017

	Number of DD/ST Short Term RHU Inmates	Average (Mean) Days Spent in RHU	Median Days Spent in RHU
All Inmates	517	30	20
Non-Mentally Ill Inmates	361	31	20
Mentally Ill Inmates	156	29	20

Length of Stay (in days) for Inmates with
Long Term RHU Custody (SD, MX, AP) on Dec. 6, 2017

	Number of SD/MX/AP Long Term RHU Inmates	Average (Mean) Days Spent in RHU	Median Days Spent in RHU
All Inmates	355	335	242
Non-Mentally Ill Inmates	203	320	216
Mentally Ill Inmates	152	354	280

Note: Inmates serving long durations in RHU can skew the "average", therefore the "median" days spent in RHU reflects the "middle" value for the group and may better represent a "typical" value for days spent in RHU.

December 2017 Recommendations: Compliance continues.

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

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

November 2017 SCDC Status Update:

- As a part of the Mental Health Collaborative, QIRM Analysts compiled baseline reports for participating institutions from the cell and temperature logs. Operations maintains a shared folder or institutions to upload daily cell and temperature logs. Analysts assessed the data to determine:

- -the percent of days with logs uploaded as required. This measure was used to determine if at least one log was uploaded daily. Other measures included:
- -the percentage of cells with a daily temperature log completed and uploaded to the system. One log includes a total of eight cells per day: four from the morning and four from the evening shift.
- -the percent of cells with identified cleanliness issues with documentation that issues were addressed. If a cell had a cleanliness deficiency, a response indicating what was done to correct the deficiency, with documentation was required. If the information was not included, it was identified as noncompliance.
- The percent of cells with identified temperature issues with documentation that issues were addressed. If a cell had a temperate out of the range of 68-78 degrees, a response indicating what was done to correct the deficiency, with documentation was required. If the information was not included, it was identified as noncompliance.

The following chart include baseline data for participating collaborative institutions and those included for the current IP site visit.

July 2017

	KCI - RHU	KCI - SSR	KCI - GPH	Leath	BRCI C SU	Camille RHU	Lieber	Kershaw	Average
% of days with logs uploaded as required	56%	90%	23%	100%	35%	100%	100%	87%	74%
% of cells with a daily temperature log completed and uploaded to the system	52%	77%	19%	100%	27%	98%	95%	84%	69%
% of cells with identified cleanliness issues with documentation that issues were addressed	0%	6%	0%	0%	0%	0%	0%	0%	1%
% of cells with identified temperature issues with documentation that issues were addressed	0%	0%	0%	5%	0%	0%	0%	0%	1%

Operations Management has developed a form for daily inspections for cleanliness and for recoding temperatures of random cells. As a part of the MH Learning Collaborative, institutional

teams were provided with baseline data, to include a summary for the month of July, for the following:

- Percentage of cells with a daily temperature log completed and uploaded to the system
- Percent of uploaded logs with identified cleanliness issues that included documentation that issues were addressed
- Percent of uploaded logs with identified temperature issues that included documentation that issues were addressed
- Percentage of days with logs uploaded as required

To ensure staff respond to sanitation deficiencies and temperate outside of the acceptable range of 68-78 degrees, QIRM recommended that the form used to collect and submit daily checks be revised to allow staff to provide specific responses when temperatures were found to be out-of-range or when sanitation issues were identified. When the temperatures are out of range, the form provides a space to report how it was addressed, with examples provided. When sanitation issues are identified, the form provides a space for staff to address how sanitation issues are addressed, with specific examples provided.

Before making this a system-wide change, Camille Graham pilot-tested the revised form for five days (October 18-22, 2017).

Pilot results

- CGCI increased to 100% for 98% in the July 2017 98% for uploading the appropriate forms to the system. (It should be noted, for the pilot test, the requirement was to submit the forms directly to QIRM staff upon completion. If this pilot form is adopted, institutions would continue the current practice of submitting the completed forms to a shared Operations folder.)
- CGCI identified two sanitation issues during the pilot test but did not respond appropriately to either resulting in 0% compliance. This remained the same as the July 2017 baseline.
- CGCI identified no out-of-range temperatures during the pilot test. There were 20 cells with temperature that were out-of-range during for the July 2017 baseline; however, none were addressed, resulting in 0% compliance.
- Based on the results of the first pilot-test, QIRM developed a following step-by-step guide to provide additional instructions on completing the Temperature and Sanitation Log and requested that Camille conduct another five-day pilot test, October 27-31, 2017.
- In this second pilot test, CGCI demonstrated improvement in documentation when deficiencies were identified.
- CGCI submission of documentation remained at 100%
- There were no sanitation issues identified
- One cell was identified to have temperature out of range. CGCI reported that a maintenance request was submitted to address the deficiency; however, supporting documentation, although requested, was not submitted.

These results were forwarded to Operations with the recommendation of providing an instruction sheet for each area within the institutions responsible for uploading temperature and sanitation logs.

December 2017 Implementation Panel findings:
Operations maintains a shared folder for institutions to upload daily cell and temperature logs. SCDC provided Cell Temperature and Cleanliness Logs for selected institutions. Overall the provided logs had missing dates as well as incomplete and blank forms.

QIRM Analysts compiled baseline reports for participating institutions from the cell and temperature logs for the month of July identifying the following:

- Percentage of cells with a daily temperature log completed and uploaded to the system
- Percent of uploaded logs with identified cleanliness issues that included documentation that issues were addressed
- Percent of uploaded logs with identified temperature issues that included documentation that issues were addressed
- Percentage of days with logs uploaded as required

Based on the findings, a revised Operations Cell Temperature and Sanitation Form was implemented and pilot tested at Camille Graham CI in October 2017. The Camille Graham CI pilots continued to identify that necessary responses were not being provided for deficiencies.

On-site observations revealed Lieber CI, and Kershaw CI cell sanitation levels were at unacceptable levels. Kirkland CI and Lee CI sanitation levels had improved since previous site visits. The sanitation levels at the Camille Graham CI RHU remained high; however, preventive maintenance remains a concern. An in-operable toilet was identified in one of the un-occupied crisis cells. Management and on duty staff did not appear aware the toilet was non-operational.

December 2017 Recommendations:

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

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

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

November 2017 SCDC Status Update:
A report of QIRM CQI activities, and progress towards the implementation of policy GA 06.06, is attached as Appendix K. Institution-specific data related to this component will be presented in the ICQMC meetings. Information regarding inmates impacted by decisions made during the Segregation Committee's meetings will be discussed at the institutional and agency level meetings and included in the report to the Senior Management Board.

December 2017 Implementation Panel findings:
Appendix K provides a report on the QIRM CQI activities and progress towards implementation of SCDC Quality Improvement Plan. Implementation of the quality management program will begin in January 2018 with the goal of full implementation by December 2018.

December 2017 Recommendations:
Begin rollout of quality management program in January 2018.

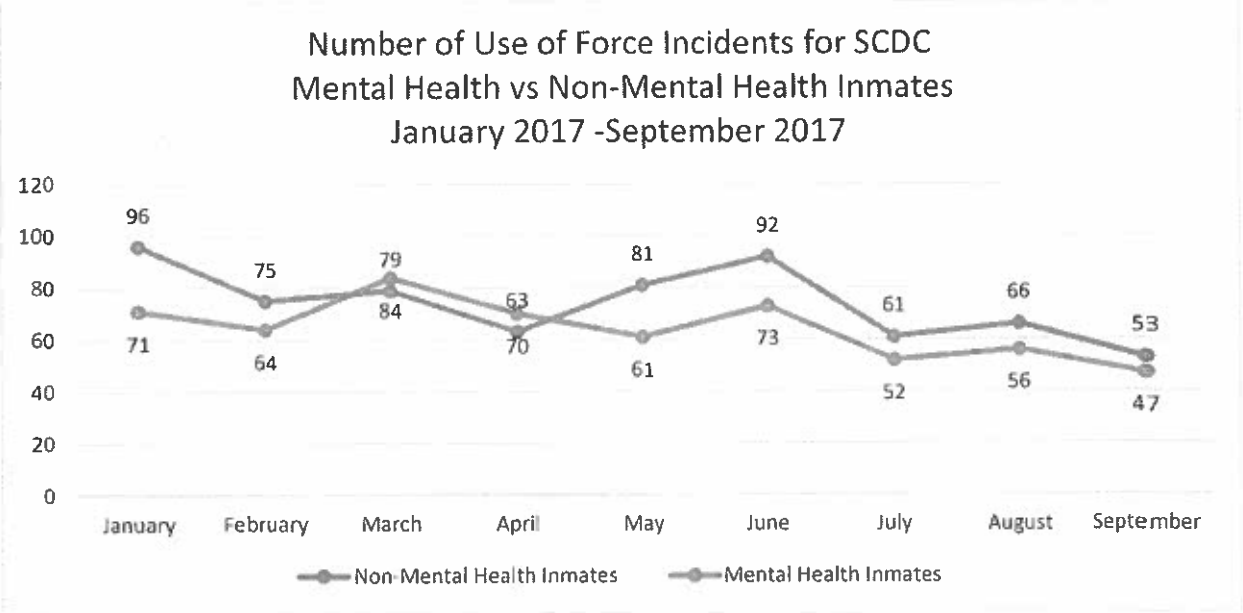
2.c. Use of Force:

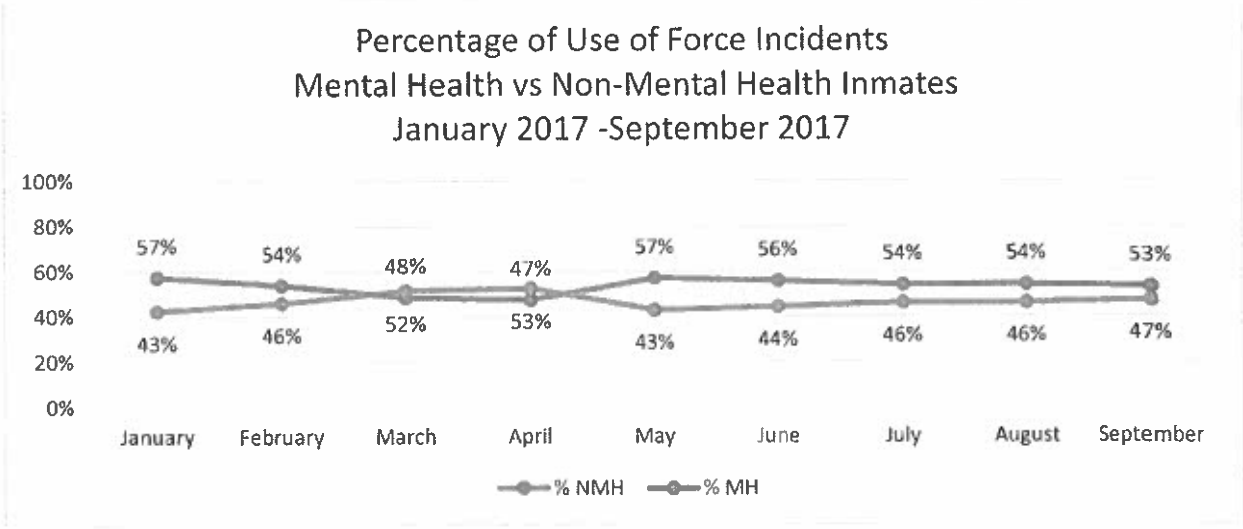
2.c.i. Development and implementation of a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness;

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

November 2017 SCDC Status Update

1. Use of Force Reviewers continue to track use of force. This includes comparing uses of force for inmates with a mental health classification to uses of force for those inmates without a mental health classification. The following chart compares this information from January-September 2017. The data for October is still being compiled and assessed. This chart has been shared with the Division of Operations.
2. The Division of Operations continues to monitor use of force reports as a part of their strategy to reduce use of force against inmates with mental illness and non- mentally ill inmates. The Assistant Deputy Director of Operations ADDO requires that the Regional Directors meet with their wardens to discuss their UOF reports and address any issues.





Use of Force Training

Overall SCDC has twenty seven (27) Use of Force Classes scheduled for various dates in October through December 2017. The current schedule will allow 1,336 employees to complete their training. The classes have been scheduled across the state at different times to accommodate the needs of the institutions and employees. Forty-four (44%) percent, or 2,682 of the 6,108 employees in the agency have completed this class.

December 2017 Implementation Panel findings:

SCDC continues disproportionate use of force against inmates with mental illness. Approximately 17.5 percent (as of 9/25/17) of the SCDC inmate population is on the mental health caseload;

however, use of force against inmates with a mental illness accounts for 54.6 percent of total incidents for the time period of June 2017 through September 2017.

SCDC has trained forty-four (44%) percent, or 2,682 of the 6,108 employees on the revised use of force policy. It is unlikely that SCDC employees will complete the revised Use of Force training by December 31, 2017.

December 2017 Recommendations:

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

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 December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update

1. QIRM's UOF Reviewers continue to review use of force incidents through the automated system and institutional MINS daily. This report included a summary of MINS relative to the types of forces used during the week, use of control cells, planned versus immediate use of force, use of force in the general population vs RHU, and UOF with MH versus NMH inmates.
2. When reviewing Institutional MINs and reports from the automated system the following issues specific to use of force are included: presence of a reasonably perceived threat; UOF appropriate based on Time/Place/Distance; was UOF planned or unplanned; was conflict resolution used prior to planned UOF; was conflict resolution conducted by CIT, SITCON or mental health employee; was mental health contacted prior to UOF regarding inmates with a mental health classification; was inmate provided with blanket or smock post UOF for inmates placed in crisis status; were chemical munitions used within policy guidelines; did report justify use of chemicals that exceeded the guidelines; was inmate afforded opportunity to decontamination, provided clean clothes and cell decontamination if necessary after use of chemical munitions, and was inmate afforded post UOF medical treatment. Reports are maintained on QIRM's shared drive.
3. QIRM staff continues to meet weekly with Operations leadership to discuss UOF and other relevant issues;
4. 6,108 staff are required to complete the revised Use-of-Force Training by December 31, 2017. As of October 23, 2017, 2,682 have completed the revised training. There are currently 1,336 slots remaining to allow staff to complete the training by the deadline.

December 2017 Implementation Panel findings: SCDC continues implementation of the revised OP 22.01 Use of Force Policy requiring instruments of force are employed in a manner consistent with manufacturer's instructions. IP review of monthly UOF MINS narratives reveals a marked improvement in employees following SCDC guidelines on the amount of chemical agents deployed for each application and restraint chair use. SCDC has agreed to revise Housing Unit Post Orders as it applies to *Cover Teams* to achieve compliance that MK 9 use is consistent with manufacturer's instructions.

SCDC used the restraint chair on two (2) occasions during the relevant period; one incident involved a mentally ill inmate and the other a non-mentally ill inmate. QIRM review of the restraint chair incidents revealed use involving the mentally ill inmate was appropriate and it was not appropriate for the incident involving the non-mentally ill inmate.

SCDC has trained forty-four (44%) percent, or 2,682 of the 6,108 employees on the revised use of force policy. It is unlikely that SCDC employees will complete the revised Use of Force training by December 31, 2017.

December 2017 Recommendations:

1. Operations and QIRM continue to review use of force incidents through the automated system to ensure instruments of force are fully consistent with the manufacturer's instructions;
2. QIRM continue to meet weekly with Operations leadership to discuss UOF and other relevant issues;
3. Revise Housing Unit Post Orders as they pertain to *Cover Teams* to require that MK 9 use will be consistent with manufacturer's instructions;
3. All staff complete the revised March 2017 Use of Force Training.

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 December 2017 Assessment: **compliance (3/2017)**

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 July–October, 2017 of inmates being placed the crucifix or other positions that do not conform to generally accepted correctional standards.

December 2017 Implementation Panel findings: SCDC remains in compliance. Neither SCDC nor the IP identified any incident where an inmate was placed in the crucifix or other position that did not conform to generally accepted correctional standards.

December 2017 Recommendations: Operations and QIRM staff continue to review and monitor use of force incidents through the automated system to ensure restraints are not used to place inmates in

the crucifix or other positions that do not conform to generally accepted correctional standards. Pursue corrective action when violations and/or issues are identified.

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

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

November 2017 SCDC Status Update

SCDC policies prohibit the use of restraints for pre-determined periods of time and for longer than necessary to gain control, and track such use to enforce compliance. After an inmate is secured in a restraint chair, policy requires that the inmate will be examined by a qualified medical staff member. In the event it is necessary that the inmate needs to be secured in a restraint chair for up to two (2) hours, a qualified medical staff member is required to examine the inmate to assess his/her condition and approve continued placement which cannot exceed a total maximum of three (3) hours in the restraint chair.

According to Policy 22.01, Use of Fore, section 13.11, the restraint chair is to be used for control purposes only and will not be used for any longer than the conditions warrant. However, if a decision is made by the Shift Supervisor or higher authority to continue restraint of the inmate longer than two hours, medical staff will be notified by the Shift Supervisor of the extended use of the restraint chair, and the qualified medical staff member on duty will be required to conduct a documented physical check of the inmate to determine if a medical reason exists that would prohibit the continued use of the chair. The inmate may not be restrained in the chair for more than a three hour period.

December 2017 Implementation Panel findings: Restraint Chair use continues to occur infrequently. SCDC reported the Restraint Chair was used for two (2) incidents. Per SCDC Update for 2.c.v:

MIN #	Date	Location	Inmate	Mental Health Status	Time in Chair
[redacted]	6/28/2017	RIDGELAND	Inmate A	NMH	120m
	9/03/2017	BROAD RIVER	Inmate B	L4	145m

Data Source-AUOF System Cross-referenced with AMR

SCDC Use of Force Reviewers were able to verify the length of time inmate A was in the restraint chair. The videos and the Automated Medical Records confirm that inmate A was placed in the restraint chair at 7:40 pm; however, the time he was released could not be determined based on the information provided. UOF Reviewers were unable to find documentation indicating who determined the length of time the inmate was authorized to remain in the restraint chair.

December 2017 Recommendations: QIRM continue to track and monitor compliance with use of the restraints.

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

Implementation Panel December 2017 Assessment: **compliance 12/2017**

November 2017 SCDC Status Update

UOF staff conducted a review of restraint chair use from June 1, 2017 – October 30, 2017. The report was produced using data from the Automated Use of Force System and cross-referenced with the Automated Medical Records. During this timeframe, the restraint chair was used in two incidents. Only one of the incidents involved self-injurious behavior. This incident occurred at Broad River's CSU. In the second incident, the inmate threw an unknown substance on staff. In this instance, UOF Reviewers did not find documentation that less restrictive measures were implemented that may have been effective in controlling the inmate's behavior as outlined in policy OP. 22.01, Use of Force and Restraints.

This review also assessed the amount of time the inmates were placed in the restraint chair. According to policy, the maximum amount of time that inmate can be placed in the restraint chair is three hours.

In neither incident was the inmate placed in the restraint chair for this maximum amount of time.

MIN #	Date	Location	Inmate	Mental Health Status	Time in Chair
[redacted]	6/28/2017	RIDGELAND	Inmate A	NMH	120m
	9/03/2017	BROAD RIVER	Inmate B	L4	145m

Data Source-AUOF System Cross-referenced with AMR

To limit the amount of time each inmate is held in the restraint chair and to ensure that no inmate is placed in the restraint chair for a pre-determined amount of time, the orders given from the physician must be in compliance with policy OP-22.01, Use of Force and Restraints, section 13.11, "the restraint chair is to be used for control purposes only and will not be used for any longer than the condition warrants."

The Use of Force Reviewers were able to verify the length of time inmate A was in the restraint chair. The videos and the Automated Medical Records confirm that inmate A was placed in the restraint chair at 7:40 pm; however, the time he was released could not be determined based on the information provided. UOF Reviewers were unable to find documentation indicating who determined the length of time the inmate was authorized to remain in the restraint chair.

On 9/3/17 inmate B was ordered to be placed in the restraint chair by Dr. [redacted] due to continued self-injurious behavior at Broad River CI. The inmate was placed in the restraint chair at 12:35 pm and was checked at 1:40 pm. At 2:30 pm the inmate was observed by medical staff scooting the restraint chair towards the wall and banging his head on the wall. Dr. [redacted] was contacted by phone and instructed Medical to extend the time in the restraint chair for up to two hours. The inmate stopped his self-injurious behavior and was removed from the restraint chair at 3:00 pm. There is no video of this restraint chair encounter. The Use of Force Reviewers forwarded this information to SCDC Operation's staff for corrective measures.

December 2017 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.

December 2017 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 December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update

As a part of the plan to implement the accountability component of OP 22.01 Use of Force, and to ensure meaningful corrective action is taken for employees found to have committed use of force violations, the Division of Operations is conferring with RIM to have a field entered on the AUOF Report to capture informal corrective action such as counselling or systems correction.

Training

Mental Health has identified that 62% of their current staff are required to take the Use of Force Class. Of the 98 employees identified 29% of them have completed the required Use of Force Training as of October 23, 2017.

December 2017 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.

SCDC Use of Force MINS for June 2017 through October 2017:

June 2017-	165
July 2017-	113
August 2017-	122
September 2017-	100
October 2017-	77

SCDC had 42 Grievances alleging excessive Use of Force from June 2017 to October 2017.

SCDC QIRM review of Use of Force incidents from June 2017 to October 2017 identified 82 incidents with potential violations.

SCDC Employee Corrective Action for Use of Force violations was reported as:

June 2017-	5 employees (all at Kershaw CI)
July 2017-	No Employee Corrective Action taken by SCDC
August 2017-	No Employee Corrective Action taken by SCDC
September 2017-	No Employee Corrective Action taken by SCDC
October 2017-	No Employee Corrective Action taken by SCDC

SCDC Operations reported informal employee corrective action for use of force violations is not officially maintained. Efforts are being made to develop a system to maintain and report informal employee corrective action for use of force violations.

The IP did not request information from SCDC Police Services regarding their involvement in Use of Force investigations:

- Referrals Received
- Investigations Opened
- Investigations Pending
- Investigations Closed and Substantiated, Unsubstantiated, or Unfounded.

The information will be requested for the next Settlement Agreement relevant period.

The IP Use of Force Reviewer and SCDC Operations Leadership has initiated a procedure to jointly review Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of force.

SCDC has trained forty-four (44%) percent, or 2,682 of the 6,108 employees on the revised use of force policy. It is unlikely that SCDC employees will complete the revised Use of Force training by December 31, 2017.

The IP Panel received inmate complaints during the site visits to Kirkland CI, Lieber CI, Kershaw CI, Lee CI, and Camille Graham CI alleging inappropriate and excessive use of force by SCDC employees.

The SCDC Use of Force Policy accountability component does not appear to be functioning appropriately based on the number of potential Use of Force violations with minimal employee corrective action.

December 2017 Recommendations:

1. Operations and QIRM continue to review use of force incidents utilizing the automated system to identify use of force violations;
2. QIRM and Operations leadership continue weekly meetings to discuss UOF and other relevant issues;
3. IP continue to review SCDC Use of Force reports and monthly Use of Force MINS Narratives and provide SCDC feedback;
4. The IP Use of Force Reviewer and SCDC Operations Leadership continue to jointly review Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of force;
5. SCDC develop a system to maintain and report informal employee corrective action for use of force violations;
6. IP request information from SCDC Police Services regarding their involvement in Use of Force investigations;
7. All staff complete the revised March 2017 Use of Force Training.
8. SCDC ensure the accountability component of OP 22.01 Use of Force is implemented and meaningful corrective action is taken for employees found to have committed use of force violations;

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

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

November 2017 SCDC Status Update

Based on SCDC policy OP 22. 01, section 6.3 Chemical Munition, the MK-4 should be the standard issued chemicals delivery system for incident control. Escalation beyond MK-4 in a closed cell environment will only occur when exigent circumstances exist (Examples include but are not limited to the inmate is armed, is barricaded in a cell, is actively assaulting another person, etc.) Use of any chemical munitions delivery system other than MK-4 must involve a Planned Use of Force, unless the need for use of the delivery systems is emergent, and a delay could cause bodily harm or death. The issue and use of all chemical munitions, other than MK-4, must be authorized and assigned by the RHU supervisor or higher. QIRM Use of Force Reviewers reviewed use of chemical munitions incidents involving crowd control canisters including MK-9 from July 1, 2017- October 27, 2017.

Based on RIM reports, there were 51 use of force incidents in which MK-9 was used between July 1, 2017 and October 27, 2017.

- There were 29 (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. This is down from 76 out of 85 (89%) from the last reporting period. However, the number of incidents involving the use of MK-9 has decreased from 85 to 51 (40%) since the last reporting period.

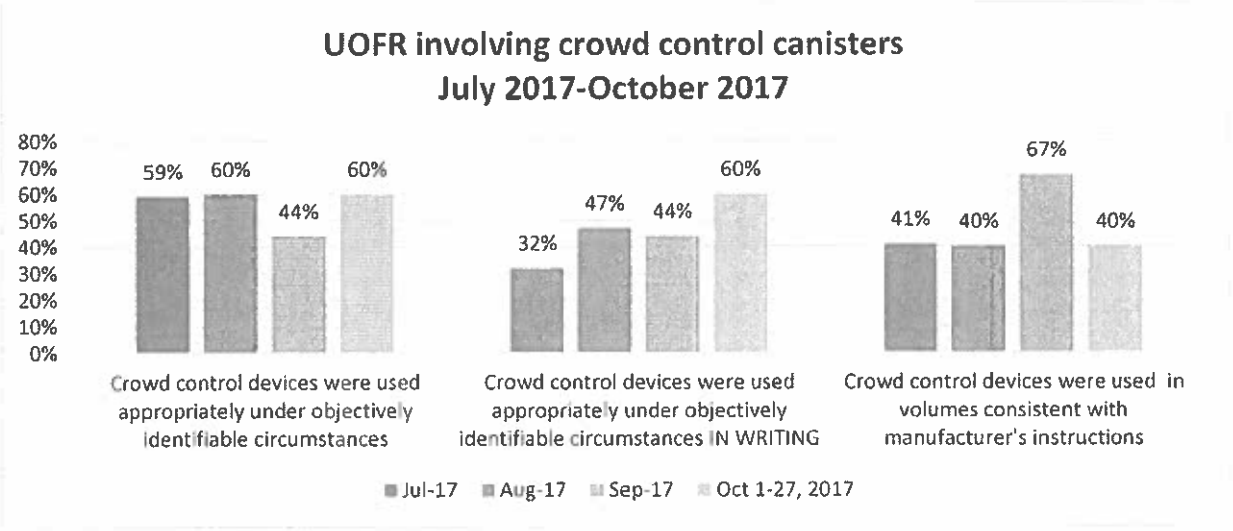
- There were 21 (41%) incidents where the crowd control devices were used appropriately under objectively identifiable circumstances in writing.
- There were 23(45%) incidents where the crowd control devices were used in volumes consistent with manufacturer's instructions.

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

	# times crowd control devices were used appropriately under objectively identifiable circumstances	# times crowd control devices were used	% of times crowd control devices were used appropriately under objectively identifiable circumstances
July	13	22	59%
August	9	15	60%
September	4	9	44%
October	3	5	60%

	# times crowd control devices were used appropriately under objectively identifiable circumstances IN WRITING	# times crowd control devices were used	% of times crowd control devices were used appropriately under objectively identifiable circumstances IN WRITING
July	7	22	32%
August	7	15	47%
September	4	9	44%
October	3	5	60%

	# times crowd control devices were used in volumes consistent with manufacturer's instructions	# times crowd control devices were used	% times crowd control devices were used in volumes consistent with manufacturer's instructions
July	9	22	41%
August	6	15	40%
September	6	9	67%
October	2	5	40%



- *December 2017 Implementation Panel findings:* As per SCDC update. SCDC continues to identify incidents where use of crowd control canisters, such as MK-9, are used in individual cells in the absence of objectively identifiable circumstances set forth in writing and only in volumes consistent with manufacturer's instructions. For the July 2017 to October 27, 2017 period there were 43% uses of force incidents in which the officer's actions were not justifiable based on circumstances set forth in agency policy OP- 22. 01, Use of Force. The number of incidents involving the use of MK-9 did decrease from 85 to 51 (40%) since the last reporting period. Crowd control devices were not used appropriately under objectively identifiable circumstances in writing in 59% of the incidents. Crowd control device volumes exceeded SCDC guidelines in 55% of the incidents.

December 2017 Recommendations:

1. Operations and QIRM continue to review use of force incidents utilizing the automated system to identify use of force violations;
2. QIRM 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;
7. All staff complete the revised March 2017 Use of Force Training.

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

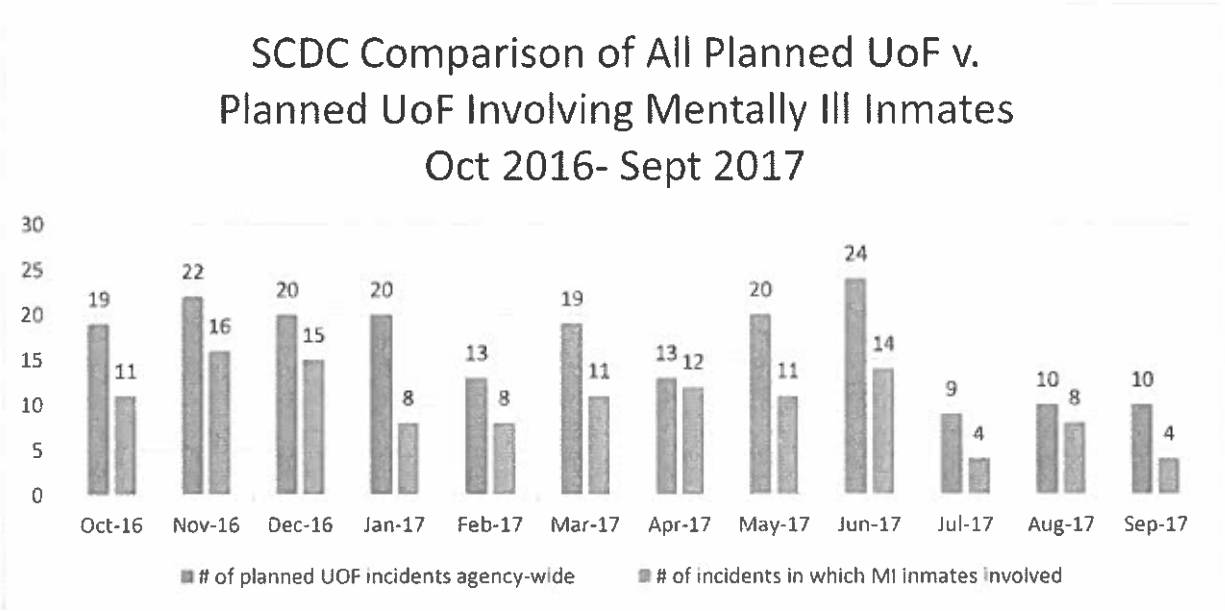
Implementation Panel December 2017 Assessment: **partial compliance**

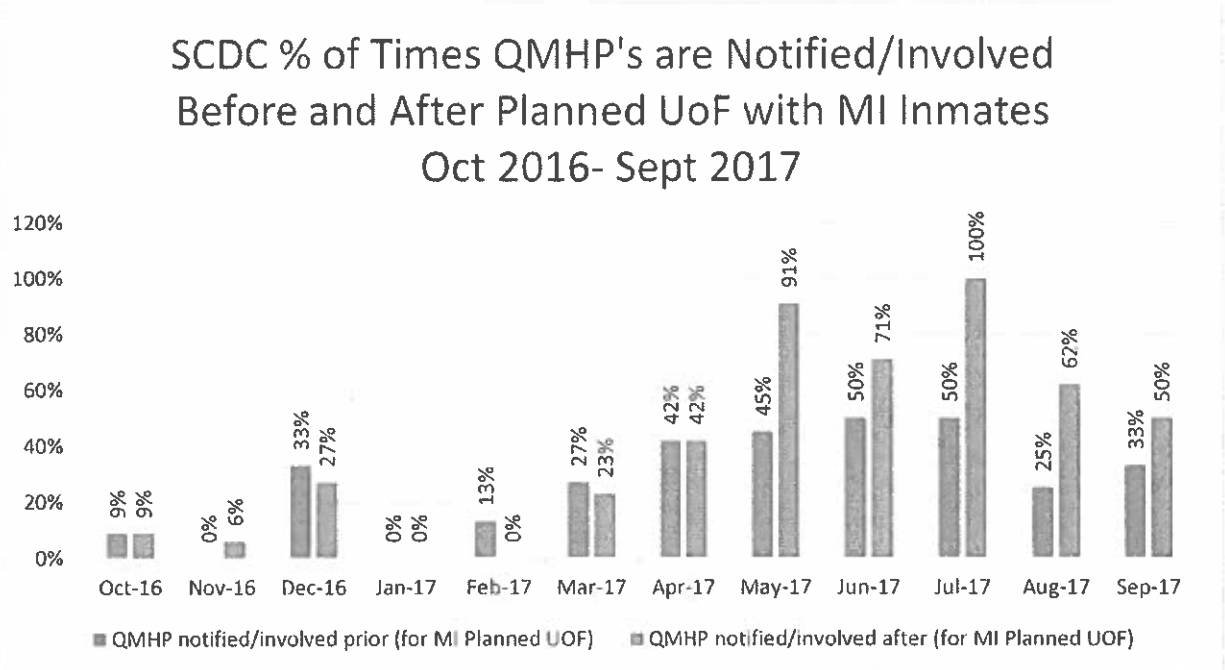
November 2017 SCDC Status Update

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

In May 2017 RIM began tracking the number of CIT officers notified prior to a planned use of force. The goal is to decrease the number of uses of force by using trained staff to de-escalate situations when possible.

	16-Oct	16-Nov	16-Dec	17-Jan	17-Feb	17-Mar	17-Apr	17-May	17-Jun	17-Jul	17-Aug	17-Sep
# of planned UOF incidents agency-wide	19	22	20	20	13	19	13	20	24	9	10	10
# of incidents in which MI inmates involved	11	16	15	8	8	11	12	11	14	4	8	4
# of incidents in which QMHP notified/involved	1	1	4	0	1	4	6	10	12	4	6	3
# CIT Officer notified/involved prior (for MI Planned UOF)								4	1	1	2	1
% of times QMHP notified/involved, when required, prior (for MI Planned UOF)	9%	0%	33%	0%	13%	27%	42%	45%	50%	50%	25%	33%
% of times QMHP was notified/involved when required, after (for MI Planned UOF)	9%	6%	27%	0%	0%	23%	42%	91%	71%	100%	62%	50%


SCDC Comparison of All Planned UoF v.
Planned UoF Involving Mentally Ill Inmates
Oct 2016- Sept 2017
30
25
20
15
10
5
0
19
11
22
16
20
15
20
8
13
8
19
11
13
12
20
11
24
14
9
4
10
8
10
4
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
# of planned UOF incidents agency-wide
# of incidents in which MI inmates involved


SCDC % of Times QMHP's are Notified/Involved
Before and After Planned UoF with MI Inmates
Oct 2016- Sept 2017
120%
100%
80%
60%
40%
20%
0%
9%
9%
0%
6%
33%
27%
0%
0%
13%
0%
27%
23%
42%
42%
45%
91%
50%
71%
50%
100%
25%
62%
33%
50%
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
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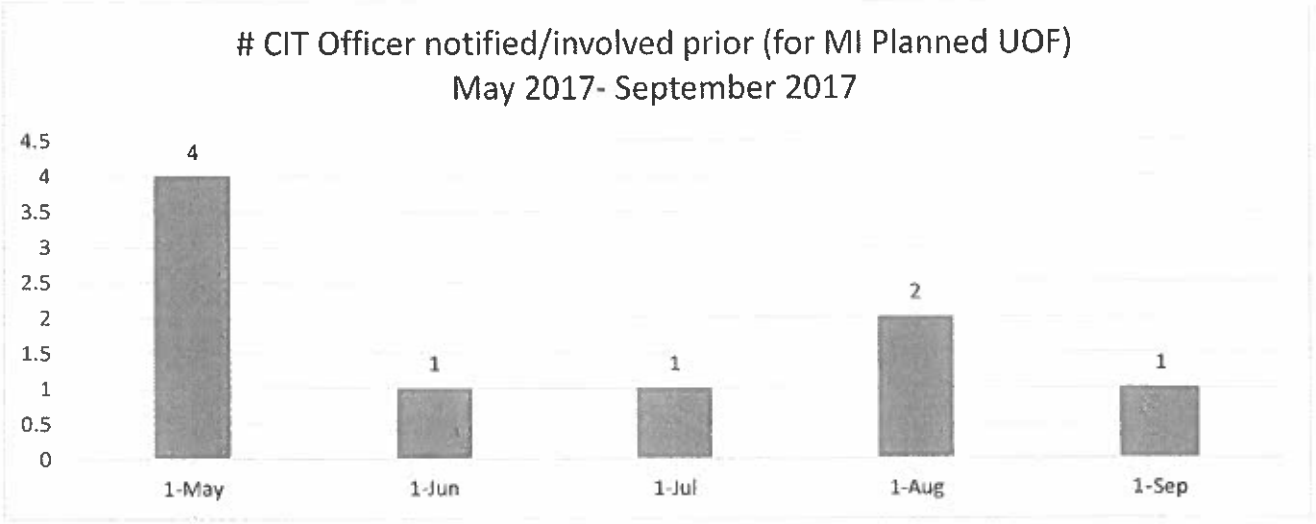
Sep-17
QMHP notified/involved prior (for MI Planned UOF)
QMHP notified/involved after (for MI Planned UOF)



December 2017 Implementation Panel findings: Per SCDC update. SCDC data identifies continued issues with notifying clinical counselors (QMHPs) to request their assistance prior to a planned use of force. CIT Officers do not meet the requirement of clinical counselor notification prior to a planned use of force. SCDC provided data for the period of June 2017 through September 2017, that QMHPs were contacted prior to a planned use of force as follows:

June 2017-	50%
July 2017-	50%
August 2017-	25%
September 2017-	33%

December 2017 Recommendations: Provide additional training to Operations Supervisory and Mental Health Staff on their duties and responsibilities in a planned use of force. Ensure Operations and Mental Health staff are aware that CIT Officers do not meet the requirement of clinical counselor notification prior to a planned use of force to request assistance in avoiding the necessity of such force and managing the conduct of inmates with mental illness.

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

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

November 2017 SCDC Status Update

The South Carolina Department of Corrections Training Academy reports the following information for 1 January 2017 – 10 October 2017. There was no information provided about the number of employees enrolled in each class to determine the completion rate.

Course Completion
1/1/17 – 10/10/17

Class Code	*Class Title*	*# completed*
3.00	*Correctional Officer Basic Training*	*508*
3.60	*Non-Security Basic Training*	*90*
3.99	*Cadet Basic Training*	*36*
3.97	*Correctional Officer Basic Training Non-uniform/ Non-certified*	*5*
3.96	*Non-uniform/ Non-certified Incomplete*	*9*

The Correctional Officer Basic Training (COBT) includes the following classes:
1. Introduction to Mental Health Class - 1.5 hours
2. Suicide - 2.0 hours
3. Pre-Crisis Intervention – 2.5-3.0 hours

The Non-Security Basic Training consists of the same classes as (COBT) except for firearms training. Cadet Basic Training is for correctional officers age 18-20, these officers did not complete the Pistol Certification. The Non-Uniformed / Non-Certified COBT category describes the employees who move to a position that requires certification. Therefore, they returned to the Training Academy for the classes needed to complete their certification. There were nine (9) individuals who were unable to complete the courses identified in the Non-Uniformed/ Non-Certified Training.

Agency Orientation is comprised of several classes of various lengths. The SCDC Training Academy and RIM report that there were 953 employees who completed the 1.5 hour Introduction to Mental Health Class between January and October 2017. There is also a two hour Suicide Class identified in the Agency Orientation however, the number of employees who completed this class was not provided on the report by class code.

Interpersonal Relations: Pre-Crisis Intervention is a 2.5 – 3.0 hour class that has been completed by 1,903 employees between January and October 2017. During the same In-Service category of classes there are three Suicide classes taught through instructor led and video classes. The Instructor led Suicide class is two hours long and has been completed by 2,545 employees. Part I of the Inmate Suicide Prevention Class is one hour and has been completed by 2,666 employees. The last hour of the Inmate Suicide Prevention Class, Part 2, has been completed by 2,585 employees.

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

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

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

December 2017 Recommendations:

The SCDC Training Division provide documentation verifying the number of required employees that have completed the mandatory training for appropriate methods of managing mentally ill inmates and the number that has not completed the required training for 2017.

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 December 2017 Assessment: **compliance (3/2017)**

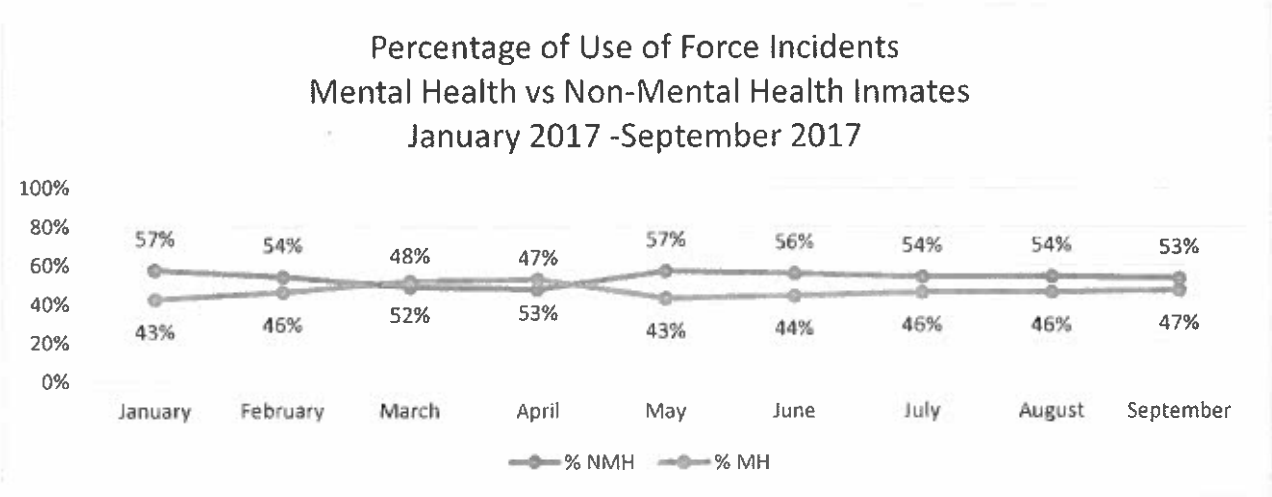
November 2017 SCDC Status Update

QIRM's Use of Force Reviewers continue to produce and disseminate the monthly UOF Mentally Ill vs. Non-Mentally Ill Report. This report is attached as Appendix L.

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

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

The following graphs show the UOF for mentally ill vs non-mentally ill inmates since January 2017.



December 2017 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.

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

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

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

November 2017 SCDC Status Update

A new protocol is being established that will require the hiring of an additional staff person to review the UOF follow-up from MH Staff across the state. This person will be placed in the section of Quality Management and report to Ms. [redacted] The position will post as a QMHP based on the scope of the review. Their primary job functions will be to:

- Ensure Planned UOF incidents are being followed up on and documented according to policy
- Ensure MH staff are providing the appropriate interventions when responding to a Planned UOF.

December 2017 Implementation Panel findings: The Mental Health Division has developed a protocol to review UOF incidents that involve mentally ill offenders (SCDC Quality Review of Use of Force Incidents-Mental Health). The new protocol will require the hiring of an additional staff person to review the UOF incidents involving mentally ill inmates. Review by the IP revealed the protocol does not have any intervention component.

December 2017 Recommendations: Revise the SCDC Mental Health Quality Review of Use of Force Incidents and include an intervention component. Hire the additional Mental Health staff person to review UOF incidents involving mentally ill inmates and implement the Mental Health Quality Review of Use of Force Incidents involving mentally ill inmates.

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 December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update
See response provided for 2.a.iv

Health Services Issue/Area of Concern: Increase clinical staffing ratios

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

December 2017 Recommendations: See 2.a.iv.

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

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

November 2017 SCDC Status Update

See Attachment 4 for data specific to this provision.

December 2017 Implementation Panel finding: Significant improvement is noted relevant to the percentage of involvement of appropriate SCDC mental health clinicians in treatment planning and treatment teams as compared to prior site visits, with Camille Griffin Graham CF showing the greatest level of compliance. The reasons for partial compliance varies according to institution related to various staffing vacancy issues. Refer to Attachment 4 for a relevant summary specific to this provision

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

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

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

November 2017 SCDC Status Update:
According to the provided RIM report. Mental Health has 59 employees who have completed a Correctional Officer Basic Training Course. This course includes Introduction to Mental Health (1.5 hours), Mental Health (2.0 hours), Suicide (2.0), Interpersonal Relations: and Pre-Crisis intervention (3.0 hours). The list is attached as Appendix M.

December 2017 Implementation Panel findings: We requested, but did not receive, data regarding the percentage of the mental health staff that have completed the Correctional Officer Basic Training Course.

December 2017 Recommendations: Provide the requested data as part of the pre-site document request for the March 2018 site assessment.

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 December 2017 Assessment: **compliance (12/17)**

November 2017 SCDC Status Update
See response for 2.a.iv

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

December 2017 Recommendations: See 2.a.iv.

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

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

November 2017 SCDC Status Update:
SCDC Policy 19.15, Mental Health Services - Mental Health Training, Section 3.4 stipulates that QMHPs will be required to maintain their professional licensure based on the requirements of their individual licensure board (Licensed Professional Counselor, Licensed Social Worker, etc.) and provide verification of continued licensure.

Those mental health counselors who are not licensed but were hired prior to above requirement are allowed to continue working under the supervision of a licensed counselor.
The attachment at Appendix N outlines current licensure prior to 2013, new staff with licensure hired as of 2013, and existing staff with licensure obtained since 2015 and the percentage of licensed staff. Based on the provisions outlined in policy, 40/40 or 100% are appropriately licensed.

December 2017 Implementation Panel findings: Compliance continues.

December 2017 Recommendations: Continue to monitor.

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

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

November 2017 SCDC Status Update:
Routine audits will begin November 2017 following the attached schedule provided earlier in the document drop. When problems are identified from reviews the following actions will occur at outlined in H.S.-19.07:

- An improvement plan specifying the tasks, suggested completion dates, and parties responsible
- Identified training issues needed to correct/rectify deficiencies
- The restriction of work responsibilities for individual employees until identified problems are corrected
- A re-review to ensure identified findings are corrected
- Recommendation of sanctions/disciplines for repeated findings after 2nd review.

December 2017 Implementation Panel findings: Attachment 5 provides a summary of the performance audits that will be performed as per the SCDC schedule provided.

December 2017 Recommendations: Implement the above.

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

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

November 2017 SCDC Status Update
See response in 3f

December 2017 Implementation Panel findings: See 3.f.

December 2017 Recommendations: See 3.f.

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

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

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

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

November 2017 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 November 6, 2017. See screenshots below: (click here to access the November 13, 2017 report)

Summary of Medical Positions as of COB Yesterday
run on November 13, 2017

Medical Job Classifications		FTE Positions			Temporary Positions			All Positions		
Code	Description	Filled	Vacant	Total	Filled	Vacant	Total	Filled	Vacant	Total
9999	UNCLASSIFIED	0	0	0	0	1	1	0	1	1
AA50	ADMIN SPECIALIST II	10	6	16	0	0	0	10	6	16
AA75	ADMINISTRATIVE ASSISTANT	9	2	11	0	0	0	9	2	11
AC07	SUPPLY MANAGER I	2	0	2	0	0	0	2	0	2
AD28	ACCTNT/FISCAL MGR I	1	0	1	0	0	0	1	0	1
AH10	ADMINISTRATIVE COORD I	5	0	5	0	0	0	5	0	5
AH15	ADMINISTRATIVE COORD II	2	0	2	0	0	0	2	0	2
AH20	ADMINISTRATIVE MGR I	5	0	5	0	0	0	5	0	5
AH35	PROGRAM COORDINATOR I	3	1	4	0	0	0	3	1	4
AH40	PROGRAM COORDINATOR II	0	1	1	0	0	0	0	1	1
AH45	PROGRAM MANAGER I	3	0	3	0	0	0	3	0	3
AH50	PROGRAM MANAGER II	3	0	3	0	0	0	3	0	3
BB30	STATISCL & RESRCH ANAL II	2	0	2	14	3	17	16	3	19
BH10	RECORDS ANALYST I	3	0	3	0	0	0	3	0	3
EA10	LICENSED PRACTICAL NURSE	56	30	86	1	9	10	57	39	96
EA15	LPN II	1	0	1	0	0	0	1	0	1
EA20	REGISTERED NURSE I	63	44	108	7	18	25	71	62	133
EA30	REGISTERED NURSE II	13	5	18	0	0	0	13	5	18
EA60	NURSE PRACTITIONER I	0	0	0	1	0	1	1	0	1

December 2017 Implementation Panel findings: Compliance continues.

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

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

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

November 2017 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.

December 2017 Implementation Panel findings: As per SCDC status.

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

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

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

November 2017 SCDC Status Update
Policy 22.38. Restrictive Housing Units, section 3, number 14 says that correctional officers assigned to the RHU are to conduct security checks and to personally observe each inmate at least every 30 minutes on an irregular, unannounced schedule. The time of each security check will be recorded in the RHU permanent log book and SCDC Form 19-7A, "Cell Check Log."

As part of SCDC's endeavor to accurately monitor and document the mentally ill population who are housed in a segregated or crisis intervention units, the Division of Behavioral Health and Substance Abuse Services currently uses a manual system to track and document 30 minute irregular cell checks, as required by policy 22.38, and unstructured activities such as showers and recreation. QIRM conducted a QI study to determine whether this manual system is effective in identifying inmates who are not given the opportunity to participate in unstructured out of cell activities for a at least 10 hours per week.

The results from the CQI study indicated that as a whole, the Agency's compliance rate for cell checks occurring at least 30 minutes irregular intervals is 26%. These results suggests that inmates are not being monitored regularly as required by Agency policy. This may be attributed to security staffing shortages.

Other issues identified that should be addressed are:

- The collection of the data was all in a paper form as opposed to an electronic form that would allow more accuracy and eliminate the issues of legibility.
- Some of the data was illegible to include times, and initials of Correctional Officers.
- Some times were written in military time and others in standard time. Those instances when standard time is used, it is difficult to determine an accurate time of day. (i.e. am or pm).

The final report, attached Appendix O was shared with the Division of Operations to outline a plan of action based on the results.

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

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

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

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

November 2017 SCDC Status Update

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

Activity and cell check logs remain on paper and are addressed in 4.a.iii., but RIM is working to create an automated system.

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

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

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

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

November 2017 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.

December 2017 Implementation Panel findings: As per SCDC update.

December 2017 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 December 2017 Assessment: **compliance (3/2017)**

November 2017 SCDC Status Update

- RIM continues to produce and disseminate a monthly, "UOF Report Mentally Ill vs. Non-Mentally Ill," report.
- UOF Reviewers continue to track and report the number of UOF incidents involving mentally ill vs non-mentally ill inmates. This 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

December 2017 Implementation Panel findings: As per SCDC update.

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

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

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

November 2017 SCDC Status Update

A "CY CISP Admissions" report continues to be produced quarterly by RIM. This report shows if an inmate stays in a CI cell in an outlying institution longer than the 60 hours allowed to have him transferred to CSU. (Click here to access the October 31, 2017 report).

The report of CISP entries entered through October 31, 2017 shows the following:
1,491 entries in the CISP application
Average number of days on crisis =6
Average Time to CSU Placement = 34:16 (Hours: Minutes)
Average Days in CSU = 5
Average Days in Outlying Facility = 3

RIM continues to produce and a weekly spreadsheet that provides a list of inmates currently in SD, DD, MX or SR custody by institution. The most recent report was disseminated on November 9, 2017 See screenshot below:

December 2017 Implementation Panel findings: Compliance continues.
Per the SCDC update:

1,491 entries in the CISP application
Average number of days on crisis =6
Average Time to CSU Placement = 34:16 (Hours: Minutes)
Average Days in CSU = 5
Average Days in Outlying Facility = 3

The weekly SCDC Report *Listing of Inmates Currently in SD, DD, MX or ST Custody in SCDC Institutions* provides the length of stay in segregation for mentally ill and non-mentally ill inmates by segregation status and by institution.

Average Time Served (in days) for Removals from **Short Term RHU Custody (DD and ST)** by month

Month Removed from Short Term RHU (DD and ST custody)	Average Time Served All Removals	Average Time Served Non-Mentally Ill	Average Time Served Mentally Ill
2017 January	26	27	24
2017 February	23	23	22
2017 March	22	22	21
2017 April	22	23	21
2017 May	23	24	20
2017 June	20	19	21
2017 July	23	23	22
2017 August	26	27	24
2017 September	24	23	26
2017 October	25	24	28

Note: Numbers reflect removals from short term RHU custody (DD - disciplinary detention and ST - short term lockup) during each month and show the average days served in short term RHU upon removal.

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.

Average Time Served (in days) for Removals from **Long Term RHU Custody (SD and MX)** by month

Month Removed from Long Term RHU (SD and MX custody)	Average Time Served All Removals	Average Time Served Non-Mentally Ill	Average Time Served Mentally Ill
2017 January	331	284	358
2017 February	377	273	458
2017 March	891	327	1097
2017 April	310	333	175
2017 May	282	286	271
2017 June	812	920	770
2017 July	282	313	265
2017 August	293	310	274
2017 September	511	684	209
2017 October	601	343	972

Note: Numbers reflect removals from long term RHU custody (SD - security detention and MX - maximum) during each month and show the average days served in long term RHU upon removal. Because of the small number of inmates removed monthly from long term RHU, averages can vary greatly. Inmates who were placed in RHU custody and removed from RHU custody on the same day were excluded.

The mental health classification is based on the inmate's status at time of removal from RHU.

December 2017 Recommendations: Continue internal monitoring via QIRM to demonstrate continued compliance. Revise the weekly SCDC Report *Listing of Inmates Currently in SD, DD, MX or ST Custody in SCDC Institutions* to include the average lengths of stay in segregation for mentally ill and non-mentally ill inmates by segregation status and 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 December 2017 Assessment: **compliance (3/2017)**

November 2017 SCDC Status Update

QIRM Analysts had been providing a summarized report on inmates in segregation by institution, custody, and mental health classification to Operations staff. After meeting with Operations leaders, it was determined that the QIRM report is duplicative to the RIM report. RIM continues to produce

and distribute the "Weekly Lockup by Custody and Mental Health Classification." This monthly report is shared with institutional and agency leaders. The most recent report was produced and distributed by RIM on November 8, 2017.

December 2017 Implementation Panel findings: Compliance continues.

December2017 Recommendations: Continue internal monitoring via QIRM to demonstrate continued compliance.

4.a.ix. Quality management documents; and

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

November 2017 SCDC Status Update
Quality management documents, including reports, audit tools, audits, and other forms of documentation continue to be available in shared network folders. Access to each folder is managed by system administrators through the IT Access Request menu. This allows for central storage of documentation for access across divisions and institutions. Examples below.
SCDC is also working to automate as many processes as possible to make data collection simpler and easier.

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

December 2017 Recommendations: Continue to develop the QI process.

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

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

November 2017 SCDC Status Update
For SCDC to expand its ability to develop, produce and maintain reports for medical and medication administration, the agency continues to assess and monitor plans for the rollout to all male institutions. Please consult the project plan timeline summary below for more information.

Remaining Overall EHR timeline:

Task:	Start	End
Female Facility Retraining	12/12/17	12/14/17
Male Facility End User Training Week 1	1/23/18	1/26/18
Male Facility End User Training Week 2	1/30/18	2/2/18
Level 3 Institution Go Live (except Kirkland) – Broad River, Lee, Lieber, McCormick, Perry	2/12/18	2/16/18
Male Facility End User Training Week 3	2/27/18	3/2/18
Kirkland Go Live (EHR, EDR, Scheduling only)	3/6/18	3/9/18

Male Facility End User Training Week 4	3/20/18	3/22/18
Level 2 Institutions Go Live (partial) – Allendale, Evans, Ridgeland, Turbeville	4/3/18	4/6/18
All remaining Institutions Go Live – Catawba, Goodman, Kershaw, Livesay, MacDougall, Manning, Trenton, Tyger River, Wateree	4/17/18	4/20/18
Kirkland eZmar Go Live	4/30/18	5/3/18

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

- 1 additional Help Desk staff member able to specifically address NextGen issues.
- 1 additional RIM staff member to conduct system configuration edits and produce reports and analysis of the NextGen data.
- 6 additional RIM staff members who will serve as statewide support staff for use of all aspects of the system: EHR, EDR, Scheduling, eZmar, interfaces, etc. These staff members will have assigned territories and perform most of their duties onsite in the institutions alongside members of the Health Services staff.

SCDC is also considering an upgrade of the Correctional Health clinical content suite in order to better facilitate the tracking of our quality measures.

QIRM recommends the EHR training be videotaped and made available online so that it can be referenced when staff have questions.

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

December 2017 Recommendations:

1. Implement the plan as per SCDC status update section.
2. For reasons summarized in other sections, QI studies should address medication administration and medication management issues (e.g., level of compliance with policies and procedures specific to medication noncompliance, continuity of medications, etc.).

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 December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update

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

- Improved user maintenance: [redacted] now has the capability to create accounts, re-

enable accounts and reset passwords immediately instead of having to log a support case with NextGen for them to do so.

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

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

December 2017 Recommendations: Implement the EHR as planned.

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

5.a. Improve the quality of MAR documentation;

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

November 2017 SCDC Status Update

Health Services Issue/Area of Concern: Improve the quality of MAR documentation

Health Services –Medical Scope/Impact	Multidisciplinary Team Scope/Impact	Assessment	Action/Anticipated Outcome
) MAR's audits and medication accountability monitored weekly/monthly.) Implementation of the E HR. system is anticipated to increase clinical efficiency, documentation standardization, and enhance the overall provision and delivery of health services though out SCDOC.) E HR./Next Gen issues impacting overall implementation of the E HR throughout SCDOC. : 1) Interface issues between Nextgen and pharmacy systems CIPS, Script Pro and EZ MAR. 2) Problems in medication orders/pharmacy receipt of complete order information through Next Gen due to data stream updates/refresh of the system in 3 second intervals. Requests from SCDOC to Medicalistics for adjusted data stream system refresh from 3 seconds to 30 minute intervals. 3) Missed medications/doses notices not automated-creating a dual system of an E HR. documentation and continued paper system. Medicalistics has recently activated the capability of a missed dose notification to providers. This process is in the preliminary monitoring stages. Inconsistency in staffing levels has created difficulty in staff training/reinforcement creating gaps in knowledge and training. Fluctuation in staffing agency nurses creates an ongoing need for training.	Pharmacy Operations Providers	The MAR's are being monitored weekly and monthly in all facilities. Camille/Leath are audited using E HR. information. Camille was audited in July as a result of information and identified problems with inmate medication administration. Information from the Camille July audit was forwarded to the IP auditors in July, 2017. This compiled information identified areas for SCDOC improvements such as: 1) documentation of the provider notifications regarding the inmates missed meds/refusal of meds. 2) interruption in the data stream for pharmacy orders from medical due to updates/refresh cycles of the Next Gen system, and 3) gaps in some re-orders/new orders of medications. Institutional MAR's audits are compiled monthly and provided to the HSOA's. HSOA's and E HR. staff have tabulated findings and results from the audits. MAR Audit results from Camille for August/September, 2017 were forwarded to the IP auditors during the week of October 23, 2017. A survey of the Camille inmates (those previously audited in July) was administered by pharmacy staff and E HR. staff in October, 2017. The purpose of the survey was to review progress levels at Camille, identify any new or existing problems areas, and to address the inmates concerns regarding their medications.	Continued monthly MAR audits will facilitate ongoing identification of issues/problematic areas allowing corrections within appropriate timeframes. Development/ implementation of standardized documentation processes within EZ MAR and Next gen will allow for improvements in data collection, documentation and delivery of health services. Completion of IT technological problems in this area/anticipated resolution of issues by end of 2017. Staff training and follow up for reinforcement training sessions ongoing at Camille by E HR. staff and IT staff. This process is expected to continue through December, 2017 and escalate in numbers of staff participation in 2018. Automation of notifications to providers for missed medication dosages and refusals of medication within EZ Mar will improve communications between pharmacy and medical. Anticipated resolution of automation requirements and from Medicalistics is December, 2017.

December 2017 Implementation Panel findings: Significant problems relevant to medication administration were found in the Marion housing unit at the Broad River Correctional Institution as

previously summarized in another section of this report. Specifically, medications were administered at the cell front because this housing unit was essentially on a locked down status. In cells that did not have a food port, medications were delivered under the door of the cell. Inmates also reported that medications were left on the food port and that it was unclear whether some inmates were receiving the medications that had been prescribed to them. In addition, other inmates were not receiving prescribed medications on a timely basis.

Similar problems were present at all other institutions assessed during this site visit except for Camille Griffin Graham CI.

December 2017 Recommendations: The above described medication administration process is unacceptable and needs to be remedied. A QI process should be established to assess the remedy that is implemented.

Also see provision 4.a.x. recommendations.

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

Implementation Panel December 2017 Assessment: **noncompliance**

November 2017 SCDC Status Update

Health Services Issue/Area of Concern: Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs

Health Services –Medical Scope/Impact	Multidisciplinary Team Scope/Impact	Assessment	Action/Anticipated Outcome
Ongoing training for providers and nurses is required for continuous process adherence. Collaborations between providers/pharmacy/medical planned for increased levels of efficiency and enhanced health service delivery. Failure to comply with policies and procedures will be addressed through corrective action processes.	a) Providers b) Pharmacy c) Nurses d) Medical Director		Multidisciplinary teams of medical, pharmacy, and operations are working on shared projects for optimization of workspace/resources/workflow organization and overall enhanced health service delivery. A variety of shared collaborations are underway such as: Camille-) Pharmacy, IT, E HR. staff and nursing participated in the July audits and compilation of results from the audits.) IT and E HR. staff have facilitated ongoing E HR. training/support for several months. Pharmacy/nursing facilitated reorganization of pill rooms/tools for improved efficiency in October, 2017. In October, 2017, Pharmacy developed a modified stock supply order /forward to institutions automatically rather than individual orders. 5) Review of the current pill line times and feasibility of revised schedules is underway between pharmacy, medical, and operations. Pharmacy and medical will conduct a site visit to Leath in November, 2017 to review Leath's processes and Camille's/share ideas. Pharmacy staff and E HR. staff conducted a survey of Camille inmates in October, 2017. The survey participants

			were previously identified in July, 2017 with concerns regarding medication administration. Kirkland-Pharmacy/Medical staff reviewed pill room workflow processes/organization in October, 2017. Wall panels to enhance pill room efficiency and space utilization were ordered by the pharmacy in October, 2017. Ideas for stock supplies/orders/organization have been discussed with pharmacy/medical with ongoing plans for future collaboration on audits/process reviews between the two departments. Pharmacy assisted in the organization and distribution of flu vaccines throughout the state in October, 2017. Vaccine administration/results will be monitored by pharmacy and medical through the end of 2017.

December 2017 Implementation Panel findings: See findings relevant to the previous provision specific to the medication administration process. Based on such findings, it is clear that the process described in the SCDC status update section has not been effective. The audit findings at CGG and the administration of medications "under the doors" and " on the food ports" at male institutions are unacceptable and must be corrected.

December 2017 Recommendations: Remedy the above referenced processes and perform a follow-up QI process.

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

Implementation Panel December 2017 Assessment: **noncompliance**

November 2017 SCDC Status Update

Health Services Issue/Area of Concern: Review the reasonableness of times scheduled for pill lines

Health Services –Medical Scope/Impact	Multidisciplinary Team Scope/Impact	Assessment	Action/Anticipated Outcome
Variability in pill line schedules/medication administration times are limited due to controlled movement schedules, frequent institutional- lock downs, and staffing shortages of officers and nurses.	Medical Providers Operations Mental health	Individual institutional staff (operations and medical) will meet consistently to review existing needs and changes to the inmate populations. Frequent communication between operations/medical regarding pill line times/schedules/medication orders will enhance knowledge and awareness of each disciplines requirements creating more cooperative environment for both areas.	Institutional meetings between operations/medical targeted for monthly or as needed basis. Frequent changes in population/transfers between facilities as well as the medical/mental health needs are indicative of the need for ongoing meetings/communication between operations/medical.

December 2017 Implementation Panel findings: HS medications were still not being provided to the ICS at Kirkland CI or at Camille Griffin Graham CI. Pill call lines were problematic at the Camille Griffin Graham CI ICS as summarized in an earlier section of this report.

December 2017 Recommendations: Implement the appropriate steps to resume HS medication administration at the ICS's and elsewhere when clinically indicated. Adequately identify and address other pill call line issues.

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

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

November 2017 SCDC Status Update

Health Services Issue/Area of Concern: Develop a formal quality management program under which medication administration records are reviewed.

Health Services –Medical Scope/Impact	Multidisciplinary Team Scope/Impact	Assessment	Action/Anticipated Outcome
Incorporation of the individual items listed for component #5 support development of a formal quality management program with MAR reviews.	Medical Providers Mental Health Operations Pharmacy	Collection and review of audit findings/results will be ongoing by DON, HSOA's and departmental members. Incorporation of the E HR. statewide will facilitate more efficient monitoring/evaluation of programs and medication administration ensuring a minimum of 90% compliance with standards and quality clinical indicators. Missed medications/doses and refusals will be monitored through E HR. facilitating more expedited responses to changes in medication compliance, treatments and health service delivery. Stabilization of staffing/resources will support the ongoing efforts of a formal quality management program	Monthly/weekly audit reviews are currently conducted for all institutions. The introduction of statewide use of the E HR. 2018 will facilitate greater sample sizes for monitoring and identification of additional variables/factors for inclusion in the measurement processes. Anticipated start dates for statewide use is the first quarter of 2018. Electronic notifications of missed medications/ doses or refusals will simplify the provider notification process and enhance the treatments prescribed/administered. Anticipated start dates for the notification system is December, 2017. Additional funding requested for salary increases in medical will create increased numbers of clinical staff in all institutions. Notification of legislative budget approval/denial expected in the first quarter of 2018.

December 2017 Implementation Panel findings: See prior findings relevant to medication administration.

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

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

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

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

November 2017 SCDC Status Update
The Division of Facilities Management has completed all renovations on designated CI cells. The Division Director for Mental Health has approved the safe cells as outlined below.

Safe Cells			
Institutions	**# or Cell**	**Location**	**Approved as Safe Cells**
Allendale Correctional Institution	4	RHU	Approved- KD
Broad River Correctional Institution	4		Approved- KD
	13	CSU	Approved- KD
Camille Graham Correctional Institution	4	RHU	Approved- KD
	13	Blue Ridge	Approved- KD
Evans Correctional Institution	3	Infirmary & RHU	Approved- KD
Kershaw Correctional Institution	4	RHU & Medical	Approved- KD
Kirkland Reception & Evaluation Center	8	F-1	Approved-KD
	5	GPH	Approved-KD
Leath Correctional Institution	4	Phoenix - A-Side	Approved- KD
Lee Correctional Institution	4	RHU	Approved- KD
Lieber Correctional Institution	4	RHU	Approved- KD
McCormick Correctional Institution	2	RHU - B-Wing	Approved- KD (need repairs based on riot)- sprinklers/ cameras damaged - reported - 10/27/17
Perry Correctional Institution	6	RHU - B-Dorm, Z-Wing	Approved- KD
Ridgeland Correctional Institution	2	RHU - South	Approved- KD
Trenton Correctional Institution	1	RHU	Approved- KD
Turbeville Correctional Institution	4	RHU - Murray	Approved- KD
Tyger River Correctional Institution	2	RHU - East	Approved- KD
TOTAL	**87**		

December 2017 Implementation Panel findings: As per SCDC status update section. Some cells in the GPH did not have a functional sprinkler. Safety cells in the CGG and Lieber CI RHUs were not suicide resistant.

December 2017 Recommendations: Continue to monitor. Repair the sprinklers in cells within GPH that need repair. Remedy the lack of suicide resistant cells in the CGG and Lieber CI RHUs.

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

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

November 2017 SCDC Status Update
Logs provided to the HSOAs did not identify inmates being placed in a holding cell or other alternative space. In a review of the cell check logs by QIRM staff, there was no documentation to indicate the cells being used were prohibited alternative spaces.

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

December 2017 Recommendations: Continue to monitor.

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

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

November 2017 SCDC Status Update
QIRM staff continue to be informed that the practice of continuous observation is being implemented in the institutions, and have witnessed the practice in action; however, CSU continues to be the only area where this is documented consistently based on the use of the 19-7C, Inmate Constant observation log.

QIRM has identified that possible issues may be attributed to the lack of appropriate documentation.

Identified Issues

- The policy references 19-7, but there are 5 version of 19-7 (A, B, C, D and E)
- Since QIRM has been tracking and reporting no actual version of the 19-7 has been seen in use.
- The language in the policy might be confusing.
    - Section 8.9 states "**Custody and/or health care staff assigned to provide continuous observation during suicide watch shall document observed behaviors every 15 minutes on SCDC Form 19-7".**
    - Section ***9.5*** states "**Cell Check Log: Security will document observed behaviors at irregular intervals, at least every fifteen minutes/continual. Security will document checks on SCDC Form 19-7, "Cell Check Log."**
        - They both reference continuous/continual

- They both instruct staff to use the 19-7

QIRM has made the following recommendations to Operations to address concerns.

If instructions are sent to security staff in the form of a memo, consider using an instruction sheet with screenshots of the forms and instructions for when to use **each** form. QIRM is drafting an instruction like that provided to CGI for the shower and temperature log reviews.

Recommendations
1. Update the policy to reflect the new and appropriate forms (A, B, C, D). (Remove reference to 19-7).
2. Address the use of the correct forms during shift briefing and provide instructions when to use each form.
3. Consider using the attached instruction manual (please review and update as appropriate).
4. Documentation that staff have been briefed on the use form. (Signatures)
5. QIRM will verify staff awareness of proper forms during institutional CQI meetings.

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

December 2017 Recommendations: As per recommendations in SCDC status update section.

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

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

November 2017 SCDC Status Update

A CQI study was completed to assess the provision and maintenance of clean and available suicide-resistant clothing, blankets, and mattresses to inmates in C. The results of the study are attached as Appendix P.

This study was conducted to determine if Suicide Prevention clothing and resources were being cleaned each time it was returned from an inmate on Crisis. Tracking the issuing and cleaning of these resources will enable SCDC to ensure that inmates are receiving clean, hygienic suicide prevention clothing and equipment when placed on Crisis.

Results showed that twenty-one (21), or eleven (11) percent of the Agency's 185 Suicide Blankets have been reported as in disrepair, with Lieber reporting almost half of their blankets in this status. There are 175 Suicide Smocks available across the state with 10% of them in disrepair. Broad River CSU reports that 15 of their 38 smocks are in disrepair. There were inmates on CI status at various institutions during the time of this audit and they were utilizing the equipment.

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

Our July 2017 report included the following: " [N]ot all CI safe cells currently have suicide resistant mattresses."

December 2017 Recommendations: Remedy the above issues described in the SCDC status update section. Add to the monitoring study the presence or absence of suicide resistant mattresses. Ensure there is documentation each inmate placed in a CI safe cell was provided clean, suicide-resistant clothing, blanket, and mattress.

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

Implementation Panel December 2017 Assessment: **noncompliance**

November 2017 SCDC Status Update
Logs used to record cell checks for CI inmates do not include documentation of the provision of showers.
QIRM recommends that SCDC Form M-120, "Crisis Intervention" be evaluated by the Mental Health and Substance Abuse Division Director, Mr. [redacted], for updates to include information about showers for inmates on CI status. Pursuant to a preliminary review, Mr. [redacted] has suggested this form be changed to require a mental health professional to evaluate the inmate for a shower once on CI for 24 hours. This will provide the security staff with specific instructions on the inmate's ability to shower versus current instructions which state "showers as tolerated.

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

December 2017 Recommendations: Remedy the above and continue to monitor results.

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

Implementation Panel December 2017 Assessment: **noncompliance**

November 2017 SCDC Status Update
The Division of BMHSAS completed a QI study to examine what types of mental health sessions were being provided to CI/SP inmates and the frequency of the various types of sessions. This study is attached as Appendix Q.

Results showed that among the three categories of mental health sessions used for this study, total number of cell front sessions, total number of confidential sessions and total number of sessions in other locations, confidential sessions accounted for the smallest portion and cell front sessions for the largest. Confidential sessions made up a relatively small minority of the mental health sessions provided to CI/SP inmates in the months of July, August, and September in the studied institutions. Cell front sessions make up the largest category, but sessions conducted in other places account for a significant minority. Mental Health staff likely chose to conduct sessions in other locations in an effort to provide the inmates with as much privacy as possible, even when they cannot be totally confidential. While this effort is laudable, it falls short of SCDC's goal to provide confidential mental health sessions to inmates on CI/SP status and in CSU. The largest stumbling blocks to

reaching this goal have been a lack of clear data regarding this issue and a shortage of security staff needed to escort inmates to sessions.

December 2017 Implementation Panel findings: As per SCDC status update section. We were also informed by custody staff that it was common for GP mental health caseload inmates to not be seen in a confidential setting as a default due to clinicians' safety concerns.

December 2017 Recommendations: Remedy the above and continue to monitor results.

GP mental health caseload inmates should not always, or almost always, be assessed/treated in a non-confidential setting due to clinicians' safety concerns. It is appropriate to not see inmates in a non-confidential setting when there are clinical reasons that justify safety concerns by the clinicians.

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

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

November 2017 SCDC Status Update
See response at 2.b.vi.

December 2017 Implementation Panel findings: See 2b.vi.

December 2017 Recommendations: See 2b.vi.

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

Implementation Panel December 2017 Assessment: **noncompliance**

November 2017 SCDC Status Update
See 2.b.vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.

December 2017 Implementation Panel findings: During the afternoon of December 5, 2017, we observed a treatment team meeting in the crisis stabilization unit at the Broad River Correctional Institution. This 36-bed unit was located in the Greenwood Unit with a census during the monitoring period ranging from 15-20 inmates. There were no on-site psychiatry hours provided although some psychiatric coverage was provided via telepsychiatry.

Staffing data reported was as follows:

> A psychologist provided on-site coverage on a two day per week basis for an average of 15 hours per week.

3.0 FTE QMHP positions were allocated with no vacancies although the staffing plan requested 7.0 FTE QMHP positions.

9.0 FTE MHTs were allocated with 3.0 FTE vacancies.

8.0 FTE nursing staff positions were allocated with 3.0 FTE vacancies. 12.0 FTE nursing staff positions were requested in the staffing plan.

We observed the staffing of two CSU inmates. A psychiatrist was not part of the treatment team planning process. The treatment team planning process demonstrated significant systemwide issues, which included the following:

1. Lack of adequate communication between the sending facility and the CSU staffs.
2. Lack of adequate communication between the CSU and the ICS staffs.
3. Lack of adequate communication between the CSU and GPH staffs.
4. Significant difficulties addressing custodial issues that were directly related to an inmate's admission to the CSU related to a variety of issues involved in the custodial housing decision process.

The "reinterpretation" of the Suicide Prevention and Management Policy by the Division of BMHSAS to extend the time period allowed for inmates in safety cells in institutions to exceed 60 hours and up to 120 hours by changing the inmates status from "suicide watch" to "observation" is a clear violation of the Settlement Agreement and must be corrected.

December 2017 Recommendations: Develop and implement a plan to address the above systemic issues.

Conclusions and Recommendations:

The IP has provided its recommendations on specific items in the Settlement Agreement in this report and while on-site. We have also provided suggestions to SCDC to continue in their pursuit of development of their own internal processes and support systems for adequate mental health services delivery system and quality management system. This report reflects the IP's findings and recommendations as of December 8, 2017. The IP is hopeful that this report has been informative. We look forward to further development of the mental health services delivery system within the South Carolina Department of Corrections and appreciate the cooperation of all parties in pursuit of adequate mental health care for inmates living in SCDC.

Sincerely,

Raymond F. Patterson, MD
Implementation Panel Member

On behalf of himself and:

Emmitt Sparkman
Implementation Panel Member

Jeffrey Metzner, MD
Subject Matter Expert

Tammie M. Pope
Implementation Panel Coordinator

MEDIATOR REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES
DECEMBER 2017 IP ASSESSMENT

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
1.	**The development of a systematic program for screening and evaluating inmates to more accurately identify those in need of mental health care:**			
	a. Develop and implement screening parameters and modalities that will more accurately diagnose serious mental illness among incoming inmates at R&E with the stated goal of referring inmates to the appropriate treatment programs. Accurately determine and track the percentage of the SCDC population that is mentally ill.	HS 19.10	12/08/17 Partial compliance	12/08/17 Partial Compliance
		HS 19.07	12/08/17 Partial compliance	12/08/17 Partial Compliance
	b. The implementation of a formal quality management program under which mental health screening practices are reviewed and deficiencies identified and corrected in ongoing SCDC audits of R&E counselors;	HS 19.07	12/08/17 Partial compliance	12/08/17 Partial Compliance
	c. Enforcement of SCDC policies relating to the timeliness of assessment and treatment once an incoming inmate at R&E is determined to be mentally ill; and	HS 19.07 HS 19.10	12/08/17 Partial compliance	12/08/17 Partial Compliance
	d. Development of a program that regularly assesses inmates within the general population for evidence of developing mental illness and provides timely access to mental health care.	HS 19.07 HS 19.10	12/08/17 Partial compliance	12/08/17 Partial Compliance

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

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
2.	**The development of a comprehensive mental health treatment program that prohibits inappropriate segregation of inmates in mental health crisis, generally requires improved treatment of mentally ill inmates, and substantially improves/increases mental health care facilities within SCDC:**			
	a. Access to Higher Levels of Care:			
	i. Significantly increase the number of Area Mental Health inmates vis-a-vis outpatient mental health inmates and provide sufficient facilities therefore;	HS 19.04 HS 19.11	12/08/17 Partial compliance	12/08/17 Partial compliance
	ii. Significantly increase the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefore;[2]	HS 19.04, HS 19.07, HS 19.11	12/08/17 Partial compliance	12/08/17 Partial compliance
	iii. Significantly increase the number of male and female inmates receiving inpatient psychiatric services, requiring the substantial renovation and upgrade of Gilliam Psychiatric Hospital, or its demolition for construction of a new facility;	HS 19.04, HS 19.07 HS 19.09	12/08/17 Partial compliance	12/08/17 Partial Compliance
		Gilliam Construction Plan	12/08/17 Partial compliance	12/08/17 Partial Compliance
	iv. Significantly increase clinical staffing at all levels to provide more mental health services at all levels of care; and	Hiring Plan attached as Exhibit E to the Settlement Agreement	12/08/17 Partial compliance	12/08/17 Partial Compliance
	v. The implementation of a formal quality management program under which denial of access to higher levels of mental health care is reviewed.	HS 19.07	12/08/17 Substantial compliance (7/14/17)	12/08/17 Substantial Compliance
	b. Segregation:			
	i. Provide access for segregated inmates to group and individual			

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

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	therapy services;			
		OP RHU Policy _22.38 Section 3.23 H.S. 19.04	12/08/17 Partial compliance	12/08/17 Partial Compliance
	ii. Provide more out-of-cell time for segregated mentally ill inmates;	HS 19.12 OP RHU Policy 22.38 Section 3.14.4 & Section 3.25	12/08/17 Noncompliance	12/08/17 Noncompliance
	iii. Document timeliness of sessions for segregated inmates with psychiatrists, psychiatric nurse practitioners, and mental health counselors and timely review of such documentation;	HS 19.04 OP RHU Policy 22.38 Section 3.15	12/08/17 Partial compliance	12/08/17 Partial Compliance
	iv. Provide access for segregated inmates to higher levels of mental health services when needed;	HS 19.04 HS 19.06	12/08/17 Partial compliance	12/08/17 Partial Compliance
	v. The collection of data and issuance of quarterly reports identifying the percentage of mentally ill and non-mentally ill inmates in segregation compared to the percentage of each group in the total prison population with the stated goal of substantially decreasing segregation of mentally ill inmates and substantially decreasing the average length of stay in segregation for mentally ill inmates;	HS 19.07 OP RHU Policy 22.38 Section 1 and Section 2	12/08/17 Substantial compliance (11/16)	12/08/17 Substantial compliance (11/16)
	vi. Undertake significant, documented improvement in the cleanliness and temperature of segregation cells; and	To be determined	12/08/17 Partial compliance	12/08/17 Partial Compliance
	vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.	HS 19.07	12/08/17 Partial compliance	12/08/17 Partial compliance
	c. **Use of Force:**			
	i. Development and implementation of a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness;	OP 22.01 HS 19.08	12/08/17 Partial compliance	12/08/17 Partial Compliance
	ii. The plan will further require that all instruments of force, (e.g., chemical agents and restraint chairs) be employed in a manner fully consistent with manufacturer's instructions, and track such use in a way to enforce such compliance;	OP 22.01 IIS 19.08	12/08/17 Partial compliance	12/08/17 Partial Compliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	iii. Prohibit the use of restraints in the crucifix or other positions that do not conform to generally accepted correctional standards and enforce compliance;	OP 22.01 HS 19.08	12/08 17 Substantial compliance (7 14 17)	12/08/17 Substantial Compliance
	iv. Prohibit use of restraints for pre-determined periods of time and for longer than necessary to gain control, and track such use to enforce compliance;	OP 22.01 HS 19.08	12/08 17 Partial compliance	12/08 17 Partial Compliance
	v. The collection of data and issuance of quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs;	HS 19.07 OP Use of Force 22.01 Section 13	12/08 17 Substantial compliance	12/ 08 17 Substantial Compliance
	vi. Prohibit the use of force in the absence of a reasonably perceived immediate threat;	OP 22.01 HS 19.08	12/0 8 17 Partial compliance	12/ 08 17 Part al Compliance
	vii. Prohibit the use of crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions;	OP 22.01 HS 19.08	12/ 08/17 Partial compliance	12/ 08 17 Partial Compliance
	viii. Notification to clinical counselors prior to the planned use of force to request assistance in avoiding the necessity of such force and managing the conduct of inmates with mental illness;	OP 22.01 HS 19.08	12/08/17 Partial compliance	12/08/17 Partial Compliance
	ix. Develop a mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates;	OP 22.01 ADM 17.01 Employee Training Standards, SCDC Annual Training Plan HS 19.08	12/08/17 Partial compliance	12/08/17 Partial Compliance
	x. Collection of data and issuance of quarterly reports concerning the use-of-force incidents against mentally ill and non-mentally ill inmates; and	OP 22.01 HS 19.07	12/08/17 Substantial compliance (3/3/17)	12/08/17 Substantial Compliance
	xi. The development of a formal quality management program under which use-of-force incidents involving mentally ill inmates are reviewed.	OP 22.01 HS 19.07	12/08/17 Partial compliance	12/08/17 Partial Compliance
3.	**Employment of a sufficient number of trained mental health Professionals:**			

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	a. Increase clinical staffing ratios at all levels to be more consistent with guidelines recommended by the American Psychiatric Association, the American Correctional Association, and/or the court-appointed monitor;	Hiring Plan attached as Exhibit E to the Settlement Agreement	12/08/17 Partial compliance	12/08/17 Partial Compliance
	b. Increase the involvement of appropriate SCDC mental health clinicians in treatment planning and treatment teams;	HS 19.05	12/08/17 Partial compliance	12/08/17 Partial Compliance
	c. Develop a training plan to give SCDC mental health clinicians a thorough understanding of all aspects of the SCDC mental health system, including but not limited to levels of care, mental health classifications, and conditions of confinement for caseload inmates;	Mental Health Training Policy Addendum	12/08/17 Partial compliance	12/08/17 Partial Compliance
	d. Develop a plan to decrease vacancy rates of clinical staff positions which may include the hiring of a recruiter, increase in pay grades to more competitive rates, and decreased workloads;	Hiring Plan attached as Exhibit E to the Settlement Agreement	12/08/17 Substantial compliance	12/08/17 Substantial Compliance
	e. Require appropriate credentialing of mental health counselors;	HS 19.04	12/08/17 Substantial compliance (3/3/17)	12/08/17 Substantial Compliance
	f. Develop a remedial program with provisions for dismissal of clinical staff who repetitively fail audits; and	HS 19.07	12/08/17 Partial compliance	12/08/17 Partial Compliance
	g. Implement a formal quality management program under which clinical staff is reviewed.	HS 19.07	12/08/17 Partial compliance	12/08/17 Partial Compliance
4.	**Maintenance of accurate, complete, and confidential mental health treatment records:**			
	a. Develop a program that dramatically improves SCDC's ability to store and retrieve, on a reasonably expedited basis:	HS 200.7		
	i. Names and numbers of FTE clinicians who provide mental health services;		12/08/17 Substantial compliance (3/3/17)	12/08/17 Substantial Compliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	ii. Inmates transferred for ICS and inpatient services;		12/08/17 Substantial Compliance (7/14/17)	12/08/17 Substantial Compliance
	iii. Segregation and crisis intervention logs;		12/08/17 Partial compliance	12/08/17 Partial Compliance
	iv. Records related to any mental health program or unit (including behavior management or self-injurious behavior programs);		12/08/17 Partial compliance	12/08/17 Partial Compliance
	v. Use of force documentation and videotapes;		12/08/17 Substantial compliance (3/3/17)	12/08/17 Substantial Compliance
	vi. Quarterly reports reflecting total use-of-force incidents against mentally ill and non-mentally ill inmates by institution;		12/08/17 Substantial compliance (3/3/17)	12/08/17 Substantial Compliance
	vii. Quarterly reports reflecting total and average lengths of stay in segregation and CI for mentally ill and non-mentally ill inmates by segregation status and by institution;		12/08/17 Substantial compliance (3/3/17)	12/08/17 Substantial Compliance
	viii. Quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution;		12/08/17 Substantial compliance (3/3/17)	12/08/17 Substantial Compliance
	ix. Quality management documents; and		12/08/17 Partial compliance	12/08/17 Partial Compliance
	x. Medical, medication administration, and disciplinary records.		12/08/17 Partial compliance	12/08/17 Partial Compliance
	b. The development of a formal quality management program under which the mental health management information system is annually reviewed and upgraded as needed.	HS 19.07	12/08/17 Partial compliance	12/08/17 Partial Compliance
5.	**Administration of psychotropic medication only with appropriate supervision and periodic evaluation:**			
	a. Improve the quality of MAR documentation;	HS 18.16	12/08/17 Partial compliance	12/08/17 Partial Compliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	b. Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs;	HS 18.16	12/08/17 Noncompliance	12/08/17 Noncompliance
	c. Review the reasonableness of times scheduled for pill lines; and	HS 18.16	12/08/17 Noncompliance	12/08/17 Noncompliance
	d. Develop a formal quality management program under which medication administration records are reviewed.	HS 18.16	12/08/17 Partial compliance	12/08/17 Partial Compliance
6.	**A basic program to identify. treat, and supervise inmates at risk for suicide:**			
	a. Locate all CI cells in a healthcare setting;	HS 19.03 OP RHU 22.38 Section 3.39	12/08/17 Partial compliance	12/08/17 Partial Compliance
	b. Prohibit any use for CI purposes of alternative spaces such as shower stalls, rec cages, holding cells, and interview booths;	HS 19.03 OP RHU 22.38 Section 3.39	12/08/17 Substantial compliance	12/08/17 Substantial Compliance
	c. Implement the practice of continuous observation of suicidal inmates;	HS 19.03	12/08/17 Partial compliance	12/08/17 Partial Compliance
	d. Provide clean, suicide-resistant clothing, blankets, and mattresses to inmates in CI;	HS 19.03	12/08/17 Partial compliance	12/08/17 Partial Compliance
	e. Increase access to showers for CI inmates;	HS 19.03	12/08/17 Noncompliance	12/08/17 Noncompliance
	f. Provide access to confidential meetings with mental health counselors, psychiatrists, and psychiatric nurse practitioners for CI inmates;	HS 19.03	12/08/17 Noncompliance	12/08/17 Noncompliance
	g. Undertake significant, documented improvement in the cleanliness and temperature of CI cells; and	HS 19.03	12/08/17 Partial compliance	12/08/17 Partial Compliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	h. Implement a formal quality management program under which crisis intervention practices are reviewed.	HS 19.03	12/08/17 Noncompliance	12/08/17 Noncompliance

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

Executive Summary

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

During this site visit, as with past site visits, the Regional Directors have assisted with the process of review of items and information relevant to the Settlement Agreement and the Wardens and their administrative staff have provided access and consistent support for the IP touring the requested areas. Dr. Sally Johnson, consultant to SCDC, accompanied the IP to the facilities during this visit and Ms. [redacted] the newly appointed Deputy Director of Healthcare Services, also was very helpful in her participation in the on-site visits. On March 23, 2018, the IP held our traditional exit briefing, attended by Director Sterling and SCDC administrative and clinical staff as well as attorney Roy Laney who represents SCDC. Plaintiffs' counsel, Daniel Westbrook, and Judge William Howard were not able to attend but were apprised of the IP's preliminary findings.

As with past reports, this Executive Summary is intended to present an overview of the SCDC analysis and the Implementation Panel's findings regarding SCDC's compliance with the Settlement Agreement. The IP has continued to provide onsite technical assistance, presented its findings, and have attempted to acknowledge the positive efforts and findings demonstrated by specific programs and/or facilities, as well as continuing concerns regarding service delivery and compliance, and specific concerns that may have presented since the last site visit.

In that regard since the last site visit there has been a Use of Force event involving a mentally ill inmate at Lee Correctional Institution, which is under investigation by SCDC because of concerns with regard to the adherence to policies and procedures and the impact on the inmate and staff. [redacted]

As in past reports, the IP has defined and reported the compliance levels as "non-compliance", "partial compliance", or "substantial compliance" in each of the elements as well as providing specific findings and recommendations onsite in the individual facility exit briefings as well as at the comprehensive exit briefing on 3/23/18.

The IP visits included the following institutions during the week of March 19-23, 2018:

Kirkland Correctional Institution
Broad River Correctional Institution
Camille Graham Correctional Institution
Allendale Correctional Institution

Included in this report are Exhibit B and Appendices A-Z and Attachments 1-7. Exhibit B is the summary of the IP's assessment of compliance with the remedial guidelines. The preliminary "Master Plan" for mental health services which was reviewed during the last site visit has been updated by [redacted] and SCDC staff and we look forward to progression of that Master Plan. Exhibit B illustrates the Implementation Panel's findings regarding the levels of compliance as follows: 1) Substantial compliance - 15 components; 2) Partial compliance - 38 components; 3) Non- compliance - 5 components.

The Implementation Panel has made consistent attempts to acknowledge the sincere efforts by SCDC to improve mental health care, however SCDC continues to struggle in their attempts to achieve compliance with the necessary requirements of the Settlement Agreement in various programs and facilities. SCDC has moved forward with its plans to "centralize" several of their mental health services by programmatic levels, including: 1) High level BMU at Kirkland Correctional Institution; 2) Low level BMU at Allendale Correctional Institution; 3) Crisis Stabilization Unit at Broad River Correctional Institution; 4) Enhanced outpatient/area mental health (Level Three) at Broad River Correctional Institution; and 5) Multiple programs at Camille

Graham Correctional Institution for Women including Crisis Stabilization Unit (CSU), Intermediate Care Services (ICS), and Outpatient Services. There has been discussion of the potential need for a Behavioral Management Unit at Camille Graham which has not yet been proposed or developed. In addition, with regard to the contractual agreement with Columbia Regional Care Center (CRCC) for inpatient hospital beds for male and female inmates in need, the availability of hospital beds at CRCC has not yet been achieved as SCDC staff report that the provider has had construction and other issues which have delayed or impeded immediate access to the 10 beds that were agreed upon by contract. The IP strongly encouraged the appropriate components of SCDC, including clinical, operations and legal to pursue assuring availability of these beds for SCDC inmates when necessary.

In the Fifth Report of the Implementation Panel, the IP identified 10 areas of serious concern from past site visits and noted in previous reports including the following:

1. Staffing - including clinical (mental health, medical and nursing), operations, administrative and support staff. The IP cannot overemphasize the vital importance of having adequate numbers of appropriately qualified and trained staff. There has been some progression on the operations side of the house and limited progression on the clinical side of the house in hiring additional staff and providing as much "coverage" as possible by clinical staff. However, the allocated staffing positions for SCDC do not appear to be adequate for the provision of necessary services across this system. SCDC has engaged outside consultants to provide their estimates of the actual allocations needed for appropriate implementation of mental health services but also of basic provisions from a correctional/operations perspective. We have reported in the past and observed during this and past visits a lack of adequate numbers of operations staff to provide basic services and requirements as per policy including inmates in general population being subjected to lockdowns because of a lack of adequate staffing. This has led to further complications involving medication administration (see below) as well as out of cell time for inmates that is required by policies and procedure. In addition, while there have been efforts to increase the mental health staffing component by implementing tele-medicine and other coverage efforts, these are at best stop gap measures that need to be replaced by onsite staff to provide consistent mental health care to inmates identified by SCDC as in need of such care. In that regard, SCDC has made very good progress in identifying the actual mental health "caseload" which is estimated at over 18% based on the SCDC calculations. The IP has made recommendations regarding addressing these needs as well as the need to provide consistency of mental health staff and multidisciplinary participation in treatment planning including inmates to facilitate the most appropriate treatment services and outcomes. The nursing staffing issues are at such critical levels that medication management has fallen below acceptable clinical standards of care (see below).

2. Conditions of Confinement - including restrictive housing units (RHU) and segregation of any type. During our last site visit the IP was made aware that SCDC administrative staff "reinterpreted" the policy on Suicide Prevention Management to allow for up to 120 hours in "safety cells" in outlying facilities before required transfer to the CSU. Although a

correction has been made that inmates cannot remain in outlying facilities in safety cells for longer than 60 hours, this condition or situation has been complicated even further because the occupancy of the CSU at Broad River has been at or near capacity and there exists a "waiting list." The Settlement Agreement essentially prohibits there being a "waiting list" and the required 60-hour timeframe during which inmates must be transferred must be adhered to. During the course of our site visit to BRCI, it was clear that the 31 available CSU cells were occupied and the additional 32 CSU cells on the second tier were being occupied by "inmate watchers." The IP advised early in this process our views with regard to inmate watchers as well as the provision of individual (single cell) housing for inmate watchers within the CSU unit. One of the options being considered by SCDC was to bring in the "boats" which are plastic objects which are intended to substitute for beds and have been used in other facilities. This is an unacceptable option in providing inmate health care when there are potentially available beds within the CSU itself, which would hopefully alleviate the need for inmates sleeping in "boats" on the floor without mattresses. The IP also discovered that mattresses are not being used in the CSU at Camille Graham because of the interpretation that a one piece suicide resistant blanket/mattress/pillow was adequate. The IP apprised the staff at Camille Graham that these substitutions were not adequate for beds or mattresses. The concerns regarding the safety cells at Gilliam Psychiatric Hospital at KCI which were found to have inadequate suicide resistance on the last visit have been corrected as of this visit.

3. Prolonged Stays in Reception and Evaluation at both Kirkland CI and Graham CI. At Graham CI there have been increased efforts to identify inmates who are in need of mental health services and efforts to try to provide group therapies and other contacts with mental health staff for female inmates who remain in the R&E at Graham for greater than 30 days. While the clinical staff at Graham CI reported an increased number of group therapies for women in R&E as well as women in RHU, the women in those programs reported less time out of cell than what was reported by clinical staff due to cancellations of groups and "competing" activities that were being run at the same time as groups. A study that will be reflected later in this report indicated that the referral process from the R&E`s at Kirkland and Graham has been monitored more closely and revealed that there has been some documentation of urgent referrals to a qualified mental health professional but essentially no documentation of emergency referrals for psychiatric providers. The collective experience of the IP challenges the concept that no one coming into the SCDC as an inmate with mental health needs is in need of emergency and/or urgent referral services to a psychiatric provider. We have made this clear on multiple visits.

4. The Lack of Timely Assessments by Multidisciplinary Treatment Teams at the Mental Health Programmatic Levels. This continues to be a concern particularly with regard to the availability of psychiatrists and nurse practitioners to provide input into the multidisciplinary treatment team process. There has been improvement at the CSU BRCI in that there is participation by psychiatrists via tele-medicine at the treatment team meetings. However, based on our onsite review, the actual participation of the psychiatrist was more along the line of a psychiatric assessment rather than actual participation by a

psychiatrist and other team members in the discussion of the inmate's required needs. Assessments by mental health professionals should be completed prior to the multidisciplinary treatment plan meeting which is intended to have all of those assessments reviewed with the inmate to determine the best course of action.

5. Operations and Clinical Staff Adherence to Policies and Procedures and Lack of Appropriate Supervision.

6. Access to All Higher Levels of Care for Male and Female Inmates - Our previous concerns with regard to access to all higher levels of care for male and female inmates focused largely on the role of the CSU's in the Continuum of Mental Health Services. The role of the male CSU at BRCI appears to be expanding and the need for not only multidisciplinary clinical staff participation but also classification staff in addition to current operational staff participation appears to be a vital component to the IP which has not yet been implemented. The CSU at CGCI continues to be developed and the need for participation of multidisciplinary, clinical and classification staff appears to be very necessary. There have been improvements in the BMU's in that they have increased their levels of programmatic participation. The low level BMU at Allendale CI was visited and inmates were interviewed. In addition the IP attended a graduation ceremony for four inmates who were graduating from the low level BMU. These are all very positive achievements, however they reflect that the actual provision of staff is inadequate for this program which has only two QMHP's and no regular psychiatric participation at treatment team meetings. In addition, because of the staffing issues, as well as space issues at Allendale CI, the program is capped at 24 beds. Similarly at the high level BMU at Kirkland CI, the program has also been capped at 20 inmates because of a lack of staffing and space resources. These are deficiencies that are affecting the overall programs as well as the availability of programs to other inmates who may have been appropriate for admission to these programs but are placed on a waiting list because of inadequate resources.

7. Future Planning for a Comprehensive Mental Health Services Delivery System including Staffing Beds and Programs. The Master Plan which was reviewed at the last site visit was largely a plan to develop a plan. There has been some progression in developing this plan, but it is highly dependent on resource allocation. Even if the current staffing allocations are satisfied for clinical and operations staff, it is the IP's opinion that the full staffing at the allocated measures would be inadequate to provide for the actual inmate needs. SCDC has sought consultation from classification and operations experts and has continued consultation with their psychiatric expert, Dr. Sally Johnson.

8. Medication Management, particularly at Graham CI and Leath CI. The IP has expressed our grave concerns with regard to medication management (not limited to the women's facilities) and the interface between the electronic medical record, the eZmar System and the RIM, as well as the very dire staffing needs for nurses at these facilities. There are similar needs for nursing staff at the male facilities, which includes the need for filling allocated positions with on board staff, as much of the coverage in SCDC facilities is being

done by an agency of pool nurses who have no consistent involvement with specific inmates and therefore the potential for medication errors and other problems with medication administration have been evident and continue. The practice of providing inmates with medications "under the door" in small manilla envelope packages even when administered via the "putter" (described as a golf club like item onto which the package of medication is placed and then slid under the door for the inmate to retrieve, which we observed while on site) is well below the standard of care and requires immediate correction. The implications of providing medications in this way to the general population inmates (with plans to reconfigure their doors to include food slots to place medications through) as well as segregation inmates who by and large have doors with food slots in them, is simply unacceptable and the actual monitoring and evaluation of medication administration, medication errors, and inmate adherence to prescribed medications are all very problematic and may contribute not only to medication contraband being distributed by inmates who are not taking their medications but also the potential of hoarding of medications by inmates that may be used subsequently for self-harm and/or suicide. The clinical and security risks of these practices cannot be overemphasized.

9. Substantial Progress in the Quality Management Program has been noted in the efforts by the Quality Improvement Risk Management Program (QIRM), which has been a major asset to the SCDC system, as well as the documentation of compliance with the Settlement Agreement requirements. The Behavioral Health Division also has a quality management component and the interface between Behavioral Health, QIRM and RIM are essential for actual demonstration of compliance in adequate mental health care. The concerns regarding collaboration, methodology, reliability and timeliness of reporting information has been reported in the IP's past reports as well as onsite and again must be reinforced in this report.

10. Implementation of the EHR including eZmar and the Interface with the Pharmacy System, which has been piloted at Graham CI and Leath CI, has been an important learning curve for SCDC. Based on some of the problematic areas identified as in need of revision and/or improvement, the rollout to the male facilities has been delayed. The IP agrees with this delay to facilitate that when the rollout is implemented it has the most likely chances for success.

11. The IP remains extremely concerned about UOF issues at certain SCDC correctional facilities. The monthly reviews by the responsible IP member continue to identify UOF incidents where a threat does not exist to justify the UOF or the UOF was not within SCDC guidelines. An extreme example is the planned UOF incident that occurred at Lee Correctional Institution where an inmate was seriously injured. SCDC officials and the IP Team reviewed the UOF video together during the March 2018 site visit and were alarmed at the magnitude of the UOF violations in conjunction with flagrant participant disregard for inmate safety and welfare. It is encouraging that SCDC management took immediate action terminating an employee and initiating a criminal investigation. SCDC management must become more proactive in identifying and addressing UOF issues. The

IP is encouraged that the Operations Division has created an Administrative Regional Director to review UOF incidents with the purpose of implementing strategies to address individual and systemic UOF deficiencies. The Mental Health Division has also created a position to review and provide input regarding UOF incidents involving inmates with a mental health designation. It is imperative that SCDC Operations and Mental Health Staff collaboratively work together on preventing UOF incidents. Further, it is essential and necessary that Operations and Mental Health staff address the unacceptably low percentage (29% in January 2018) of notifying clinical counselors (QMHPs) before planned uses of force to request assistance in avoiding the necessity of force and managing the conduct of inmates with mental illness.

The development of a systematic program for screening and evaluating inmates to more accurately identify those in need of mental health care:

1.a. Develop and implement screening parameters and modalities that will more accurately diagnose serious mental illness among incoming inmates at R&E with the stated goal of referring inmates to the appropriate treatment programs.

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
The Division of Behavioral Health and Substance Abuse Services completed CQI study to determine if the timeframes for the initial screening and follow up evaluations outlined by policy were being met, to identify root causes of any deficiencies, and to provide action plans to correct any identified deficiencies.

The complete study is included as Appendix A. Results were as follows:

During the course of this study, Camille Graham showed improvement with identification (n= 51 urgent & n= 20 emergent). Kirkland R&E demonstrated an improvement with identifying urgent referrals (n= 40); and reported that emergent referrals are triage as crisis cases and not reflected in their percentages. Compliance percentage averages from both programs based on mandated timelines in policy were as follows:

	Camille Graham	Kirkland
Screening	51.3%	47.3%
Routine Referrals (QMHP)	67%	71.1%
Routine Referrals (Psych)	57.4%	43.1%
Urgent Referrals (QMHP)	19.1%	72.8%
Urgent Referrals (Psych)	8.3%	62.5%
Emergent Referrals(QMHP)	51.1%	0%
Emergent Referrals (Psych)	0%	0%

In comparison to the last reporting period, Mental Health screening practices timeliness decreased for both programs averaging 5.47 days. Both programs have received an increase of Psychiatry time since last reporting period, which is reflected in Kirkland's routine and urgent referrals to Psychiatry for the month of January. The identification of emergent referrals appear to be problematic for Kirkland; however, they report those cases are managed on crisis intervention and not coded properly to be counted in this report.

Planned Actions

1. Assess and determine the reason why screening practices for both programs decreased this reporting period.
2. Assist Kirkland R&E staff with coding and documenting emergent referrals that are being processed through crisis intervention in order to be counted in the data.

March 2018 Implementation Panel findings: As per SCDC status update section. Improvement in meeting required timeframes since the last monitoring is noted although partial compliance remains due primarily to both custody and mental health staffing vacancies.

Staff informed us that the zero percentages related to emergency referrals to psychiatrists were due to such referrals being tracked as crisis stabilization unit referrals. They will begin to track these referrals as emergent referrals and also track what percentage of such referrals result in referrals to the crisis stabilization unit.

The partial compliance on urgent referrals is very concerning and needs to be adequately addressed.

March 2018 Implementation Panel Recommendations: Our December 2017 recommendations essentially remain unchanged and are as follows:

1. Continue to QI the relevant timeframes.
2. Adequately address the mental health and correctional staffing vacancies.
3. Accurately track the out of cell time offered to R&E inmates on a weekly basis.
4. Continue to provide the average and median LOS data in the future for inmates in the R&E upon transfer from the R&E.
5. R&E inmates need reasonable access to mental health services for both medication purposes and crisis intervention.

1.a.i. Accurately determine and track the percentage of the SCDC population that is mentally ill

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:

To track the percentage of mentally ill inmates, the Division of Resources and Information Management (RIM) generates s report entitled *Mental Health Classifications for the Mentally Ill Institutional Population*. This report includes

- the numbers of mentally ill inmates by classification,
- the percentage of mentally ill by classification as a percent of the mentally ill population, and the percent of mentally ill inmates as a percentage of the total population.

Mental Health Classifications for Mentally Ill Institutional and Female GEO Care Population on February 26, 2018

SCDC Institutional and Female GEO Care Population = 19,458
SCDC Mentally Ill Population = 3,647

Mental Health Classification	Female	Male	Total	Percent of Mentally Ill Population	Percent of Total Population
Missing	32	222	254	N/A	1.31%
BL		22	22	0.60%	0.11%
BU		20	20	0.55%	0.10%
L1	1	71	72	1.97%	0.37%
L2	17	141	158	4.33%	0.81%
L3	78	222	300	8.23%	1.54%
L4	601	2,302	2,903	79.60%	14.90%
L5	40	112	152	4.17%	0.78%
MR	2	18	20	0.55%	0.10%

The most recent reports, dated February 26, 2018 are attached as Appendices B1 and B2.

As of February 26, 2018, the following institutions have implemented this annual screening process:

During the Implementation Panel's last visit, in December 2017, SCDC submitted a quality improvement study that indicated that ten inmates out of 671 included in the study had been added to the mental health caseload as a result of this anniversary screening process. This reporting period, the quality improvement study on this topic, Appendix B3, indicates only four inmates out of 661 included in the study have been added to the caseload as a result of this anniversary screening process. However, please note that these studies examined different institutions for different lengths of time. The study submitted in December examined Camille, Lee, MacDougall, McCormick, and Perry over a three month time period (July through September of 2017) while the current study examined Camille, Broad River, and Allendale over a four month time period (October of 2017 through January of 2018). Despite the fact that the two studies examined different institutions over differing lengths of time, the number of inmates eligible for anniversary screenings in each study were very similar: 671 and 661, respectively. Thus it appears that the anniversary screening process was less effective in the most recent study than it was in the previous study. Protocol changes were implemented in October of 2017 with

the goal of increasing the efficacy of these anniversary screenings. At this point, SCDC plans to continue to implement this new protocol and monitor its efficacy while simultaneously exploring other options so that we will be prepared to replace the anniversary screening process should it ultimately prove unsuccessful. Please see the Planned Actions section of the quality improvement study attached as Appendix B3 for more information.

Assessment of the results from the above referenced study was as follows:

Only one of the three studied institutions, Camille, is completing the majority of their anniversary screenings with any consistency. Camille was the first SCDC institution to begin anniversary screenings. They did so in February of 2017. AS such they have more experience with the process than the other studied institutions. Additionally, the numbers of inmates eligible to be screened are low at Camille in comparison to the other studied institutions. Both of these factors likely contributed to Camille's success in completing these screenings. However, even at Camille where screenings are being completed, QMHP follow ups were completed at only 60% at best and no psychiatric follow ups were completed in a timely manner. Most importantly, Camille added only four inmates to the mental health caseload during the studied time period and the other studied institutions added none. Overall, it appears that the current anniversary screening procedure is not an effective way to reach the agency's goal of accurately identifying inmates with mental illness who were not classified as mentally ill prior to the screening in order to bring the identified rates of mental illness within SCDC's inmate population closer to national average rates.

Planned actions, if any:
On October 2, 2017, The Division of BMHSAS implemented a new statewide protocol (see attachment). This protocol requires that the QMHPs or Mental Health Techs account for all inmates eligible for anniversary screenings in any given month. In order to accomplish this, mental health staff will seek out inmates who fail to report for their appointments for face to face contact. Additionally, mental health staff will follow up on inmates who refuse to attend their appointment by completing a records review (AMR and medical chart) and talking with security staff. No inmate will be noted to have "refused services" until all of this has been done. The data in this study begins at the same time that this new protocol was implemented. It takes time for a new protocol or procedure to be learned at put into practice; particularly in as large and complex a system as SCDC. Thus, the Division of BMHSAS will continue under this protocol through April of 2018 and then will reassess its efficacy. The Division of BMHSAS will also explore alternatives to the anniversary screening system so that if rates of completion and additions to the mental health caseload have not improved at that time. SCDC will be prepared to move method of achieving this goal.

March 2018 Implementation Panel findings: As per the current status section, which indicates that 18.74% of the total inmate population is on the mental health caseload. It also appears clear that the annual mental health assessment from an epidemiological screening perspective is not very helpful for such purposes. These statistics, when viewed in context of the percentage of inmates being identified as requiring mental health services during the R&E process, indicate that inmates

not initially identified as requiring mental health services during the R&E process are later identified via a variety of different processes such as self-referral and staff referral, based on the increasing percentage of the inmate population receiving mental health services.

March 2018 Implementation Panel Recommendations: Continue to track the statistics relevant to this Settlement Agreement provision.

1.b. The implementation of a formal quality management program under which mental health screening practices are reviewed and deficiencies identified and corrected in ongoing SCDC audits of R&E counselors;

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
The Division of BMHSAS does not have a standard protocol or established practice that requires MH supervisors to review those inmates determined to be NMH by QMHP to assess for agreement/disagreement; however, complexed cases are staffed with MH Supervisor, who is licensed as an independent mental health practitioner to provide guidance to subordinates. The psychiatrist is also available for consultation. The Division does review cases from each QMHP caseload, during their quarterly audits, to include cases determined to be NMH. If issues are noted, these concerns are shared with the R&E Mental Health staff.

A CQI study was done to help the administrators in the SCDC Behavioral/Mental Health and Substance Abuse Services (BMH&SAS) evaluate KCI R&E counselors. The study did not include CGCI R&E, since they already have a reasonable number of inmates identified at R&E and placed on the mental health caseload.

The results of the study were as follows:

Kirkland R&E	Total # of removals from KCI R&E	Special Removals with referral to counselor that left R&E with "MH" classification.	# of Special Removals that reclassified to mentally ill within 6 months.	% of Special Removals that were reclassified.
June 2017 Removals	433	56	5	8.9%
July 2017 Removals	447	53	2	3.8%
August 2017 Removals	542	79	6	7.6%
September 2017 Removals	428	48	0	0.0%
Totals	1850	236	13	5.5% average

March 2018 Implementation Panel findings: As per status update section.

March 2018 Implementation Panel Recommendations: Repeat this study during the next monitoring period.

1.c. Enforcement of SCDC policies relating to the timeliness of assessment and treatment once an incoming inmate at R&E is determined to be mentally ill;

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
Health Services identified that a temporary pink slip position was needed to ensure the mental health MEDCLASS data was entered timely. A Medical Assistant position was identified for Kirkland R& E and processed for hiring.

Additional CNAs have been processed for hiring or brought in through agency staffing. Consistent staffing of CNAs for Kirkland and Camille have been problematic due to initial background issues or frequent turnover in these positions.

March 2018 Implementation Panel findings: As per status section. Staff reported that R&E inmates are receiving prescribed psychotropic medications, when clinically indicated, on a timely basis within the R&E units. We discussed with them the need to ensure that a clinician is identified as essentially being a mental health caseload inmate's primary mental health clinician during his or her time within the R&E unit. In addition, inmates with length of stay greater than 30 days within the R&E unit need to have additional mental health services provided to them as compared to those with length of stay less than 30 days, which include increased out of cell time.

The Implementation Panel interviewed CGCI R&E inmates in group settings on March 23, 2018, and received information regarding conditions of confinement in R&E. Out of cell recreation is normally only one (1) hour per day. For a brief period, additional evening recreation time was permitted; however, the evening sessions were discontinued. Access to the correctional facility gymnasium is provided three (3) times per week weather permitting. Showers are afforded three days per week. Meals for R&E inmates are served in the CGCI cafeteria unless the correctional facility is on lockdown. R&E inmates are not permitted to utilize the canteen until they are classified, limiting their access to personal care items while confined in R&E. Inmates complained they are not issued sufficient hygiene items to meet their personal needs. Groups were instituted approximately four (4) weeks ago with approximately three (3) groups held per week offering topics in social skills, coping and character development. Inmates are not allowed visitation while they are assigned to R&E.

March 2018 Implementation Panel Recommendations:

1. Remedy the above identified staffing issue.

2. Perform a QI study to determine whether R&E inmates are being referred to a psychiatrist, when clinically indicated, in a timely fashion as well as receiving any prescribed medications in a timely manner.

1.d. Development of a program that regularly assesses inmates within the general population for evidence of developing mental illness and provides timely access to mental health care.

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
As per 1.a.i.

March 2018 Implementation Panel findings: As per 1.a.i.

March 2018 Implementation Panel Recommendations: As per 1.a.i.

2. The development of a comprehensive mental health treatment program that prohibits inappropriate segregation of inmates in mental health crisis, generally requires improved treatment of mentally ill inmates, and substantially improves/increases mental health care facilities within SCDC.

2.a. Access to Higher Levels of Care
2.a.i. Significantly increase the number of Area Mental Health inmates vis-a-vis outpatient mental health inmates and provide sufficient facilities therefore;

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
See report at Attachment 3

March 2018 Implementation Panel findings: During the afternoon of March 20, 2018, we interviewed inmates in a community-like setting in Murray housing unit at the Broad River Correctional Institution that was occupied primarily by inmates with an L3 mental health classification with other inmates having an L4 classification. These inmates were significantly less distressed about their housing as compared to our December 2017 interviews with them. The change was largely related to the various interventions by custody and mental health staff that are summarized elsewhere in this report. However, significant issues remain that included the following:

1. Problematic access to the psychiatrist and continued problematic access to a QMHP were described, which was confirmed by QI studies.
2. Lack of access to educational activities.
3. Very poor access to medical services.
4. Morning pill line occurring at 4 AM even though breakfast was generally not served until after 6 AM.

5. Evening pill call line generally occurred at 4 PM.
6. Very limited access to group therapies.

The Access to Management meetings have allowed executive and institutional staff members from various disciplines to address and handle inmate's concerns/issues on the spot. Associate Warden Peoples has been very responsive to inmate concerns.

Significant improvement relevant to inmates housed in the Murray housing unit has occurred since the last site assessment. AW Peoples' leadership was impressive.

March 2018 Implementation Panel Recommendations: The access to management meetings should serve as a model throughout the system for how to improve conditions of confinement even when resources are very limited.

2.a.ii. Significantly increase the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefore;

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
The following chart shows the number of male and female inmates receiving intermediate care services between January 2017-January 2018. The number of inmates classified as L2 has decreased monthly since July 2017.

QIRM staff completed a CQI study to review and assess if inmates placed in ICS receive 10 hours of structured out-of-cell time as directed by the Individualized Treatment Plans per week.

The study examined the total amount of structured time received per month for each inmate in the sample.

The complete CQI study is attached as Appendix D.

Assessment of the results included the following:

Camille Graham
Data analysis in this study revealed that most treatment plans are not individualized and do not specify the structured time inmates will participate in based on their needs. At Camille Graham, most treatment plans do not refer to groups at all and the few that due state something such as "will refer to groups or inmate will attend groups". Only two of the treatment plans referred to individual counseling and/or sessions using that specific wording. Other treatment plans implied individual sessions would be held by stating something such as the following: "CCC will help inmate come up with different coping skills". A few of the treatment plans did not refer to or imply individual sessions at all. With that in mind, credit for structured time was given if the treatment plan referred to groups and/or individual sessions/implied individual sessions.

Kirkland
Data analysis in this study revealed that most treatment plans are not individualized and do not specify the structured time inmates will participate in. There were a few treatment plans that listed specific groups the inmates would participate in. However, for most of the treatment plans, when groups were mentioned, the following statements were used to include but not limited, "attend groups that aid in behavior modification", "attend assigned groups", and "attend group tailored to his identified problems and/or behavioral patterns". There were a few treatment plans that did not refer to groups at all. With that in mind, credit for structured time was given if the treatment plan referred to groups and/or individual sessions.

Planned actions:

It is unclear which groups/activities an inmate should participate in based on the wording on the treatment plans, specifically the lack of individualization for which groups would have been most appropriate for the inmates based on their mental health diagnosis. As a result, a discussion was held with ICS managers, Division Director for Behavioral/Mental Health, and the Deputy Director of Health Services in regard to placing all groups offered as structured time into categories. With categories, the treatment plan could reference any category of a group that an inmate may be referred to, based on his or her individual needs. This would ensure the individuality of treatment plans for each inmate versus a general reference to groups. Therefore, it is recommended that categories are created for groups to ensure ICS staff and inmates are receiving credit and the benefit of all of the treatment plan driven structured services that are offered and received.

March 2018 Implementation Panel findings: We discussed with staff issues related to the current number of inmates determined to be in need of an ICS level of care. For purposes of this provision, inmates in any type of mental health residential level care (e.g., a BMU) should be included in the statistics relevant to receiving an ICS level of care. It has been our experience that 10% to 15% of the total mental health caseload population is usually in need of an ICS level of care at any given time, which is significantly more than the current percentage of caseload inmates receiving an ICS level of care.

Kirkland Correctional Institution

Nursing staff continues to not be housed within the male ICS unit related to safety and space issues. Our December 2017 report included the following:

> Very little has changed from a custody staffing perspective in the male ICS since the April 2017 homicides other than assigning a unit manager and correctional counselor to the male ICS unit. Following the homicides, the male ICS unit was reorganized as follows: Unit F1, which is a 64 bed ICS housing unit, was established for ICS inmates who were considered a high risk of harming vulnerable inmates from the perspective of their functioning level. Unit F2,

> which is a 128-room ICS housing unit with a capacity of 256 inmates, was designated to treat inmates with a lower level of functioning as compared to F1 inmates. The count during the site visit of unit F2 was 97 inmates as compared to the count of 40 inmates in Unit F1.
>
> The lack of medication administration at KCI being available on an HS basis (i.e., at night) continues to be very problematic. Long acting injectable medications are available but are administered off the housing unit because nursing staff have been removed from ICS related to perceived safety issues.

Except for the inmate count during the March 2018 site visit, little has changed in the context of the above description. At the time of the site visit the total male ICS count was 156 inmates with nine of these inmates being at Gilliam Psychiatric Hospital and one inmate in the RHU.

During the morning of March 20, 2018, we observed a treatment team meeting in the male ICS at KCI. The appropriate staff was present and inmates were interviewed by the team. However, the first inmate reviewed by the treatment team resulted in a very problematic staffing process that was characterized by the inmate escalating in a very agitated manner, which continued until the unit housing manager made an appropriate intervention.

ICS inmates were reported to be offered two structured therapeutic activities (i.e., group therapies) per week as well as a variety of recreational activities each week. Structured therapeutic activities were not discussed during the treatment team meeting but were based on the inmate's primary clinician's assessment.

Clinical Staffing for the ICS was reported as follows:

1.06 FTE psychiatrist (# Hours/week on-site = 42.50)
0.00 FTE psychologist
7.0 FTE Mental Health Counselor (3.0 FTE vacancies)
3.0 FTE MHTs
16.99 FTE RNs (13.99 FTE vacancies)
12.85 FTE LPNs (9.85 FTE vacancies)

March 2018 Implementation Panel Recommendations: Our December 2017 recommendations remain unchanged and are as follows:

1. A plan needs to be developed and implemented specific to a custody staffing analysis specific to the male ICS as soon as possible due to obvious safety concerns.
2. Provide accurate information regarding the number of hours of out of cell structured therapeutic activities both offered and received by individual ICS inmates, on average, on a weekly basis.
3. The lack of medication administration on an HS basis needs to be remedied.
4. Safety [and space] issues related to the absence of nursing staff having offices within the ICS need to be resolved

Additional recommendations include the following:

1. Review the problematic treatment staffing referenced above in order to learn from the process.
2. Staffing vacancies/allocation issues need to be adequately addressed in order to meet adequate programming guidelines.

Camille Griffin Graham Correctional Institution

The inmate count during March 5, 2018 was 707 inmates. During March 5, 2018 there were 356 mental health caseload inmates (~50% of the population), which included 18 L2, 78 L3, 223 L4, and 34 L5 mental health caseload inmates.

The RHU count during March 21, 2018 was 40 inmates, which included 30 mental health caseload inmates.

There were 12 CSU beds and 2 safety cells in RHU (which were not suicide resistant). The number of inmates on CI status generally ranged from 0-4 per day with a census of five patients during our site visit.
Staffing data included the following:

> Psychiatric coverage is provided by three psychiatrists that involves 17.4 hours per week, which included the use of telepsychiatry. Additional psychiatric coverage provided two hours per week by psychiatric nurse practitioner.
>
> 7.0 FTE QMHP positions are allocated with 5.0 FTE positions filled.
> 3.0 FTE MHT positions are allocated with 3.0 FTE positions filled.
> 16.0 FTE nursing staff positions were allocated
> 1.0 FTE RN FTE positions filled and 5.0 FTE RN vacancies.
> 3.0 FTE LPN positions were filled with 7.0 FTE LPN vacancies.

We observed a treatment team meeting during the afternoon of March 21, 2018. A psychiatric nurse practitioner was present during this meeting. Very little treatment planning was discussed during this meeting.

We interviewed about 12 inmates on the D wing within the Blue Ridge housing unit. These ICS inmates reported increased access to daily mental health groups since the December 2017 site visit and generally had favorable comments regarding the program. Staff reported that ICS inmates received 3 to 20 hours per month of out of cell structured therapeutic activities in addition to having access to about four hours per week of activity therapies.

We also interviewed in a community setting the majority of inmates residing in C Wing within the Blue Ridge housing unit. Most of these inmates were mental health level 3 inmates with many also

classified as mental health level 4. Not surprisingly, medication management issues (e.g., medications expiring without being renewed in a timely manner, missed medication dosages, etc.) were common related to the significant nursing vacancies. Complaints about the 4 AM pill call line were also voiced, which included not being awakened in time for the pill call line. Access issues were described relevant to the psychiatrist and QMHPs. Many inmates voiced dissatisfaction with the psychiatrist related to the medications prescribed and/or not prescribed to them.

March 2018 Implementation Panel Recommendations:

1. The most pressing need is to fill the nursing staff vacancies as well as the psychiatrists' vacancies.
2. Remedy the lack of suicide resistant safety cells.

2.a.iii. Significantly increase the number of male and female inmates receiving inpatient psychiatric services, requiring the substantial renovation and upgrade of Gilliam Psychiatric Hospital, or its demolition for construction of a new facility;

Implementation Panel March 2018 Assessment. **partial compliance**

February 2018 SCDC Status Update:
SCDC was advised by Correct Care that the 10-bed unit dedicated to SCDC has again been delayed due to issues with contractors. However, Correct Care is admitting SCDC patients without the unit being completed. SCDC patients will be prioritized above other patients so that Correct Care can fulfill the 10-bed agreement.

QIRM staff have identified problems with the databases used by the QIAs for calculating the provision of out of cell time to inmates. The available data on out of cell time is not reliable because of these issues. These problems are being analyzed and addressed by QIRM staff so that reliable data can be produced and provided in future reports.

Because of the database issues, data to accurately represent GPH's increased provision of structured activities is not yet available to include in this report. However, GPH staff report and document the provision of out-of-cell structured and unstructured activities in addition to the documentation done by the QIAs. Initial review of that documentation demonstrates that the provision of out-of- cell structured activities and community groups being provided to the inmates has increased since the last reporting period. An increase in group activities with the Activity Therapist has also been noted.

This data will be made available for review during the March 2017 site visit. Hard copies of documentation are available in the interim, if needed. To demonstrated GPH's ongoing work and efforts to comply with this provision, QIRM staff will have detailed reports available for review.

March 2018 Implementation Panel findings: The amount of out of cell structured therapeutic activities offered to inmates was reported by staff to be 6-10 hours per day. However, during the past two weeks the amount of out of cell structured therapeutic activities has been very minimal

due to painting and renovations occurring on the unit in preparation for the site visit. Since December 2017, inmates were reported to be offered 3 to 4 hours per day of out of cell unstructured time. The limited out of cell structured therapeutic activities was reported to be due to a combination of both correctional and mental health staffing vacancies and/or allocations.

The amount of out of cell time, both structured and unstructured, actually used by GPH inmates remains alarmingly small. This issue is predominantly related to inadequate staffing allocations (both correctional and mental health staff) although institutional cultural issues likely contribute.

Renovations at GPH are not yet completed with specific reference to the nursing stations, which appears to be primarily related to waiting for various equipment to be delivered that were ordered months ago. Licensure inspection cannot occur until the equipment is in place.

Clinical staffing for GPH was reported as follows:

	Total FTE as of 3/20/18	**Staffing Plan FTE**
Psychiatrists:	2.18	4.0
Psychologists:	.60	1.50
QMHP's:	6.00 (1 starts 3/26)	9.00
MHT's:	16.00 (1 starts 3/26)	16.00
Activity Therapists	.80	1.00

MEDICAL/NURSING FTE
GPH/ICS/DEATH ROW

	Total FTE as of 3/20/18	Allotted FTE	Staffing Plan FTE
Nursing:			
RN:	3	16.99	19.00
LPN:	3	12.85	15.00
Paratech:	2	0	5.00
Other:			
NP	2		

During the morning of March 20, 2018, we interviewed GPH inmates in a community setting. These inmates complained about the limited out of cell time and limited access to out of cell structured therapeutic activities although the groups attended were described as being helpful.

As per the status update section, access for female inmates to inpatient psychiatric care remains very limited.

March 2018 Implementation Panel Recommendations: The following December 2017 recommendations are unchanged

1. Focus on providing more out of cell structured therapeutic and unstructured time to inmates in GPH. We strongly recommend at least several community meetings be conducted per week with both mental health and correctional staff in attendance and actively participating.
2. Complete the renovations.
3. Fill the mental health staffing vacancies and perform a needs analysis for custody staffing in GPH.
4. Provide information relevant to the number of hours received, on average, to each GPH inmate on a weekly basis both in terms of out of cell structured therapeutic time and out of cell unstructured time. Please provide this data as part of the pre-site document requests prior to our March 2018 site assessment.

2.a.iv. Significantly increase clinical staffing at all levels to provide more mental health services at all levels of care;

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
The following strategies outline SCDC's plan to decrease vacancy rates of clinical positions. This plan includes one-day hiring for nurses and mental health staff, spot bonuses, revised hiring practices in HR for medical and mental health – removed duplication of services in recruitment and HR to increase the speed of hiring; and the implementation of salary equity increases for all psychiatrist, QMHP and psychologist positions.

SCDC retained the expert services of [redacted] to conduct a security staffing study for SCDC. The study has been completed by [redacted]. The Director and pertinent SCDC leadership staff will meet with [redacted] on March 8, 2018, to receive the report outlining the results of the study and to receive explanations from [redacted] about his recommendations for SCDC and each institution.

An Executive Order was issued on February 27, 2018, by Governor Henry McMaster recognizing that SCDC does not enough officers to patrol the perimeter of correctional facilities to deter members of the public from throwing or dropping contraband over facility walls and fences and, in order to protect the public and prevent violence or threats of violence, proclaimed an emergency, and ordered the South Carolina State Guard to assist SCDC by staffing the exteriors and fence towers of correctional facilities and performing all other related activities to be memorialized in an agreement to be reached within 20 days. The Order is attached as Appendix E.

SCDC is awarding a bonus to eligible employees. The $500 bonuses will be awarded April 3, August 3, and December 4, totaling $1,500.

The eligibility requirements are included in a memorandum from Director Sterling as Appendix F.

SCDC hosted a "mass hiring event" on February28. 2018 where 70 scheduled applicants were slated to be hired in one day. 50 applicants of the near 70 participated in the event, of the participating candidates, 80% were hired. A list of candidates and hiring status is included as Appendix G.

This pilot event was designed to bring in a large group at one time to address staffing issues.

A comprehensive list of additional and ongoing hiring initiatives is included as Appendix H.

March 2018 Implementation Panel findings: The increased salary structure for psychiatrists and psychologists, which has recently been approved, is a very positive step. Efforts are being initiated to improve the salary structure for QMHPs as related to their working experience in the field.

We are encouraged by the various recruitment and retention strategies summarized in the current status section. However, the current hiring process remains very problematic due to the amount of time it takes to actually hire new staff, which has resulted in and will continue to result in potential new staff going elsewhere.

Attachment one provides data relevant to the health staffing plan and current staffing allocations/vacancies. The following chart summarizes current allocations and vacancies.

STAFF SUMMARY

	Total # of Positions	Full-Time		Pink Slip		Dual		Contract		Total % Filled Positions	Total % Vacant Positions
		Filled	Vacant	Filled	Vacant	Filled	Vacant	Filled	Vacant		
Administrative Support Totals (includes QA Manager and HSOA Team Lead)	11	10	1	0	0	0	0	0	0	90.91%	9.09%
Bay Area Totals - (only at GPH)	7	6	1	0	0	0	0	0	0	85.71%	14.29%
Activity Therapy Totals	3.53	3	0	0	0.53	0	0	0	0	84.99%	15.01%
Mental Health Tech Totals - (includes HSC I/CCC III's)	44	37	7	0	0	0	0	0	0	84.09%	15.91%
Qualified Mental Health Professional Totals - (includes CCC IV, CCC V, Regional Managers, Program Managers, Clinical Supervisors)	94	68	25	0.53	0	0	0	0	0	73.27%	26.73%
Psychology Totals	3.21	0	2	1	0	0	0	0.21	0	37.69%	62.31%
Psychiatry/Nurse Practitioner Totals	15.92	4	4	3.48	0.86	1.68	0	1.9	0	69.47%	30.53%
Division Totals	**178.19**	**128**	**40**	**5.01**	**1.39**	**1.68**	**0**	**2.11**	**0**	**76.77%**	**23.23%**

March 2018 Implementation Panel Recommendations: Adequately address the hiring process as referenced above.

2.a.v. The implementation of a formal quality management program under which denial of access to higher levels of mental health care is reviewed.

Implementation Panel March 2018 Assessment: **compliance (July 2017)**

February 2018 SCDC Status Update:
[redacted] Ph.D continue to review denials of referrals of inmates to higher levels of care. LLBMU has capacity for 24 inmates based on current staffing. The denial reports for LLBMU October 2017- January 2018 are attached as Appendix I. Per Dr. [redacted], GPH had no denials for the same review period.

The denial reports for ICS for October 2017- January 2018 are attached as Appendix J.

March 2018 Implementation Panel findings: As described in our December 2017 report, the QI review process included the following:

1. This committee has met three times (20 Apr 17, 17 May 17, 21 Jun 17). There are four members: [redacted] meets w/us via VTC.

2. Prior to each meeting, [redacted] receives reports from the six (five as of June) residential/inpatient programs (SIB, ICS, HAB, LLBMU, HLBMU, GPH) which reflect the number of requests for admission, the number of inmates accepted, the number wait-listed, the number removed by the referral source before they were admitted/denied and the number denied. These reports also contain a section in which all inmates who are denied admission/acceptance are identified along with the date they were denied and an explanation of why they were denied.

3. During the meeting, all inmates denied are reviewed. Their AMR and their relevant OMS data is reviewed. The committee decides to either concur or not concur with the denial. The names of those inmates whom we believe were denied inappropriately, along with the reasons we believe the denial was inappropriate, are forwarded to Mr. [redacted] for further action.

4. Mr. [redacted] replies to Dr. [redacted] regarding his decision to agree or disagree with or not concur in the finding.

We are concerned that the CSU staff at BRCI report that very few of their referrals to the ICS are accepted. Based on the SCDC status update section summary, either the CSU staff are making inappropriate referrals to ICS or the review process is flawed.

March 2018 Implementation Panel Recommendations: Re-evaluate the QI review process in the context of ICS referrals from the CSU. Implement corrective action if indicated.

2.b. Segregation:

2.b.i. Provide access for segregated inmates to group and individual therapy services

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
QIRM has identified problems with data quality. As a result, an update to address this provision cannot be made with confidence.

Health Services Office Assistance were transferred to QIRM in January 2018. The process has begun to official change their titles to Quality Improvement Assistants, and redefining and streamlining their job duties. Since January, QIRM Analysts have been able to specifically identify problems data collection and reporting which has resulted in additional training. Since January four QIAs have resigned.

QIRM staff have identified the following issues with both the LLBMU and HLBMU.

Concerns with QIA's Documentation of LLBMU Data:

- Data from all three of the phases are recorded on separate spreadsheets, which makes the compilation of data very difficult (i.e. for 4 weeks in a month, there are 12 spreadsheets not 4). A new spreadsheet is being developed by the Lead QIA to consolidate reporting of for the unit.
- Certain activities have been recorded as structured time when they should be considered unstructured. For example, in Phase 1 10/09 – 10/13, medication administration was considered structured time.
- The formulas for performing calculations for total time out of cell were removed in several reports and some databases.
- The time allotted and time offered (which are necessary data) were excluded from the structured activity sheet in most of the reports from October and November.

Concerns with QIA's Documentation of HLBMU's data:

- The program's group reports list GROUPs, but does not define what those group are. This makes it difficult to document and report the structured time.
- Inmates' names and numbers are transposed in several placed making it difficult to correctly identify and report individual structured time

Concerns with QIA's Documentation ICS's data:

- In some ICS reports, the number of inmates listed as active vs. inactive included the wrong information which increases the probability there's a possibility that some inmates were listed as having recorded time when in fact they didn't and vice versa.

Planned Actions
The Division Director has established a meeting that includes all QIAs and QIRM Analysts on the first Wednesday of each month. A staff retreat was held on January 26 to explain the roles of

the QIAs with QIRM and to provide them with an overview of the Mental Health Lawsuit. Changes in roles and expectations were outlined at this meeting.

The next staff meeting is scheduled for March 4, 2018, where data quality issues will be addressed in detail and an additional training will be provided on collection and reporting structured and unstructured out-of-cell time.

The Lead QIA and lead Analyst for each institution will begin on-site technical assistance visits beginning the week of March 9 to ensure the proper collection of appropriate forms and operation of databases.

The QIRM Division Director is in the process of updating the job announcement to include data collection and reporting experience as a mandatory requirement.

March 2018 Implementation Panel findings: As per the current status section.

HLBMU

During the afternoon of March 19, 2018, we interviewed eight level I & II inmates in a community -like meeting setting as well as separately meeting with six level III HLBMU inmates in a group setting at the KCI. The HLBMU census was 20.
Since our December 2017 site visit, the mental health staffing of this unit consists of the following staff:

3.0 FTE QMHPs (2.0 FTE vacancies, which will be filled April 2, 2018)
1.0 FTE program manager
3.0 FTE mental health technicians

Privilege level III HLBMU inmates have had access to weekend visitation on a twice per month basis since our last site visit. These inmates confirmed improvements in the program since the last site visit, which included access to at least one group therapy per weekday, good access to one-to-one sessions as needed with a mental health clinician, access to limited recreational therapy, meals in the general population dining hall and access to walks outside of the housing unit when accompanied by custody and counseling staff.

Complaints voiced by these inmates included the following:

1. Security measures (e.g., being searched on multiple occasions) required when taken off the unit despite being constantly monitored by correctional staff.
2. Minimal, if any, ability to interact with general population inmates when off the unit. For example, when in the dining hall with general population inmates, they are not allowed to sit with them or interact with them.
3. Despite being told that level III privileges include access to jobs off the unit, none of these inmates have been offered or have had access to such jobs. However, staff

confirmed that level III privileges did not include off the unit jobs, which had been told to inmates on multiple occasions.

4. Lack of clarity concerning what they need to do and over what period of time it will be required, in order to be transferred to a general population housing unit.
5. These inmates perceived that upper custody management made decisions that directly impacted them without having an adequate knowledge of the current program and/or their progress within the program.
6. One of the inmates described problems with correctional officers on the unit from the perspective of attitudinal issues (i.e., "too much testosterone [being demonstrated]").
7. Medication management issues did not appear to be present.
8. Inmates complained of lack of incentives being offered within the program. We discussed with them the possibility of tablets (i.e., iPads) being part of an incentive program, which was received by them as being a very positive incentive.

Most of the HLBMU privilege level II inmates were unhappy with the program and demonstrated a fair amount of entitlement, which was significantly less than the entitlement demonstrated by the privilege level III inmates. They had similar complaints regarding access to general population privileges with minimal understanding regarding the current lack of access to such privileges. They did describe their daily group therapies as being helpful.

March 2018 Implementation Panel Recommendations:

1. We discussed with key custody and mental health staff the need for clear expectations and understandings relevant to the privilege levels to be communicated, on a repetitive basis, to the HLBMU inmates.
2. We strongly recommended that tablets (i.e., iPads) be implemented as part of an incentive program.
3. We also recommended periodic access to management meetings as currently being provided in the Murray housing unit.

LLBMU

During the morning of March 22, 2018, we interviewed nine level II & III BMU inmates, four of whom were graduating from the program during our site assessment. Eight other inmates have graduated from this program since its inception during 2016. These inmates described participation in daily group therapies/activities that were described as being very helpful. Suggestions for improvement in the program included implementing a more active transition program to the general population (e.g., actual participation/interaction with general population inmates and/or programs prior to actual completion of the LLBMU program).

We also attended a very well organized and meaningful graduation ceremony that was very impressive.

Mental health staffing for the Allendale CI , excluding the LLBMU, was 2.0 FTE QMHPs with

both positions being vacant. The mental health caseload during our site visit was 189 inmates. The regional manager, [redacted] has been providing coverage due to these vacancies. About 12 hours per week of psychiatric coverage is provided on site by three psychiatrists.

The LLBMU is staffed by 1.0 FTE QMHP and 2.0 FTE MHTs (1 FTE is currently vacant). The current functional capacity of the LLBMU was 24 with a current census of 18 inmates.

We remain very impressed with the LLBMU.

2.b.ii. Provide more out-of-cell time for segregated mentally ill inmates;

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
To mitigate conditions of confinement within the RHUs, hundreds of crank radios have been ordered and distributed to RHU inmates.

As of February 28, 2018, the Division of Operations reports that televisions for the RHUs have been ordered. According to a report from facilities management, the following information outlines the status on the televisions for the RHUs:

- The 1st 32 TVs are on site and waiting for the Lexan to be installed in the stands.
- The 2nd 32 TVs are at the electrical shop.
- The 3rd 32 TVs are at Trenton being modified to make them wireless.
- All the metal for the TV stands has been purchased, they are being fabricated at the sheet metal shop.
- All antennas have been purchased as well as all FM transmitters.

Responses to recommendations:
Per recommendation one, a tool (Medical Administration Aide) has been developed to better administer medication for the Restrictive Housing Unit inmates. The tool is being tested and modified to improve administration of medication.

Per recommendation two, Broad River Audit interviews of the Restrictive Housing Unit on February 14, 2018 results showed that recreation just resumed and that recreation was given the day before the audit.

Per recommendation six, the CSU cells are offline at Camille and a plan is in progress to ensure compliance with safety cell standards.

Per recommendation eight, cell check logs show how long the inmates were out of their cells, but will not show how long the inmate is in an activity. Based on the interviews from the audits for Kirkland, Allendale, Broad River, and Camille, inmates take showers Monday, Wednesday, and Friday of each week. Inmates at Kirkland and Allendale do not receive recreation. Inmates at

Camille and Broad River do receive recreation time, however, the times do vary based on their responses.

March 2018 Implementation Panel findings: As per status update section.

It is very unclear, and concerning, the reasons that the work orders for the previously referenced TVs continue to not be completed, especially in the context of conditions of confinement within the RHUs.

Broad River Correctional Institution

During the afternoon of Tuesday, March 20, 2018, we obtained information relevant to the RHU at the Broad River CI and interviewed inmates within this unit. Twenty-eight (28) of the 50 RHU inmates were on the mental health caseload. Although the physical plant appeared cleaner as compared to prior site visits, the conditions of confinement within the RHU continue to be very harsh although it appeared that inmates had increased out of cell time as compared to prior site visits. During the visit to RHU, two inmates in a cell complained their toilet was leaking and a large amount of water was observed on the walkway and inside the cell. The Unit Manager advised she did not have another cell for the inmates and she was allowing them to mop their cell every 3 to 4 hours. She provided further information, the cell plumbing would not be repaired for two days until Thursday, March 22, 2018 because of waiting for a plumbing part. After the Implementation Panel expressed their concerns, the Broad River Warden intervened and gave assurances the inmates would be moved to a cell with operational plumbing that did not leak. The next day, on Wednesday, March 21, 2018, the Warden reported the cell plumbing had been repaired the previous day and the problem had been rectified.

March 2018 Implementation Panel Recommendations:

Our December 2017 recommendations included the following, which are unchanged:

1. We understand that the major reason for the very limited out of cell recreational time offered to RHU inmates in most SCDC prisons is directly related to correctional officer shortages. We also understand that these shortages will not be corrected quickly. Much stronger efforts should be made to provide RHU inmates with increased privileges within their cells in order to mitigate not providing them with the out of cell time required by policy and procedures.

2. We remain very concerned about the conditions of confinement within the RHU at the Broad River Correctional Institution. The conditions of confinement should be changed to include at least one hour per day of out of cell recreational time in addition to access to showers on a three times per week basis.

3. Access to tablets (e.g. iPads) have been successfully implemented by other correctional systems in RHU environments. It was our understanding that crank radios will be increasingly available to RHU inmates as will TVs in the dayroom-like

areas. Ensuring that inmates receive timely laundry exchanges and that shower areas are kept clean are other common sense interventions.

4. The RHU must have established procedures that prohibit housing inmates in cells that have physical plant issues: i.e. plumbing, lighting.

Camille Griffin Graham RHU

Staff reported that 5 RHU groups per week were provided to mental health caseload inmates in the RHU. RHU inmates reported being offered one hour per weekday of outdoor recreation, showers three times per week and some of the inmates reported access to weekly group therapies/activities. Poor access to a psychiatrist was described. It is still problematic that staff take recreation periods without due process for minor rule violations, i.e. failing to stand for count. MH Staff rarely conduct face to face interviews with RHU inmates in an office setting. MH staff contact is primarily cell side. During the IP tours, inmates consistently report the need for access to mental health staff and others to address basic concerns for services.

March 2018 Implementation Panel Recommendations: Remedy the staffing vacancy issues.

Allendale Correctional Institution RHU

During the afternoon of March 22, 2018, we talked to almost all of the inmates in the RHU. Sixteen of the 60 RHU inmates were on the mental health caseload. Most of the inmates confirmed that they usually had access to the outdoor recreational cages for 45 to 60 minutes on a three times per week basis. Showers were offered on a three time per week basis. Medications were received on a timely basis although access to the psychiatrist was problematic as was access to the QMHP for out of cell sessions. Mental health rounds generally occurred on a weekly basis. RHU Cell Check Logs were reviewed and revealed correctional staff do not always make checks within 30 minutes at irregular intervals. Most cell checks occur between 30 to 45 minutes; however, a time span was identified when a cell check exceeded 3 hours. There were inmate complaints they were being inappropriately held in RHU because their circumstances had changed or they had been cleared for release but remained in RHU. These complaints are being investigated and will be followed up on by the responsible Implementation Panel Member.

2.b.iii. Document timeliness of sessions for segregated inmates with psychiatrists, psychiatric nurse practitioners, and mental health counselors and timely review of such documentation;

Implementation Panel March 2018 Assessment: **noncompliance**

February 2018 SCDC Status Update:
See report at Attachment 1

Data on this topic is incomplete because some institutions failed to report their data far enough in advance of this report for it to be included. The institutional QMHPs are required to complete a

spreadsheet containing this data and send it to their institution's QIA. The QIAs are then to collate this data for their institution. The team lead then uses this collated data to create the summary below. Several QMHPs failed to provide their institution's QIA with this data for this reporting period either because the documentation has not been completed or the documentation is scattered and has not been gathered for production.

March 2018 Implementation Panel findings: As per status update section.

March 2018 Implementation Panel Recommendations: Remedy the above reporting issues.

2.b.iv. Provide access for segregated inmates to higher levels of mental health services when needed;

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
See 2.b.i.

March 2018 Implementation Panel findings: See 2.b.i.

March 2018 Implementation Panel Recommendations:

1. Implement the LLBMU and HLBMU as per policies and procedures.
2. Consider options for developing a female BMU.

2.b.v. The collection of data and issuance of quarterly reports identifying the percentage of mentally ill and non-mentally ill inmates in segregation compared to the percentage of each group in the total prison population with the stated goal of substantially decreasing segregation of mentally ill inmates and substantially decreasing the average length of stay in segregation for mentally ill inmates;

Implementation Panel March 2018 Assessment: **compliance (November 2016)**

February 2018 SCDC Status Update:
RIM continues to report and distribute the RHU Average Length of Stay report. The most recent reports are included as Appendix K. Examples of the report are captured below.

Time Served (in days) for Removals from **Long Term RHU Custody (SD and MX)** during DECEMBER 2017

	Number of Removals from RHU	Minimum Days Spent in RHU	Maximum Days Spent in RHU	Average (Mean) Days Spent in RHU	Median Days Spent in RHU

All Removals from RHU	12	13	696	286	272
Non-Mentally Ill Removals from RHU	4	13	596	291	278
Mentally Ill Removals from RHU	8	15	696	284	235

Note: Numbers reflect removals from long term RHU custody (SD – security detention and MX - maximum lockup) during each month. Due to the small number of inmates being removed from long term RHU, averages can vary greatly. Inmates who were placed in RHU custody and removed from RHU custody on the same day were excluded. The mental health classification is based on the inmate's status at time of removal from RHU.

March 2018 Implementation Panel findings: Compliance continues. However, we have concerns regarding the accuracy of the data based on reviewing median and averages, which we discussed with staff.

March 2018 Implementation Panel Recommendations: Confirm and/or correct the accuracy of the data as referenced above.

2.b.vi. Undertake significant, documented improvement in the cleanliness and temperature of segregation cells; and

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
A CQI study was done by QIRM Analysts to evaluate the temperature and cleanliness of segregation cells in Allendale RHU, Broad River CSU and RHU, Camille RHU, and Kirkland's D-Unit, F-1, and SSR.

The complete study is attached as Appendix L.

March 2018 Implementation Panel findings: Operations maintains a shared folder for institutions to upload daily cell inspections and temperature logs. SCDC QIRM conducted a CQI Study and the study can be found in Appendix L. All institutions are not uploading daily cell inspections and temperature logs. The information provided also identified correctional facilities failing to conduct the required daily inspections and temperature checks. Correctional facilities were identified not maintaining their temperatures within the acceptable range and there were correctional facilities with significant problems. Broad River Correctional Institution had the highest compliance with 89% in CSU and 100% in RHU although this was based on the fewest days recorded. Allendale CI had only 36% of their temperatures within the acceptable range. Allendale CI temperature issues are very concerning because cell temperatures were reported a problem by inmates on a previous site visit to the correctional facility approximately one year ago. Further, when Allendale

CI Maintenance was contacted by telephone during the March 18 Site Visit, they were unaware of a significant number of cells being outside the acceptable temperature range. Kirkland SSR had extreme deficiencies that should be an urgent priority. The revised SCDC Form 19-163 piloted at CGCI has the potential to improve staff documenting corrective action for cleanliness deficiencies. In the CQI Study, 4 of the 7 correctional facilities had zero percent of their deficiencies corrected. Two more facilities had 50 percent or less. Only Allendale CI had an acceptable correction action rate of 92%. A mechanism is needed to ensure work orders generated by correctional staff are addressed and the deficiencies are actually resolved. All institutions need improvement in documenting corrective measures when there are cleanliness and temperature deficiencies.

March 2018 Implementation Panel Recommendations:

1. Operations Management ensure all prisons are performing daily inspections for cleanliness and taking temperatures of random cells;
2. Ensure deficiencies identified in the cell inspections for cleanliness and temperature checks are followed up on and the action taken is documented on the Cell Temperature and Cleanliness Logs;
3. SCDC QIRM continue to perform QI Studies regarding Correctional Staff performing daily, random cell temperatures and cleanliness inspections.

2.b.vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
The Division of Quality Improvement and Risk Management conducted ICQMC Meetings at various institutions based upon the information outlined in SCDC Policy GA 06.06. "Continuous Quality Improvement Review". The meetings were agenda driven and focused on the following (this list is not all inclusive):

A. Use of Force and grievances review
B. Monitoring and Evaluation of operations practices and conditions of confinement
C. Monitoring and Evaluation of special programs and services
D. Medication management
E. Staffing
F. Barriers to provision of services
G. Staff education and training
H. Overview of IP findings and specific recommendations
I. Recommendations for performance improvement plans

The meetings have been conducted according to the schedule with the exception of Lee Correctional Institution due to preparation for the IP visit. MacDougall had their initial meeting in October of 2017 and has continued to meet identifying opportunities for improvement and implementing the changes necessary. Camille Griffin Graham and Perry Correctional Institutions, both facilitated their initial ICQMC meetings in January on the 12th and 11th respectively. They are currently preparing responses to the Performance Improvement Plans prepared by their Lead

Analyst. Kirkland Correctional Institution completed held their initial meeting on February 12, 2018. They have received their Performance Improvement Plans and are in conversations with their Lead Analyst on the completion of these. The revised schedule is below to show the new date for Lee Correctional Institution.

March 2018	April 2018	May 2018	June 2018
Leath	McCormick	Evans	Tyger River
Lee	Allendale	Ridgeland	Lieber
Broad River	Evans	Ridgeland	

Although Lieber Correctional Institution is not scheduled to begin their meetings until June 2018 they did conduct an initial meeting on February 5, 2018. QIRM is working to obtain the information from this meeting and will assist them in identifying opportunities for improvement and the preparation of the Performance Improvement Plans.

March 2018 Implementation Panel findings: As per status update section.

March 2018 Implementation Panel Recommendations: Implement the above schedule.

2.c. Use of Force:
2.c.i. Development and implementation of a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness;

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
The Office of the Deputy Director of Operations (DDO) has assigned an Administrative Regional Director (ARD) to oversee the audit of the AUOF process for their office. The ARD responsibility is to review all AUOFs to determine if all procedures were followed and make contact with the correct institutional personnel to correct concerns noted. The ARD will attend meetings with Wardens, Associate Wardens, Majors and any other entity to discuss patterns noted in correctly and incorrectly performed UOF incidents. The ARD reports directly to the Assistant Deputy Director of Operations.

Institutional corrective action related to use of force are included as Appendix M.

Use of Force (UOF) data for Mental Health inmates and Non-Mental Health Inmates is complete through January 31, 2018. The data has been analyzed in P-charts to better see whether a change in UOF incidents has been observed in the two populations since the agency began institution-wide UOF training in May 2017 for specifically required mental health, medical and security staff. Additionally, a more robust module in UOF was added to the employee orientation and basic training core curriculum.

See Attachment 4 for the analysis.

March 2018 Implementation Panel findings: SCDC began institution wide UOF training in May 2017 for specifically required mental health, medical and security staff. A more robust module in UOF training was added to the employee orientation and basic training core curriculum. By the end of Calendar Year 2017, 84.2 percent of Medical Staff, 71.6 percent of Mental Health Staff, and 87.1 percent of Security Staff completed the required the UOF training. Overall in SCDC, 86 percent of the required SCDC staff completed the UOF training in Calendar Year 2017.

SCDC Operations has created an Administrative Regional Director (ARD) to oversee the audit of the AUOF process and to determine if all procedures are followed and make contact with the correctional institutional personnel to correct concerns. This is a positive move for SCDC.

SCDC has also employed a UOF Coordinator for the Quality Management Section in the Division of Mental Health. The Division of Mental Health UOF Coordinator will be responsible for:

- reviewing UOF incidents involving mentally ill inmates;
- providing training and technical assistance to Operations and Mental Health Staff on UOF policy and conflict resolution techniques;
- reviewing UOF video tapes to assess effectiveness of intervention and compliance with following "cool down period" guidelines;
- tracking inmates on the mental health caseload with repeated UOF incidents; and
- working closely with QIRM to report inappropriate UOF actions involving inmates on the mental health caseload.

The Division of Mental Health UOF Coordinator began employment on March 19, 2018.

SCDC UOF data reveals there continue to be disproportionate UOF incidents involving mentally ill inmates. The average SCDC institutional population receiving mental health treatment for the time frame September 2017 through February 2018 was 17.9 percent. UOF incidents involving mentally ill and non-mentally ill inmates for the months of November 2017, December 2017 and January 2018 was as follows:

Month	Mentally Ill Inmate Number of UOF Incidents	Non-Mentally Ill Inmate Number of UOF Incidents
November 2017	37	48
December 2017	49	61
January 2018	69	52
Monthly Total	155	161

The SCDC inmate population receiving mental health treatment for the time frame of September 2017 through February 2018 averaged 17.9 percent while 49 percent of the UOF incidents for the months of November 2017, December 2017, and January 2018 involved inmates receiving mental health treatment.

March 2018 Implementation Panel Recommendations:

1. SCDC continue to monitor all Use of Force incidents to identify and address the reasons for disproportionate Use of Force involving inmates with mental illness;
2. Identify strategies to reduce use of force against inmates with mental illness and non-mentally ill inmates;
3. The Division of Operations Administrative Regional Director and Division of Mental Health UOF Coordinator collaboratively work together to address issues and concerns that contribute to disproportionate UOF involving mentally ill inmates;
4. All required SCDC staff complete Use of Force Training in Calendar Year 2018.

2.c.ii. The plan will further require that all instruments of force, (e.g., chemical agents and restraint chairs) be employed in a manner fully consistent with manufacturer's instructions, and track such use in a way to enforce such compliance;

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:

1. QIRM staff continues to meet weekly with Operations leadership to discuss UOF and other relevant issues. During the meeting UOF Reviewers report, by institution: the number of uses of force, type of use of force, plan or unplanned, type of chemicals used, use of force discrepancies that violate policy and procedure. An example of the weekly update is included as Appendix N.
2. QIRM's UOF Reviewers continue to monitor and review the Use of Force Incidents entered into the Automated Use of Force System as well as review the MINs for the institutions daily. Reports are compiled and distributed weekly and monthly containing the summaries for types of force utilized as well as the MINs summaries. These findings are also verbally reported and discussed in a weekly meeting with QIRM and Operations.
3. The list of SCDC approved Use of Force Equipment and Manufacturer specifications for each is available in the Sparkman Document Drop #3 section H, this information was provided by the Division of Security.
4. QIRM was not provided a revision to the Housing Unit Post Order to address the IP Recommendation of Cover Teams and their requirement to carry the MK-9 in accordance with the manufacturer's instructions.
5. As stated in this report section 2.c.vi SCDC was 86% compliant with the completion of Use of Force Training for CY 2017.

March 2018 Implementation Panel findings:

SCDC continues implementation of the revised OP 22.01 Use of Force Policy requiring instruments of force to be employed in a manner consistent with manufacturer's instructions. SCDC has not revised the Housing Unit Post Orders as it applies to *Cover Teams* to achieve compliance that MK-9 use is consistent with manufacturer's instructions. The information provided by the Division of Security did not include a list of SCDC approved Use of Force

Equipment. SCDC Operations and QIRM Staff are working to provide the list of Use of Force instruments approved and utilized by the Agency.

Appendix N identifies SCDC efforts to ensure all instruments of force, (e.g., chemical agents and restraint chairs) are employed in a manner fully consistent with manufacturer's instructions, and are tracked to enforce compliance. Reports are compiled and distributed weekly and monthly containing the summaries for types of force utilized as well as the MINs summaries. Findings are verbally reported and discussed in a weekly meeting with QIRM and Operations Staff.

SCDC had no incidents during the relevant period that required restraint chair use. No restraint chair use for the relevant period indicates significant progress.

SCDC continues to have UOF incidents where MK-9 chemical agents are not deployed in a manner consistent with manufacturer's instructions. Lee Correctional Institution (Lee CI) had several identified incidents during the relevant period where munitions were deployed from a 37 mm weapon and the use did not appear to be in accordance with manufacturer's specifications. In a March 2018 incident, an inmate sustained a leg injury that required hospital treatment and admittance to the Kirkland Infirmary. SCDC has initiated a criminal investigation for the March 2018 Lee CI incident and taken administrative action on three (3) employees. The Implementation Panel was advised by SCDC that further employee action for UOF violations is possible once an administrative investigation for the Lee CI March 2018 incident is completed.

SCDC began institution wide UOF training in May 2017 for specifically required mental health, medical and security staff. A more robust module in UOF training was added to the employee orientation and basic training core curriculum. By the end of Calendar Year 2017, 84.2 percent of Medical Staff, 71.6 percent of Mental Health Staff and 87.1 percent of Security Staff completed the required the UOF training. Overall 86 percent of the required SCDC staff completed the UOF training in Calendar Year 2017.

March 2018 Implementation Panel Recommendations:

1. Operations and QIRM continue to review use of force incidents through the automated system to ensure instruments of force are fully consistent with the manufacturer's instructions;
2. QIRM continue to meet weekly with Operations leadership to discuss UOF and other relevant issues;
3. Revise Housing Unit Post Orders as they pertain to *Cover Teams* to require that MK-9 use will be consistent with manufacturer's instructions;
4. The SCDC Division of Security provide the Implementation Panel a list of UOF instruments approved and utilized by the Agency; and
5. All required staff complete Use of Force Training in Calendar Year 2018.

2.c.iii. Prohibit the use of restraints in the crucifix or other positions that do not conform to generally accepted correctional standards and enforce compliance;

Implementation Panel March 2018 Assessment: **compliance (July 2017)**

February 2018 SCDC Status Update:
Operations and QIRM staff continue to review and monitor use of force incidents through the automated systems and in a daily review of MINS. There have been no documented reports from October 2017- January 2018 of inmates being placed the crucifix or other positions that do not conform to generally accepted correctional standards.

March 2018 Implementation Panel findings: SCDC remains in compliance. Neither SCDC nor the IP identified any incident where an inmate was placed in the crucifix or other position that did not conform to generally accepted correctional standards.

March 2018 Implementation Panel Recommendations: Operations and QIRM staff continue to review and monitor use of force incidents through the automated system to ensure restraints are not used to place inmates in the crucifix or other positions that do not conform to generally accepted correctional standards. Pursue corrective action when violations and/or issues are identified.

2.c.iv. Prohibit use of restraints for pre-determined periods of time and for longer than necessary to gain control, and track such use to enforce compliance;

Implementation Panel March 2018 Assessment: **compliance (March 2018)**

February 2018 SCDC Status Update:
A review of the restraint chair usage was conducted for Nov 1, 2017 - Jan 31, 2018. The information provided in the Automated Use of Force System and RIM report(s) were cross referenced with the Automated Medical Records. During this reporting period there were zero (0) uses of the restraint chair.

March 2018 Implementation Panel findings: SCDC reported the Restraint Chair was not utilized during the relevant period; therefore demonstrating compliance with the provision.

March 2018 Implementation Panel Recommendations: QIRM continue to track and monitor compliance with use of the restraints.

2.c.v. The collection of data and issuance of quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs.

Implementation Panel March 2018 Assessment: **compliance (December 2017)**

February 2018 SCDC Status Update:
A review of the restraint chair usage was conducted for Nov 1, 2017 - Jan 31, 2018. The information provided in the Automated Use of Force System and RIM report(s) were cross

referenced with the Automated Medical Records. During this reporting period there were zero (0) uses of the restraint chair.

March 2018 Implementation Panel findings:
Per SCDC update. QIRM collects data and issues quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs.

March 2018 Implementation Panel Recommendations:
QIRM continue to prepare a Restraint Chair Report for each monitoring period.

2.c.vi. Prohibit the use of force in the absence of a reasonably perceived immediate threat

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
Training
SCDC identified 2,488 employees, assigned to Mental Health, Medical or Security, who were required to take the Use of Force Training. The overall Agency compliance rate for the Use of Force Training for CY 2017 was 86%

Allendale Correctional Institution – The institution had 100% compliance for the 122 employees required to take the Use of Force Training for CY 2017.

Broad River Correctional Institution – There were 148 employees identified as required to take the Use of Force Training. The institution had an overall compliance of 45% for CY 2017, with Medical at 30.4%, Mental Health 33.3% and Security 47.5%.

Camille Griffin Graham Correctional Institution – The 124 employees required to take the Use of Force training achieved 98% compliance overall. The individual area compliance rates are as follows: Medical 92.3%, Mental Health 100% and Security 98%.

Kirkland Correctional Institution – The Gilliam Psychiatric Hospital is included in the numbers for the institution. Combining the GPH and institution employees required to take the Use of Force Training totaled 313. The combined overall compliance for Kirkland and GPH was 88% for CY 2017.

Gilliam Psychiatric Hospital			Kirkland Institution		
Area	# Req.	% of Compliance	Area	# Req.	% of Compliance
Medical	5	20%	Medical	30	53.3%
Mental Health	30	93.3%	Mental Health	3	66.7%
Security	N/A	N/A	Security	245	93.9%

Data Source: RIM Report *Required Staff to Take Use of Force Training*

Corrective Actions

Institutional corrective action related to use of force are included as Appendix M.

March 2018 Implementation Panel findings: The IP continues to monitor SCDC Use of Force MINS Narratives monthly and identify incidents where there did not appear to be a reasonably perceived immediate threat that required a use of force.

The IP Use of Force Reviewer and SCDC Operations Leadership continue to jointly review Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of force.

SCDC Use of Force MINS for November 17 through February 2018:

November 2017-	98
December 2017-	117
January 2017-	147
February 2017-	110

SCDC had 30 Inmate Grievances alleging excessive Use of Force from November 2017 to February 2018. The IP recommends QIRM conduct a CQI Study to assess whether grievances for excessive UOF are processed timely and inmates receive an appropriate response with a final disposition rendered.

SCDC QIRM produced an excel chart with106 incidents from June 2017 to October 2017 where potential UOF violations were identified from their reviews. There were fourteen (14) UOF incidents where there appeared to be violations and Operations had not conducted a review after receiving the QIRM referral. Operations responses for the majority of the UOF violations were to recommend additional training or concur a violation occurred. In conversations with Operations Leadership, a mechanism is not in place to track what happens once a determination is made an employee has committed a UOF violation. A review of Appendix M found that there were incidents where employees were found to have committed unnecessary and/or excessive force with no information about what occurred after the determination was made. SCDC officials acknowledged a system is not in place to track recommended corrective action for an employees.

SCDC Police Services provided data regarding their involvement in Use of Force investigations as follows:

	11/17	12/17	01/18	02/18
Referrals Received	*	*	*	*
Investigations Opened	2	0	2	1
Investigations Pending	0	0	2	1
Investigations Closed	1	2	1	0

*SCDC Police Services does not maintain data regarding incidents reviewed in which no investigation is conducted. The information Police Services provided regarding closed investigations did not identify for each investigation if it was: substantiated, unsubstantiated or

unfounded. The number of Police Services UOF investigations opened and conducted based on the number of incidents occurring each month in the system (averaging over 100 UOF incidents per month) is very low.

SCDC had 86 percent of their required employees complete Use of Force training in the Calendar Year 2017.

The SCDC has enhanced the UOF Policy accountability component to appropriately address Use of Force violations. SCDC Operations has created an Administrative Regional Director (ARD) to oversee the audit of the AUOF process and to determine if all procedures are followed and make contact with the correctional institutional personnel to correct concerns. Additional improvements are needed. The Agency does not have a written procedure to track employees referred for UOF violations from when identified to final disposition.

SCDC has purchased Canines for tracking, search, and crowd control purposes. A Canine Policy and Training Curriculum have been developed and submitted to the IP and Plaintiffs' Counsel for review and approval. The responsible IP member provided feedback on the policy and training and revisions were made before both were submitted to other IP members and the Plaintiffs' Counsel. The Settlement Agreement requires review and approval by the IP and Plaintiffs' Counsel because canine use for crowd control constitutes UOF and is therefore a UOF policy. SCDC plans to pilot the Canine Policy and Training prior to full implementation. The responsible IP Member will participate in assessing canine use during the pilot to identify any issues or concerns.

The IP remains concerned about inappropriate and excessive use of force by SCDC employees as determined by reviewing UOF MINS Narratives for the relevant period. The Lee CI March 2018 incident where an inmate sustained an injury requiring hospital treatment and admission to the Kirkland CI Infirmary is a glaring example. The IP reviewed the handheld video for the incident with SCDC officials and identified numerous UOF violations and failure by employees to intervene and respond appropriately during the incident.

March 2018 Implementation Panel Recommendations:

1. Operations and QIRM continue to review use of force incidents utilizing the automated system to identify use of force violations;
2. QIRM and Operations leadership continue weekly meetings to discuss UOF and other relevant issues;
3. IP continue to review SCDC Use of Force reports and monthly Use of Force MINS Narratives and provide SCDC feedback;
4. The IP Use of Force Reviewer and SCDC Operations Leadership continue to jointly review Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of force;
5. QIRM should conduct a CQI Study to assess if grievances for excessive UOF are processed and inmates receive an appropriate response with a final disposition rendered in a timely fashion;

6. SCDC Police Services should begin maintaining data on all incidents reviewed for UOF violations even if an investigation is not conducted;
7. Police Services needs to identify the number of investigations: substantiated, unsubstantiated or unfounded;
8. Develop and implement a written procedure to track employees recommended and/or referred for UOF violations;
9. All required staff complete Use of Force Training in the Calendar Year 2018; and
10. SCDC ensure the accountability component of OP 22.01 Use of Force is implemented and meaningful corrective action is taken for employees found to have committed use of force violations.

2.c.vii. Prohibit the use of crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions;

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
SCDC policy OP 22. 01, section 6.3 Chemical Munition, addresses the standard issued chemical for incident control. QIRM Use of Force Reviewers continue to review the use of chemical munitions incidents involving crowd control canisters.

QIRM UOF Reviewers began looking at the number of times crowd control devices were used appropriately under identifiable circumstances, the number of times crowd control devices were used appropriately under objectively identifiable circumstances in writing and the number of times crowd control devices were used in volumes consistent with manufacture's instruction in June of 2017. Based on this information June is the baseline for tracking data received from RIM reports and the Automated Used of Force System.

In an effort to determine that the MK-9 was used within the guidelines of policy OP- 22. 01 Use of Force. QIRM UOF Reviewers used the following parameters to determine that SCDC Staff members used the MK-9 in circumstances consistent with what is outlined within policy. Based on RIM reports. The QIRM Use of Force staff reviewed 115 use of force incidents in which MK-9 was used between June 1, 2017 and January 31, 2018.

In an effort to determine that the MK-9 was used within the guidelines of policy OP- 22. 01 Use of Force. QIRM UOF Reviewers used the following parameters to determine that SCDC Staff members used the MK-9 in circumstances consistent with what is outlined within policy.

Based on RIM reports, there were use of force incidents in which MK-9 was used between October 1, 2017 and January 31, 2018.

- During the reporting period there were 50 reported uses of crowd canister devices

- 34 (68%) in which the officer's actions were justifiable based on circumstances set forth in agency policy OP- 22. 01, Use of Force. This is up from 29 out of 51 (57%) from the last reporting period.

- There were 34 (68%) incidents where the crowd control devices were used appropriately under objectively identifiable circumstances in writing. This is up from 29 out of 51 (57%) from the last reporting
- There were 36 (72%) incidents where the crowd control devices were used in volumes consistent with manufacturer's instructions. This is up from 45% in the last reporting period.

The following charts provide additional information comparing uses of crowd control canisters during the reporting period.

	# times crowd control devices were used appropriately under objectively identifiable circumstances	# times crowd control devices were used
October	3	5
November	10	15
December	9	13
January	12	17

	# times crowd control devices were used appropriately under objectively identifiable circumstances IN WRITING	# times crowd control devices were used
October	3	5
Novembe r	10	15
Decembe r	9	13
January	12	17

	# times crowd control devices were used in volumes consistent with manufacturer's instructions	# times crowd control devices were used
October	2	5
November	8	15
December	12	13
January	14	17

March 2018 Implementation Panel findings: As per SCDC update. SCDC continues to identify incidents where crowd control canisters, such as MK-9, are used inappropriately and in volumes

that exceed manufacturer's and SCDC guidelines. SCDC has demonstrated improvement in using MK-9 as required by manufacturer's instructions. From October 1, 2017 through January 31, 2018 there were 34 (68%) incidents where the crowd control devices were used appropriately and under objectively identifiable circumstances in writing. This is up from 29 out of 51 (57%) from the last reporting. There were 36 (72%) incidents where the crowd control devices were used in volumes consistent with manufacturer's instructions. This is up from 45% in the last reporting period. SCDC has not revised Housing Unit Post Orders as they pertain to *Cover Teams* qualifying that MK-9 use will be consistent with manufacturer's instructions.

March 2018 Implementation Panel Recommendations:

1. Operations and QIRM continue to review use of force incidents utilizing the automated system to identify use of force violations;
2. QIRM Use of Force Reviewers continue to generate reports involving crowd control canisters including MK-9;
3. QIRM and Operations leadership continue weekly meetings to discuss UOF and other relevant issues;
4. IP continue to review SCDC Use of Force reports and monthly Use of Force MINS Narratives and provide SCDC feedback;
5. The IP Use of Force Reviewer and SCDC Operations Leadership continue jointly reviewing Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of crowd control canisters including MK-9;
6. Revise Housing Unit Post Orders as they pertain to *Cover Teams* to qualify that MK-9 use will be consistent with manufacturer's instructions; and
7. All required staff complete Use of Force Training in the Calendar Year 2018.

2.c.viii. Notification to clinical counselors prior to the planned use of force to request assistance in avoiding the necessity of such force and managing the conduct of inmates with mental illness;

Implementation Panel December• 2017 Assessment: **partial compliance**

February 2018 SCDC Status Update:
UOF reviewers continue to track the number of planned uses of force involving inmates with a mental health classification to determine if a mental health counselor is contacted prior to the incident The following reports shows the rates at which mental health counselors have been notified since May 2017.

The report is included as attachment 5.

March 2018 Implementation Panel findings: Per SCDC update from Attachment 5. SCDC data identifies continued issues with notifying clinical counselors (QMHPs) to request their assistance prior to a planned use of force involving mentally ill inmates. SCDC provided data for the period

of May 2017 through January 2018, that QMHPs were contacted prior to a planned use of force for mentally ill inmates as follows:

May 2017-	45%
June 2017-	50%
July 2017-	50%
August 2017-	25%
September 2017	33%
October 2017	17%
November 2017	50%
December 2017	45%
January 2018	29%

It is concerning for the relevant period that SCDC Operations staff failed to request assistance from QMHPs before a planned UOF involving a mentally ill inmate in the majority of the incidents. It is unacceptable for this trend to continue.

March 2018 Implementation Panel Recommendations: Provide additional training to Operations Supervisory and Mental Health Staff on their duties and responsibilities in a planned use of force. Hold responsible employees accountable when the required assistance from QMHPs is not requested prior to a planned UOF incident involving mentally ill inmates. When operations employees notify mental health staff of a planned UOF, the mental health staff must complete a face to face interaction to assist or document reasons the interaction was not completed.

2.c.ix. Develop a mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates;

Implementation Panel March 2018 Assessment: **partial compliance**

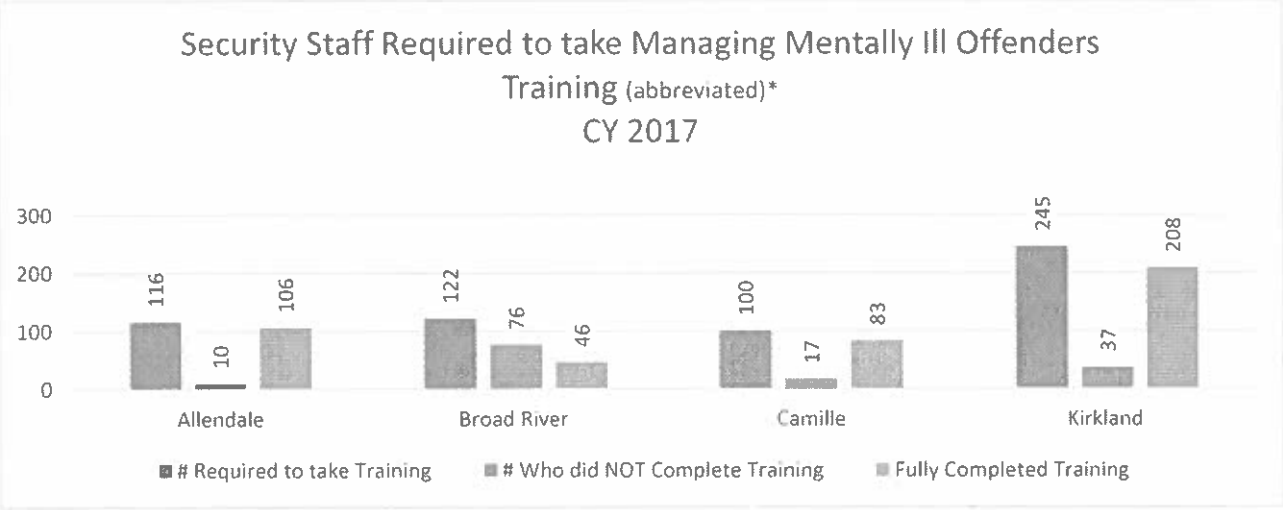
February 2018 SCDC Status Update:
The South Carolina Department of Corrections Training Academy reports the following information for Calendar Year 2017 for Allendale, Broad River, Camille Griffin Graham and Kirkland Correctional Institutions.

Allendale Correctional Institution was identified as having the most medium security employees required to take the Managing Mentally Ill Offenders training. They achieved the third highest level of completion for all institutions with a completion rate of 91.4%.

Broad River Correctional Institution had the third highest amount of maximum security employees required to take the training as well as the third lowest rate of completion for all institutions at 37.7%.

Camille Griffin Graham is one of two female institutions in South Carolina. Their completion rate for this training was 83% which is tenth for all institutions.

Kirkland Correctional Institution has the highest number of maximum security employees required to take the Managing Mentally Ill Offenders training. Kirkland had a completion rate of 85% which is thirteenth in the state for all institutions.



Source: Division of RIM Report

*The entire report of Security Staff Required to take Managing Mentally Ill Offenders Training in CY 2017 is located in the Sparkman Document Request 6 sections B,D and E.
This report was completed for all of SCDC. There were 2,171 employees required to take this training. The Agency had a completion rate of 74.9% for calendar year 2017.

March 2018 Implementation Panel findings: Per SCDC Update. There were 2171 Security Staff employees that completed the required Managing Mentally Ill Offenders training in the Calendar Year 2017 for a completion rate of 74.9 percent.

The mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates for the Calendar Year 2017 was as follows:

Introduction to Mental Health	1.5 hours	Orientation (all new employees)
Mental Health	2.0 hours	Basic Training
Pre-Crisis and Suicide Prevention	3.0 hours	Basic Training
Interpersonal Communications	10.0 hours	Basic Training
Communication Skills/Counseling	1.5 hours	Annual In-Service
Mental Health Lawsuit	4.2 hours	Annual In-Service

The SCDC Training Division reported the plan for training correctional officers concerning appropriate methods of managing mentally ill inmates is being revised for the Calendar Year 2018. The revised training plan will require review and approval by the IP.

March 2018 Implementation Panel Recommendations:

- The SCDC Training Division submit the revised plan for training correctional officers on the appropriate methods of managing mentally ill inmates to the IP for review and approval;
- SCDC document and track the number of required employees completing the mandatory training for appropriate methods of managing mentally ill in Calendar Year 2018; and
- For each relevant period, report the progress being made with required employees attending the training.

2.c.x. Collection of data and issuance of quarterly reports concerning the use-of-force incidents against mentally ill and non-mentally ill inmates;

Implementation Panel March 2018 Assessment: **compliance (3/2017)**

February 2018 SCDC Status Update:

QIRM's Use of Force Reviewers continue to produce and disseminate monthly and quarterly UOF Reports. The most recent reports are attached as attached as Appendix O.

This report is sent to the IP UOF expert, Wardens, and Agency leadership. This report also details:

- Agency Use of Force by Type
- Video Review
- Grievances Related to Use of Force
- Grievances Filed by Inmates with a Mental Health Classification
- MINS: Mainframe vs Use of Force Application
- Exception Reports

The following graphs show the UOF for mentally ill vs non-mentally ill inmates since January 2017.

March 2018 Implementation Panel findings: SCDC continues to generate a monthly UOF Report Mentally Ill vs. Non-Mentally Ill. No issues were identified with the use of force data utilized to produce the report.

March 2018 Implementation Panel Recommendations: Continue to produce and disseminate the monthly UOF Mentally Ill vs. Non-Mentally Ill Report.

2.c.xi. The development of a formal quality management program under which use-of-force incidents involving mentally ill inmates are reviewed.

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:

- An (UOF) coordinator for the Quality Management Section in the Division of Mental Health has been hired and scheduled to begin on March 19, 2018. This individual will be responsible for the following tasks:
  - reviewing the response of all planned UOF incidents from mental health employees, ensuring timely follow-up was completed and documented as outlined in policy;
  - monitoring the automated UOF system ensuring automated entries are documented and cleared as outlined in policy by mental health staff;
  - reviewing UOF video tapes to assess the effectiveness of interventions used by mental health staff determining if it was collaborative in nature following the "cool-down period" guidelines;
  - providing training and technical assistance to operations and mental health staff on the UOF policy and conflict resolution techniques;
  - tracking inmates on the mental health caseload who have repeated UOF incidents to determine if mental health treatment needs are appropriate; make recommendations to the Division Director or Chief of Psychiatry regarding the suitability of inmate's treatment needs;
  - working closely with the office of QIRM to report inappropriate UOF activities for inmates on the mental health caseload.

March 2018 Implementation Panel findings: Per SCDC update. A UOF Coordinator for the Quality Management Section of the Division of Mental Health has been hired. The Coordinator began employment on March 19, 2018 and was introduced to the IP during the March 2018 Site Visits and participated in meetings and tours.

Procedures have been developed and a Coordinator has been hired to conduct formal Mental Health Quality Reviews of Use of Force Incidents involving mentally ill inmates; however, the reviews have not begun.

March 2018 Implementation Panel Recommendations:

- Begin Mental Health Quality Reviews of Use of Force Incidents involving mentally ill inmates; and
- QIRM conduct a CQI Study once the Mental Health Quality Review of Use of Force Incidents involving mentally ill inmates has been implemented.

3. Employment of enough trained mental health professionals:
3.a Increase clinical staffing ratios at all levels to be more consistent with guidelines recommended by the American Psychiatric Association, the American Correctional Association, and/or the court-appointed monitor;

Implementation Panel March 2018 Assessment: **noncompliance**

February 2018 SCDC Status Update:
The following chart outlines the staffing ratios as reported by BMHSAS. (see staffing summary document)

March 2018 Implementation Panel findings: The staffing vacancies, and likely the staffing allocations, continue to result in inadequate employment of enough trained mental health professionals (see attachment 1). We are encouraged by the recruitment and retention efforts that have been recently initiated by SCDC.

The staffing summary chart does not provide ratios of clinicians to mental health caseload inmates. We discussed with appropriate staff providing such ratios by discipline and level of care.

March 2018 Implementation Panel Recommendations: Implement the above.

3.b Increase the involvement of appropriate SCDC mental health clinicians in treatment planning and treatment teams

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
A report for showing treatment team participation rates at the Crisis Stabilization Unit (CSU), Kirkland ICS, Gilliam Psychiatric Hospital (GPH), Allendale's Low Level Behavioral Management Unit (LLBMU), and at Camille for the months of October, November, and December 2017 and January 2018 is included as Attachment 6.

March 2018 Implementation Panel findings: We expressed our concerns regarding the accuracy of the presented data due to questions relevant to psychiatrists' participation in the CSU treatment teams at the Broad River CI based on our prior site visits. During such visits we never observed the psychiatrist participating in a CSU IDTT except for the current assessment.

March 2018 Implementation Panel Recommendations: Confirm and/or correct the accuracy of the previously referenced data.

3.c Develop a training plan to give SCDC mental health clinicians a thorough understanding of all aspects of the SCDC mental health system, including but not limited to levels of care, mental health classifications, and conditions of confinement for caseload inmates;

Implementation Panel March 2018 Assessment: **compliance (March 2018)**

February 2018 SCDC Status Update:
The RIM-generated document reports the Mental Health Staff completing General Provisions Training but location. Eight of the ninety-five mental health staff required to complete the training did not complete the training.

Mental Health Staff
Required to take Mental Health General Provisions
in CY 2017
by Location and Training Completion

Level	Budget Unit	Institution	# Required to take Training	Completed		Not Completed	
				#	%	#	%
1	123	CATAWBA	0	0	N/A	0	N/A
1	232	GOODMAN	0	0	N/A	0	N/A
1	173	LIVESAY	0	0	N/A	0	N/A
1	251	MANNING	3	3	100.0%	0	0.0%
1	563	PALMER	0	0	N/A	0	N/A
Minimum Security			**3**	**3**	**100.0%**	**0**	**0.0%**
2	411	ALLENDALE	1	1	100.0%	0	0.0%
2	531	EVANS	2	2	100.0%	0	0.0%
2	541	KERSHAW	2	0	0.0%	2	100.0%
2	422	MACDOUGALL	1	1	100.0%	0	0.0%
2	442	RIDGELAND	1	1	100.0%	0	0.0%
2	222	TRENTON	1	1	100.0%	0	0.0%
2	571	TURBEVILLE	12	11	91.7%	1	8.3%
2	161	TYGER RIVER	0	0	N/A	0	N/A
2	582	WATEREE RIVER	0	0	N/A	0	N/A
Medium Security			**20**	**17**	**85.0%**	**3**	**15.0%**
3	211	BROAD RIVER	3	3	100.0%	0	0.0%
3	242	GILLIAM PSY	30	27	90.0%	3	10.0%
3	241	KIRKLAND	3	2	66.7%	1	33.3%
3	551	LEE	3	2	66.7%	1	33.3%
3	421	LIEBER	3	3	100.0%	0	0.0%
3	181	MCCORMICK	1	1	100.0%	0	0.0%
3	191	PERRY	3	3	100.0%	0	0.0%
Maximum Security			**46**	**41**	**89.1%**	**5**	**10.9%**
	331	GRAHAM	11	11	100.0%	0	0.0%
	171	LEATH	2	2	100.0%	0	0.0%
Female Institutions			**13**	**13**	**100.0%**	**0**	**0.0%**
	1	HEADQUARTERS	13	13	100.0%	0	0.0%
All Institutions			**95**	**87**	**91.6%**	**8**	**8.4%**

March 2018 Implementation Panel findings: At the time of the site visit, all the mental health staff required to receive such training had completed the training.

March 2018 Implementation Panel Recommendations: Continue to monitor this provision in the context of newly hired employees.

3.d Develop a plan to decrease vacancy rates of clinical staff positions, which may include the hiring of a recruiter, increase in pay grades to more competitive rates, and decreased workloads;

Implementation Panel March 2018 Assessment: **compliance** (December 2017)

February 2018 SCDC Status Update:

See 2.a.iv

March 2018 Implementation Panel findings: See 2.a.iv.

March 2018 Implementation Panel Recommendations: See 2.a.iv.

3.e Require appropriate credentialing of mental health counselors;

Implementation Panel March 2018 Assessment: **compliance** (3/2017)

Allendale LLBMU	=	November 29, 2017
Lee CI	=	January 17, 2018
Kershaw CI	=	January 22, 2018
Evans CI	=	January 23, 2018
Turbeville CI	=	February 7, 2018
Broad River CI (CSU)	=	February 21, 2018
Camille CI (ICS & Area)	=	March 8, 2018
Broad River (Hab & Area)	=	March 13, 2018
Kirkland (GPH)	=	March 15, 2018
Kirkland (ICS)	=	April 16, 2018
Kirkland (HLBMU & Death Row)	=	April 18, 2018
MacDougall & Lieber	=	May 14, 2018
Ridgeland & Allendale (Pop)	=	May 21, 2018
Perry & Tyger River	=	June 4, 2018
Leath & McCormick	=	June 18, 2018

Final audit results are included for LLBMU, Lee, Kershaw, Evans and Turbeville as Attachment 2.

March 2018 Implementation Panel findings: Although data is available via the biannual individual institutional audits, they are not yet being used for purposes of this provision.

March 2018 Implementation Panel Recommendations: Implement a process to utilize the above referenced data for purposes of this provision.

3.g. Implement a formal quality management program under which clinical staff is reviewed.

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
See 3.f.

March 2018 Implementation Panel findings: See 3.f.

March 2018 Implementation Panel Recommendations: See 3.f.

4. Maintenance of accurate, complete, and confidential mental health treatment records:
4.a Develop a program that dramatically improves SCDC's ability to store and retrieve, on a reasonably expedited basis:
4.a.i. Names and numbers of FTE clinicians who provide mental health services;

Implementation Panel March 2018 Assessment: **compliance (3/2017)**

February 2018 SCDC Status Update:
RIM continues to produce and distribute a weekly "Medical Personnel Report." The following

February 2018 SCDC Status Update:
SCDC Policy 19.15, Mental Health Services - Mental Health Training, Section 3.4 stipulates that QMHPs will be required to maintain their professional licensure based on the requirements of their individual licensure board (Licensed Professional Counselor, Licensed Social Worker, etc.) and provide verification of continued licensure.

Those mental health counselors who are not licensed but were hired prior to above requirement are allowed to continue working under the supervision of a licensed counselor.

Based on the provisions outlined in policy, 40/40 or 100% are appropriately licensed.

March 2018 Implementation Panel findings: There was lack of clarity whether unlicensed mental health clinicians hired prior to the stipulated agreement were required to obtain licensure within several years in order to continue working as clinicians or whether continued supervision was required indefinitely.

March 2018 Implementation Panel Recommendations: We are requesting guidance from the parties relevant to this issue. In either case, we will be monitoring proof of supervision for such clinicians during the next monitoring round.

3. f. Develop a remedial program with provisions for dismissal of clinical staff who repetitively fail audits; and

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
Initial Audit Reviews for all programs are consultative. Refer to the attachment for the completed audit review findings for the institutions/programs listed below. The Division Director and QA Manager/Designee will meet with the institutional and mental health staff on the dates indicated to discuss the audit findings as well as the necessary action that is needed to meet policy requirements.

INSTITUTION	AUDIT REVIEW DATE	SCHEDULED DATE OF AUDIT DISCUSSION
Allendale - LLBMU	November 29, 2017	March 9, 2018
Lee CI	January 17, 2018	March 15, 2018
Kershaw CI	January 22, 2018	March 30, 2018
Evans CI	January 23, 2018	April 11, 2018
Turbeville CI	February 6, 2018	April 11, 2018
BRCI – CSU	February 21, 2018	April 13, 2018

Component 3g: Formal CQM program to review clinical staff.

Updated Audit Schedule
DIVISION OF BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE SERVICES
2017 – 2018 QA MENTAL HEALTH AUDIT DATES - REVISED

screenshot provides a snapshot of the detailed report. The most recent report was distributed on December 21, 2017. See screenshots below. The most recent report is included as Appendix P.

Detail of Medical Positions as of COB Yesterday
run on December 21, 2017

Employee Name	SCDC Position	Job Class	Job Class Title	Position Description	Budget Un	Location	Vacancy Start Date
AARON M MILLER	21014	EC20	TECH MEDICAL ASSOCIATE I	PARAMEDIC	32241	KIRKLAND	
ADETORO A SOBOWALE	15061	EA20	REGISTERED NURSE I	STAFF NURSE	31191	PERRY	
ALISHA A HUNT	12563	GA50	HUMAN SERVICES COORD I	QMHP- CCC IV	32331	GRAHAM	
ALLEN L WISE	21666	EC20	TECH MEDICAL ASSOCIATE I	PARAMEDIC	34551	LEE	
ALLISON B BRINSON	14572	EA20	REGISTERED NURSE I	RN	32211	BROAD RIVER	
ALLISON L GORDON	15921	EA80	NURSE ADMINISTRATOR MGR II	HLTH CARE AUTH II	34582	WATEREE RIVER	
ALLISON V JORDAN	19333	EC10	MEDICAL ASSISTANT TECH I	CNA	32241	KIRKLAND	
AMANDA F KELLY	18990	AA50	ADMIN SPECIALIST II	ADMIN SPEC II	53101	MEDICAL SUPPORT	
AMANDA HASSINO TUCKER	13947	GA50	HUMAN SERVICES COORD I	HUMAN SERV COORD I	32222	TRENTON	
AMANDA L MARTIN	14421	GA40	HUMAN SERVICES SPEC II	COUNSELOR	34571	TURBEVILLE	
AMANDA M DAVIS	20028	EC20	TECH MEDICAL ASSOCIATE I	PARAMEDIC	32241	KIRKLAND	
AMY L PULLIAM	15849	AA50	ADMIN SPECIALIST II	ADMIN SPEC II	34571	TURBEVILLE	
AMY L WHITTINGTON	10815	EA20	REGISTERED NURSE I	RN I - 2	34531	EVANS	
AMY M LAMPRECHT	19848	EA20	REGISTERED NURSE I	REGISTERED NURSE	33422	MACDOUGALL	
AMY R ENLOE	11753	EA65	NURSE PRACTITIONER II	NURSE PRACTITIONER II	31191	PERRY	
ANASTASIA J EUBANKS	19070	AH35	PROGRAM COORDINATOR I	COORD OF MH SUP SERV	45101	MENTAL HEALTH	
ANDRE T BROWN-DIXON	20573	BB20	STATISCL & RESRCH ANAL II	HEALTH SERV OFC ASST	32211	BROAD RIVER	
ANDRE T WHALEY	12549	GA40	HUMAN SERVICES SPEC II	CLIN CORR COUNS I	45101	MENTAL HEALTH	
ANDREW R HODGE	10287	GA50	HUMAN SERVICES COORD I	CLIN COUNS IV	45101	MENTAL HEALTH	
ANDREW W HEDGEPATH	21330	UB25	PSYCHIATRIST	PSYCHIATRIST	45101	MENTAL HEALTH	
ANGELA S GARCES	19717	EC15	MEDICAL ASST TECH II	DENTAL ASST	34541	KERSHAW	
ANGELON GRAVES	17244	GA40	HUMAN SERVICES SPEC II	COUNSELOR	34571	TURBEVILLE	

March 2018 Implementation Panel findings: Compliance continues.

4.a.ii. Inmates transferred for ICS and inpatient services;

Implementation Panel March 2018 Assessment: **compliance (July 14, 2017)**

February 2018 SCDC Status Update:
RIM continues to develop, produce and maintain reports of inmates transferred to ICS or GPH or Correct Care beds. This continues to provide MH staff the ability to track the number and timeliness of inmates being transferred to GPH, contractual providers and ICS programs. The most recent report is included as Appendix Q.

March 2018 Implementation Panel findings: Compliance continues with regard to tracking referrals, however we are concerned about the high rate of denials of the referrals from the CSU to the ICS and that issue needs to be addressed.

4.a.iii. Segregation and crisis intervention logs;

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
Policy 22.38, Restrictive Housing Units, section 3, number 14 says that correctional officers assigned to the RHU are to conduct security checks and to personally observe each inmate at least every 30 minutes on an irregular, unannounced schedule. The time of each security check will be recorded in the RHU permanent log book and SCDC Form 19-7A, "Cell Check Log." These cell checks not only foster a safer security environment, but they also help to monitor the mental health of the inmates in RHU.

SCDC currently uses a manual system to track and document 30-minute irregular cell checks, as required by policy 22.38, and unstructured activities such as showers and recreation. QIRM conducted a QI study to the compliance with these checks at Allendale, Broad River, and Camille RHU.

The results from the CQI study indicated that as a whole, the three institution's compliance rate for cell checks occurring at least 30 minutes apart intervals is 33%. These results suggests that inmates are not being monitored regularly as required by Agency policy. This may be attributed to security staffing shortages. The compliance in doing the checks at irregular intervals was 74%, when the definition for "Not Irregular" was that three or more intervals were the identical number of minutes apart. However, it was noted that the checks were often just two or three minutes apart, in effect, still being fairly regular intervals.

The collection of the data was all in a paper form as opposed to an electronic form that would allow more accuracy and eliminate the issues of legibility. SCDC's IT department is working to create the electronic version of this form, as this will eliminate errors, save time, and make monitoring more effective.

The final report is attached as Appendix R.

March 2018 Implementation Panel findings: As per status update section.

March 2018 Implementation Panel Recommendations: Remedy the above.

4.a.iv. Records related to any mental health program or unit (including behavior management or self-injurious behavior programs);

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
Clinical encounter data is available in the AMR (with additional information in the paper chart at GPH). New encounter types have been created that will better account for the type of care provided in each encounter. Staff have now received training on the new types of encounters.

Activity and cell check logs remain on paper and are addressed in 4.a.iii., but RIM is working to create an automated system. On December 4, 2017 SCDC introduced the Offender Activity Tracking System (OATS) which is an electronic cell check log system. This new method of recording the activities of an inmate relies on the use of handheld tablets, updated employee identification cards with a barcode and QR codes that were created for the cell doors. The officers who are utilizing this system will now scan the QR code on the outside of the cell and select the appropriate inmate from the provided drop down box. This information is fielded by the dorm roster and available in real time. At this time only the unstructured out of cell time such as recreation and showers can be captured by indicating if the inmate refused, was ineligible or participated. The in cell activity options available are standing, lying down and sitting which are the same options that were previously available on the paper cell check logs. When the inmate provided a meal can also be captured through the use of the electronic cell check log. The

implementation of this technology provides approved users access the electronic OATS Report through the secured login section of the intranet.
This technology is being introduced on a rollout schedule to the Restrictive Housing Units and Crisis Stabilization Units in the Columbia area initially. OATS has the ability to be customized to fit most needs of the Agency. Through the rollout schedule the CSU at Broad River Correctional Institution and RHU of Camille Griffin Graham Institution have had the opportunity to weigh in on what would make this system successful.

March 2018 Implementation Panel findings: As per status update section. The electronic medical record is going to be rolled out to all the other institutions in the very near future. However, there continue to be various issues with the EMR that should be resolved prior to the planned rollout.

March 2018 Implementation Panel Recommendations: Resolve the previously referenced issues prior to implementing the EMR system wide.

4.a.v. Use of force documentation and videotapes;

Implementation Panel March 2018 Assessment: **compliance (March 2017)**

February 2018 SCDC Status Update:
Retention policy for video and audio recordings is listed in policy OP 22.01; recordings must be retained for six years after the date of the incident, at that point, only the main report synopsis is forwarded to State Archives for permanent retention.

March 2018 Implementation Panel findings: As per SCDC update.

March 2018 Implementation Panel Recommendations: Operations and QIRM continue to monitor use of force documentation and videotapes through the SCDC automated use of force system.

4.a.vi. Quarterly reports reflecting total use-of-force incidents against mentally ill and non-mentally ill inmates by institution;

Implementation Panel March 2018 Assessment: **compliance (March 2017)**

February 2018 SCDC Status Update:
RIM continues to produce and disseminate a monthly, "UOF Report Mentally Ill vs. Non-Mentally Ill," report.

- UOF Reviewers continue to track and report the number of UOF incidents involving mentally ill vs non-mentally ill inmates. This quarterly report is sent to it IP UOF expert, Wardens, and Agency leadership. This report also details:
  - Agency Use of Force by Type
  - Video Review
  - Grievances Related to Use of Force
  - Grievances Filed by Inmates with a Mental Health Classification
  - MINS: Mainframe vs Use of Force Application

- Exception Reports

The most recent report is included as Appendix S.

March 2018 Implementation Panel findings: As per SCDC update.

March 2018 Implementation Panel Recommendations: Continue to produce and disseminate the monthly UOF Mentally Ill vs. Non-Mentally Ill Report.

4.a.vii. Quarterly reports reflecting total and average lengths of stay in segregation and CI for mentally ill and non-mentally ill inmates by segregation status and by institution;

Implementation Panel March 2018 Assessment: **compliance (March 2017)**

February 2018 SCDC Status Update:
A "CY CISP Admissions" report continues to be produced quarterly by RIM. This report shows if an inmate stays in a CI cell in an outlying institution longer than the 60 hours allowed to have him transferred to CSU. The most recent report is included as Appendix T.

RIM continues to produce and a weekly spreadsheet that provides a list of inmates currently in SD, DD, MX or SR custody by institution. The most recent report was disseminated on February 28, 2018. See screenshot below. The most recent report is included as Appendix U.

March 2018 Implementation Panel findings: Per SCDC update.

March 2018 Implementation Panel Recommendations: Compliance continues.

4.a.viii. Quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution;

Implementation Panel March 2018 Assessment: **compliance (March 2017)**

February 2018 SCDC Status Update:
QIRM Analysts had been providing a summarized report on inmates in segregation by institution, custody, and mental health classification to Operations staff. After meeting with Operations leaders, it was determined that the QIRM report is duplicative to the RIM report. RIM continues to produce and distribute the "Weekly Lockup by Custody and Mental Health Classification." This monthly report is shared with institutional and agency leaders. The most recent report was produced and distributed by RIM on November 8, 2017. The most recent report is included as Appendix U.

March 2018 Implementation Panel findings: Per SCDC update.

March 2018 Implementation Panel findings: Compliance continues.

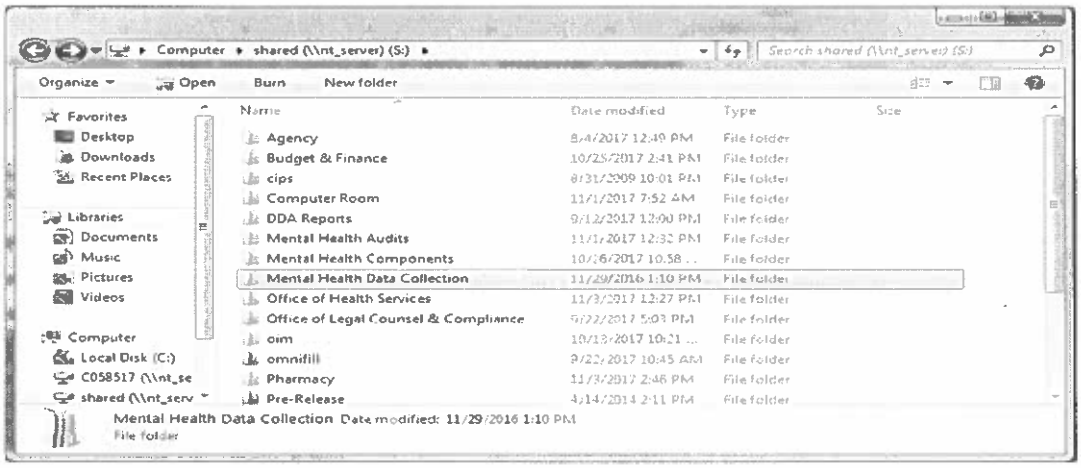
4.a.ix. Quality management documents; and

Implementation Panel March 2018 Assessment: **partial compliance**

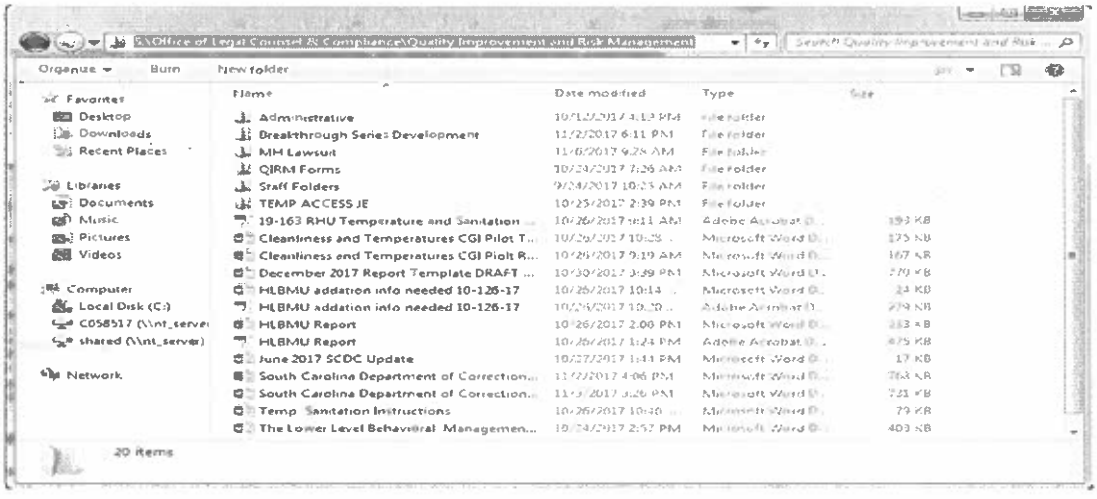
February 2018 SCDC Status Update:

Quality management documents, including reports, audit tools, audits, and other forms of documentation continue to be available in shared network folders. See examples below. Access to each folder is managed by system administrators through the IT Access Request menu. This allows for central storage of documentation for access across divisions and institutions. SCDC is also working to automate as many processes as possible to make data collection simpler and easier. Cell check logs have been automated at Broad River CSU and Camille Graham RHU.

Shared Drive:



QIRM folder:



March 2018 Implementation Panel findings: Significant improvement continues relevant to the implementation of this provision.

March 2018 Implementation Panel Recommendations: Provide all requested and necessary documentation to QIRM for provision and distribution to the IP in the requested timeframes.

4.a.x. Medical, medication administration, and disciplinary records

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:

SCDC Electronic Medical Record Implementation – UPDATE

Task:	Start	End
Male Facility End User Training Week 1	4/3/18	4/6/18
Male Facility End User Training Week 2	4/17/18	4/20/18
Level 3 Institution Go Live (except Kirkland) – Broad River, Lee, Lieber, McCormick, Perry	4/30/18	5/4/18
Male Facility End User Training Week 3	5/15/18	5/18/18
Kirkland Go Live (EHR, EDR, Scheduling only)	5/22/18	5/24/18
Male Facility End User Training Week 4	6/5/18	6/8/18
Level 2 Institutions Go Live (partial) – Allendale, Evans, Ridgeland, Turbeville	6/19/18	6/22/18
Male Facility End User Training Week 5 (if needed)	6/26/18	6/28/18
All remaining Institutions Go Live – Catawba, Goodman, Kershaw, Livesay, MacDougall, Manning, Trenton, Tyger River, Wateree	7/10/18	7/12/18
Kirkland eZmar Go Live	7/24/18	7/26/18

SCDC is in the process of hiring and training 8 new staff members to help support the EHR.

- 1 additional Help Desk staff member able to specifically address NextGen issues.
- 1 additional RIM staff member to conduct system configuration edits and produce reports and analysis of the NextGen data.
- 6 additional RIM staff members who will serve as statewide support staff for use of all aspects of the system: EHR, EDR, Scheduling, eZmar, interfaces, etc. These staff members will have assigned territories and perform most of their duties onsite in the institutions alongside members of the Health Services staff.
- 4 of the 6 support staff and the additional Help Desk member have been hired and will have started before the next panel visit.
- The remaining 2 support staff and 1 business analyst are still in the hiring process.

March 2018 Implementation Panel findings: See prior comments regarding rollout of the EHR.

March 2018 Implementation Panel Recommendations: Continue to assess and validate documentation from HER to support the Quality Management program.

4.b. The development of a formal quality management program under which the mental health management information system is annually reviewed and upgraded as needed.

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:

The system is being updated on a continual basis.

End users continue to able to submit change requests to RIM for review and implementation by the system administrator after consultation with subject matter experts. Necessary changes and improvements will be rolled out on a continual basis rather than annually. Below is a list of enhancements already implemented since the two female facilities went live on NextGen on March 28, 2016:

- Improved user maintenance: [redacted] now has the capability to create accounts, re-enable accounts and reset passwords immediately instead of having to log a support case with NextGen for them to do so.
- Added max out date to the patient's demographics bar.
- New Standing Order medication ordering template to all Standing Order meds can be ordered from one place within the nursing visit. Continued maintenance of picklists (visit types, copay exempt reasons, reasons for visit, treatment plan objectives, etc.).
- More user workgroups (Scheduling, Lab, R&E) to help separate areas of responsibility within the Clinical Tasking Workflow. Staff can now control which workgroups they are participating in based on their job role for the day.
- Increased nurse/provider communication: Nurses and providers can write comments from their own templates that get saved to the record on the document and routed to the intended recipient for follow up or response.
- An overhaul of the SCDC formulary has taken place in the medications module. All provider are defaulted to only search the formulary list instead of the complete FDB medication listing. This should hopefully cut down on unusual meds being requested from the pharmacy and improve standardization of the rigs.
- Improved Referral workflow that will mirror the FE Medication template and be more user friendly.
- Improved printing workflows.
- EHR software upgrades are published by the vendor on an intermittent basis. Adoption of each new release will be determined by weighing the degree of technical and end user functionality gained against the resources required to implement the upgrade.
- Initial install: NextGen version 5.8.22/KBM version 8.3.10
- Upgrade completed 3/1/17: NextGen version 5.8.3/KBM version 8.3.11
- October, 2017: New release announced
- June, 2018: Tentative upgrade to NextGen version 5.9/KBM 8.4

March 2018 Implementation Panel findings: As per status update section.

March 2018 Implementation Panel Recommendations: As per status update section.

5. Administration of psychotropic medication only with appropriate supervision and periodic evaluation:

March 2018 Implementation Panel findings: **noncompliance**

February 2018 SCDC Status Update

The report addressing the following topics is included as Attachment 7 :

1) RHU Medication Procedure
2) Medication Assistance Device Photos
3) Medication Assistance Device Procedure
4) Pill Line Times

March 2018 Implementation Panel findings: We discussed with staff in detail issues related to the "medication tool." This medication tool is being piloted due to current medication administration practices in RHUs systemwide as well as in general population units during lockdowns if food slots are not present in the cell doors. Attachment 2 provides SCDC's description of the medication tool. This medication tool is an attempt to provide medication administration in the context of grossly inadequate correctional officer allocations systemwide in addition to various significant correctional officer vacancies. It is not an acceptable alternative to medication administration for a number of reasons that include medication being administered in an unhygienic manner, inadequate observation regarding whether an inmate actually is swallowing the medication (i.e., does not permit acceptable direct observation therapy), and exposing nursing staff to unreasonable physical risks related to the need to bend down repetitively in order to administer inmate medications.

This below the standard of care medication administration system is exacerbated by the following:

1. Unacceptable nursing staff vacancies systemwide;
2. General lack of access to the electronic medical administration record when medication administration takes place in housing units;
3. Lack of medication carts due to both cost and inadequate nursing office space; and
4. Lack of a unit dose medication administration process due to inadequate nursing medication room space and inadequate funding.

Ironically, #s 2, 3 & 4 exacerbate the unacceptable nursing staff vacancies systemwide.

March 2018 Implementation Panel Recommendations:

1. The salary structure for nurses is not competitive and results, in part, in the systemwide staffing vacancies;

2. Funding needs to be requested and obtained in order to remedy the above issues that contribute to the below the standard of care medication administration process; and
3. Correctional staff need to be recruited specifically for escorting nurses during the medication administration process in order for such a process to occur within the standard of care.

5.a. Improve the quality of MAR documentation;

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
Please see the *Medication Administration Update* report above

March 2018 Implementation Panel findings: Significant problems were identified with the reliability of the MAR documentation because nurses generally do not have access to the electronic MAR during the time of the actual medication administration. In addition, nurses do not have proper equipment for medication administration when it is not being delivered via a pill line. For example, medication carts are not available. See provision 5.

March 2018 Implementation Panel Recommendations: See provision 5.

5.b. Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs;

Implementation Panel March 2018 Assessment: **noncompliance**

February 2018 SCDC Status Update:
Please see the *Medication Administration Update* report above

March 2018 Implementation Panel findings: Due to the very significant nursing vacancies and systemic deficiencies previously summarized that are not due to individual nursing staff, it is not reasonable to hold clinicians responsible for completing and monitoring MAR's under these conditions. It is reasonable to expect nursing staff to continually advocate for necessary staff, supplies and equipment.

March 2018 Implementation Panel Recommendations: As above.

5.c. Review the reasonableness of times scheduled for pill lines; and

Implementation Panel March 2018 Assessment: **noncompliance**

February 2018 SCDC Status Update:
Pill line times are attached at Appendix W.

March 2018 Implementation Panel findings: HS medications were still not being provided to the ICS at Kirkland CI or at Camille Griffin Graham CI. Morning pill lines at 4 AM within the Broad River CI are not reasonable if breakfast does not begin until 6 AM.

March 18, 2017 Implementation Panel Recommendations: Implement the appropriate steps to resume HS medication administration at the ICS's and elsewhere when clinically indicated. Adequately identify and address other pill call line issues. For example, issues related to 4 AM pill call lines should be identified and remedied.

5.d. Develop a formal quality management program under which medication administration records are reviewed.

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
Please see the *Medication Administration Update* report above

March 2018 Implementation Panel findings: See prior findings relevant to medication administration.

March 2018 Implementation Panel Recommendations: For reasons previously summarized, QI studies should address medication administration and medication management issues (e.g., level of compliance with policies and procedures specific to medication noncompliance, continuity of medications, etc.).

6. A basic program to identify, treat, and supervise inmates at risk for suicide:
6.a. Locate all CI cells in a healthcare setting;

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
The Deputy Director of Health Services and Division Director for BMHSAS evaluated all CI cells for approval for use for CI purposes.
Approvals- Allendale, Lee, Ridgeland, Kirkland F1, and Camille Graham's CSU.

Problems were noted with water faucets at CSU and statewide, but have since been approved (pictures are included as Appendix X).

Problems were also noted with sprinkler heads at Broad River CSU.
Evans visited, however need some cosmetic work (sealing of holes) and painting are needed.

March 2018 Implementation Panel findings: As per SCDC status update section.
March 2018 Implementation Panel Recommendations:

1. Complete the inspection and renovation process re: suicide resistant cells systemwide; and
2. Begin to assess the implementation of the suicide prevention policy via the QI process.

6.b Prohibit any use for CI purposes of alternative spaces such as shower stalls, rec cages, holding cells, and interview booths;

Implementation Panel March 2018 Assessment: **compliance (December 2017)**

February 2018 SCDC Status Update:

Logs provided to the HSOAs (QIAs) did not identify inmates being placed in a holding cell or other alternative space. In a review of the cell check logs by QIRM staff, there was no documentation to indicate the cells being used were prohibited alternative spaces.

March 2018 Implementation Panel findings: As per SCDC status update.

March 2018 Implementation Panel Recommendations: Compliance continues.

6.c Implement the practice of continuous observation of suicidal inmates;

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:

QIRM staff continue to be informed that the practice of continuous observation is being implemented in the institutions, and have witnessed the practice in action; however, CSU continues to be the only area where this is documented consistently based on the use of the 19-7C, Inmate Constant observation log. QIRM staff provided information and instructions on uses of the continuous logs during institutional site visits and ICQMC meetings with Lee, Allendale, Perry, Kirkland, Camille and Broad River Correctional Institutions.

Recommendations continue to be the same:
1. Update the policy to reflect the new and appropriate forms (A, B, C, D). (Remove reference to 19-7).
2. Address the use of the correct forms during shift briefing and provide instructions when to use each form and document through signatures that that staff have been briefed on the use of the appropriate.

March 2018 Implementation Panel findings: As per SCDC status update.

March 2018 Implementation Panel Recommendations: As per SCDC recommendations.

6.d. Provide clean, suicide-resistant clothing, blankets, and mattresses to inmates in CI;

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
During institutional visits to Allendale, Broad River, Camille and Perry CIs, QIRM staff assess the processes for issuing, cleaning and providing clean suicide-resistant clothing and equipment for inmates when placed on CI. Interview with inmates and an assessment of supplies indicated that clean, suicide-resistant supplies were available and being supplied to inmates when placed on CI.

The complete report is included as Appendix Y.

March 2018 Implementation Panel findings: As per SCDC status update section. In recent weeks, CSU inmates at Camille Graham CI were not receiving mattresses.

March 2018 Implementation Panel Recommendations: Remedy the above.

6.e. Increase access to showers for CI inmates;

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
Logs used to record cell checks for CI inmates do not include documentation of the provision of showers.

QIRM recommended that SCDC Form M-120, "Crisis Intervention" be evaluated by the Mental Health and Substance Abuse Division Director, Mr. [redacted] and Quality Assurance Manager, [redacted] for updates to include information about showers for inmates on CI status. Pursuant to a preliminary review, Mr. [redacted] has suggested this form be changed to require a mental health professional to evaluate the inmate for a shower once on CI for 24 hours. This would provide the security staff with specific instructions on the inmate's ability to shower versus current instructions which state "showers as tolerated. As of the writing of this report, this forma has not been updated to reflect the recommended change.

March 2018 Implementation Panel findings: As per SCDC status update. Security Staff do not allow CI inmates access to showers without documented authorization from the responsible clinician on SCDC Form M-120 Crisis Intervention. The identified form does not include a section for the clinician to authorize showers. Mental Health and Substance Abuse Director [redacted] and his staff have recommended a form revision requiring a mental health professional evaluate an inmate on CI status for a shower every 24 hours.

March 2018 Implementation Panel Recommendations: As per SCDC recommendations.

6.f. Provide access to confidential meetings with mental health counselors, psychiatrists, and psychiatric nurse practitioners for CI inmates;

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
As part of SCDC's ongoing efforts to ensure that inmates on Crisis Intervention/Suicide Prevention (CI/SP) have access to confidential sessions with mental health professionals, this study was undertaken to assess where SCDC is in reaching that goal and to identify barriers to success. This study examined what types of mental health sessions were being provided to CI/SP inmates and the frequency of the various types of sessions.

Confidential sessions made up a relatively small minority, between 17% and 24%, of the mental health sessions provided to CI/SP inmates in the months of October, November, and December 2017 and January 2018 in the studied institutions. Cell front sessions made up the largest category, between 42% and 47%, but sessions conducted in other places accounted for a significant minority, between 33% and 38%. Mental Health staff chose to conduct sessions in other locations in an effort to provide the inmates with as much privacy as possible, even when they cannot be totally confidential. While this effort is laudable, it falls short of SCDC's goal to provide confidential mental health sessions to inmates on CI/SP status and in CSU.

Among the three categories of mental health sessions used for this study, confidential sessions accounted for the smallest portion and cell front sessions for the largest.

Moving forward, SCDC will continue its aggressive recruitment campaign in order to alleviate security staffing issues. Outside of CSU, Mental Health staff continues to face challenges having inmates removed from cells for individual counseling sessions based on security shortages. CSU, at Broad River, has been mandated to have a minimum of two security officers per shift, in addition to Mental Health Techs who will assist with the pulling of inmates for individual counseling sessions. This should assist with improving their compliance rate.

The complete study is attached as Appendix Z

March 2018 Implementation Panel findings: As per SCDC status update section.

March 2018 Implementation Panel Recommendations: As per SCDC recommendations.

6.g Undertake significant, documented improvement in the cleanliness and temperature of CI cells;

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
See 2b.vi.

March 2018 Implementation Panel findings: Operations maintains a shared folder for institutions to upload daily cell inspections and temperature logs. SCDC QIRM conducted a CQI Study and the study can be found in Appendix L. All institutions are not uploading daily cell inspections and

temperature logs. The information provided also identified correctional facilities failing to conduct the required daily inspections and temperature checks. Correctional facilities were identified not maintaining their temperatures within the acceptable range and there were correctional facilities with significant problems. Broad River Correctional Institution had the highest compliance with 89% in CSU and 100% in RHU although this was based on the fewest days recorded. Allendale CI had only 36% of their temperatures within the acceptable range. Allendale CI temperature issues are very concerning because cell temperatures were reported as a problem by inmates on a previous site visit to the correctional facility approximately one year ago. Further, when Allendale CI Maintenance was contacted by telephone during the March 18 Site Visit, they were unaware of a significant number of cells being outside the acceptable temperature range. Kirkland SSR had extreme deficiencies that should be an urgent priority. The revised SCDC Form 19-163 piloted at CGCI has the potential to improve staff documenting corrective action for cleanliness deficiencies. In the CQI Study, 4 of the 7 correctional facilities had zero percent of their deficiencies corrected. Two more facilities had 50 percent or less. Only Allendale CI had an acceptable correction action rate of 92%. A mechanism is needed to ensure work orders generated by correctional staff are addressed and the deficiencies are actually resolved. All institutions need improvement in documenting corrective measures when there are cleanliness and temperature deficiencies.

March 2018 Implementation Panel Recommendations:

1. Operations Management ensure all prisons are performing daily inspections for cleanliness and taking temperatures of random cells;
2. Ensure deficiencies identified in the cell inspections for cleanliness and temperature checks are followed up on and the action taken is documented on the Cell Temperature and Cleanliness Logs; and
3. SCDC QIRM continue to perform QI Studies regarding Correctional Staff performing daily, random cell temperatures and cleanliness inspections.

6.h Implement a formal quality management program under which crisis intervention practices are reviewed.

Implementation Panel March 2018 Assessment: **partial compliance**

February 2018 SCDC Status Update:
See 2.b.vii.

March 2018 Implementation Panel findings: Pre-site information included the following:

CY 2018 CISP Entries through February 28, 2018
Entries in CISP Application = 315
Average Days on Crisis = 5
Average Time to CSU Placement = 41:16 (Hours:Minutes)
Average Days in CSU = 5
Average Days in Outlying Facility = 4
Active Cases = 69

Staff provided the following mental health staffing data for the BRCI:

Clinical Staffing for Area/Outpatient

Discipline	Allotted	Filled	Vacant
Clinical Supervisor – LPC(s)	1	1	0
Program Manager – LMSW	1	1	0
QMHPs	5	2	3
Mental Health Technicians	3	3	0

Psychiatry Coverage

- Dr. [redacted] 6 hours weekly (tele-psychiatry)
- Dr. [redacted] 2 hours every other week
- NP [redacted] 5 hours weekly

Psychology- None

Clinical Staffing/CSU

Discipline	Allotted	Filled	Vacant
Unit Manager	1	1	0
Mental Health Supervisor	1	1	0
QMPHs	3	1	2
Mental Health Technicians	8	4	4

Psychiatry Coverage

- Dr. [redacted] 5 hours weekly (tele-psychiatry)
- Dr, [redacted] 16 hours every other week
- Dr. [redacted] 5 hours weekly (tele-psychiatry)
- NP [redacted] 6 hours weekly (tele-psychiatry)
- Dr. [redacted] PRN (as needed)

During the morning of March 21, 2018, we observed a CSU treatment team meeting at the BRCI CSU. Dr. [redacted] attended via telepsychiatry. The treatment team was essentially led by Dr. [redacted] in a very competent manner. It appeared that this time was used for both psychiatric assessments of new admissions as well as follow-up for other CSU patients.

It was very common that CSU patients had been admitted following a self-harming event or suicide attempt which was later assessed to have been directly related to safety and security concerns or other custodial issues. Interventions within the CSU frequently involved a "therapeutic transfer" that was often only a temporary solution as evidenced by subsequent repeat CSU admissions within the next six months. Such interventions turned out to be

temporary solutions due to resource issues at the receiving institution that resulted in recommended interventions not being implemented.

The CSU at BRCI has essentially been functioning as a clearing house for the entire system in the context of admitting many inmates who have security issues that were either not being adequately addressed or perceived by the inmates as not being adequately addressed. The CSU is hampered in adequately intervening due for the following reasons:

1. The lack of a central office classification officer, who could implement appropriate interventions specific to safety concerns; and
2. Lack of timely access to specific treatment programs such as the LLBMU and the HLBMU due to waiting list issues.

It would be very helpful if the Adjustment Unit at Perry CI was moved to the BRCI, which would then serve as another resource for disposition purposes and facilitate communication with staff at the CSU.

March 2018 Implementation Panel Recommendations: Consider remedying and implementing the recommendations as summarized above.

Conclusions and Recommendations:

This Sixth Report of the IP represents its findings and recommendations as of March 23, 2018. As always we hope this report has been informative and helpful. We continue to look forward to further development of the mental health services delivery system within the South Carolina Department of Corrections and appreciate the cooperation of all parties in pursuit of adequate mental health care for inmates living in SCDC.

We recognize that the severe staffing shortages among medical, nursing, mental health and security staffs result in lack of compliance with many of the Settlement Agreement provisions in addition to SCDC policies and procedures that are not covered by the Settlement Agreement (SA) but negatively impact compliance with the SA (e.g., frequent lockdowns in general population housing units, 24-hour lockdowns in RHUs, etc.). Under such circumstances, we strongly recommend implementation of measures that would mitigate lack of compliance with the SCDC policies. The effort to place TVs in the RHUs is such an example, although thus far not a successful one since the televisions obtained months ago still have not been installed.

We have discussed with leadership staff the use of tablets in locked down settings as part such an effort in addition to an incentive program.

The enforced rule in certain prisons of inmates not being allowed to talk in the dining room is an example of a practice that instead of mitigating effects of the staffing shortages actually exacerbates

such effects. For reasons that were summarized during the exit conference it is our recommendation to rescind such a rule and/or practice. We recognized that this recommendation is outside of the confines of the Settlement Agreement and is a recommendation only.

The IP has provided its recommendations on specific items in the Settlement Agreement in this Sixth Report as well as past reports. We provided our preliminary findings at the full Exit Briefing on 3/23/18 and have provided partial preliminary reports at each of the facilities that we visited during this site visit. We continue to encourage SCDC to develop and implement their own internal processes and support systems to provide access, and monitor an adequate mental health services delivery system and quality management system. The quality management system in SCDC is complex based on the size and the requirements in the Settlement Agreement. It includes at its forefront Quality Improvement and Risk Management (QIRM), from whom the IP expects to receive the documents, reports and data requested prior to site visits, Research and Information Management (RIM), and the Division of Behavioral Health and Substance Abuse Services.

We must reemphasize, as we have throughout our site visits and during our Exit Briefings, the need for adequate resources to allow the SCDC to provide adequate mental health care and meet the requirements of the Settlement Agreement. The need for adequate resources cannot be overstated and even with some modest increases in operations staff and efforts to increase clinical staff, the deficiencies have not been corrected to the extent of providing substantial compliance in the elements of the Settlement Agreement. It is the view of the IP that fulfilling the requirements of the Settlement Agreement cannot be accomplished without there being a provision of adequate resources which have been woefully inadequate for years. The allocations that have been requested and approved, while increases, in our view based on the population and their mental health needs including the development of additional programs to address the issues of inappropriate use of segregation and restricted housing have not been alleviated. Based on our ongoing site visits, the staffing deficiencies are reflective of the SCDC's inability to provide even the very basic requirements as reflected in its policies and procedures regarding all inmates having access to out of cell time, humane conditions and appropriate mental health services.

Sincerely,

Raymond F. Patterson, MD
Implementation Panel Member

On behalf of himself and:

Emmitt Sparkman
Implementation Panel Member

Jeffrey Metzner, MD
Subject Matter Expert

Tammie M. Pope
Implementation Panel Coordinator

EXHIBIT B
IMPLEMENTATION PANEL REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
1.	**The development of a systematic program for screening and evaluating inmates to more accurately identify those in need of mental health care:**			
	a. Develop and implement screening parameters and modalities that will more accurately diagnose serious mental illness among incoming inmates at R&E with the stated goal of referring inmates to the appropriate treatment programs. Accurately determine and track the percentage of the SCDC population that is mentally ill.	HS 19.10	10/31/16 Partial compliance	10/31/16 Partial Compliance
		HS 19.07	10/31/16 Partial compliance	10/31/16 Partial Compliance
	b. The implementation of a formal quality management program under which mental health screening practices are reviewed and deficiencies identified and corrected in ongoing SCDC audits of R&E counselors;	HS 19.07	10/31/16 Partial compliance	10/31/16 Partial Compliance
	c. Enforcement of SCDC policies relating to the timeliness of assessment and treatment once an incoming inmate at R&E is determined to be mentally ill; and	HS 19.07 HS 19.10	10/31/16 Partial compliance	10/31/16 Partial Compliance
	d. Development of a program that regularly assesses inmates within the general population for evidence of developing mental illness and provides timely access to mental health care.	HS 19.07 HS 19.10	10/31/16 Noncompliance	10/31/16 Noncompliance
2.	**The development of a comprehensive mental health treatment program that prohibits inappropriate segregation of inmates in mental health crisis, generally requires improved treatment of mentally ill inmates. and substantially improves/increases mental health care facilities within SCDC:**			
	a. Access to Higher Levels of Care:			

[1] The Order components are for reference only and are to be used as references to identify those aspects of the Policies which apply to the Implementation.

EXHIBIT B
IMPLEMENTATION PANEL REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	i. Significantly increase the number of Area Mental Health inmates vis-a-vis outpatient mental health inmates and provide sufficient facilities therefore;	HS 19.04 HS 19.11	10/31/16 Noncompliance	10/31/16 Noncompliance
	ii. Significantly increase the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefore;[2]	HS 19.04, HS 19.07, HS 19.11	10/31/16 Noncompliance	10/31/16 Noncompliance
	iii. Significantly increase the number of male and female inmates receiving inpatient psychiatric services, requiring the substantial renovation and upgrade of Gilliam Psychiatric Hospital, or its demolition for construction of a new facility;	HS 19.04, HS 19.07 HS 19.09	10/31/16 Partial compliance	10/31/16 Partial Compliance
		Gilliam Construction Plan	10/31/16 Noncompliance	10/31/16 Noncompliance
	iv. Significantly increase clinical staffing at all levels to provide more mental health services at all levels of care; and	Hiring Plan attached as Exhibit E to the Settlement Agreement	10/31/16 Partial compliance	10/31/16 Partial Compliance
	v. The implementation of a formal quality management program under which denial of access to higher levels of mental health care is reviewed.	HS 19.07	10/31/16 Partial compliance	10/31/16 Partial Compliance
	b. Segregation:			
	i. Provide access for segregated inmates to group and individual therapy services;			
		OP RHU Policy _22.38 Section 3.23 H.S. 19.04	10/31/16 Noncompliance	10/31/16 Noncompliance
	ii. Provide more out-of-cell time for segregated mentally ill inmates;	HS 19.12 OP RHU Policy 22.38 Section 3.14.4 & Section 3.25	10/31/16 Noncompliance	10/31/16 Noncompliance
	iii. Document timeliness of sessions for segregated inmates with psychiatrists, psychiatric nurse practitioners, and mental health counselors and timely review of such documentation;	HS 19.04 OP RHU Policy 22.38 Section 3.15	10/31/16 Noncompliance	10/31/16 Noncompliance

[2] The Parties agree that 10-15% of male inmates and 15-20% female inmates on the mental health case load should receive Intermediate Care Services.

EXHIBIT B
IMPLEMENTATION PANEL REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	iv. Provide access for segregated inmates to higher levels of mental health services when needed;	HS 19.04 HS 19.06	10/31/16 Partial compliance	10/31/16 Partial Compliance
	v. The collection of data and issuance of quarterly reports identifying the percentage of mentally ill and non-mentally ill inmates in segregation compared to the percentage of each group in the total prison population with the stated goal of substantially decreasing segregation of mentally ill inmates and substantially decreasing the average length of stay in segregation for mentally ill inmates;	HS 19.07 OP RHU Policy 22.38 Section 1 and Section 2	10/31/16 Substantial compliance	10/31/16 Substantial compliance
	vi. Undertake significant, documented improvement in the cleanliness and temperature of segregation cells; and	To be determined	10/31/16 Noncompliance	10/31/16 Noncompliance
	vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.	HS 19.07	10/31/16 Noncompliance	10/31/16 Noncompliance
	c. Use of Force:			
	i. Development and implementation of a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness;	OP 22.01 HS 19.08	10/31/16 Noncompliance	10/31/16 Noncompliance
	ii. The plan will further require that all instruments of force, (e.g., chemical agents and restraint chairs) be employed in a manner fully consistent with manufacturer's instructions, and track such use in a way to enforce such compliance;	OP 22.01 HS 19.08	10/31/16 Partial compliance	10/31/16 Partial Compliance
	iii. Prohibit the use of restraints in the crucifix or other positions that do not conform to generally accepted correctional standards and enforce compliance;	OP 22.01 HS 19.08	10/31/16 Noncompliance	10/31/16 Noncompliance
	iv. Prohibit use of restraints for pre-determined periods of time and for longer than necessary to gain control, and track such use to enforce compliance;	OP 22.01 HS 19.08	10/31/16 Partial compliance	10/31/16 Partial Compliance
	v. The collection of data and issuance of quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs;	HS 19.07 OP Use of Force 22.01 Section 13	10/31/16 Partial compliance	10/31/16 Partial Compliance
	vi. Prohibit the use of force in the absence of a reasonably perceived immediate threat;	OP 22.01 HS 19.08	10/31/16 Noncompliance	10/31/16 Noncompliance **See addendum note 1**
	vii. Prohibit the use of crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions;	OP 22.01 HS 19.08	10/31/16 Noncompliance	10/31/16 Noncompliance

EXHIBIT B
IMPLEMENTATION PANEL REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	viii. Notification to clinical counselors prior to the planned use of force to request assistance in avoiding the necessity of such force and managing the conduct of inmates with mental illness;	OP 22.01 HS 19.08	10/31/16 Partial compliance	10/31/16 Partial Compliance
	ix. Develop a mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates;	OP 22.01 ADM 17.01 Employee Training Standards, SCDC Annual Training Plan HS 19.08	10/31/16 Partial compliance	10/31/16 Partial Compliance
	x. Collection of data and issuance of quarterly reports concerning the use-of-force incidents against mentally ill and non-mentally ill inmates; and	OP 22.01 HS 19.07	10/31/16 Partial compliance	10/31/16 Partial Compliance
	xi. The development of a formal quality management program under which use-of-force incidents involving mentally ill inmates are reviewed.	OP 22.01 HS 19.07	10/31/16 Noncompliance	10/31/16 Noncompliance
3.	**Employment of a sufficient number of trained mental health Professionals:**			
	a. Increase clinical staffing ratios at all levels to be more consistent with guidelines recommended by the American Psychiatric Association, the American Correctional Association, and/or the court-appointed monitor;	Hiring Plan attached as Exhibit E to the Settlement Agreement	10/31/16 Partial compliance	10/31/16 Partial Compliance
	b. Increase the involvement of appropriate SCDC mental health clinicians in treatment planning and treatment teams;	HS 19.05	10/31/16 Partial compliance	10/31/16 Partial Compliance
	c. Develop a training plan to give SCDC mental health clinicians a thorough understanding of all aspects of the SCDC mental health system, including but not limited to levels of care, mental health classifications, and conditions of confinement for caseload inmates;	Mental Health Training Policy Addendum	10/31/16 Partial compliance	10/31/16 Partial Compliance
	d. Develop a plan to decrease vacancy rates of clinical staff positions which may include the hiring of a recruiter, increase in pay grades to more competitive rates, and decreased workloads;	Hiring Plan attached as Exhibit E to the Settlement Agreement	10/31/16 Partial compliance	10/31/16 Partial Compliance
	e. Require appropriate credentialing of mental health counselors;	HS 19.04	10/31/16 Partial compliance	10/31/16 Partial Compliance
	f. Develop a remedial program with provisions for dismissal of clinical staff who repetitively fail audits; and	HS 19.07	10/31/16 Noncompliance	10/31/16 Partial Compliance **See addendum note 2**
	g. Implement a formal quality management program under which clinical staff is reviewed.	HS 19.07	10/31/16 Partial compliance	10/31/16 Partial Compliance

EXHIBIT B
IMPLEMENTATION PANEL REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
4.	**Maintenance of accurate, complete, and confidential mental health treatment records:**			
	a. Develop a program that dramatically improves SCDC's ability to store and retrieve, on a reasonably expedited basis:	HS 200.7		
	i. Names and numbers of FTE clinicians who provide mental health services;		10/31/16 Compliance	10/31/16 Compliance
	ii. Inmates transferred for ICS and inpatient services;		10/31/16 Partial compliance	10/31/16 Partial Compliance
	iii. Segregation and crisis intervention logs;		10/31/16 Noncompliance	10/31/16 Noncompliance
	iv. Records related to any mental health program or unit (including behavior management or self-injurious behavior programs);		10/31/16 Noncompliance	10/31/16 Noncompliance
	v. Use of force documentation and videotapes;		10/31/16 Partial compliance	10/31/16 Partial Compliance
	vi. Quarterly reports reflecting total use-of-force incidents against mentally ill and non-mentally ill inmates by institution;		10/31/16 Partial compliance	10/31/16 Partial Compliance
	vii. Quarterly reports reflecting total and average lengths of stay in segregation and CI for mentally ill and non-mentally ill inmates by segregation status and by institution;		10/31/16 Partial compliance	10/31/16 Partial Compliance
	viii. Quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution;		10/31/16 Partial compliance	10/31/16 Partial Compliance
	ix. Quality management documents; and		10/31/16 Partial compliance	10/31/16 Partial Compliance
	x. Medical, medication administration, and disciplinary records.		10/31/16 Partial compliance	10/31/16 Partial Compliance
	b. The development of a formal quality management program under which the mental health management information system is annually reviewed and upgraded as needed.	HS 19.07	10/31/16 Noncompliance	10/31/16 Partial Compliance **See addendum note 3**
5.	**Administration of psychotropic medication only with appropriate supervision and periodic evaluation:**			
	a. Improve the quality of MAR documentation;	HS 18.16	10/31/16 Noncompliance	10/31/16 Noncompliance
	b. Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs;	HS 18.16	10/31/16	10/31/16

EXHIBIT B
IMPLEMENTATION PANEL REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
			Noncompliance	Noncompliance
	c. Review the reasonableness of times scheduled for pill lines; and	HS 18.16	10/31/16 Noncompliance	10/31/16 Noncompliance
	d. Develop a formal quality management program under which medication administration records are reviewed.	HS 18.16	10/31/16 Noncompliance	10/31/16 Noncompliance
6.	**A basic program to identify. treat, and supervise inmates at risk for suicide:**			
	a. Locate all CI cells in a healthcare setting;	HS 19.03 OP RHU 22.38 Section 3.39	10/31/16 Noncompliance	10/31/16 Noncompliance
	b. Prohibit any use for CI purposes of alternative spaces such as shower stalls, rec cages, holding cells, and interview booths;	HS 19.03 OP RHU 22.38 Section 3.39	10/31/16 Partial compliance	10/31/16 Partial Compliance
	c. Implement the practice of continuous observation of suicidal inmates;	HS 19.03	10/31/16 Partial compliance	10/31/16 Partial Compliance
	d. Provide clean, suicide-resistant clothing, blankets, and mattresses to inmates in CI;	HS 19.03	10/31/16 Partial compliance	10/31/16 Partial Compliance
	e. Increase access to showers for CI inmates;	HS 19.03	10/31/16 Partial compliance	10/31/16 Partial Compliance
	f. Provide access to confidential meetings with mental health counselors, psychiatrists, and psychiatric nurse practitioners for CI inmates;	HS 19.03	10/31/16 Noncompliance	10/31/16 Noncompliance
	g. Undertake significant, documented improvement in the cleanliness and temperature of CI cells; and	HS 19.03	10/31/16 Noncompliance	10/31/16 Noncompliance
	h. Implement a formal quality management program under which crisis intervention practices are reviewed.	HS 19.03	10/31/16 Partial compliance	10/31/16 Partial Compliance

SEE NEXT PAGE FOR MEDIATOR'S ADDENDUM:

EXHIBIT B
IMPLEMENTATION PANEL REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES

1) The Settlement Agreement incorporates provisions from Judge Baxley's Order specifically delineating the requirement that use of force is prohibited in the absence of a reasonably perceived immediate threat. See Settlement Agreement, Provision 4(g)("The components of the Remedial Plan shall consist of each subpart as identified in the Implementation Report"); See Exhibit B, Implementation Report, subsection 2(c)(vi), incorporating this provision. The current version of the Use of Force policy does not specifically delineate the threshold requirement that use of force is prohibited in the absence of a reasonably perceived immediate threat. It would appear this could be easily added as a threshold requirement to the Policy.
2) The Remedial Plan constitutes a first step towards the development of a program and compliance, although, as the IP has indicated, implementation of a properly working program is necessary to obtain Substantial Compliance.
3) The approved policy HS 19.07 constitutes a first step toward compliance, although, as the IP has indicated, implementation of a properly working program is necessary to obtain Substantial Compliance.

MEDIATOR REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES
MARCH 2018 IP ASSESSMENT

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
1.	**The development of a systematic program for screening and evaluating inmates to more accurately identify those in need of mental health care:**			
	a. Develop and implement screening parameters and modalities that will more accurately diagnose serious mental illness among incoming inmates at R&E with the stated goal of referring inmates to the appropriate treatment programs. Accurately determine and track the percentage of the SCDC population that is mentally ill.	HS 19.10	03/23/18 Partial compliance	12/08/17 Partial Compliance
		HS 19.07	03/23/18 Partial compliance	12/08/17 Partial Compliance
	b. The implementation of a formal quality management program under which mental health screening practices are reviewed and deficiencies identified and corrected in ongoing SCDC audits of R&E counselors;	HS 19.07	03/23/18 Partial compliance	12/08/17 Partial Compliance
	c. Enforcement of SCDC policies relating to the timeliness of assessment and treatment once an incoming inmate at R&E is determined to be mentally ill; and	HS 19.07 HS 19.10	03/23/18 Partial compliance	12/08/17 Partial Compliance
	d. Development of a program that regularly assesses inmates within the general population for evidence of developing mental illness and provides timely access to mental health care.	HS 19.07 HS 19.10	03/23/18 Partial compliance	12/08/17 Partial Compliance

[1] The Order components are for reference only and are to be used as references to identify those aspects of the Policies which apply to the Implementation.

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
2.	**The development of a comprehensive mental health treatment program that prohibits inappropriate segregation of inmates in mental health crisis, generally requires improved treatment of mentally ill inmates. and substantially improves/increases mental health care facilities within SCDC:**			
	a. Access to Higher Levels of Care:			
	i. Significantly increase the number of Area Mental Health inmates vis-a-vis outpatient mental health inmates and provide sufficient facilities therefore;	HS 19.04 HS 19.11	03/23/18 Partial compliance	12/08/17 Partial compliance
	ii. Significantly increase the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefore;[2]	HS 19.04, HS 19.07, HS 19.11	03/23/18 Partial compliance	12/08/17 Partial compliance
	iii. Significantly increase the number of male and female inmates receiving inpatient psychiatric services, requiring the substantial renovation and upgrade of Gilliam Psychiatric Hospital, or its demolition for construction of a new facility;	HS 19.04, HS 19.07 HS 19.09	03/23/18 Partial compliance	12/08/17 Partial Compliance
		Gilliam Construction Plan	03/23/18 Partial compliance	12/08/17 Partial Compliance
	iv. Significantly increase clinical staffing at all levels to provide more mental health services at all levels of care; and	Hiring Plan attached as Exhibit E to the Settlement Agreement	03/23/18 Partial compliance	12/08/17 Partial Compliance
	v. The implementation of a formal quality management program under which denial of access to higher levels of mental health care is reviewed.	HS 19.07	12/08/17 Substantial compliance (7/14/17)	12/08/17 Substantial Compliance
	b. Segregation:			
	i. Provide access for segregated inmates to group and individual			

[2] The Parties agree that 10-15% of male inmates and 15-20% female inmates on the mental health case load should receive Intermediate Care Services.

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	therapy services;			
		OP RHU Policy _22.38 Section 3.23 H.S. 19.04	03/23/18 Partial compliance	12/08/17 Partial Compliance
	ii. Provide more out-of-cell time for segregated mentally ill inmates;	HS 19.12 OP RHU Policy 22.38 Section 3.14.4 & Section 3.25	03/23/18 Partial compliance	12/08/17 Noncompliance
	iii. Document timeliness of sessions for segregated inmates with psychiatrists, psychiatric nurse practitioners, and mental health counselors and timely review of such documentation;	HS 19.04 OP RHU Policy 22.38 Section 3.15	03/23/18 Noncompliance	12/08/17 Partial Compliance
	iv. Provide access for segregated inmates to higher levels of mental health services when needed;	HS 19.04 HS 19.06	03/23/18 Partial compliance	12/08/17 Partial Compliance
	v. The collection of data and issuance of quarterly reports identifying the percentage of mentally ill and non-mentally ill inmates in segregation compared to the percentage of each group in the total prison population with the stated goal of substantially decreasing segregation of mentally ill inmates and substantially decreasing the average length of stay in segregation for mentally ill inmates;	HS 19.07 OP RHU Policy 22.38 Section 1 and Section 2	03/23/18 Substantial compliance (11/16)	12/08/17 Substantial compliance (11/16)
	vi. Undertake significant, documented improvement in the cleanliness and temperature of segregation cells; and	To be determined	03/23/18 Partial compliance	12/08/17 Partial Compliance
	vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.	HS 19.07	03/23/18 Partial compliance	12/08/17 Partial compliance
	c. Use of Force:			
	i. Development and implementation of a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness;	OP 22.01 HS 19.08	03/23/18 Partial compliance	12/08/17 Partial Compliance
	ii. The plan will further require that all instruments of force, (e.g., chemical agents and restraint chairs) be employed in a manner fully consistent with manufacturer's instructions, and track such use in a way to enforce such compliance;	OP 22.01 HS 19.08	03/23/18 Partial compliance	12/08/17 Partial Compliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	iii. Prohibit the use of restraints in the crucifix or other positions that do not conform to generally accepted correctional standards and enforce compliance;	OP 22.01 HS 19.08	03/23/18 Substantial compliance (7/14/17)	12/08/17 Substantial Compliance
	iv. Prohibit use of restraints for pre-determined periods of time and for longer than necessary to gain control, and track such use to enforce compliance;	OP 22.01 HS 19.08	03/23/18 Substantial compliance	12/08/17 Partial Compliance
	v. The collection of data and issuance of quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs;	HS 19.07 OP Use of Force 22.01 Section 13	03/23/18 Substantial compliance 12/08/17	12/08/17 Substantial Compliance
	vi. Prohibit the use of force in the absence of a reasonably perceived immediate threat;	OP 22.01 HS 19.08	03/23/18 Partial compliance	12/08/17 Partial Compliance
	vii. Prohibit the use of crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions;	OP 22.01 HS 19.08	03/23/18 Partial compliance	12/08/17 Partial Compliance
	viii. Notification to clinical counselors prior to the planned use of force to request assistance in avoiding the necessity of such force and managing the conduct of inmates with mental illness;	OP 22.01 HS 19.08	03/23/18 Partial compliance	12/08/17 Partial Compliance
	ix. Develop a mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates;	OP 22.01 ADM 17.01 Employee Training Standards, SCDC Annual Training Plan HS 19.08	03/23/18 Partial compliance	12/08/17 Partial Compliance
	x. Collection of data and issuance of quarterly reports concerning the use-of-force incidents against mentally ill and non-mentally ill inmates; and	OP 22.01 HS 19.07	03/23/18 Substantial compliance (03/03/17)	12/08/17 Substantial Compliance
	xi. The development of a formal quality management program under which use-of-force incidents involving mentally ill inmates are reviewed.	OP 22.01 HS 19.07	03/23/18 Partial compliance	12/08/17 Partial Compliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
3.	**Employment of a sufficient number of trained mental health Professionals:**			
	a. Increase clinical staffing ratios at all levels to be more consistent with guidelines recommended by the American Psychiatric Association, the American Correctional Association, and/or the court-appointed monitor;	Hiring Plan attached as Exhibit E to the Settlement Agreement	03/23/18 Noncompliance	12/08/17 Partial Compliance
	b. Increase the involvement of appropriate SCDC mental health clinicians in treatment planning and treatment teams;	HS 19.05	03/23/18 Partial compliance	12/08/17 Partial Compliance
	c. Develop a training plan to give SCDC mental health clinicians a thorough understanding of all aspects of the SCDC mental health system, including but not limited to levels of care, mental health classifications, and conditions of confinement for caseload inmates;	Mental Health Training Policy Addendum	03/23/18 Substantial compliance	12/08/17 Partial Compliance
	d. Develop a plan to decrease vacancy rates of clinical staff positions which may include the hiring of a recruiter, increase in pay grades to more competitive rates, and decreased workloads;	Hiring Plan attached as Exhibit E to the Settlement Agreement	03/23/18 Substantial compliance 12/08/17	12/08/17 Substantial Compliance
	e. Require appropriate credentialing of mental health counselors;	HS 19.04	03/23/18 Substantial compliance (03/03/17)	12/08/17 Substantial Compliance
	f. Develop a remedial program with provisions for dismissal of clinical staff who repetitively fail audits; and	HS 19.07	03/23/18 Partial compliance	12/08/17 Partial Compliance
	g. Implement a formal quality management program under which clinical staff is reviewed.	HS 19.07	03/23/18 Partial compliance	12/08/17 Partial Compliance
4.	**Maintenance of accurate, complete, and confidential mental health treatment records:**			
	a. Develop a program that dramatically improves SCDC's ability to store and retrieve, on a reasonably expedited basis:	HS 200.7		
	i. Names and numbers of FTE clinicians who provide mental health services;		03/23/18 Substantial compliance (03/03/17)	12/08/17 Substantial Compliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	ii. Inmates transferred for ICS and inpatient services;		03/23/18 Substantial Compliance (7/14/17)	12/08/17 Substantial Compliance
	iii. Segregation and crisis intervention logs;		03/23/18 Partial compliance	12/08/17 Partial Compliance
	iv. Records related to any mental health program or unit (including behavior management or self-injurious behavior programs);		03/23/18 Partial compliance	12/08/17 Partial Compliance
	v. Use of force documentation and videotapes;		03/23/18 Substantial compliance (03/03/17)	12/08/17 Substantial Compliance
	vi. Quarterly reports reflecting total use-of-force incidents against mentally ill and non-mentally ill inmates by institution;		03/23/18 Substantial compliance (03/03/17)	12/08/17 Substantial Compliance
	vii. Quarterly reports reflecting total and average lengths of stay in segregation and CI for mentally ill and non-mentally ill inmates by segregation status and by institution;		03/23/18 Substantial compliance (03/03/17)	12/08/17 Substantial Compliance
	viii. Quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution;		03/23/18 Substantial compliance (03/03/17)	12/08/17 Substantial Compliance
	ix. Quality management documents; and		03/23/18 Partial compliance	12/08/17 Partial Compliance
	x. Medical, medication administration, and disciplinary records.		03/23/18 Partial compliance	12/08/17 Partial Compliance
	b. The development of a formal quality management program under which the mental health management information system is annually reviewed and upgraded as needed.	HS 19.07	03/23/18 Partial compliance	12/08/17 Partial Compliance
5.	**Administration of psychotropic medication only with appropriate supervision and periodic evaluation:**		03/23/18 Noncompliance	

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	a. Improve the quality of MAR documentation;	HS 18.16	03/23/18 Partial compliance	12/08/17 Partial Compliance
	b. Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs;	HS 18.16	03/23/18 Noncompliance	12/08/17 Noncompliance
	c. Review the reasonableness of times scheduled for pill lines; and	HS 18.16	03/23/18 Noncompliance	12/08/17 Noncompliance
	d. Develop a formal quality management program under which medication administration records are reviewed.	HS 18.16	03/23/18 Partial compliance	12/08/17 Partial Compliance
6.	**A basic program to identify. treat, and supervise inmates at risk for suicide:**			
	a. Locate all CI cells in a healthcare setting;	HS 19.03 OP RHU 22.38 Section 3.39	03/23/18 Partial compliance	12/08/17 Partial Compliance
	b. Prohibit any use for CI purposes of alternative spaces such as shower stalls, rec cages, holding cells, and interview booths;	HS 19.03 OP RHU 22.38 Section 3.39	03/23/18 Substantial compliance 12/08/17	12/08/17 Substantial Compliance
	c. Implement the practice of continuous observation of suicidal inmates;	HS 19.03	03/23/18 Partial compliance	12/08/17 Partial Compliance
	d. Provide clean, suicide-resistant clothing, blankets, and mattresses to inmates in CI;	HS 19.03	03/23/18 Partial compliance	12/08/17 Partial Compliance
	e. Increase access to showers for CI inmates;	HS 19.03	03/23/18 Partial compliance	12/08/17 Noncompliance
	f. Provide access to confidential meetings with mental health counselors, psychiatrists, and psychiatric nurse practitioners for CI inmates;	HS 19.03	03/23/18 Partial compliance	12/08/17 Noncompliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	g. Undertake significant, documented improvement in the cleanliness and temperature of CI cells; and	HS 19.03	03/23/18 Partial compliance	12/08/17 Partial Compliance
	h. Implement a formal quality management program under which crisis intervention practices are reviewed.	HS 19.03	03/23/18 Partial compliance	12/08/17 Noncompliance

South Carolina Department of Corrections
Implementation Panel Report of Compliance
July 2018

Executive Summary

The South Carolina Department of Corrections (SCDC) has continued to have substantial difficulties in meeting the requirements of the Settlement Agreement. This report of the Implementation Panel (IP) will provide our review and analysis of the status of compliance based on our review of documents provided, our onsite visits to SCDC facilities from July 12-16, 2018, and discussions and technical assistance to the SCDC since our last Implementation Panel visit from March 19-23, 2018.

There was a major and extremely serious incident, the riot at Lee Correctional Institution on April 15, 2018 in which seven inmates were killed and twenty two inmates were seriously injured by other inmates. The SCDC facilities went on statewide lockdown following the riot and the subsequent management of the facilities and inmates, as well as the debriefing and assistance to both inmates and staff, are continuing.

During this on site review and analysis the IP spent significant time and effort to review the responses to the riot and the impact on both staff and inmates. The lockdown has had substantial impact on the delivery of mental health services, and compliance with the requirements of the Settlement Agreement have been impacted; however there have been significant efforts by SCDC administration, operations and clinical staff at specific facilities to restore mental health services, despite the continuing staff and other resource deficiencies that existed before the riot.

While SCDC has not demonstrated compliance with the great majority of requirements, the efforts to restore those services that were being provided, the efforts specific to particular facilities and the continuing necessary contributions by mental health leadership and the Quality Improvement Risk Management (QIRM) components, as well as collaboration with Operations must be acknowledged by the IP. In those facilities in which the lockdown restrictions have been reduced or eliminated for mentally ill inmates, progress has been demonstrated; for those in which the lockdown has continued, the impact has contributed to fewer and inadequate services and noncompliance with the Settlement Agreement. The longer mentally ill inmates are on lockdown status, the lack of necessary treatment and more harm is highly likely.

There have been some facilities that have discontinued the lockdown of inmates, largely contributing to the health and welfare of mentally ill inmates. Specific events include the first graduation of inmates in the High Level Behavioral Management Unit (HLBMU), and mixed success with the mass transfer of approximately 180 female inmates from Camille Graham C.I. to Leath C.I., which appears to have been beneficial in reducing the population at CGCI (along with very necessary increases in psychiatric and nursing staffing) but adversely impacted an already short-staffed clinical and security staff at Leath C.I. Further, this mass movement of inmates on the mental health caseload did not include time and notice to provide transition/termination for at least 60 female inmates on the mental health caseload which is very necessary for inmates who were in active treatment with mental health staff and/or had long term relationships with staff and inmates. These issues are necessarily important and impacted mental health care and stability for inmates and staff during the earlier mass movement of Level 3-Area Mental Health/enhanced outpatient care from various institutions to Broad River C.I. which, while well intended, was not well coordinated between staff to facilitate transition/termination for inmates actively engaged in treatment and/or other programs including Character Dorms/Programs.

The entire SCDC system continues to be understaffed by security and mental health, medical and nursing staff. There are ongoing efforts for recruitment and retention of staff. The recent increases in salaries for

psychiatrists have had a very positive impact; the clarifications that the parties agreed on hiring and retaining licensed mental health professionals by a date certain must be understood and re-enforced by SCDC; and the acknowledged necessity for adequate numbers of qualified nursing staff and medical staff to support and supplement the mental health staff are non-negotiable in order to achieve compliance with the provisions of the Settlement Agreement. Concurrently, the acknowledged necessity for adequate numbers of trained and supervised operations/corrections staff is vitally required for management of the facilities for basic requirements and support of the clinical staff. The Implementation Panel has reported these ongoing concerns at every site visit and in every report.

The IP has consistently reported our grave concerns regarding the inadequate staffing at SCDC. This a longstanding problem, and as with many systems, it has adversely impacted mental health care and resulted in associated lockdowns/segregation and uses of force, including chemical and physical restraints. The more recent efforts to recruit and retain clinical staff has resulted in some improvement at specific facilities or programs. However the critical shortages in nursing staff and inconsistencies with coverage by agency nurses continues with unacceptable medication management practices which the IP has previously reported.

Despite efforts to recruit and retain security staff, the security staffing remains inadequate to support the basic policy and procedural requirements and further compromises the adequate delivery of mental health services, as well as compliance with the Settlement Agreement. The following information summarizes the security staffing concerns and deficiencies.

Concerns

- The SCDC increased dollars for Security Staffing has not been successful in reducing correctional officer vacancies:

Additional Dollars* for Security Staffing
Fiscal Years 2013 – 2018

FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	Total
$1,899,103	$1,295,537	$2,552,804	$3,722,509	$16,979,426	$22,331,031	$48,780,410

*Includes overtime, spot bonuses, raises and others.

Historical Correctional Officer Starting Salary

Fiscal Year	LEVEL 1 (Min. Security)	LEVEL 2 (Med. Security)	LEVEL 3 (Max. Security)	Weighted Average (All Levels)
2014	$25,060	$26,062	$27,897	$26,826
2015	$25,561	$26,583	$28,438	$27,377
2016	$25,561	$26,583	$28,438	$27,384
2017	$27,891	$28,913	$30,768	$29,560
2018	$31,263	$32,560	$34,596	$33,289
2019	$32,263	$33,560	$35,596	$34,311
FY14 - FY19 Increase (%)	$7,203 (28.7%)	$7,498 (28.8%)	$7,699 (27.6%)	$7,485 (27.9%)

Filled Frontline Security Positions*

January 1, 2017	January 1, 2018	July 1, 2018
1,732	1,805	1,795

*cadets, correctional officers and corporals.

The overall average starting salary for correctional officers in FY2018 was $33,289. With overtime, eligible correctional officers earned $41,964.

- On Duty Correctional Staff for Day and Night Shifts are routinely less than 50 percent of the authorized staffing-Shortages are at critical levels for a number of institutions;
- Even prior to the Agency System-Wide Lockdown most Level 2 and 3 Institutions are locked down from 7p to 7a daily;
- Correctional Officer Staff vacancies prevent SCDC from providing even the basic services in the Restrictive Housing Units and General Population;
- When food is served to inmates in their housing units, temperatures are not checked after the food leaves the food service department. Numerous inmates complained about the food being served cold and frequently meals were not served at the scheduled times;
- Correctional Staff continue to deny showers, recreation and other privileges for minor violations without due process;
- The RHU Policy for Behavior Levels and Step Down Programs Policy has not been fully implemented and the programs have been revised without policy changes;
- The Agency has a Lockdown Lift Plan; however, the plan has not prioritized releasing inmates in designated mental health housing units from the lockdown where possible.

Improvement or Potential for Improvement:

- SCDC is making progress ensuring RHUs have televisions and each inmate in RHU receives a crank radio;
- Crank Radios are not taken from RHU inmates unless the inmate commits a rule violation;
- SCDC is preparing RFP to purchase tablets for use by inmates ;
- Perry CI has begun providing RHU inmates outside recreation 1 to 2 times per week;
- Lieber CI Leadership has demonstrated inmate medication can be properly distributed even with critical staffing shortages;
- SCDC was receptive to developing a strategy that in the near future would remove all inmates from RHU on Security Detention with a Mental Health Designation Level 1, 2, or 3.

SCDC is highly unlikely, if not completely unable, to achieve substantial compliance with the Settlement Agreement and the provision of constitutionally adequate and required mental health care without major and consistent increases in staffing and resources and/or major reductions in the numbers of inmates housed in SCDC facilities. In calendar year 2018 there have been six completed suicides in SCDC facilities including one in the Crisis Intervention Program at Broad River C.I., which is specifically designed to treat and mange inmates who are at increased risk for self-harm and/or suicide.

Despite these challenges and deficiencies, the SCDC administration has reduced or removed the lockdown restrictions at several facilities and the IP has encouraged all facilities visited to provide proposals to the administration for the transition of mentally ill inmates to receive required services and for all inmates to be provided education and community/town hall meetings to keep them and staff informed. Several wardens and their staff, supported by regional directors and central administration, are clearly trying to provide the services they can, given the long term staff deficiencies and needs for policy/procedures revisions, training and supervision.

As Exhibit B illustrates, the Implementation Panel determined the following levels of compliance:

1. Substantial Compliance---18
2. Partial Compliance---34
3. Non-Compliance---8

The assessments, reviews and recommendations of the IP are detailed in this report. The IP is deeply concerned and has communicated its distress at the problematic progress of SCDC in meeting the requirements of the Settlement Agreement, while it also acknowledges the sincere and progressive efforts made in facilities by leadership staff to provide what they can despite these ongoing deficiencies. SCDC has over time begun to implement a number of programs including the Crisis Stabilization Unit (CSU), High and Low Level Behavioral Management Units (HLBMU, LLBMU), Step Down units and enhancements for the Gilliam Psychiatric Hospital (GPH) and Intermediate Care Services (ICS) with plans to open a "Choices" program at the ICS level, and has progressed in identification of inmates who require mental health services (currently 18-19% of the population). Unfortunately, all of these programs are maxing out/reaching or are past capacity and require resources to provide required services. The resource deficiencies in security, mental health, nursing, and medical services as well as space limitations and lockdowns preventing adequate service provision, including medication management, timely assessments and treatment and security support greatly impact the ability to provide adequate and required services and compliance with the provisions of the Settlement Agreement.

The development of a systematic program for screening and evaluating inmates to more accurately identify those in need of mental health care:
1.a. Develop and implement screening parameters and modalities that will more accurately diagnose serious mental illness among incoming inmates at R&E with the stated goal of referring inmates to the appropriate treatment programs.

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
On June 2, 2018, one hundred eighty (180) women were transferred from Camille to Leath to allow Camille to clear R&E within acceptable time frames. Leath's nursing hours of operation have been extended from 7:00 AM to 10:00 PM daily. Health Services leaders are currently considering extending hours to 24/7 to relieve the backlog at Camille's R&E.

While SCDC inmates with mental health issues are not identified at as high a rate as nationwide averages, SCDC has made steady progress at identifying mentally ill inmates as they enter the Reception and Evaluation program areas. Both Camille Graham R&E and Kirkland R&E have shown notable improvement with administering mental health screenings in a timely fashion. Camille Graham's R&E has made continual efforts at identification with its steadily increasing rate of QMHPs evaluating Routine referrals in a timely manner, as well as its overall change over time in evaluating Urgent referrals by QMHPs. Kirkland R&E has also demonstrated improvement with identifying Routine referrals; however, more progression is required to adequately assess and evaluate inmates who are referred on an Urgent basis. Efforts have been made to better code and track Emergent referrals since the March IP visit. Graham R&E faces difficulties in completing psychiatric follow-ups within the required timeframes for its Routine referrals, since most of the second follow-up evaluations tend to be Routine to the psychiatrist. Kirkland continues to demonstrate major improvement in assessing routine referrals to the QMHP within the required timeframe for the months and assessing Routine referrals to the psychiatrist. There is room for growth for both institutions to better manage and/or track Emergent referrals.

A new psychiatrist joined the Camille R&E staff June 11, 2018 to aid in the psychiatric services provided to inmates in R&E.

Planned Actions

1. Kirkland R&E staff and Graham R&E manager and Lead QMHP have begun implementing a new method of tracking and logging Emergent referrals. Additionally, monthly monitoring will continue to occur by the Division's Quality Assurance department.

The tables below provide information in regard to R&E timeframes for Camille R&E and Kirkland R&E for the months of February through May. Attention was given to average length of stay, median length of stay, average number of days from intake to screening, and mental health screenings, routine referrals, urgent referrals, and emergent referrals completed within mandated timeframes. For the complete study, refer to Appendix A.

Graham R&E	February	March	April	May
Average Length of Stay (days)	53.5	45.8	44.2	43.3
Median Length of Stay (days)	56	41	47.5	39
Average # of days from intake to screening	2.3	2.6	2.8	1.3
MH screening completed within mandated timeframe (=m), (n = total; m/n *100 = %)	(n =28; m=26) 92.9%	(n =29; m=25) 86.2%	(n =12; m=11) 91.7%	(n =33; m=33) 100.0%
Routine referrals completed within mandated timeframe	(n =17; m=15) QMHP = 88.2% (n =28; m=14) Psychiatry = 50.0%	(n =14; m =14) QMHP = 100% (n =29; m=2) Psychiatry = 6.9%	(n =5; m =5) QMHP = 100% (n =12; m=2) Psychiatry = 16.7%	(n =13; m =13) QMHP = 100% (n =33; m=23) Psychiatry = 69.7%
Urgent referrals completed within mandated timeframe	(n =9; m=5) QMHP = 55.6% (n =0) Psychiatry	(n =10; m=6) QMHP = 60.0% (n =0) Psychiatry	(n =5; m=2) QMHP = 40.0% (n =0) Psychiatry	(n =11; m =5) QMHP = 45.5% (n =0) Psychiatry
Emergent referrals* completed within mandated timeframe	(n =2; m=1) QMHP = 50.0% (n =0) Psychiatry	(n = 0) QMHP (n =0) Psychiatry	(n = 2; m=0) QMHP = 0% (n =0) Psychiatry	(n = 9; m=4) QMHP = 44.4% (n =0) Psychiatry

Kirkland R&E	February	March	April	May
Average Length of Stay (days)	61.2	63.7	56.2	66.2
Median Length of Stay (days)	62	59	55	64
Average # of days from intake to screening	3.2	3.3	3.2	3.6
MH screening completed within mandated timeframe (=m), (n = total; m/n *100 = %)	(n =40; m=32) 80.0%	(n =42; m=35) 83.3%	(n =61; m=57) 93.4%	(n =53; m=45) 84.9%
Routine referrals completed within mandated timeframe	(n =37; m=23) QMHP = 62.2% (n =39; m=20) Psychiatry = 51.3%	(n = 39; m=35) QMHP = 89.7% (n = 42; m=34) Psychiatry = 81.0%	(n=52; m= 51) QMHP = 98.1% (n = 58; m=54) Psychiatry = 93.1%	(n=41; m= 41) QMHP = 100.0% (n = 51; m=46) Psychiatry = 90.2%
Urgent referrals completed within mandated timeframe	(n =3; m =2) QMHP = 66.7% (n=1; m =1) Psychiatry =100%	(n = 2; m=0) QMHP= 0% (n = 0) Psychiatry	(n=6; m=3) QMHP = 50.0% (n =3; m = 3) Psychiatry = 100%	(n=7; m=6) QMHP = 85.7% (n =2; m = 1) Psychiatry = 50.0%
Emergent referrals* completed within mandated timeframe	(n = 0) QMHP (n =0) Psychiatry	(n = 0) QMHP (n =0) Psychiatry	(n=2; m=2) QMHP = 100% (n =0) Psychiatry	(n = 0) QMHP (n =0) Psychiatry

July 2018 Implementation Panel findings: As per status update section. Problems in meeting relevant timelines were related to mental health and correctional staffing allocations/vacancies. Tracking response times to emergent referrals continues to be problematic.

July 2018 Implementation Panel Recommendations: Our December 2017 recommendations essentially remain unchanged and are as follows:

1. Continue to QI the relevant timeframes.
2. Adequately address the mental health and correctional staffing vacancies.

1.a.i. Accurately determine and track the percentage of the SCDC population that is mentally ill

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

Tracking

To track the percentage of mentally ill inmates, the Division of Resources and Information Management (RIM) generates a report entitled *Mental Health Classifications for the Mentally Ill Institutional Population*. This report includes:

- the numbers of mentally ill inmates by classification,
- the percentage of mentally ill by classification as a percent of the mentally ill population, and the percent of mentally ill inmates as a percentage of the total population.

The most recent reports, shows that of SCDC's 19,111 inmates, 3,722 or 19.5% are classified as mentally ill.

Mental Health Classifications for Mentally Ill Institutional and Female GEO Care Population on June 18, 2018

SCDC Institutional and Female GEO Care Population = 19,111
SCDC Mentally Ill Population = 3,722

Mental Health Classification	Female	Male	Total	Percent of Mentally Ill Population	Percent of Total Population
Missing	21	377	398	N/A	2.08%
BL	0	17	17	.457%	.089%
BU	0	18	18	.484%	.094%
L1	3	79	82	2.20%	.429%
L2	15	161	176	4.73%	.921%
L3	71	232	303	8.14%	1.59%
L4	578	2,370	2,948	79.2%	15.4%
L5	46	113	159	4.27%	.832%
MR	2	17	19	.510%	.099%

The screenshots above were created from the **June 18, 2018** RIM reports. The full reports are attached as Appendices B (Word) and C (Excel).

Identifying Inmates in the Population

An analysis of data was done to compare the percentage of mentally ill inmates who transferred out of SCDC's two R&E centers to the percentage of the total population that is classified as mentally ill to the total number of inmates who ended up on the MH caseload. The theory is that if there is a higher percent of the total population that is mentally ill than what transfers from R&E, then it follows that inmates whose diagnoses were missed at R&E or who develop mental illness after leaving R&E are indeed being picked up through the current processes and added into the mental health caseload.

Historically, if an inmate in the general population and inmates in segregation needed mental health care, they could be self-referred through sick call or referred by medical or other SCDC staff members, as well as by family or other outside sources. However, it was noted that this was sometimes a cumbersome process, as inmates were being told to sign up on sick call, and at times, it was weeks or months before they were evaluated by the QMHP. An effort has been made by the Div. Behavioral and Mental Health Services to ensure inmates referred for evaluation are seen more timely, even if they do not go through sick call. The Division has also initiated routine mental health rounding in the segregation units over the past two years, which not only helps to pick up on decompensating inmates, but it is felt that this type of interaction may help avert an inmate from decompensating into mental illness. Furthermore, in February 2017, the Division began doing annual screening of inmates who were not on the caseload to determine if mental health services were indicated.

This latest practice (annual screening) has not resulted in any significant increase in the caseload and was therefore discontinued after a year's trial. This review will show the overall effectiveness of SCDC's existing methods, even though the data will not identify exactly how/why each case was added to the caseload.

Overall findings for October 2017 – March 2018 are that between 25-50% (mean 37.2%) of the inmates transferring out of Camille Graham R&E were on the caseload, while 49-53% (mean 51.0%) of the agency's total female population was on the caseload, a difference of 13.8%.

Regarding the male inmates, findings for October 2017 – March 2018 are that between 10-12% (mean 11.7%) of the inmates transferring out of Kirkland R&E were on the caseload, while 15-16% (mean 15.6%) of the agency's total male population was on the caseload, a difference of 3.9%.

Overall findings are that inmates who leave R&E with no mental health classification but who later need mental health services are indeed being identified through the existing processes. From October through March, the female inmates have been identified at a higher rate (average 13.8%) than the males (average 3.9%). This data has been forwarded to the Division Director for his analysis to help determine if the current processes are adequate or if some other means of identifying inmates in the non-R&E population who need services should be considered.

July 2018 Implementation Panel findings: As per status update section. Significant improvement is noted.

July 2018 Implementation Panel Recommendations:

1. Continue to track the statistics relevant to this Settlement Agreement provision.
2. Perform a QI study to assess whether inmates admitted during past 12 twelve months, who were not placed on the mental health caseload in R&E but were currently on the mental health caseload, should have been placed on the mental health caseload while in R&E.

1.b. The implementation of a formal quality management program under which mental health screening practices are reviewed and deficiencies identified and corrected in ongoing SCDC audits of R&E counselors;

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

The Division of Behavioral/Mental Health & Substance Abuse Services (BMHSAS) has implemented a review process of the Mental Health R&E Counselors to determine the appropriateness of cases being triaged as outlined in policy. This review entails a detailed overview of two cases (at a minimum) from each counselor conducting evaluations during the reporting period. The findings from the review are outlined as follows:

Follow-up findings from R&E Audit (Camille Graham & Kirkland)

- Sixteen total cases reviewed.
- 9/16 cases reviewed did not present any documentation or clinical issues.
- One case reviewed (375551) documentation was limited and did not included on C-SSRS findings.
- One case reviewed (375641) MEDCLASS was entered incorrectly as NMH instead of L4.
- One case reviewed (359772) inmate was not med-classed as NMH; however, documentation supports inmate should be included as a L5.
- One case reviewed (323759) notated disruption between prescribed medication for inmate between admission to CSU and return back to R&E.
- One case reviewed (1981470) inmate was med- classed as L3 but documentation supported needing a higher level of care.
- Although emergent referrals are being notated by QMHP at both Kirkland and Camille Graham, documentation is not clear regarding the referral process to the Psychiatrist or if the referral type has changed from emergent to urgent or routine.

Findings was forwarded to R&E MH Managers at Camille Graham and Kirkland for appropriate follow-up. R&E staff were required to sign receipt, review and when applicable correction of findings.

A detailed analysis of the institutional audits is included as Appendix D.

July 2018 Implementation Panel findings: As per status update section. Partial compliance is assessed due to the absence of data relevant to follow-up and effectiveness of corrective action.

July 2018 Implementation Panel Recommendations: Continue to monitor via a QI process. Refer to the previous provision's recommendation.

1.c. Enforcement of SCDC policies relating to the timeliness of assessment and treatment once an incoming inmate at R&E is determined to be mentally ill;

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

It is intended that the inmates who arrive at the Reception & Evaluation center (R&E) of the South Carolina Department of Corrections (SCDC) will be transferred to their assigned institutions no more than 30 days after their admission. For inmates who are identified as mentally ill (MI) through the R&E screening processes and who remain over 30 days in R&E, it is the goal of SCDC to ensure that those inmates are receiving adequate and appropriate mental health services to meet their needs. The study seeks to identify whether MI inmates – as identified from mental health screenings and evaluations – who do not transfer from R&E to their institutions in a timely manner, are still afforded the following services while at the R&E Centers:

- receive continual and consistent mental health care;
- have access to QMHP and psychiatrist follow-ups as clinically indicated;
- receive their psychotropic medications prescribed by the psychiatrist;
- have a treatment plan developed; and
- attend group therapy.

Methodology used in the Study

The sample size for this study consisted of all the inmates classified as mentally ill who remained at Camille Griffin Graham Correctional Institution's R&E and Kirkland Correctional Institution's R&E for more than 30 days. Information was gathered on those inmates who ended up on the caseload after their initial mental health screenings and evaluations for February, March, April, and May. Information was pulled from RIM generated reports for all R&E removals each month, excluding those who were released within 90 days, to determine which inmates remained in R&E over 30 days before transferring to another institution. Also, clinical chart reviews were conducted to obtain the required data regarding services received by inmates.

Results:

Graham R&E	February	March	April	May
Total MI Inmates Removed from R&E	28	29	12	33
Total # MI Inmates in R&E > 30 days | %	25| 89%	28| 97%	10| 83%	29| 88%
# I/M with a Tx Plan Developed| %	0 | 0%	0 | 0%	0 | 0%	0 | 0%
# I/M with a QMHP F/u Due| %	4| 16%	2| 7%	2| 20%	2| 7%
# I/M with a QMHP F/u Completed| %	0 | 0%	0 | 0%	1 | 50%	2 | 100%
# I/M with a Psychiatrist F/u Due| %	0 | 0%	2| 7%	1 | 10%	1 | 3%
# I/M with a Psychiatrist F/u Completed| %	N/A	0 | 0%	0 | 0%	1 | 100%
# I/M with Psychotropic Meds Prescribed & Received| %	25 | 100%	28 | 100%	7 | 70%	29 | 100%
# I/M who Attended Group Therapy| %	25 | 100%	28 | 100%	10 | 100%	29 | 100%

Source: RIM R&E Removals Report

Kirkland R&E	February	March	April	May
Total MI Inmates Removed from R&E	40	52	61	53
Total # MI Inmates in R&E > 30 days| %	34| 85%	46| 88%	54| 89%	53| 100%
# I/M with a Tx Plan Developed| %	0 | 0%	0 | 0%	0 | 0%	0 | 0%
# I/M with a QMHP F/u Due| %	8 | 24%	10| 22%	8| 15%	8| 15%
# I/M with a QMHP F/u Completed| %	4 | 50%	3| 30%	5| 63%	1| 13%
# I/M with a Psychiatrist F/u Due| %	3 | 9%	5| 11%	4| 7%	6| 11%
# I/M with a Psychiatrist F/u Completed| %	2 | 67%	3| 60%	2| 50%	1| 17%
# I/M with Psychotropic Meds Prescribed & Received| %	23 | 68%	38| 83%	48| 89%	34| 64%
# I/M who Attended Group Therapy| %	0 | 0%	0 | 0%	0 | 0%	0 | 0%

Source: RIM R&E Removals Report

Assessment

As evidenced by the results, the majority of inmates who received a mentally ill classification at R&E remain in R&E for more than 30 days. In May at Kirkland R&E, 100% of all inmates who ended up on the mental health caseload remained in R&E over 30 days. At Graham R&E in May, 88% of all inmates who ended up on the mental health caseload remained in R&E over 30 days. For the months of February through May 2018 at both Graham's and Kirkland's R&E center, between 82% and 100% of all inmates who were classified as mentally ill remained in R&E over 30 days.

The MI inmates who remained at Graham R&E over 30 days received group therapy sessions at a rate of 100% for the months of February through May; however, none had treatment plans developed. No inmates remaining over 30 days at Kirkland R&E received group therapy sessions or had a treatment plan developed during the reviewed time period.

There were very few inmates who required a follow-up session with a QMHP or psychiatrist during their extended stay at R&E, based on their levels of care. Of those inmates who had follow-up evaluations due during that timeframe, 0% to 25% actually received a follow-up QMHP or psychiatric evaluation.

The study reviewed, with regards to psychotropic medications, whether or not the inmates were prescribed or were receiving medications. At Kirkland R&E, from February to May 2018, 64% - 89% of all mentally ill inmates who remained in R&E over 30 days were prescribed medications. At Graham R&E, from February to May 2018, 70% - 100% of all inmates who remained in R&E over 30

days were prescribed medications. The remaining inmates were not prescribed psychotropic medications by the psychiatrist or they refused medication as part of their treatment.

Both programs' results indicate room for improvement in providing services to inmates who are not transferred from R&E in a timely manner, particularly group therapy sessions, treatment planning, and appropriate follow-up evaluations as clinically indicated. SCDC continues to work towards compliance and transferring mentally ill inmates to their placed institutions within a reasonable time frame so that they can receive adequate and consistent care.

Planned Actions

1. Graham R&E staff and Kirkland R&E staff will begin completing treatment plans for inmates who remain at R&E for more than 30 days after being classified as mentally ill.

July 2018 Implementation Panel findings: As per status update section. Improvement is noted. Issues at Kirkland are more problematic related to staffing vacancies and physical plant limitations.

Many R&E inmates at Camille Graham CI reported significant delays in being prescribed psychotropic medications. However, the scheduled medication administration times were now much more reasonable. These inmates reported generally receiving 45-60 minutes of out of cell recreational time on a daily (Monday -Friday) basis.

July 2018 Implementation Panel Recommendations:

1. Continue to monitor via a QI process.
2. Accurately track the out of cell time offered to R&E inmates on a weekly basis.
3. Continue to provide the average and median LOS data in the future for inmates in the R&E upon transfer from the R&E.
4. R&E inmates need reasonable access to mental health services for both medication purposes and crisis intervention.
5. Remedy the staffing issues.

1.d. Development of a program that regularly assesses inmates within the general population for evidence of developing mental illness and provides timely access to mental health care.

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

The annual mental health screenings were not proving to be helpful based on the numbers of inmates being added to the mental health caseload. Therefore, per the recommendation of the Implementation Panel during their March visit, the Division discontinued this practice.

See response in 1.a.i.

Appendix E indicates inmates who added to the caseload from the period of February- May 2018 post their R&E placement (N= 194).

July 2018 Implementation Panel findings: As per status update section.

July 2018 Implementation Panel Recommendations: As per 1.a.i.

2. The development of a comprehensive mental health treatment program that prohibits inappropriate segregation of inmates in mental health crisis, generally requires improved treatment of mentally ill inmates, and substantially improves/increases mental health care facilities within SCDC.

2.a. Access to Higher Levels of Care
2.a.i. Significantly increase the number of Area Mental Health inmates vis-a-vis outpatient mental health inmates and provide sufficient facilities therefore;

Implementation Panel July 2018 Assessment: noncompliance

June 2018 SCDC Status Update:
In May, 2018, [redacted] from QIRM was hired by the Office of Operations to serve as Deputy Warden for Compliance (DWC) for Broad River Correctional Institution. The DWC works closely with the Warden and Regional Director to develop, implement, evaluate and provide oversight of a comprehensive system to track and measure institutional compliance, coordinate the institution's data collection, tracking and reporting system and develop corrective action plans to facilitate compliance.

[redacted] is being reassigned as SOTP Program Coordinator on July 1, 2018. [redacted] MH Administrator, is moving from HQ to BRCI to manage the MH Program.

Caseload Management
The Murray dorm hosted a Mental Health Day on June 14, 2018, which brought the unit into 100% compliance with QMHP sessions. All inmates who were past due or due for the month of June were seen or had the opportunity to be seen. Several QMHPs from various institutions set up confidential stations in BRCI's visitation room. A total of sixty-six (66) inmates were either past due or needed to be seen before the end of June. Staff report that 21 of the 66 (32%) of eligible inmates refused the session. Twelve inmates requested to be added to groups. QMHP session with Area MH inmates at BRCI in 100% compliance.

Staffing in Murray Dorm
BRCI staff housed within the Murray Dorm include:

1 Deputy Warden of Compliance
1 Unit Manager
1 Unit Counselor
2 Security staff (one on each wing)
1 Qualified Mental Health Professional
2 Mental Health Techs
1 Classifications Staff

Two QMHPs joined the staff at BRCI in June. With that addition, three QMHPs are now assigned to the Murray dorm. Planned caseload ratio for the Murray dorm QMHPs will be 1:48. The regional supervisor will no longer maintain a caseload once all QMHPs have started. One Psychiatric Nurse Practitioner has been dedicated to Area Mental Health.

Provision of Services
Staff report that since the statewide lockdown, provision of groups was limited. During the lockdown, staff report that 5-6 inmates were allowed to participate in groups. Due to the limitation, all inmates were allowed to participate in each group with the exception of the Coping & Living Mindfully (CALM) group. Staff reported that six groups were provided during the statewide lockdown:

On June 6, 2018, Sexual Trauma Services of the Midlands (STSM) began offering the CALM groups. Due to the lockdown, only 11 inmates were allowed to participate in the two weekly groups. From these group participants, 5 inmates requested and will begin up to eight individual counseling sessions. Due to the sensitive nature of the sessions, the inmates will be given OTR's to report to the conference room in the front of the institution to have the individual sessions.

Access To Management

Access to Management meetings were held on January 19 & 22 and February 23, 2018. The March 29, 2018, Access to Management Meeting was canceled due to security concerns in the unit. Because of the statewide lockdown, no Access to Management meetings have been held since February. Broad River CI plans to continue the meeting with the Murray dorm once the lockdown has been lifted and expand to the yard to give all inmates the opportunity to address issues/concerns.

Expanding this process within one month from the Murray Unit to the BRCI compound was discussed at the June 20, 2018 Wardens' meeting.

Crank Radios

An incentive-based program to promote good behavior in the unit. This program provides an opportunity for inmates to maintain the use of a crank radio. All inmates were provided a radio on May 11, 2018. New residents receive radios on Fridays. Refer to Appendix F for the BRCI Murray Dorm Update.

L3 Inmates not at BRCI

Although the Murray Dorm has been centralized for L3 inmates, as of the June 18, 2018, RIM-generated report of MH classifications for mentally ill inmates, 87 or 37% of the 303 L3 male inmates are housed in other institutions.

Structured time for this report was analyzed using daily activity rosters received from the institution and the structured-time database. Below is a summary of the structured time Area inmates received by week for each month in the reporting period.

High Intensity Outpatient/Area MH	February			March				
	9-Feb	16-Feb	23-Feb	2-Mar	9-Mar	16-Mar	23-Mar	30-Mar
n=	180	184	184	230	228	226	223	222
Percentage inmates getting 0 min	92%	74%	90%	86%	76%	82%	78%	70%
Percentage inmates getting 15-59 mins	0.0%	2.2%	4.3%	6.1%	8.8%	8.0%	10.8%	11.7%
Percentage inmates getting 60-359 mins	7.8%	15.8%	4.9%	4.8%	10.1%	4.9%	8.5%	14.0%
Percentage inmates getting 360-599 mins	0.0%	0.0%	0.0%	0.0%	1.3%	0.0%	0.4%	0.5%
Percentage inmates getting 10 hours	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.5%

High Intensity Outpatient/Area MH	April				May			
	6-Apr	13-Apr	20-Apr	27-Apr	4-May	11-May	18-May	25-May
n=	223	233	232	237	240	236	232	232
Percentage inmates getting 0 min	76%	67%	69%	68%	79%	78%	82%	91%
Percentage inmates getting 15-59 mins	9.9%	14.6%	16.8%	16.9%	7.9%	11.4%	10.3%	3.4%
Percentage inmates getting 60-359 mins	9.0%	14.2%	0.9%	3.8%	6.3%	7.2%	5.2%	2.6%
Percentage inmates getting 360-599 mins	0.4%	0.0%	0.0%	0.4%	0.4%	0.0%	0.0%	0.0%
Percentage inmates getting 10 hours	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

The chart below demonstrates SCDC's ability to track the percentage of L3 inmates in comparison to the mentally ill population and the percentage of the overall population and shows an increase in the numbers and percentages of inmates receiving services. Since May of 2017, this population has 1.16% to 1.58% of the overall SCDC population.

Month	Female L3 inmates	Male L3 inmates	Total Population	Percent of Mentally Ill Population	Percent of Total Population
May-17	47	190	237	6.93%	1.16%
Jun-17	48	183	231	6.79%	1.14%
Jul-17	50	215	265	7.63%	1.32%
Aug-17	52	222	274	7.99%	1.38%
Sep-17	61	227	288	8.17%	1.43%
October-17	69	246	315	8.89%	1.57%
November-17	72	237	309	8.63%	1.55%
December-17	80	220	300	8.37%	1.51%
January-18	85	218	303	8.45%	1.55%
February-18	78	222	300	8.23%	1.54%
March-18	78	218	296	8.10%	1.54%
April-18	76	235	311	8.40%	1.60%
May-18	75	231	306	8.24%	1.58%

Data source: RIM: Weekly Mentally Ill Report for Institutional and Female GEO Care Population

July 2018 Implementation Panel findings: As per status update section.

Prior to the April 15, 2018 systemwide lockdown, compliance with the Settlement Agreement was difficult to achieve related primarily to custody and mental health staffing shortages, physical plant limitations and institutional cultural issues, especially in high security housing units that were essentially locked down. We had consistently recommended that staff attempt to mitigate the harm associated with such limitations by increasing out of cell time, providing crank radios/ tablets, etc. Unfortunately, the current lockdown has resulted in the problems found in the high security housing units likely being spread to most of the housing units that remain on locked down status. Specifically, inmates on the mental health caseload are at significant risk of their mental illness symptoms being exacerbated by the conditions of confinement associated with their lockdown status, which increases with the duration of being locked down. Ironically, attempts to mitigate the harm associated with lack of compliance with the Settlement Agreement are now outweighed by the harm associated with the prolonged locked down status.

Broad River Correctional Institution

Related to the lockdown status, previous improvements in access to care have generally not been maintained. Improvement is noted relevant to staffing allocations/vacancies as summarized in the status update section. The June 14, 2018 mental health day was a very helpful temporary remedy to problems related, in part, to the lockdown status following the riot at the Lee Correctional Institution.

During the afternoon of July 17, 2018, the Implementation Panel (IP) met with a group of about 10 Murray dormitory inmates in a group setting. These inmates complained about poor access to mental health services since the systemwide lockdown. Other complaints included the timing of the morning medication administration process, the manner of the medication administration (i.e., under the cell door) and conditions of confinement related to lockdown status. They confirmed that they were being offered showers on a three time per week basis. They stated that the interventions by Deputy Warden [redacted] have been very helpful to many of them.

Staff reported that the mental health technicians were making daily rounds within the Murray dormitory.

Related to custody staff shortages and the current prolonged lockdown, it was clear that mental health services offered to inmates in the Murray dormitory were severely limited and compromised.

Lee Correctional Institution

During the afternoon of July 18, 2018, the IP met with about thirty inmates in a community meeting-like setting in the Better Living Incentive Community (BLIC) housing unit at the Lee CI. These inmates clearly verbalized their distress re: their conditions of confinement since the system-wide lockdown that began following the April 15, 2018 riot at Lee CI. Issues included poor access to mental health services, lack of access to cleaning supplies, sparse information re: when the lockdown will end, medications being administered to them under the cell doors, and increasing stress and frustration due to their locked down status. Inmates did have access to showers on a three times per week basis and visitation privileges.

July 2018 Implementation Panel Recommendations:

The prolonged lockdown for all inmates, especially those on the mental health caseload, is very stressful and is likely to exacerbate the symptoms of many inmates on the mental health caseload. More efforts need to be implemented to mitigate such negative effects that should include a plan to facilitate a transition to ending the lockdown soon (e.g., begin allowing inmates out of cell time on a daily basis, which will be the most effective approach). Providing inmates with reading materials, music, crank radios, etc. are examples of other interventions that can help to mitigate the harmful effects of the lockdown. Community meetings should be held to facilitate successful implementation of such a transition.

Leath Correctional Institution

During the afternoon of July 19, 2018, the IP site visited the Leath CI. About 180 inmates from Camille Graham CI had been transferred to Leath CI beginning during June 2018. During June 5, 2018, about 112 inmates were transferred with 65 of the inmates reportedly being on the mental health caseload. These inmates were given no advanced notice of the transfer. Since the transfer, ~ 10 of these inmates have had one or more of the 19 CSU admissions of Leath CI inmates.

We subsequently interviewed most of the inmates in the Phoenix housing unit in a community-like setting. These inmates had numerous complaints which included the following issues:

1. poor access to the psychiatrist;
2. poor access to the mental health counselors;
3. very limited access to group therapies;
4. medication discontinuity issues (i.e., medications running out resulting in significant lapses of receiving medications;
5. receiving disciplinary reports with subsequent restrictions and punitive segregation time due to charges of self-mutilation (when the self-mutilation is self-harming behaviors in contrast to tattoos);
6. disrespectful and provocative behaviors by correctional officers directed at inmates in the housing unit;
7. limited access to jobs;
8. their housing unit having more restrictions than most other housing units at Leath related to custody staff shortages, which includes a "rotation" process;
9. not being permitted to talk while in the dining hall; and
10. inmates recently transferred from Camille Graham CI had numerous complaints re: the transfer process and their current placement as compared to Camille Graham CI.

We subsequently discussed these complaints with key clinical and custodial staff. There was agreement that the following would occur:

1. QI the medication discontinuity issue, which appeared to be related both to training issues and apparent flaws with the NextGen EMR.
2. Discontinue writing disciplinary reports for self-cutting behaviors related to an inmate's mental health problems.
3. Improve communication among custody staff involved with job assignments.
4. Consider changing the rules re: talking in the dining hall.

We recommend that the issues re: disrespectful behaviors by some of the correctional officers be addressed.

We discussed at length with staff issues related to caseload inmates who were recently transferred from CGCI and were experiencing significant problems related to the transfer. Specifically, we recommended that their continued placement at Leath CI be reconsidered via a staffing with the treatment team and discussing with them other housing placement options at Leath CI.

We also discussed with staff issues related to disciplinary infractions issued to inmates who were reportedly cheeking medications and charged with trafficking medications based on cheeking the medications. We discussed other possible reasons for cheeking medications such as not wanting to take H.S. meds at 4 pm. We recommended that this issue be further addressed. We have no disagreement in issuing DRs when trafficking medications is proven.

July 2018 Implementation Panel Recommendations: As above.

2.a.ii. Significantly increase the number of male and female inmates receiving intermediate care

services and provide sufficient facilities therefore;

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

Dr. [redacted] Chief Psychiatrist, and [redacted], Division Director of BMHSAS, have developed a program draft and goals for Behavioral residential treatment in Kirkland's F1 unit. The F1 unit will continue to be considered a residential mental health unit; however, the scope of services provided will target inmates who repeatedly re-cycled back and forth to Broad River's Crisis Stabilization Unit and outpatient MH services (including intensive outpatient). The cohort of inmates who will be admitted in this program are too disruptive to have combined programming with the current offenders in ICS, specifically those diagnosed with a serious mental illness. The F1 and F2 populations will be separated to establish F1 being behavioral and higher functioning and F2 as SMI and lower functioning. This separation will also address the number of inmates that are currently denied admission into the presently structured ICS. The program will be managed separately from F2 which also addresses the current administrative structure of not being able to achieve 10 structured hours in both F2 and F1 units.

A reclassification of positions was submitted to HR for processing on June 22, 2018, to include three MH Techs, four QMHPs and one Program Manager. The nursing vacancies will be replaced/requested in FY20 Budget Year). Preparations are underway to prepare nursing to return to the unit on July 15, 2018. While the telephone and computer for medication room is currently pending, an iron door was installed. The treatment room will be used by nursing in F1 to prevent movement of behavioral ICS inmates. The need for eight additional correctional officers has been identified to fully operate the F1 unit.

The chart below demonstrates SCDC's ability to track the percentage of L2 inmates in comparison to the mentally ill population and the percentage of the overall population and shows an increase in the numbers and percentages of inmates receiving residential treatment services. These numbers include HLBMU, LLBMU and Male and Female ICS (L2) inmates.

Residential Level of Care*							
Month	**Male Residential**	**Female Residential**	**Total Residential Pop**	**MI Population**	**% MI Pop**	**Total Pop**	**% of Total Pop**
May-17	165	27	192	3,420	5.61%	20,373	0.94%
Jun-17	170	28	198	3,371	5.87%	20,015	0.99%
Jul-17	182	27	209	3,473	6.02%	20,141	1.04%
Aug-17	186	26	212	3,458	6.13%	20,035	1.06%
Sep-17	181	27	208	3,524	5.90%	20,109	1.03%
Oct-17	176	25	201	3,543	5.67%	20,056	1.00%
Nov-17	187	25	212	3,582	5.92%	19,929	1.06%
Dec-17	186	20	206	3,585	5.75%	19,811	1.04%
Jan-18	180	16	196	3,602	5.44%	19,580	1.00%
Feb-18	183	17	200	3,647	5.48%	19,458	1.03%
Mar-18	187	18	205	3,656	5.61%	19,281	1.06%
Apr-18	190	16	206	3,704	5.56%	19,410	1.06%
May-18	193	15	208	3,713	5.60%	19,313	1.08%

Provision of Services Camille Graham ICS Structured Out-of-Cell Time

Limitations to Structured Time Reporting at Camille

There are no automated reports generated from NextGen that demonstrate structured time received by inmates whose records are maintained in that system. Currently, structured time is analyzed by manual audits in NextGen and/or using daily activity logs which is a very time consuming process and increases the potential for inaccuracies due to human error when manually entering structured time into an Excel database.

Structured time for this report was analyzed using daily activity rosters received from the institution and the structured-time database. All of the ICS inmates were included in the sample. Below is a summary of the structured time inmates received by week for each month in the reporting period. The total number of structured activities scheduled and corresponding number of hours shown are approximations. The data was taken from the QIA databases for Structured/Unstructured Time. SCDC Policy 19.12, *Intermediate Care Services (ICS)*, section 3.4 states: "ICS inmates are provided ten (10) hours of structured out-of-cell activities weekly, which take place Monday through Friday."

According to schedules provided to QIRM by the Institution, there were approximately 9-10 groups specifically scheduled per week for the ICS inmates, for an average of approximately 14 hours per week. These inmates also have access to the groups scheduled for the general population, of which there are typically about 23 groups per week, for an average of approximately 28 hours per week. (Note that there are of some instances of ICS groups and general populations groups that are scheduled at the same time, which would reduce the opportunity slightly for ICS inmates.) An analysis of the number of groups scheduled indicate that there were enough group sessions scheduled by the institution to allow ICS inmates to participate in the required 10 hours of structured out of cell time.

For the months in the reporting period, with the exception of one week, zero percent (0%) of inmates received the required 10 hours of structured out-of-cell unstructured time; however, most inmates received some level of structured services throughout the month as reported in the charts below. In the third week of May, 1 inmate (6% of the ICS population) received the required 10 hours. The charts below provide the percentages of inmates who received structured services based on the breakdown below:

- ☐ 0 min
- ☐ 15-59 mins
- ☐ 60-359 mins
- ☐ 360-599 mins
- ☐ 10 hours

To see the numbers of inmates receiving the reported hours captured by the percentages below, see Appendix G.

Camille ICS Inmates Structured Time (minutes)

	February				March			
	9-Feb	16-Feb	23-Feb	2-Mar	9-Mar	16-Mar	23-Mar	30-Mar
n	15	16	16	17	16	15	14	14
% inmates getting 0 min	13%	0%	25%	12%	19%	20%	21%	21%
% inmates getting 15-59 mins	0%	0%	38%	0%	13%	7%	14%	14%
% inmates getting 60-359 mins	80%	81%	25%	76%	63%	47%	50%	57%
% inmates getting 360-599 mins	7%	19%	13%	12%	6%	27%	14%	7%
% inmates getting 10 hours	0%	0%	0%	0%	0%	0%	0%	0%

*February 2 fell at the end of the last week of January and would have been included week 4 of January's report

	April				May			
	6-Apr	13-Apr	20-Apr	27-Apr	4-May	11-May	18-May	25-May
n	14	15	15	14	13	12	16	14
% inmates getting 0 min	29%	7%	100%	0%	8%	8%	19%	0%
% inmates getting 15-59 mins	29%	20%	0%	7%	0%	0%	6%	7%
% inmates getting 60-359 mins	36%	60%	0%	36%	77%	92%	38%	43%
% inmates getting 360-599 mins	0%	13%	0%	57%	15%	0%	31%	43%
% inmates getting 10 hours	0%	0%	0%	0%	0%	0%	6%	0%

Kirkland ICS Structured Out of Cell Time

Structured time for this report was analyzed using data from the RIM reports (groups and individual sessions with the QMHP and Psychiatrist) and the structured time database with information entered by the QIAs. Below is a summary of the structured time inmates received by the week for each month in the reporting period.

For the months in the reporting period, with the exception of two weeks, (0%) of inmates received the required 10 hours of out-of-cell structured time; however, most inmates received some level of structured services throughout the month as reported in the charts below. During weeks four and five in March, one inmate (2% of the sample) received the required 10 hours of structured out-of-cell time. The charts below provide the percentages of inmates who received structured services based on the breakdown below. To see the numbers of inmates receiving the reported hours captured by the percentages below, see Appendix AAA.

Kirkland ICS Inmates Structured Time (minutes)

	February*			March				
	9-Feb	16-Feb	23-Feb	2-Mar	9-Mar	16-Mar	23-Mar	30-Mar
n=	40	40	41	37	43	42	42	45
% inmates getting 0 mins	40%	38%	27%	16%	30%	29%	36%	31%
% inmates getting 15-59 mins	13%	20%	24%	30%	14%	17%	26%	22%
% inmates getting 60-359 mins	48%	40%	49%	51%	51%	45%	31%	38%
% inmates getting 360-599 mins	0%	0%	0%	0%	0%	0%	0%	0%
% inmates getting 10 hours	0%	0%	0%	0%	0%	0%	2%	2%

*February 2 fell at the end of the last week of January and would have been included week 4 of January's report

	April				May			
	6-Apr	13-Apr	20-Apr	27-Apr	4-May	11-May	18-May	25-May
n=	45	48	50	47	45	45	45	45
% inmates getting 0 mins	33%	40%	76%	28%	42%	33%	33%	36%
% inmates getting 15-59 mins	18%	4%	24%	19%	29%	13%	18%	16%
% inmates getting 60-359 mins	44%	48%	0%	47%	20%	51%	36%	42%
% inmates getting 360-599 mins	2%	0%	0%	0%	0%	2%	0%	0%
% inmates getting 10 hours	2%	0%	0%	0%	0%	0%	0%	0%

The first graduation set for HLBMU for four or five inmates with aftercare plans is scheduled for July 18, 2018 during the IP's site visit. The HLBMU and LLBMU are each expected to be at full capacity by July 15, 2018.

Plans to expand the BMU and aftercare has begun. Moultrie Dorm side B, which is identical to the B-side of the CSU dorm is being considered for the BMU expansion. This expansion would allow one tier to have single cells and one tier to include both single and double cells to allow for phase 3 inmates to begin double celling prior to graduation. The plans include fencing on the second tier and gated showers for added security. The drawings for these changes are currently underway;

A meeting will be scheduled with Columbia International University (CIU) leadership to discuss recruitment of additional inmate watchers for CSU Broad River. SCDC is considering an expansion of the watcher program outside of CIU. Specific criteria, training and expectations will be developed with specific program goals and will focus on statewide character dorms as the program "feeder" for inmate watchers.

July 2018 Implementation Panel findings: As per status update section. Our previous report included the following:

We discussed with staff issues related to the current number of inmates determined to be in need of an ICS level of care. For purposes of this provision, inmates in any type of mental health residential level care (e.g., a BMU) should be included in the statistics relevant to receiving an ICS level of care. It has been our experience that 10% to 15% of the total mental health caseload population is usually in need of an ICS level of care at any given time, which is significantly more than the current percentage of caseload inmates receiving an ICS level of care.

Our opinion re: the above remains unchanged.

Kirkland Correctional Institution

During the morning of July 17, 2018, we attended an ICS treatment team meeting/staffing and interviewed most of the F1 ICS inmates in the community meeting setting. The process observed during the treatment team staffing meeting was problematic from the perspective of minimal treatment planning occurring with the interviews being predominantly a check in.

The F1 ICS inmates were generally very complementary of the treatment being provided although most inmates were being offered only 3-4 groups per week. They described the group treatment as being helpful as was individual treatment. In addition, good access to the psychiatrists was reported by these inmates.

We were very encouraged that the ICS program is no longer on a locked down status.

Nursing staff are again housed within the male ICS unit.

Clinical Staffing for the ICS was reported as follows:

1.13 FTE psychiatrists (# Hours/week on-site = 42.50)
9.0 FTE Mental Health Counselor (3.0 FTE vacancies)
4.0 FTE MHTs (1.0 FTE vacancy)
16.0 FTE RNs (12.0 FTE vacancies)
13.0 FTE LPNs (13.0 FTE vacancies)
4.0 FTE paramedics/tech

July 2018 Implementation Panel Recommendations: Previous recommendations included the following and remain unchanged as follows:

1. Provide accurate information regarding the number of hours of out of cell structured therapeutic activities both offered and received by individual ICS inmates, on average, on a weekly basis.
2. The lack of medication administration on an HS basis needs to be remedied.
3. Staffing vacancies/allocation issues need to be adequately addressed in order to meet adequate programming guidelines.

Camille Griffin Graham Correctional Institution

The inmate count during July 20, 2018 was 608 inmates. During July 20, 2018 there were 267 mental health caseload inmates (-~44% of the population), which included 18 L2, 59 L3, 160 L4, and 24 L5 mental health caseload inmates.

The RHU count during March 21, 2018 was 23 inmates, which included 15 mental health caseload inmates.

There were 12 CSU beds and 2 safety cells in RHU. The census during July 20, 2018 was zero.

Staffing data included the following:

Psychiatric coverage is provided by 1.0 FTE psychiatrist.

7.0 FTE QMHP positions are allocated with 5.0 FTE positions filled.
3.0 FTE MHT positions are allocated with 3.0 FTE positions filled.
16.0 FTE nursing staff positions were allocated
3.0 FTE RN FTE positions filled and 3.0 FTE RN vacancies.
2.0 FTE LPN positions were filled with 8.0 FTE LPN vacancies.

We observed a treatment team meeting during the afternoon of July 20, 2018, which was also attended by the psychiatrist. Very little treatment planning was discussed during this meeting.

We interviewed about 12 inmates on the D wing within the Blue Ridge housing unit. These ICS inmates reported increased access to mental health groups and generally had favorable comments regarding the program.

We also interviewed in a community setting the majority of inmates residing in C Wing within the Blue Ridge housing unit. Most of these inmates were mental health level 3 inmates with many also classified as mental health level 4. Medication management issues (e.g., medications expiring without being renewed in a timely manner, missed medication dosages, etc.) continued to be a common complaint. Medications were now administered by the nursing staff in the housing unit, generally around 7 a.m. and 7 p.m. Inmates reported improvement in the mental health services, especially as compared to one year ago. Most inmates reported attending at least one mental health group therapy per week, in addition to weekly community meetings and access to programs run by the Chaplain's office.

July 2018 Implementation Panel Recommendations: The most pressing need is to fill the nursing staff vacancies and adequately address the medication management issues.

2.a.iii. Significantly increase the number of male and female inmates receiving inpatient psychiatric services, requiring the substantial renovation and upgrade of Gilliam Psychiatric Hospital, or its demolition for construction of a new facility;

Implementation Panel July 2018 Assessment. partial compliance

June 2018 SCDC Status Update:
SCDC has established a regular Compliance Initiatives meeting to discuss plans and priorities to address and monitor progress in programs and services relative to the Mental Health Settlement Agreement. On March 29, 2018 a multidisciplinary meeting including staff from Health Services, Operations, Health Services Compliance and Mental Health convened to identify priorities from the Settlement Agreement. A follow-up meeting was convened by the Chief Legal & Compliance Officer where committees were assigned by each of the pretty areas identified at the March meeting.

GPH's subcommittee focused on completing the nurses station including furnishings, computer & phone lines, locks on doors, pill window pass-through; and reclassified a third shift QMHP from vacant position for GPH.

The nursing station will be complete when outlets are installed and locks have been put in place. Pending completion, DHEC will conduct a final inspection as soon as the pill window is ready. On June 12, 2018, the Deputy Director of Health Services (DDHS) and Warden held a meeting with nursing to discuss the function of nursing station. The QMHPs working with inpatient and residential inmates were informed that day-shift hours will be until 7 pm on weekdays, and that they would also be responsible to ensure on-site clinical coverage each weekend day shift.
Church services are now authorized. Staffing has improved to include a full-time onsite Psychiatrist [redacted] and the addition of (Dr. [redacted] who is scheduled to begin in July. The following changes/additions have improved the GPH custody staffing:

- One additional Escort officer 8AM-4PM (February)
- Unit Counselor schedule changed from 8AM-4PM to 6AM-2PM to assist with showers and recreation.
- One additional Unit Counselor (custody) 10AM- 6PM (April)

Staffing analysis has identified the need for 37 additional CO's, and additional Sergeants and Lieutenants.

The chart below demonstrates SCDC's ability to track the percentage of L1 inmates in comparison to the mentally ill population and the percentage of the overall population the numbers and percentages of inmates receiving services.

L1 Population

Month	Female L1	Male L1	Total Pop.	% L1 MI Pop.	% of Total Pop.
May-17	1	78	79	2.31%	0.388%
Jun-17	0	74	74	2.20%	0.373%
Jul-17	0	77	77	2.22%	0.382%
Aug-17	0	81	81	2.34%	0.404%
Sep-17	0	81	81	2.30%	0.403%
October-17	0	73	73	2.06%	0.364%
November-17	0	73	73	2.04%	0.366%
December-17	0	80	80	2.23%	0.404%
January-18	0	75	75	2.08%	0.383%
February-18	1	71	72	1.97%	0.370%
March-18	0	80	80	2.19%	0.415%
April-18	1	80	81	2.19%	0.417%
May-18	2	74	76	2.05%	0.394%

Structured Out-of-Cell Time

Structured Therapeutic Activity for Gilliam Psychiatric Hospital (GPH)
The entire GPH population was analyzed to determine structured out of cell time scheduled, offered, and received by inmates. The data represented in this report is inclusive of RIM reports from the AMR for February 2018 through May 2018. Activity therapy and community meetings are inclusive from

February 1, 2018 through April 8, 2018. The data for Activity Therapy and Community meetings after April 9, 2018 have not been entered nor calculated in the weekly/monthly totals for GPH. Below is a summary of the structured time inmates received by the week for each month in the reporting period.

Gilliam Psychiatric Hospital	February			March				
	9-Feb	16-Feb	23-Feb	2-Mar	9-Mar	16-Mar	23-Mar	30-Mar
n=	78	81	79	77	81	82	87	89
% inmates getting 0 mins	15%	14%	24%	16%	16%	27%	20%	28%
% inmates getting 15-59 mins	9%	6%	13%	14%	12%	23%	24%	26%
% inmates getting 60-359 mins	40%	40%	56%	43%	44%	38%	51%	45%
% inmates getting 360-599 mins	23%	32%	6%	23%	19%	9%	6%	1%
% inmates getting 10 hours	13%	7%	0%	3%	6%	0%	0%	0%

Gilliam Psychiatric Hospital	April				May			
	6-Apr	13-Apr	20-Apr	27-Apr	4-May	11-May	18-May	25-May
n=	88	87	85	92	89	88	89	88
% inmates getting 0 mins	22%	39%	66%	60%	45%	41%	26%	20%
% inmates getting 15-59 mins	10%	39%	25%	27%	40%	43%	30%	39%
% inmates getting 60-359 mins	36%	21%	5%	5%	10%	11%	39%	41%
% inmates getting 360-599 mins	25%	0%	0%	0%	0%	0%	0%	0%
% inmates getting 10 hours	3%	0%	0%	0%	0%	0%	0%	0%

CRCC CONTRACT UPDATE

CRCC continues to undergo construction modifications, which has impeded full implementation of the 10 bed unit devoted solely to SCDC. However, CRCC has made accommodations to accept SCDC inmates during their construction period. CRCC has provided treatment to a total of twelve mental health patients from the period of March-May 2018.

Currently, there are eleven SCDC inmates admitted to CRCC; eight males and two females.

July 2018 Implementation Panel findings: As per status update section.

Clinical staffing for GPH was reported as follows:

	Total FTE as of July 2018	Staffing Plan FTE
Psychiatrists:	1.68 (67.25 hrs/week)	4.0
Psychologists:	.56 (22.50 hrs/week)	.5
QMHP's:	8.00 (1.0 FTE vacancy)	8.00
MHT's:	7 (1.0 FTE vacancy))	16 .0
Recreational therapists	3.0 FTEs	3.0

Nursing:	RN/LPN	Staffing Plan FTE

	GPH Allotted FTE		
RN:	16 (12.0 vacancies)		19.00
LPN:	13		15.00
Paramedic /tech:	4 (4.0 FTE vacancies)		5.00

The amount of out of cell time, both structured and unstructured, actually used by GPH inmates remains alarmingly small. This issue is predominantly related to inadequate staffing allocations (both correctional and mental health staff) although institutional cultural issues likely contribute.

Renovations at GPH are not yet completed with specific reference to the nursing stations, which appears to be primarily related to a recent inspection that identified issues with the nursing station door's lock.

Significant progress is noted from the perspective of hiring 2 psychiatrists for providing psychiatric services to GPH inmates/patients.

Staffing analysis has identified the need for 37 additional CO's, and additional Sergeants and Lieutenants.

We met with about 40 inmate GPH inmate/patients in GPH via a community-like meeting on both sides of the housing unit. B unit inmate/patients, who generally had a higher acuity level than the A side of the housing unit, reported limited access to group therapies on a weekly basis as well as limited out of cell structured time. It was not unusual for inmates to have to choose between attending a group therapy or unstructured out of cell time due to scheduling issues.

Unit A inmates generally described more satisfaction with the GPH program as compared to B side inmates.

Lockdown status in GPH ended about 4-6 weeks prior to the site assessment.

July 2018 Implementation Panel Recommendations: Continue to monitor via a QI process.

The following December 2017 recommendations are unchanged:

1. Focus on providing more out of cell structured therapeutic and unstructured time to inmates in GPH. We strongly recommend at least several community meetings be conducted per week with both mental health and correctional staff in attendance and actively participating.
2. Complete the renovations.

The significant custody staffing allocations should be a high priority to remedy. These officers should be regularly assigned to GPH and receive enhanced mental health training relevant to working in an inpatient setting.

2.a.iv. Significantly increase clinical staffing at all levels to provide more mental health services at all levels of care;

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

Additional Staff

[redacted] and [redacted] completed interviews for chief and staff psychologist positions, and they have selected a Chief and two psychologists. The Chief Psychologist will start on August 1, 2018, but has agreed to be onsite for the July 16, 2018, visit. Offers for 2 psychologists are pending position reclassification.

All positions for psychiatry will be filled by end of August with psychiatrists or psychiatric NP (15+ positions. (15+ positions= SCDC full-time, part-time, dual with DMH, contract: in-person and tele psych)

A position for Assistant Deputy Director of Behavioral Health is currently posted. NextGen Program Manager, [redacted] left employment with SCDC; however, the position was filled by [redacted] Staff anticipate that HCA and Head Nurse positions (except McCormick) will be filled by 9/1/18.

New Recruitment Initiatives

A director of recruiting has been hired from the private sector with significant Linkedin experience, and extensive contacts in the military community. SCDC is also piloting an expanded telehealth program with the University of South Carolina and the Medical University of South Carolina to provide greater, geographic telehealth coverage. SCDC is also in discussions with a private company to provide additional telehealth services. Further, SCDC is seeking an amendment to the settlement agreement provision identifying its subject matter experts in order to seek innovative, cutting edge, data driven recruitment initiatives. Lastly, SCDC revamped its billboard recruitment efforts by mapping the locations of the homes of current employees to target those communities for billboard advertisement.

Critical Incident Stress Management Program

The Critical Incident Stress Management Program (CISM) has continued to develop since the initial report July 2017. The CISM Program has been established to provide support services to staff who have been assaulted and/or otherwise experienced trauma. There are several levels of support that are being implemented within the CISM Program. While not all of these services are yet available, they continue to be established at this time and are in varying states of implementation projected over the coming months and years.

- Peer Support (one-on-one support)
- Group Intervention (diffusing, debriefing, demobilization, crisis management briefing)
- Post Critical Incident Seminar (PCIS) (3-day event for staff experiencing long-term challenges resulting from traumatic experience(s)) PCIS's will eventually be implemented and occurring on a periodic basis throughout each year)
- Desert Waters (addresses challenging environment we work in – entire SCDC workforce would participate in this, once implemented)

Since that time, the following accomplishments/activities have been achieved:

1) Four SCDC staff trained in ICISF (International Critical Incident Stress Foundation) Model for CISM (Fall 2017)
2) Strategic Plan developed for the Division of Victim Services, which includes the CISM Program
3) Three positions dedicated to CISM Program (hired February 2018)
   a. [redacted] – CISM Program Administrator
   b. [redacted] – CISM Program Manager
   c. [redacted] – Administrative Assistant
4) Memorial Service coordinated at Headquarters for staff person who had passed away (April 2018)
5) Peer Support has been provided for staff who have been assaulted over the past year on an ongoing basis throughout the agency. These services complement the work being done by the SITCON Team, adding another layer of support for SCDC employees to have in the aftermath of any traumatic experience.
6) Peer Support provided for staff involved in Lee Correctional Riot (April 2018 and ongoing since)
7) Trauma/Crisis Intervention Dog was obtained through a partnership with PAALS (Palmetto Animal Assisted Life Services). Flossy has already responded to several situations, providing support in both group and individual situations. Additionally, she has participated in several trainings not only in South Carolina for staff, but also in Ohio and Idaho!
8) Formal Debriefings conducted June 21st & 22nd, 2018. 232 first responders to Lee Correctional Riot participated (Including Police Services, RRT, SORT, SITCON, Operations, Lee staff, Lee County Sheriff's Department, Lee County Fire/Rescue staff, etc…). Facilitators for the debriefings came from the North Carolina Department of Corrections, Georgia Department of Community Services (parole/probation), SC-LEAP (Law Enforcement Assistance Program), Columbia Police Department, Horry County Sheriff's Department and SCDC to support all participants.

It is important to note that the CISM Program is being developed with research in mind to eventually be able to evaluate the difference the services are making in the lives of SCDC staff. We are in the process of developing an initial survey about the current climate of staff attitudes/feelings. This will serve as the baseline for future surveys/research to compare the difference CISM support services is having on the agency in the areas of morale, retention, well-being, etc.

MH Vacancy Rates

Based on the current staffing chart below, BMHSAS reports a vacancy rate of 17.67%, which is a decrease from last reporting period (< 5.56). The Division attributes the continued decrease to the recent salary enhancements for both Psychiatrists and Qualified Mental Health Professionals (QMHPs).

Title	Total # of Positions	Full-Time		Pink Slip		Dual		Contract		Total % Filled Position
		Filled	Vacant	Filled	Vacant	Filled	Vacant	Filled	Vacant	
Division Administration										
Division Director - QMHP	**1**	1	0	0	0	0	0	0	0	100.00%
Quality Assurance	**4**	3	1	0	0	0	0	0	0	75.00%
Training Coordinator	**1**	1	0	0	0	0	0	0	0	100.00%
PREA Coordinator/ Grievance/ Special Projects QMHP (Non-Licensed)	**1**	1	0	0	0	0	0	0	0	100.00%
Support Staff	**2**	2	0	0	0	0	0	0	0	100.00%
Institutional Administration	**2**	4	0	0	0	0	0	0	0	200.00%
Institutional Admin Support Staff	**8**	7	1	0	0	0	0	0	0	87.50%
Bay Area Totals - (only at GPH)	**9**	9	0	0	0	0	0	0	0	100.00%
Activity Therapy Totals	**3.53**	3	0	0	0.53	0	0	0	0	84.99%
Mental Health Tech Totals	**43**	36	7	0	0	0	0	0	0	83.72%
QMHP Totals (includes MH Supervisors	**87.06**	70	16	0.53	0.53	0	0	0	0	81.01%
Psychology Totals	**4.14**	0	3	0.94	0	0	0	0.20	0	27.54%
Psychiatry/Nurse Practitioner Totals - (Based on 40 hours/week)	**14.62**	6	2	3.60	0.81	0.98	0	1.23	0	80.78%
Division Totals	**180.35**	**143**	**30**	**5.07**	**1.87**	**0.98**	**0**	**1.43**	**0**	**83.44%**

A MH vacancy report is included as Appendix H.

The Health Services Position Tracking Log is included as Appendix CCC
A report submitted from the Division of Administration reports the days from selection entry to hire date has decreased by 43% for non-security positions and 67% for security positions.

Position Type	Days from section entry to hire		Decrease in days	% decrease
	7/1/2017-12/31/2017	2/1/2018-4/30/2018		
Non-security	58.87	33.31	25.56	-43%
Security	66.55	22.22	44.33	-67%

These decreases in wait time are attributed to more streamlined processes and improved workflow.

As a result of the Governor's Executive Order on April 23, 2018, institutional Lieutenants are allowed to earn overtime pay for three months, effective May 22, 2018. Lieutenants will be eligible for overtime for time worked greater than 160 hours in a 28-day FLSA working week.

Each institution is responsible for monitoring and reporting their overtime usage. Meetings will be held with Operations, Human Resources and Finance at the end of each 28-day pay cycle. Meetings are scheduled as follows:

- June 11, 2018
- July 9, 2018
- July 30, 2018
- August 27, 2018

A copy of the memo sent to staff with this information is included as Appendix I. A copy of the Executive Order is included as Appendix J.

July 2018 Implementation Panel findings: As per status update section. We were very encouraged by the improvement in decreasing the staff vacancy rate as described in the status update section, which was clearly related to both improved salaries and more streamlined hiring practices.

July 2018 Implementation Panel Recommendations: Continue to monitor via a QI process.

2.a.v. The implementation of a formal quality management program under which denial of access to higher levels of mental health care is reviewed.

Implementation Panel July 2018 Assessment: compliance (July 2017)

June 2018 SCDC Status Update:

Intermediate Care Services (ICS)

There were a total of 27 cases that were denied entry into the ICS program for the period of October - December 2017 and February - April 2018. All 27 ICS denials were reviewed by the Committee. The committee did not concur with 5 of the decisions and indicated their "Reason for Overturn of Denial/Reconsideration." One of those cases has since been admitted to the ICS Program. The remaining 4 cases were scheduled to be re-staffed the week of June 11, 2018; however, as of this narrative no updated information has been received. The committee concurred with the remaining 22 denials.

Lower Level Behavioral Management Unit (LLBMU)

There were a total of 54 cases that were denied entry into the LLBMU program for the period of October - December 2017 and February - April 2018. Of those cases. All 54 LLBMU denials were reviewed by the Committee. They did not concur with 13 of the denial decisions and indicated their "Reason for Overturn of Denial/Reconsideration." All of the cases were re-staffed and per the Program Supervisor, the results are as follows: 3 = accepted and are awaiting transfer to LLBMU; 1 = already in a program; 2 = HLBMU referral recommended; 2 = not accepted due to pending disciplinary issues; 2 are already in other mental health programs; 2 cases were initially returned to LLBMU for reconsideration, as the Committee did not concur with the denial decision, and then they were denied a second time with a different reasoning and the Committee concurred with the denials, and; 1 case is pending LLBMU recommendation. The committee concurred with the other 41 denials.

* No January 2018 data was received for ICS or LLBMU.

GPH

Four cases were denied between the months of February-May. The review committee concurred with two of the recommendations and have not yet reviewed the remaining cases.

Denial Reviews			
	ICS	LLBMU	GPH
Total Program Denials	27	54	4
Denials Returned for Reconsideration	5	13	0
Percent of Denials Overturned	19%	24%	0%

July 2018 Implementation Panel findings: As per status update section.

July 2018 Implementation Panel Recommendations: Continue to monitor via a QI process.

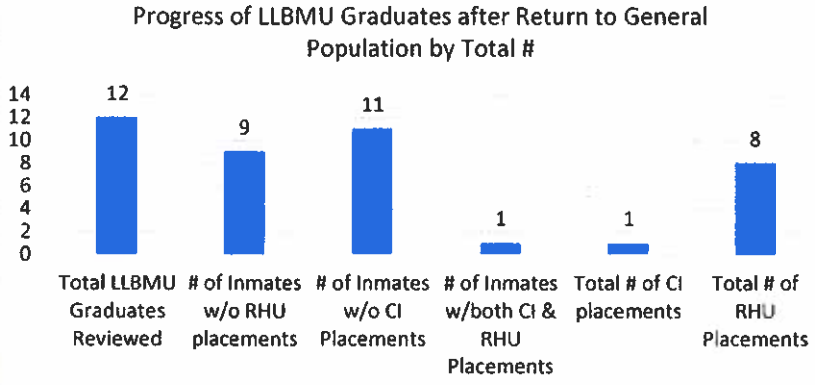
2b. Segregation:
2b.i. Provide access for segregated inmates to group and individual therapy services

Implementation Panel July 2018 Assessment: partial compliance

June 2018 Update

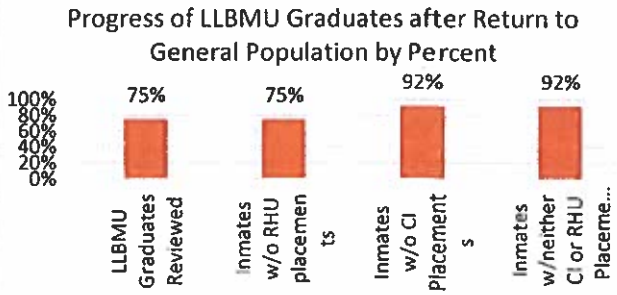
Although the LLBMU will not be toured during the June, 2018, IP visit, the following information provided details regarding the progress of inmates since graduating from the LLBMU.

Inmate Progress Since LLBMU Graduation		
	Total #	% of Total
# of LLBMU Graduates	16	-
Total LLBMU Graduates Reviewed	12	75%
# of Inmates w/o RHU placements	9	75%
# of Inmates w/o CI Placements	11	92%
# of Inmates w/both CI & RHU Placements	1	8%
Total # of CI placements	1	-
Total # of RHU Placements	8	-



*Progress at Transferring Institutions as of 5/29/18

Inmate Progress Since LLBMU Graduation		
	% of Total	Total #
LLBMU Graduates Reviewed	75%	12
Inmates w/o RHU placements	75%	9
Inmates w/o CI Placements	92%	11
Inmates w/neither CI or RHU Placements	92%	11



Progress at Transferring Institutions as of 5/29/18

Out-of-Cell Structured and Unstructured Time

HLBMU

Unstructured Time

Unstructured time is not captured in a RIM report. According to the QMHP for the program, Phase I inmates are allowed to be out of their cells for 2 hours/day from Monday-Friday. Phase II inmates are allowed to be out of their cells from 7:00am - 5:45pm daily. Phase III inmates are allowed to be out of their cells from 7:00am - 8:45pm daily. This schedule provides inmates in all three phases the opportunity to be out of their cells for at least 10 hours/week. Unstructured activity includes recreation, library time, and religious services.

Structured Time

This summary reports the percentage of inmates who received the required 10 hours of structured time as this is the requirement of the MH settlement agreement. Each institutional report includes the number and percentage of inmates who received at least 1 structured activity and the number and percentage of hours received. Although this summary may indicate in some weeks that 0% of inmates received 10 hours, the detailed report will reflect that most inmates received some structured time.

HLBMU

HLBMU Structured Out of Cell Time

Structured time for this report was analyzed using data from the RIM reports (groups and individual sessions with the QMHP and Psychiatrist) and the structured time database with information entered

by the QIAS (community meetings and activity therapy). Below is a summary of the structured time inmates received by the week for each month in the reporting period.

The following chart shows the number and percentage of inmates receiving structured time by minutes each week for the reporting period. In weeks four and five of March the percentage of inmates receiving 10 hours of structured time was at its highest at 94% and 83%, respectively.

HLBMU Inmates Summary	February			March				
	9-Feb	16-Feb	23-Feb	2-Mar	9-Mar	16-Mar	23-Mar	30-Mar
n=	17	17	17	17	17	17	18	18
% inmates getting 0 mins	12%	12%	18%	29%	6%	0%	6%	11%
% inmates getting 15-59 mins	0%	6%	0%	0%	0%	0%	0%	0%
% inmates getting 60-359 mins	41%	71%	47%	41%	12%	47%	0%	0%
% inmates getting 360-599 mins	41%	12%	35%	29%	24%	47%	0%	6%
% inmates getting 10 hours	6%	0%	0%	0%	59%	6%	94%	83%

HLBMU Inmates Summary	April				May				
	6-Apr	13-Apr	20-Apr	27-Apr	4-May	11-May	18-May	25-May	1-Jun
n=	18	18	18	19	17	17	17	16	16
% inmates getting 0 mins	6%	6%	6%	53%	24%	6%	18%	19%	6%
% inmates getting 15-59 mins	0%	0%	22%	16%	12%	0%	0%	0%	19%
% inmates getting 60-359 mins	17%	17%	67%	21%	47%	88%	71%	38%	63%
% inmates getting 360-599 mins	0%	28%	0%	0%	18%	0%	12%	38%	6%
% inmates getting 10 hours	78%	50%	0%	0%	0%	0%	0%	0%	0%

The following chart shows the number and percentage of inmates receiving structured time by minutes each week for the reporting period for the RHUs.

Restrictive Housing Units

Broad River RHU Inmates Summary	February				March				April				May				
	10-Feb	17-Feb	24-Feb	3-Mar	10-Mar	17-Mar	24-Mar	31-Mar	7-Apr	14-Apr	21-Apr	28-Apr	5-May	12-May	19-May	26-May	2-Jun
n=	31	32	33	33	31	30	34	35	37	39	40	43	44	42	43	44	43
Number inmates getting 0 min	55%	84%	85%	76%	84%	57%	79%	80%	78%	54%	80%	81%	82%	79%	88%	89%	100%
Number inmates getting 15-59 mins	19%	6%	3%	15%	0%	17%	3%	11%	11%	13%	13%	7%	14%	7%	0%	2%	0%
Number inmates getting 60-359 mins	19%	6%	3%	9%	16%	27%	18%	9%	5%	28%	0%	9%	5%	10%	7%	2%	0%
Number inmates getting 360-599 mins	6%	3%	0%	0%	0%	0%	0%	0%	3%	0%	0%	0%	0%	0%	0%	0%	0%
Number inmates getting 10 hours	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Kirkland RHU Inmates Summary	February				March				April				May				
	10-Feb	17-Feb	24-Feb	3-Mar	10-Mar	17-Mar	24-Mar	31-Mar	7-Apr	14-Apr	21-Apr	28-Apr	5-May	12-May	19-May	26-May	2-Jun
n=	6	7	8	9	8	7	6	7	7	7	10	9	9	12	14	16	16
Number inmates getting 0 min	83%	57%	75%	78%	13%	43%	83%	100%	43%	71%	100%	56%	89%	92%	93%	81%	75%
Number inmates getting 15-59 mins	0%	29%	13%	11%	25%	43%	0%	0%	29%	14%	0%	33%	0%	0%	7%	13%	25%
Number inmates getting 60-359 mins	0%	0%	0%	0%	38%	0%	0%	0%	0%	0%	0%	0%	11%	0%	0%	6%	0%
Number inmates getting 360-599 mins	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Number inmates getting 10 hours	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Perry RHU Inmates Summary	February				March				April					May			
	10-Feb	17-Feb	24-Feb	3-Mar	10-Mar	17-Mar	24-Mar	31-Mar	7-Apr	14-Apr	21-Apr	28-Apr	5-May	12-May	19-May	26-May	2-Jun
n=	41	45	51	44	37	35	38	47	38	36	35	33	35	40	35	39	37
Number inmates getting 0 min	85%	73%	78%	91%	81%	83%	97%	74%	87%	78%	97%	73%	100%	80%	97%	100%	100%
Number inmates getting 15-59 mins	10%	22%	16%	9%	16%	11%	3%	21%	13%	22%	3%	27%	0%	15%	3%	0%	0%
Number inmates getting 60-359 mins	2%	4%	0%	0%	3%	6%	0%	2%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Number inmates getting 360-599 mins	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Number inmates getting 10 hours	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Lee RHU Inmates Summary	February				March				April				May				
	10-Feb	17-Feb	24-Feb	3-Mar	10-Mar	17-Mar	24-Mar	31-Mar	7-Apr	14-Apr	21-Apr	28-Apr	5-May	12-May	19-May	26-May	2-Jun
n=	48	41	42	46	46	46	41	38	40	39	48	51	52	49	48	56	49
Number inmates getting 0 min	85%	88%	98%	96%	93%	91%	90%	95%	88%	95%	96%	98%	90%	94%	94%	100%	100%
Number inmates getting 15-59 mins	15%	10%	2%	4%	2%	7%	10%	5%	13%	5%	2%	2%	8%	4%	2%	0%	0%
Number inmates getting 60-359 mins	2%	0%	0%	0%	0%	0%	0%	0%	3%	0%	0%	0%	0%	2%	2%	0%	0%
Number inmates getting 360-599 mins	0%	0%	0%	0%	2%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Number inmates getting 10 hours	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Camille RHU Inmates Summary	February			March					April				May				
	10-Feb	17-Feb	24-Feb	3-Mar	10-Mar	17-Mar	24-Mar	31-Mar	7-Apr	14-Apr	21-Apr	28-Apr	5-May	12-May	19-May	26-May	2-Jun
n=	28	27	21	25	22	20	25	26	30	38	33	33	34	39	33	36	40
Number inmates getting 0 min	79%	74%	76%	80%	50%	60%	56%	73%	97%	95%	91%	76%	100%	87%	82%	22%	75%
Number inmates getting 15-59 mins	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Number inmates getting 60-359 mins	11%	22%	14%	16%	36%	25%	40%	19%	3%	5%	9%	24%	0%	13%	18%	33%	13%
Number inmates getting 360-599 mins	11%	4%	10%	4%	14%	15%	4%	4%	0%	0%	0%	0%	0%	0%	0%	44%	13%
Number inmates getting 10 hours	0%	0%	0%	0%	0%	0%	0%	4%	0%	0%	0%	0%	0%	0%	0%	0%	0%

July 2018 Implementation Panel findings: Problems remain in tracking out of cell time, which needs to be reconciled for future reporting purposes. All the programs were negatively impacted by the lockdown following the Lee CI riots. However, it was our understanding that both the HLBMU and LLBMU are no longer on a lockdown status. We did not assess either the HLBMU or LLBMU during this site assessment.

During the morning of July 17, 2018, we attended a graduation ceremony for five HLBMU inmates that was very impressive and meaningful for the inmates and family members who were able to attend.

July 2018 Implementation Panel Recommendations: SCDC should identify strategies that could potentially immediately remove all inmates in RHU on Security Detention status with the Mental Health Designation Levels 1, 2, 3. A QI Study should be conducted to assess why a high number of inmates that graduated from the LLBMU in March 2018 have been placed in RHU.

2b.ii. Provide more out-of-cell time for segregated mentally ill inmates;

Implementation Panel July 2018 Assessment: noncompliance

June 2018 SCDC Status Update:

To mitigate conditions of confinement within the RHUs, crank radios have been distributed in some of the RHUs. It is unclear how many radios were designated specifically for the RHUs. QIRM staff conducted an assessment of the distribution of radios issued to inmates in the RHUs based on contracts and/or tracking logs received from the institutions. The table below illustrates the number of radios issued at institutions from which documentation was received.

Institution	# of radios issued
Broad River	61
Lee	95
Perry	22
Camille	89

In early assessments QIRM staff determined a lack of uniformity in guidelines directing the distribution of radios from one institution to another. Another concern identified was the stipulation that inmates had to be disciplinary-free for up to 90 days to qualify for the receipt of a radio. It was felt that this was counterproductive, as disciplinary infractions were factors for the RHU placement.

Several institutions developed contracts to track and outline provisions for inmates to receive and maintain radios. QIRM reported the lack of consistency across the agency. If an inmate qualified in one institution based on one institution's rules he/she may not qualify at another based on their different set of rules. This was brought to the attention of the Operations staff, and one set of guidelines has been developed to increase continuity and consistency across the system. This information was discussed at the June 20 Warden's meeting, and followed up with a memo outlining the official procedure and for distributing the crank radio. See Appendix K for copy of the memo and accompanying inmate contract.

Televisions

The chart below shows the status of the addition of televisions to the RHUs as reported by the Office of Operations. One hundred seventy one (171) televisions were purchased for installation in RHU's and 56 are installed and functioning to date.

Institution	# of TV's needed	TVs delivered To Institution
Allendale	8	8
Broad River	8	4
Evans	24	24
Camille	16	16
Kershaw	16	16
Kirkland	0	
Leath	5	5
Lee	10	10
Lieber	4	4
MacDougall	6	6
McCormick	8	8
McCormick (Step-down)	5	5
It was uncle and number of televisions that have been delivered to the institution of actually been set up. ArRidgeland	5	5
Trenton	4	4
Turbeville	10	10
Tyger River	40	0
Wateree	2	2
Total	171	127

July 2018 Implementation Panel findings: As per status update section. The uncertainty and apparent inconsistency re: the distribution of crank radios needs to be remedied. In addition, it was unclear the number of televisions, which had been delivered to various institutions, that were actually installed.

Previous efforts to mitigate the harmful effects of not being able to comply with many aspects of the Settlement Agreement have essentially ended at the present time related to the systemwide lockdown.

Broad River Correctional Institution

July 2018 Implementation Panel findings: Conditions of Confinement continue to be impacted by correctional staff shortages. The system-wide lockdown has further exacerbated BRCI being able to provide basic services. There did not appear to be any progress in improving RHU conditions of confinement since the March 2018 IP Site Visit. Also a significant number of inmates were transferred from Lee CI increasing the number of inmates in RHU. Out of Cell recreation did not occur in April 2018 and May 2018 due to the system-wide lockdown. Prior to the system-wide lockdown, BRCI had begun affording RHU inmates out of cell recreation. QIRM QI studies identified that 60-80 percent of the randomly selected RHU inmates in February 2018 and March 2018 were offered out of cell recreation 5 times per week. BRCI Management reported RHU inmates are receiving showers 3 times per week. QIRM QI studies conducted for randomly selected BRCI RHU inmates for the month of May 2018 indicated 0

percent received showers 3 times per week. SCDC records indicate that correctional staff are consistently failing to perform 30 minute inmate welfare checks at irregular times.

RHU inmates complained they are not receiving clothing exchange, opportunity to clean their cells and sick call access. Maintenance personnel were in RHU performing electrical repairs when the designated IP member visited RHU.

July 2018 Implementation Panel Recommendations: Remedy the identified deficiencies and begin providing basic RHU services. Continue QI studies monitoring BRCI efforts to improve RHU conditions of confinement.

Lee Correctional Institution

July 2018 Implementation Panel findings: During the morning of July 18, 2018, we observed the mental health rounding process in the RHU, which was performed in a competent manner but was significantly hampered by the noise level within the housing unit. Due to the lockdown status systemwide, inmates in the RHU have not had any recreational time since April 15, 2018.

During the rounding process, one inmate was identified as being actively psychotic, who was subsequently transferred to GPH following the cell front assessment. Another inmate, who was on suicide watch in a crisis cell within the RHU, only had a blanket. It was unclear why the institution did not have mattresses available for inmates on suicide watch.

The April 15, 2018 riot had a major impact on Lee CI RHU Operations. For a period of time after April 15, 2018, the second RHU had to be re-opened and operated without additional staff. Fortunately, SCDC has been able to transfer a number of inmates and again closed the 2nd RHU. However, the Lee CI lockdown continues to impact RHU operations. The IP identified that correctional staff are not making 30 minute inmate welfare checks at irregular times and the times between inmate welfare checks routinely exceeded one hour. RHU inmates complained they are not receiving clothing exchange or the opportunity to clean their cells. General RHU maintenance and sanitation was observed to be at an unacceptable level. Upon the IP receiving complaints from several RHU inmates that their cell lights were broken, Lee CI Management completed an inspection and reported 8 of 92 cells had lights that were broken and not working on the day of the site visit. SCDC QIRM QI studies indicate 20 percent of the RHU inmates are receiving showers 3 times a week.

July 2018 Implementation Panel Recommendations: Remedy the identified deficiencies and begin providing basic RHU services. Continue QI studies monitoring Lee CI efforts to improve RHU conditions of confinement. Obtain essential property, such as mattresses, for inmates on suicide watch.

Perry Correctional Institution

July 2018 Implementation Panel findings: During the morning of July 19, 2018, the IP observed the mental health rounding process in the RHU, which was done in a competent manner by the mental health tech. In general, this RHU was reasonably quiet and clean. Showers were being offered to inmates on a three times per week basis. Recreational time began to be offered to a limited number of inmates during the past two weeks. Medication administration occurred through the food slot. 57 of the 107 RHU inmates were on the mental health caseload.

July 2018 Implementation Panel Recommendations: Continue to implement access to out of cell time for all inmates in the RHU.

Leath Correctional Institution

July 2018 Implementation Panel findings: The RHU was clean and quiet. Inmates were receiving adequate access to showers but not adequate access to out of cell recreational time due to custody staff shortages.

July 2018 Implementation Panel Recommendations: Remedy the above.

Camille Griffin Graham RHU

Fifteen of the 23 RHU inmates were on the mental health caseload.

Staff reported that RHU groups continue to be provided to mental health caseload inmates in the RHU. RHU inmates reported generally being offered one hour per weekday of outdoor recreation, showers three times per week and some of the inmates reported access to weekly group therapies/activities. Access issues to the psychiatrist were described. Medication management issues did not appear to be present.

The unit was clean and quiet.

Drs. Metzner and Johnson observed a group therapy that involved 4 inmates that was well run by the mental health clinician.

July 2018 Implementation Panel Recommendations: Address the access issues to the psychiatrist and counselors. The statewide lockdown resulted in fewer out of cell activities and treatment in RHU's and General Population units.

2b.iii. Document timeliness of sessions for segregated inmates with psychiatrists, psychiatric nurse practitioners, and mental health counselors and timely review of such documentation;

Implementation Panel July 2018 Assessment: noncompliance

June 2018 SCDC Status Update:
All mental health inmates should receive timely individual sessions with the QMHP and Psychiatrist, even when in the RHU. The frequency of individual sessions is based on the mental health classification or clinical need of the inmate. Below are the results of an analysis of the timeliness of QMHP and Psychiatrist sessions for HLBMU and RHU inmates with a mental health classification.

HLBMU
During the reporting period, while inmates in phase 1 and phase 2 did receive individual sessions with the QMHP, none of the inmates were seen weekly as required in policy. For phase 3 inmates, 75% received timely sessions with the QMHP. Sessions with the Psychiatrist were also reviewed for timeliness, and 77% of BMU inmates had timely sessions with the Psychiatrist. For the complete analysis of timeliness of sessions, refer to pages 30 -33 in Kirkland's Institutional Report, Appendix L.

RHU

During the reporting period, RIM caseload monitoring reports were used to review timeliness of sessions with the QMHP and Psychiatrist. The reports used were dated March 1st, April 1st, May 1st, and June 1st. Sample sizes were based on the number of inmates on each report with a RHU classification. For complete details, refer to each institutions' report under the Caseload Management Section.

Broad River RHU

- From the **March 1st** report, 47% of the inmates had timely sessions with the QMHP and 63% had timely sessions with the Psychiatrist.
- From the **April 1st** report, 57% of the inmates had timely sessions with the QMHP and 50% had timely sessions with the Psychiatrist.
- From the **May 1st** report, 67% of the inmates had timely sessions with the QMHP and 47% had timely sessions with the Psychiatrist.
- From the **June 1st** report, 57% of the inmates had timely sessions with the QMHP and 63% had timely sessions with the Psychiatrist.

Camille RHU

There are no reports generated from NextGen that demonstrate timeliness of sessions. Therefore, a manual audit of ten (10) L3 RHU inmates was conducted in NextGen to analyze timeliness of sessions for the month of May. Of the 10 inmates reviewed, 40% had timely sessions with the QMHP and 0% had a timely sessions with the Psychiatrist. There was 1 inmate with a documented session with the Psychiatrist in May; however, the last session held prior to that one was in January, which makes the May session overdue.

Kirkland RHU

- From the **March 1st** report, 62% of the inmates had timely sessions with the QMHP and 62% had timely sessions with the Psychiatrist.
- From the **April 1st** report, 50% of the inmates had timely sessions with the QMHP and 100% had timely sessions with the Psychiatrist. (The sample size was 2 RHU inmates).
- From the **May 1st** report, 75% of the inmates had timely sessions with the QMHP and 75% had timely sessions with the Psychiatrist.
- From the **June 1st** report, 85% of the inmates had timely sessions with the QMHP and 77% had timely sessions with the Psychiatrist.

Lee RHU

- From the **March 1st** report, 60% of the inmates had timely sessions with the QMHP and 57% had timely sessions with the Psychiatrist.
- From the **April 1st** report, 69% of the inmates had timely sessions with the QMHP and 62% had timely sessions with the Psychiatrist.
- From the **May 1st** report, 60% of the inmates had timely sessions with the QMHP and 70% had timely sessions with the Psychiatrist.
- From the **June 1st** report, 57% of the inmates had timely sessions with the QMHP and 43% had timely sessions with the Psychiatrist.

Perry RHU

- From the **March 1st** report, 83% of the inmates had timely sessions with the QMHP and 90% had timely sessions with the Psychiatrist.

- From the **April 1st** report, 87% of the inmates had timely sessions with the QMHP and 93% had timely sessions with the Psychiatrist.
- From the **May 1st** report, 92% of the inmates had timely sessions with the QMHP and 80% had timely sessions with the Psychiatrist.
- From the **June 1st** report, 96% of the inmates had timely sessions with the QMHP and 93% had timely sessions with the Psychiatrist.

July 2018 Implementation Panel findings: As per status update section.

July 2018 Implementation Panel Recommendations: Need to determine the reasons for noncompliance and remedy the underlying causes.

2b.iv. Provide access for segregated inmates to higher levels of mental health services when needed;

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

Between June 19- June 21, 2018, forty-eight inmates of significant concern to SCDC were transferred to an out-of-state private prison in Mississippi, which will potentially relieve some RHU tensions. Lee CI RHU inmates on medications are being swapped with inmates NOT on medications due to the continuing challenges within the Lee RHU and to decrease the nursing workload. As of June 19, the RHU inmates on medication were being cohorted for to make it easier for nurses to dispense medication. Several facilities, including Lee and BRCI, have had a "mental health day" with consolidated efforts to catch up on backlogs of visits for inmates. Turbeville is being targeted to become a specialized RHU for mental health inmates, with additional programming.

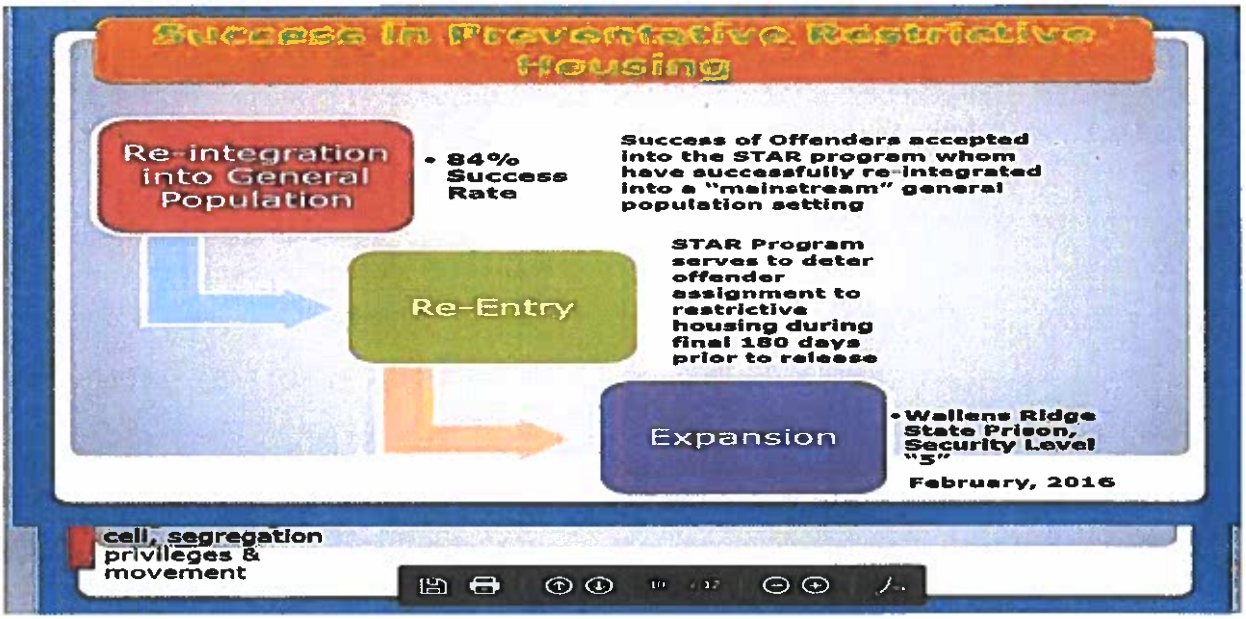
One thousand, nine hundred fifty (1950) crank Radios have been purchased this fiscal year and distributed to the mentally ill and non-mentally ill RHU inmates with priority first to SD (long-term), then SP (protective concerns), then to all in RHU inmates.

One hundred sixty-three (163) televisions were purchased for installation in RHUs, and 56 are installed and functioning to date.

Class 16 of CIT staff completed training on June 15, 2018. NIC has approved offer of Mental Health first Aid for SCDC with training scheduled for 60 staff from September 26-27, 2018.

To address segregation and the cycle of fear that impacts readmissions to CSU, Evans CI has been designated for a Specialty Concerns Unit. This Unit will house inmates who refuse to leave the RHU due to fear and it will eventually be used to house the inmates who are threatening suicide and going to CSU to escape fearful situations.
Evans is awaiting the appointment of an AW of Programs. The former AW Programs retired but returned as a QMHP. The position for AW of programs has been posted.

Key staff including the Warden from Evans traveled to Virginia to see its STAR program in action, considering it as a program model. Additional programming will be identified. A position for a QMHP was offered but was declined due to salary. The position has since been reposted. Currently there are two Mental Health Techs.



Character dorm inmates from Kershaw and Ridgeland (50 each) have been identified to transfer to Evans when programming is available. Seventeen Allendale Character Inmates have transferred to Evans CI at this point with over 200 "protective concerns" inmates in RHUs across SCDC awaiting potential movement to Evans when programming is available.

July 2018 Implementation Panel findings: As per status update section. It is concerning that the trip to Virginia resulted in apparent enthusiasm by custody staff to add canines as part of the security detail.

We look forward to receiving more information re: the proposed Specialty Concerns Unit.

During the morning of July 19, 2018, the IP interviewed about 40 inmates in the stepdown unit at the Perry CI in a community meeting setting. Twenty-four (24) of the 43 inmates in this unit were on the mental health caseload. Medication management issues were not present. Caseload inmates generally met with their QMHPs about every 90 days. A very structured program for all transition unit inmates was described by the inmates, which were generally reported to be very positive.

July 2018 Implementation Panel Recommendations: Please send additional information re: the Specialty Concerns Unit.

2b.v. The collection of data and issuance of quarterly reports identifying the percentage of mentally ill and non-mentally ill inmates in segregation compared to the percentage of each group in the total prison population with the stated goal of substantially decreasing segregation of mentally ill inmates and substantially decreasing the average length of stay in segregation for mentally ill inmates;

Implementation Panel July 2018 Assessment: compliance (November 2016)

June 2018 SCDC Status Update:

The "Mental Health Classifications for Mentally Ill Institutional and Female GEO Care Population" Report produced by RIM each Tuesday identifies the percentage of mentally ill and non-mentally ill inmates for each institution. Utilizing this report along with the "Inmates in Lockup by Institution and Mentally Ill vs. Non-Mentally Ill Population" Report QIRM was able to compare populations as charted below. For the months of February through May 2018, about 41% of the Segregation Population was Mentally Ill inmates. That remains disproportionate to the approximately 16% of the total population that were mentally ill.

	Week	Tot. MI	Tot. Pop.
Feb	1	**3,585**	**19,323**
	2	**3,602**	**19,333**
	3	**3,614**	**19,406**
	4	**3,647**	**19,458**
March	1	**3,613**	**19,208**
	2	**3,610**	**19,160**
	3	**3,640**	**19,204**
	4	**3,656**	**19,281**
April	1	**3,603**	**19,064**
	2	**3,623**	**19,089**
	3	**3,640**	**19,137**
	4	**3,674**	**19,286**
	5	**3,704**	**19,410**
May	1	**3,648**	**19,088**
	2	**3,662**	**19,130**
	3	**3,682**	**19,169**
	4	**3,713**	**19,313**
Quarter Tot.		**61,916**	**327,059**

Percentages of Mentally Ill & Non Mentally Ill Inmates in Segregation vs Total Population

	Segregation			Tot. Population		
	Mentally Ill	Non Mentally Ill	Total	Mentally Ill	Non Mentally Ill	Total
	6,033	8,736	14,769	61,916	327,059	388,975
% of Total	**40.85 %**	**59.15 %**	100%	**15.92 %**	**84.08 %**	100%

July 2018 Implementation Panel findings: As per status update section. We remain concerned regarding the overrepresentation of mentally ill inmates in RHUs.

July 2018 Implementation Panel Recommendations: Assess the underlying reasons that mentally ill inmates are so overrepresented in RHU and remedy the situation.

2b.vi. Undertake significant, documented improvement in the cleanliness and temperature of segregation cells; and

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

A review of temperature and cell check logs was completed to evaluate the temperature and cleanliness of segregation cells as self-reported by the officers in Broad River CSU and RHU; Camille CSU and RHU; and Kirkland's D-Unit, F-1, and GPH; Evans RHU; and Perry RHU (B, C, and D Dorms). Officers are required to check temperature and cleanliness in segregation units twice daily in a total of 8 randomly chosen cells daily. The documentation from these checks (SCDC Form 19-163) is to be uploaded into the S:/Operations folder or, if done through the newly developed electronic OATS system, it is uploaded by RIM into the Secure Login App. Therefore, the data source for this review was taken from this shared folder or the App. If the documentation had not been uploaded, it was considered not done. The full review, attached as Appendix M.

Random, Daily Cell Checks

Each institution is required to check random cells in each segregation unit twice daily for temperature and cleanliness, document the check, and upload the documentation to the shared Operations folder. Some institutions had significant deficiency in checking the number of cells required every day. Some deficiencies came because no documentation was uploaded; others were because only one shift would document the daily temperature and cleanliness checks.

The review showed that only BRCI CSU (80%), BRCI RHU (72%) and CGCI CSU (82%) did not upload data daily with at least a 90% compliance. BRCI's RHU had low compliance at 72%; however, this is a tremendous improvement over the 3% they had showed in the October 2017 – January 2018 period. It appears the OATS system which they started in April, has helped to increase their compliance significantly.

Temperature Checks

Of all the cell checks that were documented, across the board, 100% of the cells did have temperature checks documented.

Temperature Range

Some institutions maintained most of their temperatures within the acceptable range while others had significant problems. Broad River RHU (97%), Camille CSU (97%), KCI GPH (93%), and Perry RHU (B-Dorm 96%, C-Dorm 96%, D-Dorm 98%) all had substantial compliance keeping their temperatures within the accepted range (68°-78°). Kirkland's F-1 had 89% and the D-Unit 86% compliance with temperature ranges, and BRCI CSU (76%) and Evans RHU (77%) had the lowest compliance.

There were two segregated areas where some temperatures were significantly (> 8 degrees) outside the accepted range. Evans RHU and Perry's C-dorm had 10% and 13% of their out-of-range temperatures respectively that were significantly out of range.

Correcting Temperature Deficiencies

When temperatures were out of range, there was seldom documentation that anything was done to correct the problem. In previous months, CGCI had piloted using a revision to Form 19-163 in which a field was required if the temperature was outside the accepted range of 68°-78°. In the first study, Camille documented taking action in 43% of the cases where the temperature was out of range; in this study, CGCI RHU reported 82% compliance and CGCI CSU reported 38% compliance, compared to 2% at BRCI CSU, and 0% elsewhere. This was in spite of the fact that several of the units began using the revised form during the time period covered in this audit. As noted in the previous study, no documentation has been provided to show if the work orders have been acted upon or if the facility

temperatures have improved. It appears that the OATS app format does not require any specific action if the temperature is out of range, so the officers are not documenting anything, if they are doing anything.

Cleanliness and Sanitation Checked
All institutions were consistent (~97 - 100% compliance) in documenting cell cleanliness when they checked a cell.

Cleanliness and Sanitation Deficiencies Corrected
Of those cells that were checked for cleanliness, no institution showed a substantial compliance in documenting the correction of problems with cell cleanliness, though Evans scored the highest (82%). Camille CSU was second at 50%. Officers at KCI's GPH occasionally documented if a deficiency was addressed (18%).

July 2018 Implementation Panel findings: As per status update section. There was significant improvement in institutions performing and uploading temperature checks and cell inspection forms. Institutions failing to address and/or correct identified temperature and sanitation deficiencies remains an issue.

July 2018 Implementation Panel Recommendations:

1. Operations Management ensure all prisons are performing daily inspections for cleanliness and taking temperatures of random cells;
2. Ensure deficiencies identified in the cell inspections for cleanliness and temperature checks are followed up on and the action taken is documented on the Cell Temperature and Cleanliness Logs;
3. SCDC QIRM continue to perform QI Studies regarding Correctional Staff performing daily, random cell temperatures and cleanliness inspections.

2b.vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
QIRM continues to identify processes to improve data collection and reporting to accurately and effectively reflect improvement work and compliance with the components of the Mental Health Settlement Agreement.

After a policy review, it has been identified that policy–driven processes have not been fully implemented which may be a contributing factor in concerns regarding data and reporting. A conceptual model was generated based on the criteria for reporting as outlined in policies HS 19.07, Mental Health Services - Continuous Quality Management (CQM), and GA 06.06, Continuous Quality Improvement Review.

A Quality Management Master plan, Appendix N, has been developed that outlines how both policies, when fully implemented as written, will result in improved data reporting and monitoring throughout all levels of the agency. The plan will compel institutional and program staff to identify areas for

improvement and allow them to self-monitor progress towards compliance. The plan incorporates reporting from the program and institutional level through the Senior Management Board.

During the last reporting period, the following ICQMC Meetings were held at various institutions as outlined in SCDC Policy GA 06.06. Meeting minutes and agenda are included in Appendix O

Camille Graham Correctional Institution
An Institutional Continuous Quality Management Committee (IQCMC) meeting for Camille Graham was conducted on Thursday, May 31, 2018 at 1:00pm. Based on information provided and discussed, the institution identified the following Process Improvement Plans to address deficiencies:

During this meeting, areas identified for a PIP (Process Improvement Plan) focused on creating a protocol for CSU and improving NextGen documentation. Improper documentation in NextGen has been identified by staff as a possible reason for low compliance ratings in different areas. For example, treatment plans are sometimes entered in places other than the treatment plan tab, individual sessions with the QMHP are sometimes coded as contact notes, and RHU rounds are coded as group notes. The completed PIP which outlines the institution's plan to address these areas has not been received.

Agenda, minutes and submitted PIP updates for each institution are included Appendix O

Lee Correctional Institution
An Institutional Continuous Quality Management Committee (IQCMC) meeting for Lee was conducted on Tuesday, March 27, 2018 @ 10:30am. Based on information provided and discussed, the institution identified the following Process Improvement Plans to address deficiencies RHU out of cell group activity

- Lack of Mental Health staffing
- Update M-120 to reflect increased shower for inmates on CI/SP status.

MacDougall Correctional Institution
An Institutional Continuous Quality Management Committee (IQCMC) meeting for MacDougall was conducted on Wednesday, March 28, 2018, at 10:00am. Based on information provided and discussed, the institution identified the following Process Improvement Plans to address deficiencies:

- Weekly Treatment Teams Participation and MUSC Contract Review
- Staffing of CIT members (2 each Shift)
- Internal Audit process

Broad River Correctional Institution
An Institutional Continuous Quality Management Committee (IQCMC) meeting for Broad River was conducted on Wednesday, June 6, 2018, at 9:00am. Broad River has not identified any PIPS.

Kirkland Correctional Institution
An Institutional Continuous Quality Management Committee (IQCMC) meeting for Kirkland was conducted on Monday, Feb.12, 2018, at 9:00am. The agenda outlined discussion topics to include the following:

The second Institutional Continuous Quality Management Committee (IQCMC) meeting for Kirkland was conducted on Thursday, June 14, 2018, at 9:00am

July 2018 Implementation Panel findings: As per status update section. It is our understanding that the current plan is for the individual institutions to be responsible for the relevant continuous quality improvement process, which will be monitored by QIRM.

July 2018 Implementation Panel Recommendations: As above.

2.c. Use of Force:
2.c.i. Development and implementation of a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness;

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
In efforts to bring the agency into compliance with the stipulations set forth in the SCDC Mental Health Lawsuit settlement, the Implementation Panel has been particularly focused on certain areas of SCDC policies and practices. One area of focus for the Implementation Panel is Use of Force as it applies to inmates on the Mental Health Caseload. The frequency and severity of force that is used with this population is a major concern. For this reason, a Use of Force Coordinator for the Division of Mental/Behavioral Health and Substance Abuse Services was hired on March 19, 2018. The Coordinator reviews medical records and Offender Management System for recent psychiatry visits, Treatment Team reviews, individual counseling sessions, group counseling sessions, uses of force on client, and disciplinary history to assess whether a possible change to level of care, medications, etc., may be indicated. In this role the Coordinator determines if protocols were followed relative to contacting QMHP prior to a planned use of force and determines if the response was timely and effective in mitigating a use of force.

In a review of uses of force involving mentally ill and non-mentally ill inmates, the data continues to demonstrate that although the mentally ill population makes up the smaller percentage of inmates, the uses of force continues to be used at a higher rate among this population. Although they only make up 19% of the population, the data shows that they 54% of the uses of force involved inmates with a mental health classification for these reporting months.

	Mental Health Inmates (MH)	UOF MH	Non-mental Health NMH	UOF NMH	Total Pop	Total UOF
February	3585	44	15738	52	19323	96
March	3613	68	15592	38	19205	106
April	3603	46	15461	43	19064	89
	10801	158	46791	133	57592	291
% of uses of Force		54%		46%		
% of the Total Population	19%		81%			

July 2018 Implementation Panel findings: As per status update section. The Use of Force Coordinator for the Division of Mental/Behavioral Health and Substance Abuse Services is formalizing procedures to review use of force incidents involving inmates with a mental health designation. A study is currently underway to review and assess inmates with a mental health designation that are frequently involved in use of force incidents. The Use of Force Coordinator for the Division of Mental/Behavioral Health and Substance Abuse Services and Operations Administrative Regional Director (ARD) have begun collaborating on use of force incidents involving inmates with a mental health designation. Data reveals a

slight percentage decrease in the number of inmates with a mental health designation being involved in use of force incidents from 49 percent to 46 percent since the March 2018 Assessment while the SCDC inmate population with a mental health designation increased from 18.7 percent to 19 percent.

July 2018 Implementation Panel Recommendations:

1. SCDC continue to monitor all Use of Force incidents to identify and address the reasons for disproportionate Use of Force involving inmates with mental illness;
2. SCDC formalize and implement procedures to review inmates with a mental health designation that are involved in use of force incidents.
3. Identify strategies to reduce use of force against inmates with mental illness and non-mentally ill inmates;
4. The Division of Operations Administrative Regional Director and Division of Mental Health UOF Coordinator collaboratively work together to address issues and concerns that contribute to disproportionate UOF involving mentally ill inmates;
5. All required SCDC staff complete Use of Force Training in Calendar Year 2018.

2.c.ii. The plan will further require that all instruments of force, (e.g., chemical agents and restraint chairs) be employed in a manner fully consistent with manufacturer's instructions, and track such use in a way to enforce such compliance;

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

A report of Employee Corrective Actions was provided for July 2017 through April 2018. During this timeframe there were nineteen reported corrective actions imposed at eight institutions. The imposed sanctions ranged from verbal warnings to termination for the following offenses:

1. Excessive Use of Chemical Munitions
2. Gross Misconduct
3. Unnecessary/ Excessive Use of Force
4. Negligence in Carrying Out Job Duties
5. Policy Violation
6. Violation of Rules/ Regulation

Institution	Incident Date	Date of CA	Reason for CA	Corrective Action	Additional Corrective Action
Evans CI	1/15/2018	5/4/2018	Policy Violation	Memo/ Letter of Understanding (LOU) or Discussion	Attended Training 4/18/18
Evans CI	2/22/2018	5/1/2018	Policy Violation	Memo/ LOU or Discussion	Training 4/18/18
Evans CI	3/6/2018	5/11/2018	Policy Violation	Memo/ LOU or Discussion	
Evans CI	3/26/2018	4/16/2018	Policy Violation	Memo/ LOU or Discussion	Training 4/18/18
Leath CI	1/26/2018	3/28/2018	Negligence Carrying Out Job Duties	Memo/ LOU or Discussion	

Leath CI	1/26/2018	3/28/2018	Negligence Carrying Out Job Duties	Memo/ LOU or Discussion	
Lee CI	1/27/2018	2/2/2018	Unnecessary and/or Excessive Force	Verbal Warning	
Lee CI	3/12/2018	3/14/2018	Gross Misconduct & Unnecessary / Excessive Force	Termination	
Perry CI	11/4/2017	2/15/2018	Violation Rules/ Regulations	Written Warning	
Perry CI	1/4/2018	2/15/2018	Unprofessional Conduct	Suspension	
Perry CI	1/14/2018	4/9/2018	Excessive Use of Chem Munitions	Verbal Warning	
Ridgeland CI	1/6/2018	6/6/2018	Policy Violation	Memo/ LOU or Discussion	
Ridgeland CI	2/27/2018	2/28/2018	Excessive Use of Chem Munitions	Letter of Discussion	Attended Training 5/31/18
Trenton CI	11/23/2017	2/15/2018	Excessive Use of Chem Munitions	Memo/ LOU or Discussion	
Trenton CI	2/10/2018	2/24/2018	Excessive Use of Chem Munitions	Memo/ LOU or Discussion	
Trenton CI	4/3/2018	5/8/2018	Negligence Carrying Out Job Duties	Suspension	
Turbeville CI	12/15/2017	1/22/2018	Negligence Carrying Out Job Duties	Written Warning	
Turbeville CI	12/27/2017	3/1/2018	Negligence Carrying Out Job Duties	Suspension	
Tyger River CI	7/12/2017	7/22/2017	Unnecessary/ Excessive Force	Suspension	

July 2018 Implementation Panel findings:
SCDC continues implementation of the revised OP 22.01 Use of Force Policy requiring instruments of force to be employed in a manner consistent with manufacturer's instructions. SCDC has not provided documentation the Housing Unit Post Orders as it applies to *Cover Teams* has been revised to achieve compliance that MK-9 use is consistent with manufacturer's instructions. The SCDC Division of Security provided a list of SCDC approved Use of Force Equipment in April 2018.

SCDC continues efforts to ensure all instruments of force, (e.g., chemical agents and restraint chairs) are employed in a manner fully consistent with manufacturer's instructions, and are tracked to enforce compliance. Reports are compiled and distributed weekly and monthly containing the summaries for types of force utilized as well as the MINs summaries. Findings are verbally reported and discussed in a weekly meeting with QIRM and Operations Staff.

SCDC had two incidents during the relevant period that required restraint chair use. UOF Reports identified that hard restraints were utilized a total of 6 times: February (2), March (1), April (3), and May (0). The IP was not provided data on the amount of time the inmates remained in hard restraints nor was information provided regarding whether an assessment was conducted to determine if SCDC guidelines for hard restraint use were followed.

SCDC reported no incidents where canines or batons were used in a UOF.

SCDC data continues to identify a high percentage of incidents where MK 9 was not employed in a manner fully consistent with manufacturer's instructions. As identified in the status update section, there is more accountability for employees committing UOF violations.

July 2018 Implementation Panel Recommendations:

1. Operations and QIRM continue to review use of force incidents through the automated system to ensure instruments of force are fully consistent with the manufacturer's instructions;
2. QIRM continue to meet weekly with Operations leadership to discuss UOF and other relevant issues;
3. SCDC revise the UOF Report to include Canines;
4. All required staff complete Use of Force Training in Calendar Year 2018.

2.c.iii. Prohibit the use of restraints in the crucifix or other positions that do not conform to generally accepted correctional standards and enforce compliance;

Implementation Panel July 2018 Assessment: compliance (July 2017)

June 2018 SCDC Status Update:

Operations and QIRM staff continue to review and monitor use of force incidents through the automated systems and in a daily review of MINS. There have been no documented reports from February- May 2018 of inmates being placed the crucifix or other positions that do not conform to generally accepted correctional standards.

July 2018 Implementation Panel findings: As per status update section. SCDC remains in compliance. Neither SCDC nor the IP identified any incident where an inmate was placed in the crucifix or other position that did not conform to generally accepted correctional standards.

July 2018 Implementation Panel Recommendations: Operations and QIRM staff continue to review and monitor use of force incidents through the automated system to ensure restraints are not used to place inmates in the crucifix or other positions that do not conform to generally accepted correctional standards. Pursue corrective action when violations and/or issues are identified.

2.c.iv. Prohibit use of restraints for pre-determined periods of time and for longer than necessary to gain control, and track such use to enforce compliance;

Implementation Panel July 2018 Assessment: **compliance (March 2018)**

June 2018 SCDC Status Update:
During the months of February – April 2018 there were two documented incidents involving the use of the restraint chair. Both incidents involved inmates with a mental health classification, one occurring at Broad River CSU and the other at Perry RHU. This information is provided in the Automated Use of Force System and cross reference with the inmate's Automated Medical Record and the RIM report, which is produced on the 22nd of each month, therefore the month of May 2018 was not available. The restraint chair report is included in the Regional Monthly Reports. The most recent report is included as Appendix P.

July 2018 Implementation Panel findings: As per status update sections. From February through April 2018 there were two (2) reported uses of the restraint chair. Both incidents occurred in April 2018 and involved inmates with a mental health designation. IP document reviews found the required restraint chair guidelines were followed. SCDC continues to rarely use the restraint chair and is commended on their success in limiting its use. UOF Reports identified that hard restraints were utilized a total of 6 times during the relevant period: February (2), March (1), April (3), and May (0). The IP was not provided data on the amount of time the inmate remained in hard restraints and whether SCDC guidelines for hard restraint use were followed.

July 2018 Implementation Panel Recommendations: QIRM continue to track and monitor compliance with use of the restraint chairs. Inmates placed in hard restraints should be monitored and tracked by QIRM in addition to restraint chairs to include: compliance with guidelines and the amount of time in hard restraints.

2.c.v. The collection of data and issuance of quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs.

Implementation Panel July 2018 Assessment: compliance (December 2017)

June 2018 SCDC Status Update:
The QIRM Use of Force Reviewer was able to substantiate the length of time for both inmates placed in the restraint chair during this reporting period. The inmate at BRCI CSU was in the restraint chair for 47 minutes (7:05pm – 7:52pm). The inmate in Perry RHU was in the restraint chair for 120 minutes (2:20pm – 4:20pm). The videos for both inmates were reviewed and the Automated Medical Records were utilized to verify this information. The restraint chair report is included in the Regional Monthly Reports. The most recent report is included as Appendix P.

July 2018 Implementation Panel findings: Per SCDC update. QIRM collects data and issues quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs. For the 2 restraint chair uses in the relevant period (both occurred in April 2018): one was for 47 minutes and the other 2 hours.

July 2018 Implementation Panel Recommendations: QIRM continue to prepare a Restraint Chair Report for each monitoring period.

2.c.vi. Prohibit the use of force in the absence of a reasonably perceived immediate threat

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

During the June 20, 2018, Wardens meeting, ADDO [redacted] discussed the use of chemical munitions in the RHUs. He later followed up with an email, Appendix R that reinforced the need for monitoring how force is applied, with a focus on only using force only when necessary and appropriate. The email provided the policy statement and sections of SCDC Policy, OP 22.01 *Use of Force,* relative to the variables in determining if force should be used and when force should be planned versus unplanned. Wardens, Associate Wardens and Majors were provided with a list of the use of force components with the directive to focus on the highlighted sections below:

Use of Force

- Development and implementation of a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness;
- Prohibit the use of force in the absence of a reasonably perceived immediate threat; Prohibit the use of crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions;

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
OFFICER OF THE DEPUTY DIRECTOR FOR OPERATIONS

MEMORANDUM

The following has been implemented by the Division of Operations to ensure that Use of Force (UOF) are conducted only when necessary and appropriate, in accordance with SCDC Policy OP-22.01, Use of Force.

1. **The Division of Operations, will discuss UOF issues, with emphasis placed on UOF violations, at all monthly Wardens meetings, Quarterly A/W meetings and Captains/Majors Meetings.**
2. **Wardens will administer employee corrective action when UOF violations are observed by the Regional Director Reviewer.**
3. **All employee corrective action is required to be documented, including Letters of Understanding and Verbal Counseling, with a copy send to the Division of Operations ARD.**
4. **The Administrative Regional Director (ARD) is conducting refresher training at institutions to address specific policy violations that occur in the institution. Refresher training has been conducted at the following institutions: Evans Correctional Institution on April 18, 2018, Trenton Correctional Institution on May 17, 2018, Ridgeland Correctional Institution on May 31, 2018 and Kershaw Correctional Institution on June 14, 2018.**
5. **The ARD is tracking trends of the number of UOF an employee is involved in on a monthly basis. Employees with high numbers of UOF will be assessed and interviewed to determine whether the UOF was necessary and appropriate.**
6. **Quality Improvement Risk Management have identify the following institutions as having the high number of UOF, (Broad River, Lieber, and Perry.) The Regional Directors will met with each Warden and his staff to determine if the resolutions to the incidents were appropriate or could they have been resolved differently.**

Glenn Stone, Admin. Regional Director

Institutional leaders were required to discuss with and provide a copy of the email and attachment to executive staff and RHU employees; and by July 1, provide documentation that the information was received by and discussed with staff.

The memo below was sent to institutional staff outlining steps implemented by the Division of Operations to ensure that Use of Force (UOF) are conducted only when necessary and appropriate, in accordance with SCDC Policy OP-22.01, Use of Force.

UOF Referrals to Police Services

SCDC Police Services maintains the complete records for Use of Force referrals to their Office for cases that are opened for investigation. A newly implemented function within the AUOF system will now allow approved positions, such as Wardens and Regional Directors, to make referrals to Police Services. For February – April 2018, the following case information was provided:

Investigations opened in Police Services Case Management System (PCM)

Case #	Status	Incident Date	Incident Location	Open Date	Closed Date	Primary	Classification Codes
31-2018-017	Administratively closed	3/14/2018	(0442) Ridgeland	3/22/2018	5/9/2018	UOF	Personnel investigations
32-2018-042	Active	3/12/2018	(0551) lee	3/13/2018		UOF	Assistance to institutions or other
34-2018-028	Administratively closed	3/4/2018	(0191) Perry	3/8/2018	3/19/2018	UOF	Personnel investigations
31-2018-011	Administratively closed	2/8/2018	(0442) Ridgeland	2/8/2018	5/25/2018	UOF	None

18-02-0421-0024 – incident date 2/13/18 - no case warranted

Excessive UOF Grievance Study

It is required by policy, GA-01.12, Inmate Grievance System, number 11, that in most instances, grievances will be processed from initial to final disposition within 171 days, except when an extension is requested by the authorized person (Grievance Branch Chief). As part of SCDC's ongoing efforts to ensure this requirement is met, a CQI study was completed to evaluate the timeliness of the processing of excessive use of force, unprofessional conduct, and physical abuse grievances and to determine if an appropriate response was provided to the inmates who filed such grievances. In this study, grievances coded as excessive use of force, unprofessional conduct, and physical abuse were reviewed for the months of February 2018, March 2018, and April 2018. The grievances were included in the study if the narrative of the grievances described excessive use of force or if an alleged action by the officer lead to a physical injury to an inmate.

During the month of February, there were a total of 20 grievances filed that met the criteria outlined in the detailed report in Appendix R. Of those 20 grievances filed, 10 of them were unprocessed and returned to the inmates. The remaining 10 were processed per policy.

During the month of March, there were a total of 10 grievances filed that met the criteria for inclusion. Of those 10 grievances filed, four of them were unprocessed and immediately returned to the inmates. The remaining 6 were processed, but not all were processed per policy.

During the month of April, there were a total of 15 grievances filed that met the criteria for inclusion. Of those 15 grievances filed, 11 were unprocessed and immediately returned to the inmates. The remaining four were processed per policy.

Issues Identified:

- Several of the unprofessional conduct grievances should have been coded as excessive use of force based on the narrative in the grievance summary.
- Some grievances were returned to inmates citing the inmate's failure to attempt a sufficient informal resolution; however, Policy GA 01.12, section 13.2 states in certain cases informal resolution may not be appropriate or possible when the matter involves allegations of criminal activity.
- Inmates were not always served with the warden's response within the required timeframe.

July 2018 Implementation Panel findings:
The IP continues to monitor SCDC Use of Force MINS Narratives monthly and identify incidents where there did not appear to be a reasonably perceived immediate threat that required a use of force. Headquarters Operations Leadership has begun holding meetings with Institution Management staff where high numbers of problematic UOF incidents are identified to develop strategies to address inappropriate UOF. The IP Use of Force Reviewer and SCDC Operations Leadership also continue to jointly review Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of force.

SCDC Use of Force MINS for February 2018 through May 2018:

February 2018	110
March 2018	120
April 2018	100
May 2018	156

As indicated, the number of UOF incidents have remained steady except May 2018 when there was an approximate 33 percent increase in UOF incidents. A likely contributing factor to the dramatic increase in UOF incidents is the Agency system-wide lockdown. The IP is not aware of SCDC performing a formal analysis to determine why there was a dramatic increase in UOF incidents for May 2018.

SCDC had 18 Inmate Grievances alleging excessive UOF from March 2018 to May 2018. QIRM conducted a CQI Study to assess whether grievances for excessive UOF are processed timely and inmates receive an appropriate response with a final disposition rendered. The Agency Inmate Grievance Program Administrator was interviewed by an IP member. He had serious concerns with how the QI Study was conducted and believed the study had serious flaws. The Grievance Administrator identified the Agency does not clearly identify the department responsible for investigating grievances related to excessive UOF.

SCDC Police Services provided data regarding their involvement in Use of Force investigations as follows for the relevant period March 2018 through June 2018:

Referrals Received	5*
Investigations Opened	4
Investigations Pending	1
Investigations Closed	3**
Investigation Unwarranted	1

* The number of Police Services UOF investigations opened and conducted based on the number of incidents occurring each month in the system (averaging over 100 UOF incidents per month) is very low.
** Administratively Closed.

SCDC continues to enhance the UOF Policy accountability component to appropriately address Use of Force violations. SCDC provided documentation verifying corrective action is being taken for employees identified committing UOF violations. The Agency still does not have a written

procedure to track employees referred for UOF violations from when they are identified to final disposition.

SCDC continues to pilot the Canine Policy and Training prior to full implementation. The responsible IP Member has not been forwarded any UOF incidents involving canines during the relevant period to assess if there are any issues or concerns.

The IP remains concerned about inappropriate and excessive use of force by SCDC employees as determined by reviewing UOF MINS Narratives for the relevant period. The main concerns are: 1) employees utilizing immediate UOF when the circumstances appear to meet the criteria for a planned UOF; 2) failure to contact a QMHP prior to planned UOF when time permits; 3) inappropriate MK9 use in volumes that is excessive without justification; and 4) failure to follow required SCDC decontamination procedures after chemical agent use.

July 2018 Implementation Panel Recommendations:

1. Operations and QIRM continue to review use of force incidents utilizing the automated system to identify use of force violations;
2. QIRM and Operations leadership continue weekly meetings to discuss UOF and other relevant issues;
3. IP continue to review SCDC Use of Force reports and monthly Use of Force MINS Narratives and provide SCDC feedback;
4. The IP Use of Force Reviewer and SCDC Operations Leadership continue to jointly review Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of force;
5. QIRM and the Agency Grievance Coordinator develop a research design to conduct a CQI Study that properly assesses if grievances for excessive UOF are processed and inmates receive an appropriate response with a final disposition rendered in a timely fashion;
6. Police Services continue to provide the number of investigations: substantiated, unsubstantiated or unfounded;
7. Develop and implement a written procedure to track employees recommended and/or referred for UOF violations;
8. All required staff complete Use of Force Training in the Calendar Year 2018; and
9. Require meaningful corrective action for employees found who have committed use of force violations;
10. Provide the IP with an update on the Canine UOF and Training Pilot and include canines on the UOF Report.

2.c.vii. Prohibit the use of crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions;

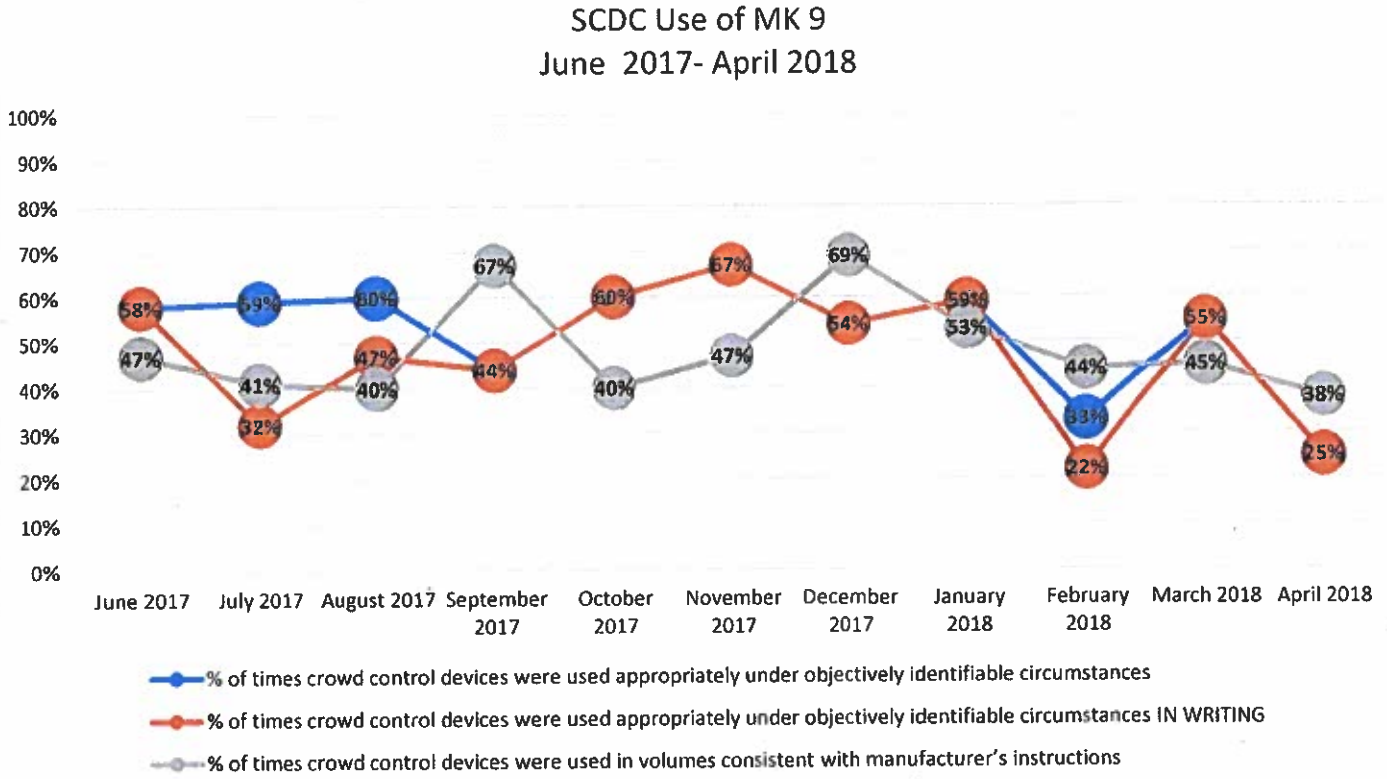
Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

The chart below provides information comparing uses of crowd control canisters during this reporting period but includes data since June 2017 to show changes over time. A QIRM UOF Reviewer began looking at the number of times crowd control devices were used appropriately under identifiable circumstances, the number of times crowd control devices were used appropriately under objectively

identifiable circumstances in writing, and the number of times crowd control devices were used in volumes consistent with manufacture's instruction in June of 2017. Based on this information, June 2017 is the baseline for tracking data received from RIM reports and the Automated Used of Force System. The QIRM Use of Force staff reviewed **145** use-of- force incidents in which MK-9 was used between June 1, 2017, and April 30, 2018.

- There were 78 (54%) uses of force incidents in which the officer's actions were justifiable based on circumstances set forth in agency policy OP-22.01 Use of Force.
- There were 69 (48%) incidents where the crowd control devices were used appropriately under objectively identifiable circumstances in writing.
- There were 69 (48%) incidents where the crowd control devices were used in a manner consistent with manufacturer's instructions.



July 2018 Implementation Panel findings: SCDC continues to have a high percentage of incidents where MK9 is used in individual cells without objectively identifiable circumstances set forth in writing and with volumes that exceed SCDC and manufacturer's guidelines. For the relevant period MK9 non-compliance was:

% of time MK9 identified as not being used within SCDC guidelines: February 18 (78%), March 18(45%) and April 18 (75%);
% of time MK9 volumes exceeded SCDC guidelines: February 18 (56%), March 18 (55%), and April 18 (62%);

July 2018 Implementation Panel Recommendations: A finding of lack of improvement for the next relevant period will require strong consideration for a rating of non-compliance. Recommendations:

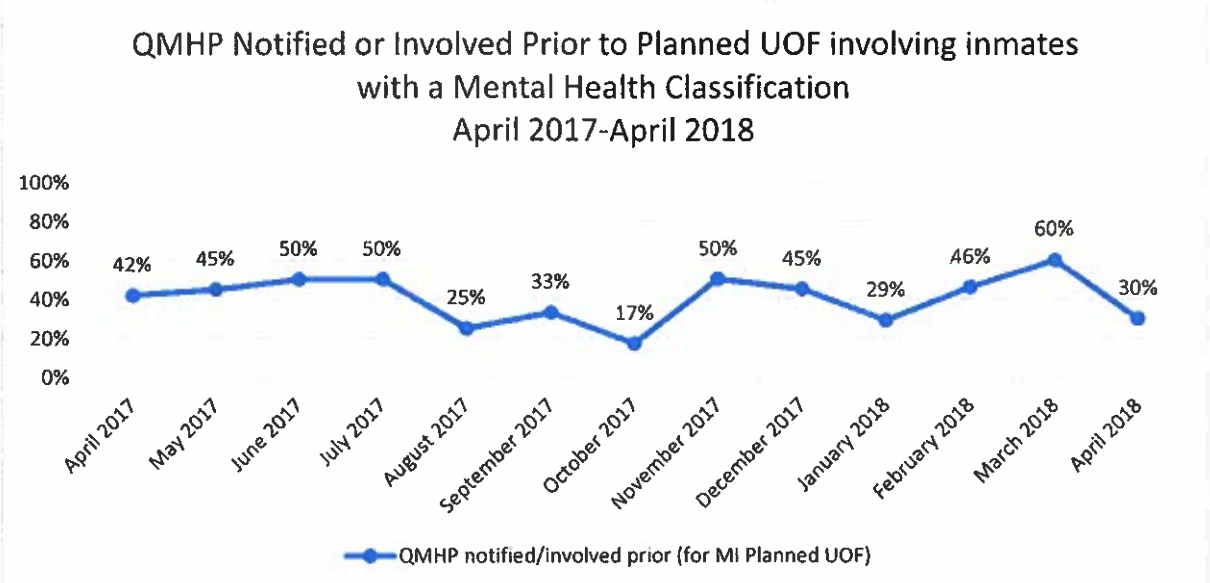
1. Operations and QIRM continue to review use of force incidents utilizing the automated system to identify use of force violations;
2. QIRM Use of Force Reviewers continue to generate reports involving crowd control canisters including MK-9;
3. QIRM and Operations leadership continue weekly meetings to discuss UOF and other relevant issues;
4. IP continue to review SCDC Use of Force reports and monthly Use of Force MINS Narratives and provide SCDC feedback;
5. The IP Use of Force Reviewer and SCDC Operations Leadership continue jointly reviewing Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of crowd control canisters including MK-9;
6. Revise Housing Unit Post Orders as they pertain to *Cover Teams* to qualify that MK-9 use will be consistent with manufacturer's instructions; and
7. All required staff complete Use of Force Training in the Calendar Year 2018.

2.c.viii. Notification to clinical counselors prior to the planned use of force to request assistance in avoiding the necessity of such force and managing the conduct of inmates with mental illness;

Implementation Panel December• 2017 Assessment: partial compliance

June 2018 SCDC Status Update:

The chart below shows the rates at which QMHPs are contacted prior to a planned UOF. The data shows that this continues to be an inconsistent process; however, the UOF Coordinator for MH has been charged with working to increase awareness among security personnel of Use of Force policies and procedures when dealing with Mental Health caseload clients, specifically ensuring that a QMHP is contacted prior to planned uses of force and "cool down" periods are utilized.



Because staff identified that there is inconsistency in either the process or with tracking and reporting, on May 30, 2018, the ADDO created and distributed codes for reporting and tracking averted uses of

force. The email shared with Wardens, Associate Wardens. Majors, and Headquarters staff acknowledged that although use of forces incidents were being tracked, a process was not in place to track the potential planned UOF incidents that were averted due to the skills of trained SCDC staff to include. Mental Health staff, Crisis Intervention Team (CIT) and the Situation Controllers Members (SITCON).

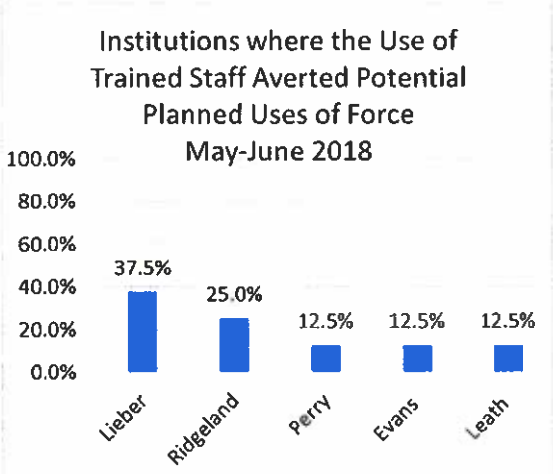
The following MIN codes were created with instructions to use them when potential planned UOF became unnecessary due to the intervention of staff noted above.

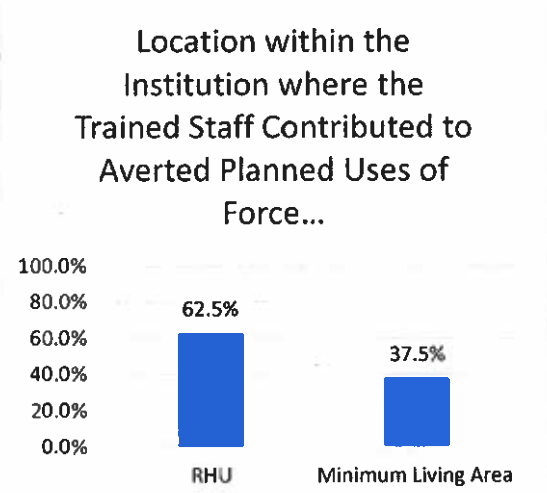
MIN Code
1070 - Diverted Use of Force (Mental Health)
1071 – Diverted Use of Force (C.I.T.)
1072 – Diverted Use of Force (SITCON)

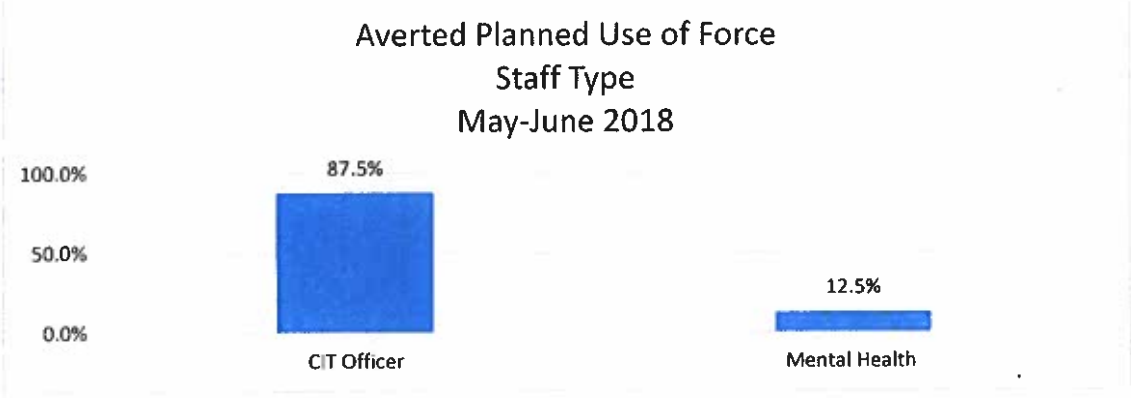
If one of the above noted MIN codes are used: 1) no Use of Force MIN Code would be entered on the same MIN; and, 2) no Automated Use of Force Report would be needed.

During the reporting period, eight MINS were generated using the three new codes for tracking uses of force averted due to the Intervening of trained staff.

Of the eight MINS, Evans, Perry and Leath each reported one incident averted in the RHU. Lieber reported three; two in the minimum living area and one in the RHU. Ridgeland reported two: one in the minimum living area and one in the RHU.







July 2018 Implementation Panel findings: Per the update Section. SCDC has been unsuccessful in making any progress. SCDC data identifies continued issues with notifying clinical counselors (QMHPs) to request their assistance prior to a planned use of force involving mentally ill inmates. The data for the period of May 2017 through April 2018, provides a historical perspective of the percentage of time QMHPs were contacted prior to a planned use of force involving mentally ill inmates:

May 2017-	45%
June 2017-	50%
July 2017-	50%
August 2017-	25%
September 2017	33%
October 2017	17%
November 2017	50%
December 2017	45%
January 2018	29%
February 2018	46%
March 2018	60%
April 2018	30%

Quite disturbing in April 2018 (the last month SCDC reported data for the relevant period), data indicated prior to a planned UOF QMHPs were only contacted in 30 percent of the incidents. This is the second lowest monthly percentage out of 12 months.

A positive development is the Agency beginning to track incidents where UOF is avoided or diverted. SCDC has revised the Agency MINS (Management Information Note) Reports to include incidents where a UOF was averted.

July 2018 Implementation Panel Recommendations: Remedy the above. A finding of lack of improvement for the next relevant period will require strong consideration for a rating of non-compliance. As identified in previous reports, additional training to Operations Supervisory and Mental Health Staff on their duties and responsibilities in a planned use of force is needed. Employees must be held accountable when the required assistance from QMHPs is not requested prior to a planned UOF incident involving mentally ill inmates. When operations employees notify mental health staff of a planned UOF, the mental health staff must complete a face to face interaction to assist or document reasons the interaction was not completed.

2.c.ix. Develop a mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates;

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

The following report shows that between 99% and 100% of all institutions report partial completion of the required training. From January 1- May 31, 2018, 0.4% of security staff have completed required General Provisions Training for calendar year 2018.

Security Staff Required to take Managing Mentally Ill Offenders Training in CY 2018 by Institution and Training Completion January 1 - May 31, 2018

Level		Institution	# Required to take Training	Partial Completion #	Partial Completion %	Fully Completed #	Fully Completed %	Did NOT Complete Training
1	252	GOODMAN	72	72	100.0%	3	4.2%	69
1	179	LIVESAY	58	58	100.0%	0	0.0%	58
1	251	MANNING	96	96	100.0%	0	0.0%	96
1	563	PALMER	26	26	100.0%	0	0.0%	26
		Minimum Security	252	252	100.0%	3	1.2%	249
2	411	ALLENDALE	130	130	100.0%	1	0.8%	129
2	551	EVANS	93	93	100.0%	2	2.2%	91
2	541	KERSHAW	126	126	100.0%	0	0.0%	126
2	422	MACDOUGALL	110	110	100.0%	1	0.9%	109
2	442	RIDGELAND	98	98	100.0%	0	0.0%	98
2	222	TRENTON	92	92	100.0%	1	1.1%	91
2	571	TURBEVILLE	133	133	100.0%	0	0.0%	133
2	161	TYGER RIVER	122	122	100.0%	0	0.0%	122
2	582	WATEREE RIVER	117	117	100.0%	1	0.9%	116
		Medium Security	1,021	1,021	100.0%	6	0.6%	1,015
3	211	BROAD RIVER	164	164	100.0%	0	0.0%	164
3	241	KIRKLAND	287	287	100.0%	1	0.3%	286
3	551	LEE	140	140	100.0%	0	0.0%	140
3	421	LIEBER	123	123	100.0%	0	0.0%	123
3	181	MCCORMICK	97	96	99.0%	0	0.0%	97
3	191	PERRY	130	130	100.0%	0	0.0%	130
		Maximum Security	941	940	99.9%	1	0.1%	940
	551	GRAHAM	115	115	100.0%	0	0.0%	115
	171	LEATH	70	70	100.0%	0	0.0%	70
		Female Institutions	185	185	100.0%	0	0.0%	185
	129	CATAWBA	1	1	100.0%	0	0.0%	1
	40	CORRECTIONAL INDUSTRIES	1	1	100.0%	0	0.0%	1
	1	HEADQUARTERS	1	1	100.0%	0	0.0%	1
	26	HQ ANNEX #2	40	40	100.0%	0	0.0%	40
	45	INMATE TRANSPORTATION TER	15	15	100.0%	1	6.7%	14
	22	RECRUITING & EMPLOYMENT	61	61	100.0%	0	0.0%	61
	90	SUPPORT SERVICES	1	1	100.0%	0	0.0%	1
	28	TRAINING ACADEMY	31	31	100.0%	0	0.0%	31
		Non-Institutional	151	151	100.0%	1	0.7%	150
		Agency Total	2,550	2,549	100.0%	11	0.4%	2,539

July 2018 Implementation Panel findings: We requested from SCDC the plan for implementing the required training but did not receive such a plan.

The SCDC mandatory courses for correctional officers concerning appropriate methods of managing mentally ill inmates for the Calendar Year 2018 are as follows:

2018 MH Training Schedule

Course Title	Hours	Program
Mental Health Services Overview	2.0 hours	Orientation
Suicide Prevention	2.0 hours	Orientation
Mental Health	2.0 hours	Basic
Pre-Crisis Communication	3.0 hours	Basic
Suicide Prevention	2.0 hours	In-Service (Instructor Led)
Suicide Prevention Video (Part 1)	1.0 hours	In-Service
Suicide Prevention Video (Part 2)	1.0 hours	In-Service
Working With the MI Population (USC Modules)	1.5-2.0 hours	In-Service
Total	14.5 -15.0 hours	

July 2018 Implementation Panel Recommendations: Develop and implement a plan for completing the required training. Also SCDC:

- Document and track the number of required employees completing the mandatory training for appropriate methods of managing mentally ill in Calendar Year 2018; and
- For each relevant period, report the progress being made with required employees attending the training.

2.c.x. Collection of data and issuance of quarterly reports concerning the use-of-force incidents against mentally ill and non-mentally ill inmates;

Implementation Panel July 2018 Assessment: compliance (March 2017)

June 2018 SCDC Status Update:
QIRM's Use-of-Force Reviewers continue to produce and disseminate monthly and quarterly UOF Reports. The most recent reports are attached as attached as Appendix S.
This report is sent to the IP UOF expert, Wardens, and Agency leadership. This report also details:

- Total use of force incidents that occurred in institution involving ALL inmates
- Types of force used involving chemical munitions, defensive tactics and the Restraint Chair
- Use of Control Cell
- Use of the Restraint Chair planned use of force and immediate use of force at each institution.
- Percentage of use of force incidents of Mentally Ill vs Not Mentally Ill type of force used on inmates classified as mentally ill
- Reports for the current reporting period are included in the QIRM document drop # 19

July 2018 Implementation Panel findings: SCDC continues to generate a monthly UOF Report Mentally Ill vs. Non-Mentally Ill. No issues were identified with the use of force data utilized to produce the report.

July 2018 Implementation Panel Recommendations: Continue to produce and disseminate the monthly UOF Mentally Ill vs. Non-Mentally Ill Report.

2.c.xi. The development of a formal quality management program under which use-of-force incidents involving mentally ill inmates are reviewed.

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
The UOF Coordinator for Behavioral Health reports no uses of force averted as a result of QMHP intervention prior to a planned use of force that can be substantiated by MIN, AMR, NextGen, or Incident reports for the current reporting period.

July 2018 Implementation Panel findings: The UOF Coordinator for Behavior Health reported to the IP he is reviewing UOF incidents involving inmates with a mental health designation and following up with the assigned QMHP. There are written procedures for the review; however, the procedures have not been formalized in policies and procedures delineating review responsibilities and the action to be taken when an inmate with a mental health designation is involved in a UOF. SCDC has revised the Agency MINS (Management Information Note) Reports to include incidents where a UOF was averted. The Department

of Behavioral Health is currently conducting a study reviewing inmates with a mental health designation that are frequently involved in UOF incidents.

July 2018 Implementation Panel Recommendations: The Department of Behavioral Health should formalize the procedures for reviewing UOF incidents involving inmates with a mental health designation. Once the policies and procedures are approved responsible Behavioral Health staff should receive training on the policy. QIRM should begin performing QI studies assessing the Department of Behavioral Health review of UOF incidents involving inmates with a mental health designation.

3. Employment of enough trained mental health professionals:
3.a Increase clinical staffing ratios at all levels to be more consistent with guidelines recommended by the American Psychiatric Association, the American Correctional Association, and/or the court-appointed monitor;

Implementation Panel July 2018 Assessment: noncompliance

June 2018 SCDC Status Update:
The inpatient ratio was based on 1 psychiatrist per 25 Mentally Ill inmates for care which includes the following areas: GPH, CSU (BRCI), and CSU (Camille). Using the maximum amount of inmates at each of these locations, the following results are based on a full time equivalent of 37.50 hours for a professional provider. The ratio goal at GPH is currently below by -.85 percent or 31.88 hours is needed to reach the ratio standard. However, in July 2018, after hiring one full time equivalent (FTE) of 37.5 hours, SCDC will exceed the expected ratio. Both CSU's are within limits of the required ratio. All of the in-patient care will require additional FTE's based on time requirements for new admissions and the length of time for initial assessments. In addition, there will be a need for additional FTEs for a professional provider to be available for Treatment Team.

Residential treatment was based on 1 psychiatrist per 100 mentally ill inmates which includes ICS (Intermediate Care Unit – chronic care), HLBMU (High Level Behavior Management Unit), and LLBMU (Lower Level Behavior Management Unit). Based on this staffing pattern, ICS is in need of additional FTE's of 9.37 hours; however, additional coverage will be needed if ICS is expanded to take more inmates.

The outpatient ratio was 1 psychiatrist for every 500 mentally ill inmates. This covers 19 institutions housing inmates on the MH caseload. SCDC will be within a range of compliance after the hiring of one full time equivalent in July, which will provide additional coverage for ICS, R&E and CSU, and 15 additional FTE hours for BRCI. Appendix T shows the institutional staffing for psychiatric coverage for June and July 2018.

QMHP Staffing Ratios
Appendix U shows the staff to inmate ratio for each program and institution by Levels. The number of mentally ill inmates in each mental health classification (L1, L2, L3, L4 or L5) are shown in each program (GPH, BRCI/CSU, KR&E/HLBMU, KR&E/ICS, ACI/LLBMU, and CRCC). The number of mentally ill inmates that are L3, L4 and L5 are shown (by level) in each institution.

Staffing is shown for current and allocated QMHP's. Where indicated, Mental Health Managers are assisting with the caseload until the institution becomes fully staffed.

July 2018 Implementation Panel findings: The outpatient ratio of 1 psychiatrist for every 500 mentally ill inmates is not acceptable. An acceptable ratio would be between 1:200 to 1:250 caseload inmates who are receiving psychotropic medications.

July 2018 Implementation Panel Recommendations: As above.

3.b Increase the involvement of appropriate SCDC mental health clinicians in treatment planning and treatment teams

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

Treatment team participation rates at the Crisis Stabilization Unit (CSU) and Gilliam Psychiatric Hospital (GPH) for the months of February through May 2018 are included below. The full report for CSU can be found in the Broad River Correctional Institution's Data Summary in Appendix M. The full report for GPH can be found in the Kirkland Correctional Institution's Data Summary in Appendix M.

CSU

- During the month of February 2018, Psychiatry participated 67% of the time, 0% for Psychology, 98% for QMHP, 74% for medical, 98% for Operations, 42% for classification, and 98% for inmates.
- During the month of March 2018, Psychiatry participated 62% of the time, 0% for Psychology, 100% for QMHP, 100% for medical, 89% for Operations, 100% for classification, and 100% for inmates.
- During the month of April 2018, Psychiatry participated 72% of the time with 7% from tele-psychiatry and 65% from face-to-face, 0% for Psychology, 100% for QMHP, 72% for medical, 100% for Operations, 100% for classification, and 100% for inmates.
- During the month of May 2018, Psychiatry participated 48% of the time, 100% for Psychology, 100% for QMHP, 27% for medical, 100% for Operations, 100% for classification, and 100% for inmates.

Significant improvement has occurred relative to the participation of psychiatrists, classification, operations, and inmates.

GPH

- During the month of **February 2018**, Psychiatry participated 89% of the time with 60.19% from tele-psychiatry and 28.7% from face-to-face, 100% for Psychology, 100% for QMHP, 66% for medical, 47% for Operations, 0% for classification, and 13% for inmates with 35 or 32% who were either not required or inappropriate for treatment team.
- During the month of **March 2018**, Psychiatry participated 95% of the time with 47.69% from tele-psychiatry and 47.69% from face-to-face, 100% for Psychology, 100% for QMHP, 85% for medical, 84% for Operations, 18% for classification, and 39% for inmates with 51 or 39% who were either not required or inappropriate for treatment team.
- During the month of **April 2018**, Psychiatry participated 36% of the time with 36% from tele-psychiatry and 0% from face-to-face, 100% for Psychology, 100% for QMHP, 90% for medical, 100% for Operations, 26% for classification, and 35% for inmates with 23 or 19% who were either not required or inappropriate for treatment team.

- During the month of **May 2018**, Psychiatry participated 89% of the time with 68.42% from tele-psychiatry and 23.18% from face-to-face, 100% for Psychology, 100% for QMHP, 100% for medical, 80% for Operations, 45% for classification, and 54% for inmates with 40 or 28% who were either not required or inappropriate for treatment team.

July 2018 Implementation Panel findings: As per status update section. Provide statistics relevant to attendance about inmates' lack of attendance due to either refusal or being "inappropriate" to attend the treatment team.

We observed a treatment team meeting at BRCI during the morning of July 18, 2018. The treatment planning that occurred during this meeting was excellent.

We also observed a treatment team meeting at Lee CI during the morning of July 19, 2018, which was conducted in a competent manner.

July 2018 Implementation Panel Recommendations: As above.

3.c Develop a training plan to give SCDC mental health clinicians a thorough understanding of all aspects of the SCDC mental health system, including but not limited to levels of care, mental health classifications, and conditions of confinement for caseload inmates;

Implementation Panel July 2018 Assessment: compliance (March 2018)

June 2018 SCDC Status Update:

The Mental Health General Provisions training is required for all employees hired in the division of Mental Health. This training provides an overview of all aspects of the SCDC mental health system, including but not limited to levels of care, mental health classifications, classifications, and assurance for the care and management for all inmates in need of Mental Health Services at SCDC. At time of report, 55% of employees who have started with the agency since January 01, 2018 have completed the training.

New Mental Health Staff (Hires and Transfers) in CY 2018 and Mental Health General Provisions Training taken in CY 2018 by Location and Training Completion January 1 - June 26, 2018

Level	Budget Unit	Institution	# Required to take Training	Completed		Not Completed	
				#	%	#	%
1	123	CATAWBA	0	0	N/A	0	N/A
1	232	GOODMAN	0	0	N/A	0	N/A
1	173	LIVESAY	0	0	N/A	0	N/A
1	251	MANNING	0	0	N/A	0	N/A
1	563	PALMER	0	0	N/A	0	N/A
Minimum Security			**0**	**0**	**N/A**	**0**	**N/A**
2	411	ALLENDALE	3	2	66.7%	1	33.3%
2	531	EVANS	2	2	100.0%	0	0.0%
2	541	KERSHAW	1	1	100.0%	0	0.0%
2	422	MACDOUGALL	0	0	N/A	0	N/A

2	442	RIDGELAND	1	0	0.0%	1	100.0%
2	222	TRENTON	0	0	N/A	0	N/A
2	571	TURBEVILLE	0	0	N/A	0	N/A
2	161	TYGER RIVER	1	1	100.0%	0	0.0%
2	582	WATEREE RIVER	0	0	N/A	0	N/A
Medium Security			**8**	**6**	**75.0%**	**2**	**25.0%**
3	211	BROAD RIVER	5	2	40.0%	3	60.0%
3	242	GILLIAM PSY	14	5	35.7%	9	64.3%
3	241	KIRKLAND	2	1	50.0%	1	50.0%
3	551	LEE	2	0	0.0%	2	100.0%
3	421	LIEBER	2	1	50.0%	1	50.0%
3	181	MCCORMICK	0	0	N/A	0	N/A
3	191	PERRY	2	2	100.0%	0	0.0%
Maximum Security			**27**	**11**	**40.7%**	**16**	**59.3%**
	331	GRAHAM	1	0	0.0%	1	100.0%
	171	LEATH	0	0	N/A	0	N/A
Female Institutions			**1**	**0**	**0.0%**	**1**	**100.0%**
	1	HEADQUARTERS	2	0	0.0%	2	100.0%
	26	HQ ANNEX #2	0	0	N/A	0	N/A
Non-Institutional Locations			**2**	**0**	**0.0%**	**2**	**100.0%**
All Institutions			**38**	**17**	**44.7%**	**21**	**55.3%**

July 2018 Implementation Panel findings: As per status update section. Newly hired health staff have 45 days from the date of hire to receive the required training.

July 2018 Implementation Panel Recommendations: Continue to monitor.

3.d Develop a plan to decrease vacancy rates of clinical staff positions, which may include the hiring of a recruiter, increase in pay grades to more competitive rates, and decreased workloads;

Implementation Panel July 2018 Assessment: compliance (December 2017)

June 2018 SCDC Status Update:
See 2.a.iv

July 2018 Implementation Panel findings: See 2.a.iv.

July 2018 Implementation Panel Recommendations: See 2.a.iv.

3.e Require appropriate credentialing of mental health counselors;

Implementation Panel July 2018 Assessment: compliance (March 2017)

June 2018 SCDC Status Update:
On June 13, 2018, the DDHS and Division Director for BMHSAS met with HR leaders, Legal, and Employee Relations regarding a letter to 19 unlicensed MH staff to inform of licensure requirement

and need to: 1) identify requirements to obtain licensure, or 2) determine alternative to QMHP position. Staff were required to provide a reply within 30 days, by August 1, to acknowledge receipt.

The discussion further focused on: 1) determining how long staff would be allowed to pursue licensure for those willing to obtain QMHP and increase salary; and 2) pursuing alternative positions within SCDC for those unwilling to pursue licensure.

A formal letter from [redacted] Deputy Director for Health Services, and [redacted] Chief Counsel, was sent out to each of 19 (2 HQ staff) unlicensed QMHP staff on 6/22/18. Acknowledgement of receipt is due by August 1, 2018, to indicate how staff will pursue licensure and how long it would take to achieve licensure or not to pursue licensure and seek alternative employment.

Depending on licensure issues, it is likely that that licensure may take up to one year. Time frames will be established for alternative placement in alternative SCDC positions for those unwilling or unable to obtain licensure.

A procedure and form has been drafted to implement supervision by licensed clinician for all unlicensed QMHPs. The Director is willing to consider SCDC payment for licensure for those who pursue licensure.

In SCDC Policy 19.15, Mental Health Services - Mental Health Training, Section 3.4 stipulates that QMHPs will be required to maintain their professional licensure based on the requirements of their individual licensure board (Licensed Professional Counselor, Licensed Social Worker, etc.) and provide verification of continued licensure. The division is taking the necessary steps to require all employees serving in a QMHP role to become licensed within a defined period or be re-assigned in the agency to a more appropriate role based on their qualifications. Those mental health counselors who are not licensed but were hired prior to above requirement are allowed to continue working under the supervision of a licensed counselor.

Based on the provisions outlined in policy, 55/57 or 96% are appropriately licensed.

July 2018 Implementation Panel findings: As per status update section. We are encouraged that SCDC has established a process pertinent to licensure for non-licensed clinicians, which is consistent with the Settlement Agreement negotiation process.

July 2018 Implementation Panel Recommendations: Continue to self-monitor.

3. f. Develop a remedial program with provisions for dismissal of clinical staff who repetitively fail audits; and

Implementation Panel July 2018 Assessment: compliance (July 2018)

June 2018 SCDC Status Update:
Initial Audit Reviews for all programs are consultative. Once the report is complete, it is forwarded to the BMHSAS Division Director for review. Afterwards, it is sent to the Warden, Associate Wardens' and Mental Health staff along with a scheduled date to meet with the Division Director and the QA Manager to discuss the audit findings. During the meeting, the Mental Health supervisor is notified to submit a written audit response outlining a plan of action addressing noncompliance issues to the QA

Manager by a designated deadline. It should be noted that when there are findings of significant noncompliance issues, it brought to the attention of the Mental Health Manager during the audit or via email so that immediate correction can be done. Continued noncompliance or regularly failed audits, will result in the implementation of Improvement Action Plans and/or corrective action as outlined in ADM-11.04 "Employee Corrective Action" policy. Since last reporting period, one QMHP resigned in lieu of termination due to repeated unsatisfactory audit reviews.

Formal CQM program to review clinical staff
Refer to the chart below for the audit review and scheduled discussion dates. Refer to Appendix X for complete audit reports for institutions listed below. Manager Responses are also included for those done prior to 5/3/18. BMHSAS audit dates are included as Appendix Y.

INSTITUTION	AUDIT REVIEW DATE	SCHEDULED DATE OF AUDIT DISCUSSION
Evans CI	January 23, 2018	April 3, 2018
Lee CI	January 17, 2018	April 4, 2018
Kershaw CI	January 22, 2018	April 4, 2018
Turbeville CI	February 6, 2018	April 13, 2018
BRCI – CSU	February 21, 2018	April 19, 2018
Camille	March 8, 2018	May 3, 2018
Kirkland - ICS	April 24, 2018	June 26, 2018
Kirkland – HLBMU	April 24, 2018	June 26, 2018
Perry	April 26, 2018	June 20, 2018
Kirkland – GPH	May 8, 2018	Pending

July 2018 Implementation Panel findings: As per status update section.

July 2018 Implementation Panel Recommendations: Continue to monitor.

3.g. Implement a formal quality management program under which clinical staff is reviewed.

Implementation Panel July 2018 Assessment: compliance (July 2018)

June 2018 SCDC Status Update:
See 3.f.

July 2018 Implementation Panel findings: See 3.f.

July 2018 Implementation Panel Recommendations: See 3.f.

4. Maintenance of accurate, complete, and confidential mental health treatment records: 4.a Develop a program that dramatically improves SCDC's ability to store and retrieve, on a reasonably expedited basis:

4.a.i. Names and numbers of FTE clinicians who provide mental health services;

Implementation Panel July 2018 Assessment: compliance (March 2017)

June 2018 SCDC Status Update:

RIM continues to produce and distribute a weekly "Medical Personnel Report." The following screenshot provides a snapshot of the detailed report. The most recent report was distributed on June 18, 2018. See screenshots below. The most recent report is included as Appendix Y.

Summary of Medical Positions as of COB Yesterday
run on June 18, 2018

Medical Job Classifications			FTE Positions			Temporary Positions			All Positions		
Job Class	State Title	SCDC Title	Filled	Vacant	Total	Filled	Vacant	Total	Filled	Vacant	Total
AA50	ADMIN SPECIALIST II	ADMIN SPEC	1	0	1	0	0	0	1	0	1
		ADMIN SPEC A	1	0	1	0	0	0	1	0	1
		ADMIN SPEC B	1	0	1	0	0	0	1	0	1
		ADMIN SPEC C	2	0	2	0	0	0	2	0	2
		ADMIN SPEC II	6	0	6	0	0	0	6	0	6
		ADMIN SPEC-PHARMACY TECH	1	0	1	0	0	0	1	0	1
		ADMIN SPECIALIST - INTERN	0	0	0	0	1	1	0	1	1
		PHARMACY TECH	1	0	1	0	0	0	1	0	1
AA50	ADMIN SPECIALIST II	Subtotal:	13	0	13	0	1	1	13	1	14
AA75	ADMINISTRATIVE ASSISTANT	ADMIN ASST	4	1	5	0	0	0	4	1	5
		ADMIN ASST - MENT HLTH	1	0	1	0	0	0	1	0	1
		ADMIN ASST I	1	0	1	0	0	0	1	0	1
		ADMIN ASST II	3	0	3	0	0	0	3	0	3
		ADMINISTRATIVE ASSISTANT	1	0	1	0	0	0	1	0	1
AA75	ADMINISTRATIVE ASSISTANT	Subtotal:	10	1	11	0	0	0	10	1	11

4.a.ii. Inmates transferred for ICS and inpatient services;

Implementation Panel July 2018 Assessment: substantial compliance (July 2017)

June 2018 SCDC Status Update:

RIM continues to develop, produce and maintain reports of inmates transferred to ICS or GPH or Correct Care beds. This continues to provide MH staff the ability to track the number and timeliness of inmates being transferred to GPH, contractual providers and ICS programs. The most recent report is included as Appendix Z.

Male ICS Admissions and Discharges
February 1, 2018 through May 31, 2018
Patients/Clients = 41
Admissions = 35
Discharges = 18

(Only Admission and Discharge dates between February 1, 2018 and May 31, 2018 are displayed. However, Days in ICS is displayed for all completed stays. Admissions and Discharges determined by M.H. Classification changes made in MEDCLASS. CISP admissions are through date report was run (June 8, 2018).)

Inmate #	Name	MH Class Prior to Admission	Admission Date	Discharge Date	New MH Class	Days in ICS	Days till First CISP Admission after Discharge	Date of First CISP Admission after Discharge	# of CISP Admissions Since this Discharge
[redacted]		L1	04/10/2018						
		L3	04/04/2018						
		L1	03/02/2018						
		L1	02/23/2018						
		L3		02/21/2018	L3	2151			
		L3	03/13/2018						
		L1	03/09/2018	04/19/2018	L1	41			
		RU	04/12/2018	05/02/2018	L1	20			
		L1	05/16/2018						
				02/21/2018	L4	4451			
		L3	03/15/2018						
			03/20/2018						
		L1	04/10/2018						
		L1	02/13/2018						
		L1	02/02/2018	03/05/2018	L1	31	0	03/05/2018	
		L3	02/15/2018						
		L1		02/07/2018	L1	133			
		L1	02/13/2018						
		L3	04/10/2018						
		L1		03/05/2018	L1	169			
		L1	05/21/2018						

July 2018 Implementation Panel findings: Compliance continues with regard to tracking referrals, however the IP is deeply concerned regarding the referrals from the CSUs at KCI and CGCI. We extend the rating of compliance based on SCDC assurances of appropriate referrals, but are not satisfied the responses to referrals address the needs of the inmate population; and waiting lists for services throughout the system for higher levels of care are not acceptable. The data produced by SCDC will be very closely reviewed.

July 2018 Implementation Panel Recommendations: Address the issues raised above.

4.a.iii. Segregation and crisis intervention logs;
Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
Policy 22.38, Restrictive Housing Units, section 3, number 14 says that correctional officers assigned to the RHU are to conduct security checks and to personally observe each inmate at least every 30 minutes on an irregular, unannounced schedule. A CQI study was conducted to evaluate if these cell checks were completed per policy at Broad River, Camille, Lee, and Perry. The results of the study is below. For the complete study, refer to Appendix AA.

Results:
Average time between checks should be less than 30 minutes—in fact, to accommodate the requirement of irregularity, this measure should be reasonably closer to 20 minutes. Perry came the closest to this measure in May; however, the cell checks still exceed 30 minutes.
Longest time between checks should be no more than 30 minutes. All institutions had longest times significantly greater than 30 minutes, but Broad River and Camille had the longest times for the month of May at 920 minutes each
The Percent Compliance with Keeping Cell Checks at Less than 30-Minute Intervals: Broad River and Lee have the lowest compliance in this measure, and their average time between checks supports this finding. Camille has the highest compliance average at 52%; however, their average time between checks still exceeds 30 minutes.
Irregularity of Cell Checks: All four institutions had fairly good compliance with this measure; however, the average time between checks indicates the checks are considerably exceeding 30 minutes, so the intent of the "irregular" requirement was frequently not met.
BRCI CSU
CSU began using the Offender Activity Tracking System (OATS) on December 4, 2017. (While the normal cell-check interval time is a maximum 30 minutes [irregular], in the CSU and for any inmate on CISP, the maximum interval is 15 minutes [irregular].) A review to determine if observation checks were being conducted at irregular intervals of no more than 15 minutes was completed on May 3, 2018. Inmates were randomly selected for review. To be included in the sample, inmates would have to have been in the CSU with information uploaded into the OATS reporting system on April 29 & 30 and May 2 & 3. Inmates were randomly selected until five met the dates' criteria. Although the percentage of overall scans in CSU has not yet reached full compliance, based on this review, of the cell checks that were conducted, all inmates in the sample had an increase in the percentage of cells checks that were completed within 15-minutes, as required by policy. The Unit has demonstrated an overall increase of 64.9%.

Any scan exceeding 15-minutes is noncompliant. The goal is to see a decrease in the number of scans non-compliant in this area. This was evident for each inmate in the sample with an overall decrease for the Unit of 77.8%.

July 2018 Implementation Panel findings: As per status update section.

July 2018 Implementation Panel Recommendations: Remedy the above.

4.a.iv. Records related to any mental health program or unit (including behavior management or self-injurious behavior programs);

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
EHR staff are developing a batch encounter extract process in NextGen that will allow staff to utilize the existing reporting logic currently used to report from the mainframe medical encounter data. This information will provide a means to monitor all medical and mental health encounters to review timelines and help document compliance. This process is close to being finalized which will ensure that the data integrity and quality is appropriate; however, it will need to be tested further to be certain. Additionally, the EHR Business Analyst position is currently vacant; when filled, this position will be able to run advanced reporting tools within the Nextgen and EZmar system that we are not able to currently utilize. Advertising through additional recruiting services will begin the week of 6/25/18.

July 2018 Implementation Panel findings: As per status update section.

July 2018 Implementation Panel Recommendations: Fill the vacant EHR business analyst position.

4.a.v. Use of force documentation and videotapes;

Implementation Panel July 2018 Assessment: compliance (March 2017)

June 2018 SCDC Status Update:
Retention policy for video and audio recordings is listed in policy OP 22.01; recordings must be retained for six years after the date of the incident, at that point, only the main report synopsis is forwarded to State Archives for permanent retention.

July 2018 Implementation Panel findings: As per SCDC update.

July 2018 Implementation Panel Recommendations: Operations and QIRM continue to monitor use of force documentation and videotapes through the SCDC automated use of force system.

4.a.vi. Quarterly reports reflecting total use-of-force incidents against mentally ill and non-mentally ill inmates by institution;

Implementation Panel July 2018 Assessment: compliance (March 2017)

June 2018 SCDC Status Update:
RIM continues to produce and disseminate a monthly, "UOF Report Mentally Ill vs. Non-Mentally Ill," report on the 22nd of each month for the previous month's information.
UOF Reviewers continue to track and report the number of UOF incidents involving mentally ill vs non-mentally ill inmates. This quarterly report is sent to it IP UOF expert, Wardens, and Agency leadership. This report also details:

- Agency Use of Force by Type

- Video Review
- Grievances Related to Use of Force
- Grievances Filed by Inmates with a Mental Health Classification
- MINS: Mainframe vs Use of Force Application

- Exception Reports

The most recent report (March 2018) is included as Appendix BB.

A recent review of UOF for MI vs non-MI indicates that although they only make up 19% of the population, the data shows that they 54% of the uses of force involved inmates with a mental health classification for these reporting months. This data is included in *2.c.i. Development and implementation of a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness.*

July 2018 Implementation Panel findings: As per SCDC update.

July 2018 Implementation Panel Recommendations: Continue to produce and disseminate the monthly UOF Mentally Ill vs. Non-Mentally Ill Report.

4.a.vii. Quarterly reports reflecting total and average lengths of stay in segregation and CI for mentally ill and non-mentally ill inmates by segregation status and by institution;

Implementation Panel July 2018 Assessment: compliance (March 2017)

June 2018 SCDC Status Update:
RIM continues to generate monthly report, CY 2018 CISP Entries. The most recent report for May was distributed on June 6, 2018. The following summarizes the average lengths of stay for inmates and *CY 2018 CISP Entries through May 31, 2018*See Appendix CC for the complete RIM report.

Entries in CISP Application = 977
Average Days on Crisis = 7
Average Time to CSU Placement = 50:25 (Hours:Minutes)
Average Days in CSU = 7
Average Days in Outlying Facility = 3
Active Cases = 53
RIM continues to produce and distribute a weekly spreadsheet that provides a list of inmates currently in SD, DD, MX ST, or AP custody by institution, MH classification, custody level and days in custody level. . The most recent report was disseminated on June 14, 2018. See screenshot below. The most recent report is included as Appendix.DD.

Institution	Days in DD SD MX ST AP Cust	SCDC #	Name	Current Custody	Begin Date in DD SD MX ST AP Custody	Dorm	Current Mental Classification
ALLENDALE	493	[redacted]		SD	02/06/17	MA 0206Z	MH

July 2018 Implementation Panel findings: As per status update section.

July 2018 Implementation Panel Recommendations: Continue to produce and disseminate quarterly reports reflecting total and average lengths of stay in segregation and CI for mentally ill and non-mentally ill inmates by segregation status and by institution

4.a.viii. Quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution;

Implementation Panel July 2018 Assessment: compliance (March 2017)

June 2018 SCDC Status Update:
QIRM Analysts had been providing a summarized report on inmates in segregation by institution, custody, and mental health classification to Operations staff. After meeting with Operations leaders, it was determined that the QIRM report is duplicative to the RIM report. RIM continues to produce and distribute the "Weekly Lockup by Custody and Mental Health Classification." This monthly report is shared with institutional and agency leaders. The most recent report was produced and distributed by RIM on June 20, 2018. The most recent reports (Excel and PDF) are included as Appendix EE.

July 2018 Implementation Panel findings: As per status update section.

July 2018 Implementation Panel Recommendations: Continue to produce and disseminate quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution.

4.a.ix. Quality management documents; and

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
Quality management documents, including reports, audit tools, audits, and other forms of documentation continue to be available in shared network folders. See examples below. Access to each folder is managed by system administrators through the IT Access Request menu. This allows for central storage of documentation for access across divisions and institutions.
Automated web-based systems include:

Temperature and Sanitation Log Entry

- Choose your Institution, Dorm, and Cell to enter a Temperature and Sanitation log.

Intake Education Assessment Report

- This report shows all inmates having an educational assessment during their intake within a date range.

Medical Transport Report

- This report shows all institutions with their transportation methods within a date range.

Mental Health Report

- This report shows inmates with a Mental Health classification housed in SMU.

Pending Disciplinary Dispositions

- This report shows inmates pending disciplinary disposition report.

OATS Report

- This report shows cell log activity from the Oat sOnlin eAppl dat ion.

July 2018 Implem entation Panel findings :As per status update section.

July 2018 Implementation Panel Recommendations: Continue to assess and validate quality management documents.

4.a.x. Medical, medication administration, and disciplinary records

Implementation Panel July 2018 Assessment. partial compliance

June 2018 SCDC Status Update:

Task:	Start	End
Male Facility End User Training Week 1	4/30/18	5/4/18
Male Facility End User Training Week 2	5/15/18	5/18/18
Level 3 Institution Go Live (except Kirkland) – Broad River, Lee, Lieber, McCormick, Perry	5/21/18	5/25/18
Male Facility End User Training Week 3	6/5/18	6/8/18
Male Facility End User Training Week 4	6/19/18	6/22/18
Kirkland Go Live (EHR, EDR, Scheduling only)	6/26/18	6/28/18
Male Facility End User Training Week 5	7/10/18	7/13/18
Level 2 Institutions Go Live (partial) – Allendale, Evans, Ridgeland, Turbeville	7/24/18	7/27/18
Kirkland eZmar Go Live	8/14/18	8/16/18
Male Facility End User Training Week 6 (if needed)	8/28/18	8/30/18
All remaining Institutions Go Live – Catawba, Goodman, Kershaw, Livesay, MacDougall, Manning, Trenton, Tyger River	9/18/18	9/20/18
Specialty Clinics	10/2/18	10/4/18

SCDC has hired and trained 5 employees to help support the EHR. SCDC is still awaiting the hire of our business analyst position that will manage the reporting and analysis of NextGen data.

- 1 Help Desk staff member able to specifically address NextGen issues.
- 4 RIM staff members who will serve as statewide support staff for use of all aspects of the system: EHR, EDR, Scheduling, eZmar, interfaces, etc. These staff members will have

assigned territories and perform most of their duties onsite in the institutions alongside members of the Health Services staff.
- Position currently posted for hire—1 additional RIM staff member to conduct system configuration edits and produce reports and analysis of the NextGen data. Due to this staff absence, we are very limited
- A Project manager transition has occurred since the Implementation Panel's last visit; Daniel Mullins is now the project manager for the EHR implementation.

July 2018 Implementation Panel findings: As per status update section.

July 2018 Implementation Panel Recommendations: Continue to assess and validate documentation from EHR to support the Quality Management program. Perform a QI Study to assess SCDC Mental Health Disciplinary Treatment Team review of disciplinary sanctions received by inmates with a mental health designation.

4.b. The development of a formal quality management program under which the mental health management information system is annually reviewed and upgraded as needed.

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
See 4.a.iv

July 2018 Implementation Panel findings: See 4.a.iv.

July 2018 Implementation Panel Recommendations: Fill the vacant EHR business analyst position.

5. Administration of psychotropic medication only with appropriate supervision and periodic evaluation:

March 2018 Implementation Panel findings: noncompliance

June 2018 SCDC Status Update
The Health Services and BMHSAS administration are in preliminary stages of determining if some mental health medications can be given to inmates in KOP packaging. They are considering the possibility of piloting mental health medications as KOP versus dose by dose, and several facilities have been suggested for the pilot. The preference of the group was to utilize level 2 facilities initially and then consider and target level 3 facilities at a later date.

The suggested pilot facilities are Allendale, Evans, and Turbeville, but the Mental Health staffing at these institutions needs to be studied to ensure the pilot project is feasible. Inmates at these facilities would receive a 30-day supply of specified KOP meds. SCDC's Chief of Pharmacy is going to consolidate the list of medications which are appropriate for this process and forward for review.

Once the list of approved KOP medications and the institutions are agreed upon, the specific staff at the designated locations will be contacted and trained to ensure there is a consistent process in place for adequate monitoring.

July 2018 Implementation Panel findings: Our March 2018 findings included the following:

We discussed with staff in detail issues related to the "medication tool." This medication tool is being piloted due to current medication administration practices in RHUs systemwide as well as in general population units during lockdowns if food slots are not present in the cell doors. Attachment 2 provides SCDC's description of the medication tool. This medication tool is an attempt to provide medication administration in the context of grossly inadequate correctional officer allocations systemwide in addition to various significant correctional officer vacancies. It is not an acceptable alternative to medication administration for a number of reasons that include medication being administered in an unhygienic manner, inadequate observation regarding whether an inmate actually is swallowing the medication (i.e., does not permit acceptable direct observation therapy), and exposing nursing staff to unreasonable physical risks related to the need to bend down repetitively in order to administer inmate medications.

This below the standard of care medication administration system is exacerbated by the following:

1. Unacceptable nursing staff vacancies systemwide;
2. General lack of access to the electronic medical administration record when medication administration takes place in housing units;
3. Lack of medication carts due to both cost and inadequate nursing office space; and
4. Lack of a unit dose medication administration process due to inadequate nursing medication room space and inadequate funding.
5. Ironically, #s 2, 3 & 4 exacerbate the unacceptable nursing staff vacancies systemwide.

Staff reported that six institutions continue to have medications delivered under the cell door. Our opinion remains unchanged regarding this issue.

July 2018 Implementation Panel Recommendations: Our March 2018 recommendations included the following,

1. The salary structure for nurses is not competitive and results, in part, in the systemwide staffing vacancies;
2. Funding needs to be requested and obtained in order to remedy the above issues that contribute to the below the standard of care medication administration process; and
3. Correctional staff need to be recruited specifically for escorting nurses during the medication administration process in order for such a process to occur within the standard of care.

Our recommendations remain the same.

5.a. Improve the quality of MAR documentation;

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update

Access to proper equipment is addressed in detail above under MMCAP Contract Option and RHU/Medication Administration.

A QI study was done of the MARS documenting administration of medications ordered by psychiatrists for inmates at Perry, BRCI, Lee, and KCI, McCormick, and Lee. It looked at MARS from

February – April 2018. CGCI was not included in this study, since CGCI is using the EHR system, and the auditor did not yet have access to the system.
The measures studied were:

- Inmate compliance with taking the medications
- Nursing compliance with documentation

The auditor looked inmate medication compliance, nursing documentation, and if there were runs of 3 or more consecutive doses of medication missed, whether there was documentation of nursing or QMHP compliance counseling in these cases. The full methodology for the study and detailed results are found in the complete report, Appendix FF (Word and Excel spreadsheet). The report includes narratives of each institution as well as specific deficiencies noted when the medical records were reviewed to see if counseling was done.

But in general, an Excel spreadsheet was created to collect data Formula columns were inserted to calculate the following measures, as well as summaries for each institution.

- Inmate compliance with taking the medications (# doses taken / # doses possible)
- Nursing compliance with documentation (# completed MAR cells / # doses possible)

Findings
The following chart shows the number of MARs reviewed for each institution, the percent compliance of inmates in taking medications, compliance of nurses in documenting medication administration, the average number of days for inmates to receive new medications ordered, as well as the percent of inmates in whose chart reviews there were deficiencies noted. Note that it was not always clear which unit the MARs were taken from (such as RHU v. non-RHU), so it is possible that some of these measures should have been calculated on a different unit's spreadsheet.

MAR Summary Feb-April 2018						
	# MARs Reviewed	% Medication Compliance	% Nursing Documentation Compliance	Ave # of Days from New Medication order to 1st dose	# of Inmates in whose MARs Deficiencies Were Identified	% of Inmates in whose MARs Deficiencies Were Identified
Perry	9	94%	100%	N/A	1	11%
Broad River	50	54%	93%	5	33	66%
BRCI CSU	1	100%	100%	N/A	0	0%
Lee	6	53%	88%	N/A	2	33%
McCormick	9	89%	100%	1	1	11%
Lieber	5	98%	99%	N/A	0	0%
Kirkland	4	83%	88%	3	2	50%
KCI RHU and HLBMU	31	91%	95%	N/A	0	13%
KCI ICS	30	100%	100%	N/A	0	0%
GPH	24	100%	100%	2	4	0%

Summary:
The handwritten MARs from these institutions show:

- Inmate medication compliance is highest at the inpatient or ICS units. It was the lowest at Lee and BRCI, although Lee had many fewer MAR's audited. It is noted that most of BRCI's

MARs were from the Murray dorm immediately and up to 3 months after the L3 inmates were first moved to Murray Dorm.

- Although it appears that the nursing documentation compliance has improved since the time of the mental health lawsuit, there is still room for improvement.
- Although only a few MARs showed new medication orders, there were some that took more than 2 days for the inmate to receive the first dose.
- When the inmates were non-compliant with their medication, there was seldom any compliance counseling done.

This QI Study report was forwarded to the Health Services and Behavioral Health Administration for their review on June 27, 2018.

July 2018 Implementation Panel findings: As per status update section. Compliance with this provision should significantly improve as nursing staff vacancies decrease and the continued rollout and improvement of the electronic medical administration records system is implemented.

July 2018 Implementation Panel Recommendations: As above.

5.b Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs;

Implementation Panel July 2018 Assessment: noncompliance

June 2018 SCDC Status Update

The nursing shortage within the SCDC is only anticipated to worsen without significant relief from the legislature in the form of funding for raises to a competitive rate. Short of that, our efforts for recruitment continue but are not especially successful when compared to the community at large. We continue to propose a variety of recruitment initiatives that will be addressed separately. The lockdown situation created by the Lee CI disturbance in mid-April, 2018, has exacerbated our medication administration challenges significantly throughout the agency, especially at the Level 3 facilities.

Medication Assistance Device: The medication assistance device or "pill putter" was not found to be especially useful to the nursing staff in the medication process and has not taken form. As such, it has been essentially discontinued.

Food Flaps: The construction of the food flaps is contracted out to the State of Georgia and we have only one firm that is able to assist SCDC with the installation on a facility by facility basis for procurement reasons, so it is a slow process. But the installation of the food flaps by facility is progressing, which is improving the delivery of medications and is an improved alternative to "under-the-door" distribution.

Medication Windows: Some facilities, such as Level 2's, are off of lock down now and have returned to routine operations. They are conducting medication lines as they would routinely at pill windows in the Health Services units. However, the nurses continue to have to prepackage medications into coin envelopes and clear plastic envelopes into soufflé cups for the inmates, rather than this being carried out by the pharmacy staff.

Pharmacy continues to package medications in the ScriptPro vials for the Top 40 drugs and other medications and placed in labeled zip-lock bags, which are shipped to the facilities Monday through Friday. These vials and bags then require significant hours of nursing time to repackage into coin envelopes for inmates, alphabetically by dorm.

MMCAP Contract Option: There is an option through our MMCAP contract, but it is not available to us in SCDC, although it is an amendment available and utilized by other states such as VA and MT. It allows for not only the drug purchasing, which we currently utilizing, but the dispensing itself. Virginia made the transition and now utilizes the MMCAP pharmacy agreement for all pharmacy services, retaining two full-time pharmacists on staff, while all other pharmacy staff work through the contract pharmacy through MMCAP, Diamond Pharmaceuticals, out of Indiana, PA. Diamond then packages the medications to the specifications of the Commonwealth of VA DOC. A variety of packaging systems are available, including blister packs and unit of use, and Diamond then provides the medication carts as well and all storage mechanisms as needed, as well as software interface. The SCDC inquiry was specific to the use of the "pill pack" system that actually packages each inmate's dose of ALL medications for am and pm into each dose so the nurse is not repackaging at all. The problem appears to be the lack of availability of return of these drugs for credit so the loss of perhaps 15-18% in funding, despite the fact that the unit is sealed completely and labeled for each drug contained in the package. Diamond indicated their willingness to follow up with the South Carolina Pharmacy Board on this issue in greater detail, given that it is allowed for return in other jurisdictions. A provider changing drug orders frequently as is seen with our psychiatry staff could also be problematic with this system, but there are mechanisms to work around this.

Pharmacy Procurement: Procurement for SCDC went to State Procurement and identified that we could NOT amend our existing MMCAP agreement and had to put the pharmacy services out to bid, a process that can take up to two years in South Carolina. We continue to investigate this option.

Parata Pill PASS: This is one of a few systems that actually packages the medications into dose packs for inmates with all of the prescribed medications in one package, all labeled appropriately by inmate and time with all medications. This is a packaging system that our central pharmacy could actually utilize internally in lieu of the ScriptPro system now in use, and this would prevent the nurses from repackaging for hours on end into coin envelopes. All medications would be SEALED and LABELED from the pharmacy. In the worst case, even if a medication went under a door, which we will make every attempt to avoid, it would be labeled with all of the correct information for the specific inmate and would be SEALED in a plastic container, thus remaining hygienic. Of course, procurement indicates that this too must be advertised and bid, but perhaps there is only one other competitor; so we are investigating pricing for these two systems, Parata and TCG, as the two largest packaging competitors in this market.

RHU/Medication Administration: The RHU medication administration procedural guidelines have been developed/distributed/reviewed with all of the HCA's outlining the appropriate processes for medication administration in RHU. The process guidelines address proper inmate identification, medication administration/ documentation, and steps to be taken in the event of disruptions in the normal medication administration processes for RHU. Additional measures that are currently being reviewed to address the needs of the RHU population are: alternative medication delivery methods include the use of mobile medication carts, varied medication packaging systems, and revisions to medication administration schedules. (See guidelines in Appendix GG).

DISRUPTION IN THE RHU MEDICATION ADMINISTRATION PROCESS DUE TO DISTURBANCES OR OPERATIONS LOCK DOWN SITUATIONS:

If medical staff members are unable to conduct medication administration processes (pill lines or dorm delivery), the medical staff are to initiate the following process:

- Medical notifies the operations shift supervisor to verify the lock down status/obtain assistance. If the shift supervisor confirms they are unable to conduct medication pass, the medical staff is to notify the next operations member in the chain of command (Major, AW, Warden) on duty.
- When medication administration processes are unable to be completed, an incident report is to be completed by the medical staff with specific detailed information explaining the situation, who was notified, and steps that were taken to resolve the issue.
- The facility HCA/HN are to be notified by the medical staff of this occurrence.
- An email summary with a copy of the incident report should be scanned to the Deputy Director of Health Services, Assistant Deputy Director, Director of Nursing. Regional Nurse Manager, and the institutional Warden.

*July 2018 Implementation Panel findings: A*s per status update section. Our March 2018 findings included the following:

> Due to the very significant nursing vacancies and systemic deficiencies previously summarized that are not due to individual nursing staff, it is not reasonable to hold clinicians responsible for completing and monitoring MAR's under these conditions. It is reasonable to expect nursing staff to continually advocate for necessary staff, supplies and equipment.

Our opinion remains the same.

July 2018 Implementation Panel Recommendations: Decide which of the remedies described in the status update section will be implemented.

5.c Review the reasonableness of times scheduled for pill lines; and

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update

Effective 06/20/2018, Camille Graham nursing has decided that all of Blue Ridge C and D medications will be passed in the dorm for AM and PM pill passes. The new pill line time change to 7am and 7pm. Staff are now required to notify the HCA immediately when inmates with court-ordered medications refuse. Staff were provided a list of all L2 inmates. If any identified L2 refuses their mental health medications, the HCA must be notified. Staff were notified that all pill passes must be signed off before their shifts end. If an inmate refuses a medication at the time of administration, the inmate is required to sign a refusal and forward to the ordering provider. Morning insulin is now done by the night shift nurses. Nursing coverage is now in place for CGI. An HCA, two LPNs, and one RN have been hired. An additional seven agency nurses have been also been hired.

July 2018 Implementation Panel findings: HS meds at the Kirkland ICS are administered during the late afternoon. Morning medications in the Murray dormitory at the BRCI were often administered between 3 and 4 AM.

July 2018 Implementation Panel Recommendations: Remedy the above.

5.d. Develop a formal quality management program under which medication administration records are reviewed.

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update
Food flap installation projects (multiple contracts - manufacture of flaps, installation of flaps) should be completed statewide SCDC by end of calendar year 2018. Inmates on meds at Lee CI RHU are being swapped out with non-medicated inmates from other RHU's to lighten nursing load on Lee nursing, given the number of nursing resignations since the major disturbance and lockdown. HCA's have been instructed how to document disruption of medication administration due to either: 1) lack of security escort, 2) lack of lockdown of the inmates for medication administration on the tiers, or 3) disruption of medication administration due to security issue/disturbance on the unit. Staff have been directed to complete an incident report with notice to the senior Operations management as well as Health Services management and to make attempts to make up the medication administration, with an emphasis on insulin-dependent diabetics.

Food Flap installation to improve safety within general population settings are now complete at McCormick and Evans and is now moving to Lieber.

Trial medication carts to improve medication administration are currently being tested. Nursing positions and salaries are a priority focus for the FY20 budget.

July 2018 Implementation Panel findings: See prior findings relevant to medication administration.

July 2018 Implementation Panel Recommendations: For reasons previously summarized, QI studies should address medication administration and medication management issues (e.g., level of compliance with policies and procedures specific to medication noncompliance, continuity of medications, etc.).

6. A basic program to identify, treat, and supervise inmates at risk for suicide:
6.a. Locate all CI cells in a healthcare setting;

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
Plans for the BRCI CSU include renovating 32 rooms in Greenwood B on the lower tier to be suicide-resistant cells. The upper tier rooms will accommodate double-celled, character unit Inmate Watchers and the creation of therapeutic spaces for group and individual services. A nurses station will be located on the unit. A staffing assessment will be completed for an additional 32 beds expansion.

Boats with mattresses are being delivered for the male CSU; however, they will not be utilized until the CSU expansion process is underway and after a written process has been approved by the IP. The expansion will require the hiring of sixteen additional security staff for the current unit and twenty-three for the expanded unit. Positions have been allocated as a part of year 3 of the MH Lawsuit funding to support this expansion in addition of reclassification of other vacant positions in Health Services to support this expansion. Based on current Facilities Management's priorities, this project is anticipated to begin no later than January, 2019.

The Deputy Director of Health Services and Division Director for BMHSAS reevaluated CI cells for approval for use for CI purposes. Final inspection of safe cells in Kershaw and Lieber will be completed by July 1. All others have been completed and approved. Staff used a Safe Cells Inspection tool developed by the Ohio Department of Corrections and Rehabilitation as a guide. Refer to Appendix HH for the tool.

Safe cells for the CSU expansion were reviewed on June 19, 2018, with architect Steven Li. The following chart shows the location and status of safe cell that have been approved.

Safe Cells			
Institutions	**# or Cell**	**Location**	**Approved as Safe Cells**
Allendale Correctional Institution	4	RHU	Approved- KD/TM
Broad River Correctional Institution	4		Approved- KD/TM
	13	CSU	
Camille Graham Correctional Institution	4	RHU	
	12	Blue Ridge	Approved- KD/TM
Evans Correctional Institution	3	Infirmary & RHU	Approved- KD/TM
Kershaw Correctional Institution	4	RHU & Medical	
Kirkland Reception & Evaluation Center	8	F-1	Approved- KD/TM
	5	GPH	Approved- KD/TM
Leath Correctional Institution	4	Phoenix - A-Side	Approved- KD/TM
Lee Correctional Institution	4	RHU	Approved- KD/TM
Lieber Correctional Institution	4	RHU	
McCormick Correctional Institution	2	RHU - B-Wing	Approved- KD/TM
Perry Correctional Institution	6	RHU - B-Dorm, Z-Wing	Approved- KD/TM
Ridgeland Correctional Institution	2	RHU - South	Approved- KD/TM
Trenton Correctional Institution	1	RHU	Approved- KD/TM
Turbeville Correctional Institution	4	RHU - Murray	Approved- KD/TM
Tyger River Correctional Institution	2	RHU - East	Approved- KD/TM
TOTAL	**86**		

July 2018 Implementation Panel findings: As per status section update.

During the afternoon of July 17, 2018, we observed a staffing of an inmate in the BRCI CSU. This inmate's precipitating factor for the admission appeared to be primarily a safety concern. Staff reported that such concerns were frequently the precipitating factor for other inmates admitted to the CSU as well.

We were informed that CSU staff can no longer directly discharge to the Adjustment Unit, which has limited their discharge disposition options.

Our March 2018 findings included the following:

> It was very common that CSU patients had been admitted following a self-harming event or suicide attempt which was later assessed to have been directly related to safety and security concerns or other custodial issues. Interventions within the CSU frequently

involved a "therapeutic transfer" that was often only a temporary solution as evidenced by subsequent repeat CSU admissions within the next six months. Such interventions turned out to be temporary solutions due to resource issues at the receiving institution that resulted in recommended interventions not being implemented.

The CSU at BRCI has essentially been functioning as a clearing house for the entire system in the context of admitting many inmates who have security issues that were either not being adequately addressed or perceived by the inmates as not being adequately addressed. The CSU is hampered in adequately intervening for the following reasons:

1. The lack of a central office classification officer, who could implement appropriate interventions specific to safety concerns; and
2. Lack of timely access to specific treatment programs such as the LLBMU and the HLBMU due to waiting list issues.

It would be very helpful if the Adjustment Unit at Perry CI was moved to the BRCI, which would then serve as another resource for disposition purposes and facilitate communication with staff at the CSU.

The above findings and recommendations remain the same.

July 2018 Implementation Panel Recommendations: See above.

6.b Prohibit any use for CI purposes of alternative spaces such as shower stalls, rec cages, holding cells, and interview booths;

Implementation Panel July 2018 Assessment: compliance (December 2017)

June 2018 SCDC Status Update:
Logs provided to the QIAs and observation during institutional audits did not identify inmates being placed in a holding cell or other alternative space. In a review of the cell check logs by QIRM staff, there was no documentation to indicate that shower stalls, rec cages, holding cells, and interview booths were being used for CI purposes. Any inmate assigned to a livable cell outside a designated safe cell is placed on one-to one and given immediate prioritization to CSU.

July 2018 Implementation Panel findings: As per status update section.

6.c Implement the practice of continuous observation of suicidal inmates;

Implementation Panel July 2018 Assessment: noncompliance

June 2018 SCDC Status Update:
QIRM staff continue to be informed that the practice of continuous observation is being implemented in the institutions, and have witnessed the practice in action; however, The CSU is the only program where this is documented consistently based on the use of the 19-7C, *Constant Observation Log/INMATE WATCHER.*

- Staff reviewed documentation recorded on SCDC form 19-7C "Constant Observation log/Inmate Watcher" logs for three randomly selected inmates each month (February-May) to determine:

- rates for cell check completion
- Average time between checks
- Number of checks great than 15 minutes
- When greater than 15 minutes, the average time between checks
- Longest time between checks
- **Results**
- Average time between checks is between 13-15 minutes.
- Checks greater than 15 minutes ranged from 2-3 occurrences.
- The average time between checks that were >15 minutes ranged from 23-67 minutes.
- The longest time between checks range from 23-115 minutes.

The 115 minute gap was documented by the inmate watcher as the CISP inmate being out of his cell for either medical, treatment team, or recreation. There was no concurrent officer's documentation submitted to the auditor to show that the CISP inmate was still under constant observation.

July 2018 Implementation Panel findings: As per status update section. Further, a QI study indicated approximately 68% of inmates on suicide precautions received documented staggered q15 (every 15) minute checks/observation by assigned inmate watchers. A suicide occurred in the CSU by an inmate on suicide precautions.

July 2018 Implementation Panel Recommendations: Perform a QI study in other institutions where constant observation occurs; repeat study in CSU's at BRCI and CGCI.

6.d. Provide clean, suicide-resistant clothing, blankets, and mattresses to inmates in CI;

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
SCDC is seeking a different vendor for suicide clothing/blankets based on current products being easily disassembled, which could cause a major liability issue for inmates who are on crisis watch. The new bid will go after 07/01/18 with the following specs:

Suicide Blanket Bid
- Size of suicide blankets are 56" x 80"
- Blankets must be made with 1000 denier nylon Cordura, lock-stitch quilted with 6 oz./yard polyester batting.
- Blankets must have a five-year guarantee.
- Blankets must be flame resistant and tear resistant (not easily disassembled, twisted into knots or nooses)
- Outer layers must be made where chafing or irritation won't occur to bare skin
- Blanket should not require any special laundering. Machine washing and drying are required so blankets can go back into cells quickly.

Five (5) institutions, Leath, Evans, Broad River, Camille, Kirkland and Perry, were included in a review of their provision of clean, suicide-resistant clothing, blankets, and mattresses. Broad River and Camille Graham use suicide-resistant supplies in both their Crisis Stabilization Units and in the crisis

cells located in the Restrictive Housing Units (RHU); however, Camille's safety cells in RHU have been taken "offline" and were not included in this study.

QIRM staff assessed the processes for issuing, cleaning and providing clean suicide-resistant clothing and equipment for inmates when placed on CI to determine if suicide resistant supplies were being cleaned each time they were returned from an inmate on Crisis Intervention (CI). Interviews with inmates and an assessment of supplies indicated that clean, suicide-resistant supplies were available and being supplied to inmates when placed on CI.

Tracking the issuing and cleaning of this equipment will enable SCDC to ensure that inmates are receiving clean, sanitary suicide prevention equipment when placed on CI.

Five (5) institutions (Evans, Broad River, Camille, Kirkland and Perry) participated in this study. Broad River and Camille Graham use suicide resistant supplies in both their Crisis Stabilization Units and Restrictive Housing Units (RHU). However, Camille's safety cells in RHU have been taken "offline" and are not included in this study.

The QIRM analyst completed a Suicide Resistant Supplies Review Form based on available equipment in the institutions. In addition inmate interviews were conducted and a qualitative analysis was done based on information provided from the interviews. The individual institutional reports are below.

Assessment of the results:
Overall, from the institutions included in this study, there were many suicide resistant supplies in disrepair. The number varies because of the 17 large bags in CSU at Broad River CI. All suicide resistant supplies were either in use by an inmate on CI/SP status or in a secured storage area. There were inmates on CI status at two institutions during the time of this audit and they were utilizing the appropriate suicide resistant supplies. All inmates who were interviewed indicated they received clean supplies (except one who responded he did not know). Due to the condition of many of the supplies and the large numbers of inmates on CI/SP status, it has been recommend that most institutions request additional supplies. A tracking system was established at some institutions to track their stock of suicide-resistant equipment, ensure items are cleaned regularly and are maintained in good repair; it is necessary that the other institutions begin using a written tracking system. Many institutions are allowing non-CISP inmates to use suicide resistant. Those institutions need to ensure that non-CISP inmates are not allowed to use the suicide-resistant equipment; they need to provide enough normal supplies for their non-CISP population. Lastly, at Kirkland, there are many areas at Kirkland where suicide resistant supplies are used (F1, GPH, SSR, and Infirmary). I recommended there be a refined method to track supplies at each unit.

The complete report is included as Appendix II.

July 2018 Implementation Panel findings: As per status update section. Mattresses were not available to inmates on suicide watch in the RHU at Lee Correctional Institution.

July 2018 Implementation Panel Recommendations: Remedy the above.

6.e Increase access to showers for CI inmates;

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:

Protocol in the Crisis Stabilization Unit (CSU) dictates that inmates in the CSU will receive a shower daily, except when the inmate has a RHU (Restrictive Housing Unit) custody level when he or she is admitted into the CSU. Per Policy 19.03, Inmate Suicide Prevention and Crisis Intervention, ***"8.5 RHU inmates in CSU will be allowed daily showers if security staffing presence permits. Otherwise, RHU inmates with be allowed to shower a minimum of 3 times a week."*** As part of SCDC's ongoing efforts to ensure this protocol is followed, a CQI study was completed to evaluate the frequency of showers in the CSU.

A sample of 10 male inmates was selected for each of the months of February 2018, March 2018, April 2018, and May 2018 to review the number of showers the inmates received while they were in the CSU. For the month of May 2018, 10 female inmates were reviewed for the same.
Due to the variations in the length of stay in the CSU, the denominators were not always the same. For non-RHU inmates, the numerator is the number of showers an inmate received and the denominator is the number of days the inmate was in the CSU (which is the total number of showers the inmate should have received). For inmates who had a RHU custody level, the numerator is the number of showers the inmate received and the denominator is the number of showers the inmate should have received based on the length of stay in the CSU and the RHU policy requirement for showers. Inmates highlighted in yellow had a RHU custody level on their day of admittance into the CSU.

- For the month of February, the highest rate of compliance for showers for non-RHU inmates was 50%. The lowest rate of compliance was 15%. The compliance rate for showers for inmates with a RHU custody level was 100%, and one of the inmates received one additional shower.
- For the month of March, the highest rate of compliance for showers for non-RHU inmates was 36%. The lowest rate of compliance was 6%. There was one inmate with a RHU custody level, and the compliance rate for showers was 20%.
- For the month of April, the highest rate of compliance for showers for non-RHU inmates was 100%, with one inmate receiving all 10 of his possible showers. The next highest compliance rate for showers was 54%. The lowest compliance rate was 0% as there was one inmate who did not receive any of his eight possible showers. There was one inmate with a RHU custody level, and the compliance rate for showers was 40%.
- For the month of May
    - at the Broad River CSU, the highest rate of compliance for showers for non-RHU inmates was 100%, with one inmate receiving all 9 of his possible showers. The next highest compliance rate for showers was 50%. The lowest compliance rate was 19%. There were no inmates with a RHU custody level in the sample for the month of May.
    - at the Camille CSU, the highest rate of compliance for showers for non-RHU inmates was 100%, with one inmate receiving both of her possible showers. The next highest compliance rate was 50%. The lowest compliance rate was 25%. There was one inmate with a RHU custody level and the compliance rate for showers was 100%.

Overall Assessment

- Out of 35 non-RHU male inmates, only two (2), or 6%, received showers daily per protocol. This indicates staff are not providing showers daily per protocol for most non-RHU inmates or that scans are not properly completed for entry into the OATS report.
- At Broad River, in the month of February, the compliance rate for showers for inmates with a RHU custody level was 100%. This compliance rate dropped to 20% in the month of March and 40% in the month of April. This indicates staff are not providing showers three times per week per protocol and RHU policy or that scans are not properly completed for entry into the OATS report.

- At Camille, most non-RHU inmates received fewer than 50% of the recommended number of showers.

The study along with the methodology is included as Appendix JJ.

This study focused on CSU because tracking showers to CI inmates in the institutions continues to pose a challenge because are showers for inmates on CI/SP status are documented in the RHU logbook. General entries are made but there is no way to determine which specific inmate received a shower for the day, nor does the log entry indicate the timeframe in which the inmate received the shower. For example, the general entry will report, "7:15am - Showers conducted" or "10:15am – showers ended".

To incorporate a uniform system, it has been recommended that the back of SCDC form 19-7A, "30 Minute Cell check log", be added to the back of SCDC form 19-7B, "15 Minute cell check log" to accurately capture who and when a specific inmate received a shower. In addition to showers, this addition will show meals received and recreation. A snippet of the back of SCDC form 19-7A is shown below.

CELL CHECK LOG

Please answer in the spaces provided with (Yes) Y (No) N (Refuse) R or (Ineligible) I

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
BKFST ___	BKFST ___	BKFST ___	BKFST ___	BKFST ___	BKFST ___	BKFST ___
LUNCH ___	LUNCH ___	LUNCH ___	LUNCH ___	LUNCH ___	LUNCH ___	LUNCH ___
DINNER ___	DINNER ___	DINNER ___	DINNER ___	DINNER ___	DINNER ___	DINNER ___
SHOWER ___	SHOWER ___	SHOWER ___	SHOWER ___	SHOWER ___	SHOWER ___	SHOWER ___
REC ___	REC ___	REC ___	REC ___	REC ___	REC ___	REC ___

(Initial)

PRINT NAME: _____ /___

PRINT NAME: _____ /___

(Initial)

PRINT NAME: _____ /___

PRINT NAME: _____ /___

The M120 forms do not clearly identify if the inmates are allowed to shower. The M120 has been updated to indicate showers; however, it is included among a list of instructions as opposed to a distinct entry requiring an exclusive response. (Example: Treatment Plan (Include instructions for observation, shower, precautions, and property allowed). Plans to expand the OATS system to all RHU's are underway which will enable staff to document showers into this electronic system. A recommendation has been made to the Division of BMHSAS to revise the form again to highlight eligibility for showers.

July 2018 Implementation Panel findings: Per status update section. SCDC QI Studies have identified that CI inmates are not receiving the increased access to showers. Non-RHU CI inmates are to receive daily showers and CI inmates on RHU status are to receive showers 3 times per week. SCDC Mental Health Form M120 was revised to indicate showers; however, the form remains deficient in clearly identifying the CI inmate is authorized to shower.

July 2018 Implementation Panel Recommendations: Remedy the above. SCDC Operations and Mental Health Staff need to implement revised procedures to ensure inmates on CI status receive their required access to showers. An accurate electronic or manual system needs to be developed and implemented to record CI inmates are receiving showers in compliance with the established shower schedule.

6.f Provide access to confidential meetings with mental health counselors, psychiatrists, and psychiatric nurse practitioners for CI inmates;

Implementation Panel July 2018 Assessment: noncompliance

June 2018 SCDC Status Update:

As part of SCDC's ongoing efforts to ensure that inmates on Crisis Intervention/Suicide Prevention (CI/SP) have access to confidential sessions with mental health professionals, the Division of BMHSAS completed a CQI study to assess where SCDC is in reaching that goal and to identify barriers to success. The study, included as Appendix KK examined what types of mental health sessions were being provided to CI/SP inmates and the frequency of the various types of sessions. Confidential sessions made up a relatively small minority - between 15% and 21% - of the mental health sessions provided to CI/SP inmates in the months of February, March, April, and May 2018 in the facilities that were reviewed. "Other Locations" for sessions made up the largest category, between 39% and 48%, but sessions conducted cell front accounted for between 36% and 46% of all session locations. As stated previously, the "Other Locations" category is not abundantly clear if the session was confidential. While SCDC has not yet met the goal to provide confidential mental health sessions to all inmates on CI/SP status and in CSU, the results show that QMHPs and other Mental Health staff work to respect the mentally ill inmates by holding fewer sessions in front of the inmates' cells and other individuals when possible.

Location of Sessions for Inmates on CI/SP Status

Month	Cell Front	Confidential Setting	Other Locations
Feb-18	45.3%	15.3%	39.4%
Mar-18	36.7%	20.2%	42.0%
Apr-18	37.5%	16.1%	46.4%
May-18	37.4%	15.4%	47.2%

nth	# Cell Front Sessions	# Confidential Setting Sessions	# Sessions in Other Locations	# Sessions in All Locations
Feb-18	836	282	726	1844
Mar-18	676	372	772	1820
Apr-18	818	351	1012	2181
May-18	710	293	897	1900

Location of Sessions for Inmates on CI/SP Status

Moving forward, SCDC will continue its aggressive recruitment campaign in order to alleviate security staffing issues, as this is a major contributing factor to not being able to provide confidential QMHP sessions. Outside of CSU, Mental Health staff continue to face challenges having inmates removed from cells for individual counseling sessions based on security shortages. Mental Health staff will also be directed, until transitioning to EHR, that CI reporting and data coding should only consist of selecting from either cell front or confidential settings.

July 2018 Implementation Panel findings: As per status update section. Access to confidential spaces has worsened with the statewide lockdown.

July 2018 Implementation Panel Recommendations: Remedy the above.

6.g Undertake significant, documented improvement in the cleanliness and temperature of CI cells;

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
See 2b.vi

July 2018 Implementation Panel findings: As per status update see 2 b.vi. Institutions have improved performing random cell temperatures and cleanliness inspections and uploading the information. There continues to be major issues with institutions correcting identified temperature and cell cleanliness deficiencies and reporting the corrective action as required.

July 2018 Implementation Panel Recommendations: Remedy the above. Continue to perform QI studies assessing compliance with correctional staff performing daily, random cell temperatures and cleanliness inspections and validate identified deficiencies are corrected in a timely manner.

6.h Implement a formal quality management program under which crisis intervention practices are reviewed.

Implementation Panel July 2018 Assessment: partial compliance

June 2018 SCDC Status Update:
The following chart outlines the process for monitoring SCDC policy, *19.03 Inmate Suicide Prevention and Crisis Intervention*

Component to be Monitored	Process for Monitoring
Monitor and track all suicides and suicide attempts statewide.	Agency Suicide Prevention Committee convenes a meeting after every completed suicide to identify root causes from an institution and systems perspective. A report is compiled listing findings and recommendations from every review. QIRM recently announced at the Agency Suicide Prevention Committee they will begin monitoring follow-up from recommendations made at the committee. Local Suicide Prevention Committee-meets every quarter and review all suicide attempts statewide.
Provide for the selection and dispatch of a mental health suicide reviewer (MHSR) after a suicide occurs.	Agency Suicide Prevention Committee – The Mental Health Suicide Reviewer (MHSR) dispatches 72 hours after a completed suicide. A roaster and summary report is included as part of the Agency Suicide Prevention Committee final report.
All staff with the responsibility for inmate supervision will receive 8 hours of training in mental health related content to include suicide prevention and intervention. New employees will receive the training during institutional orientation and/or during the Correctional Officer Certification Course.	Training Records kept on file regarding employees who have completed mandatory trainings. This information is available to QIRM.

SCDC certified correctional officers, and all medical and mental health staff (SCDC and contract) are required to maintain CPR certification every two (2) years. All other employees with direct inmate contact/supervision are strongly encouraged to become certified.	Training Records kept on file regarding employees who have completed mandatory trainings. This information is available to QIRM.
Suicide Risk Assessment - All inmates scoring a positive result for suicidality on the MHSF-III and receiving an emergent or urgent evaluation are administered the Columbia Suicide Severity Rating Scale (C-SSRS)-Lifetime/Recent form by a QMHP to identify modifiable or treatable acute, high-risk suicide factors, and available protective factors that inform of inmate's treatment and safety management requirements.	Information tracked through Divisional Audits performed by Q/A staff within the Division of Behavioral Health and results shared with QIRM. The Division of QIRM also conducts independent on site audits at institutions to collect information.
Upon referral, during normal working hours, the QMHP assigned to the institution will provide a confidential, face-to-face evaluation the same working day and the C-SSRS Lifetime/Recent form will be utilized. This evaluation will be documented in the Automated Medical Record (AMR or EHR). During off duty hours, the on-call Mental Health Professional will provide a telephone consultation within 30 minutes of being paged by Medical or Correctional staff. Continuous observation (face-to face, in person) will be provided while awaiting an assessment by a QMHP.	Information gathered from documentation completed by the QMPHs and audited by Behavioral Health Q/A and QIRM staff.
Inmates on CI/SP or Observation Status are re-assessed at a minimum every 24 hours to identify changes in condition that indicate a need for a change in supervision level and placement. The C-SSRS Daily/Shift Screen form is completed as a part of the re-assessment	Information gathered from documentation completed by the QMPHs and audited by Behavioral Health Q/A and QIRM staff.
Prior to an inmate's removal from CI, the inmate must be re-evaluated either face-to-face or via tele-psychiatry technology by a licensed psychologist or psychiatrist. The reason for removal shall be documented in the AMR	Information gathered from documentation completed by the QMPHs and audited by Behavioral Health Q/A and QIRM staff.
Inmates needing CSU level of care will be transferred to the CSU at Graham (females) or Broad River (males) within 60 hours of the initial referral. If the QMHP determines a CSU level of care is not needed, or is undecided, the QMHP will consult with a psychiatrist or licensed psychologist within 48 hours of the initial referral regarding disposition. When an inmate arrives at the CSU, he/she will be evaluated by the psychiatrist or licensed psychologist within 24 hours. A	Regarding the 60-hour threshold, information entered into Crisis Intervention/Suicide Precaution web based application by the QMHP is time stamped. Weekly reports are generated from the Division of Resource Information Management (RIM) system to the Division of Behavioral Health and QIRM for compliance monitoring. Documented sessions for inmates arriving at CSU are obtained from chart reviews conducted by Behavioral Health Q/A and QIRM staff.

preliminary treatment plan will be developed by a QMHP after conducting a clinical assessment.	
All safe cells must be kept clean and temperatures regularly monitored and documented to assure they are in an appropriate range.	Cell check reports submitted from each institution to QIRM.
All non-RHU CSU inmates, unless clinically contraindicated, shall have access to out-of-cell time for 10 hours of structured and 10 hours of unstructured activity in a seven day period. This includes access to the dayroom and outdoor recreation.	Structured time reports generated from EHR and unstructured time reports generated from the OATS automated system submitted from both CSU programs to the Division of BH and QIRM.
Training of Inmate Observers. Inmate Observers will receive at least four hours of initial training before being considered eligible for suicide watch duty. Additionally, each observer will also receive at least four hours of training semiannually	Bi-annual report submitted from CSU program staff to QIRM outlining training received from all Inmate Observers.

July 2018 Implementation Panel findings: As per status update section.

Significant improvement is noted in the most recent psychological autopsy report. We made specific suggestions to Dr. [redacted] re: the process.

July 2018 Implementation Panel Recommendations: Implement the above QI schedule.

Conclusions and Recommendations:

Consistent with its previous six reports, the Implementation Panel has provided recommendations in this report as well as onsite during this visit from July 16-20, 2018. This report includes the IP findings and recommendations thru the end of the site visit, July 20, 2018. We have also discussed with SCDC staff, inmates, and the parties the impact of the riot at Lee and subsequent statewide lockdown. While some facilities and programs have been removed from the lockdown and others have not, the impact of the riot and lockdown continue to impact the SCDC mental health services delivery. During the visit we strongly encouraged facilities and programs to provide proposals to SCDC leadership to restore mental health services including considerations of safety concerns of staff and inmates. The system was already understaffed and the IP cannot overemphasize the continuing need for adequate staffing, facilities and programs to achieve adequate mental health care and compliance with the Settlement Agreement.

As always, we hope this report has been informative and the technical assistance provided has been helpful. We appreciate the cooperation and assistance of all parties in the pursuit of these goals and look forward to the next visit in November, 2018.

Sincerely,

Raymond F. Patterson, MD
Implementation Panel Member

On behalf of himself and:

Emmitt Sparkman
Implementation Panel Member

MEDIATOR REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES
JULY 2018 IP ASSESSMENT

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
1.	**The development of a systematic program for screening and evaluating inmates to more accurately identify those in need of mental health care:**			
	a. Develop and implement screening parameters and modalities that will more accurately diagnose serious mental illness among incoming inmates at R&E with the stated goal of referring inmates to the appropriate treatment programs. Accurately determine and track the percentage of the SCDC population that is mentally ill.	HS 19.10	07/20/18 Partial compliance	07/20/18 Partial Compliance
		HS 19.07	07/20/18 Partial compliance	07/20/18 Partial Compliance
	b. The implementation of a formal quality management program under which mental health screening practices are reviewed and deficiencies identified and corrected in ongoing SCDC audits of R&E counselors;	HS 19.07	07/20/18 Partial compliance	07/20/18 Partial Compliance
	c. Enforcement of SCDC policies relating to the timeliness of assessment and treatment once an incoming inmate at R&E is determined to be mentally ill; and	HS 19.07 HS 19.10	07/20/18 Partial compliance	07/20/18 Partial Compliance

[1] The Order components are for reference only and are to be used as references to identify those aspects of the Policies which apply to the Implementation.

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	d. Development of a program that regularly assesses inmates within the general population for evidence of developing mental illness and provides timely access to mental health care.	HS 19.07 HS 19.10	07/20/18 Partial compliance	07/20/18 Partial Compliance
2.	**The development of a comprehensive mental health treatment program that prohibits inappropriate segregation of inmates in mental health crisis, generally requires improved treatment of mentally ill inmates. and substantially improves/increases mental health care facilities within SCDC:**			
	a. Access to Higher Levels of Care:			
	i. Significantly increase the number of Area Mental Health inmates vis-a-vis outpatient mental health inmates and provide sufficient facilities therefore;	HS 19.04 HS 19.11	07/20/18 Noncompliance	07/20/18 Noncompliance
	ii. Significantly increase the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefore;[2]	HS 19.04, HS 19.07, HS 19.11	07/20/18 Partial compliance	07/20/18 Partial Compliance
	iii. Significantly increase the number of male and female inmates receiving inpatient psychiatric services, requiring the	HS 19.04, HS 19.07 HS 19.09	07/20/18 Partial compliance	07/20/18 Partial Compliance

[2] The Parties agree that 10-15% of male inmates and 15-20% female inmates on the mental health case load should receive Intermediate Care Services.

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	substantial renovation and upgrade of Gilliam Psychiatric Hospital, or its demolition for construction of a new facility;	Gilliam Construction Plan	07/20/18 Partial compliance	07/20/18 Partial Compliance
	iv. Significantly increase clinical staffing at all levels to provide more mental health services at all levels of care; and	Hiring Plan attached as Exhibit E to the Settlement Agreement	07/20/18 Partial compliance	07/20/18 Partial Compliance
	v. The implementation of a formal quality management program under which denial of access to higher levels of mental health care is reviewed.	HS 19.07	07/20/18 Substantial compliance (7/14/17)	07/20/18 Substantial Compliance (7/14/17)
	b. Segregation:			
	i. Provide access for segregated inmates to group and individual therapy services;			
		OP RHU Policy _22.38 Section 3.23 H.S. 19.04	07/20/18 Partial compliance	07/20/18 Partial Compliance
	ii. Provide more out-of-cell time for segregated mentally ill inmates;	HS 19.12 OP RHU Policy 22.38 Section 3.14.4 & Section 3.25	07/20/18 Noncompliance	07/20/18 Noncompliance
	iii. Document timeliness of sessions for segregated inmates with psychiatrists, psychiatric nurse practitioners, and mental health counselors and timely review of such documentation;	HS 19.04 OP RHU Policy 22.38 Section 3.15	07/20/18 Noncompliance	07/20/18 Noncompliance
	iv. Provide access for segregated inmates to higher levels of mental health services when needed;	HS 19.04 HS 19.06	07/20/18 Partial compliance	07/20/18 Partial Compliance
	v. The collection of data and issuance of quarterly reports identifying the percentage of mentally ill and non-mentally ill inmates in segregation compared to the percentage of each group in the total prison population with the stated goal of substantially decreasing segregation of mentally ill inmates and substantially decreasing the average length of stay in segregation for mentally ill inmates;	HS 19.07 OP RHU Policy 22.38 Section 1 and Section 2	07/20/18 Substantial compliance (11/16)	07/20/18 Substantial Compliance (11/16)

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	vi. Undertake significant, documented improvement in the cleanliness and temperature of segregation cells; and	To be determined	07/20/18 Partial compliance	07/20/18 Partial Compliance
	vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.	HS 19.07	07/20/18 Partial compliance	07/20/18 Partial Compliance
	c. Use of Force:			
	i. Development and implementation of a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness;	OP 22.01 HS 19.08	07/20/18 Partial compliance	07/20/18 Partial Compliance
	ii. The plan will further require that all instruments of force, (e.g., chemical agents and restraint chairs) be employed in a manner fully consistent with manufacturer's instructions, and track such use in a way to enforce such compliance;	OP 22.01 HS 19.08	07/20/18 Partial compliance	07/20/18 Partial Compliance
	iii. Prohibit the use of restraints in the crucifix or other positions that do not conform to generally accepted correctional standards and enforce compliance;	OP 22.01 HS 19.08	07/20/18 Substantial compliance (7/14/17)	07/20/18 Substantial Compliance (7/14/17)
	iv. Prohibit use of restraints for pre-determined periods of time and for longer than necessary to gain control, and track such use to enforce compliance;	OP 22.01 HS 19.08	07/20/18 Substantial compliance	07/20/18 Substantial Compliance
	v. The collection of data and issuance of quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs;	HS 19.07 OP Use of Force 22.01 Section 13	07/20/18 Substantial compliance 12/08/17	07/20/18 Substantial Compliance
	vi. Prohibit the use of force in the absence of a reasonably perceived immediate threat;	OP 22.01 HS 19.08	07/20/18 Partial compliance	07/20/18 Partial Compliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	vii. Prohibit the use of crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions;	OP 22.01 HS 19.08	07/20/18 Partial compliance	07/20/18 Partial Compliance
	viii. Notification to clinical counselors prior to the planned use of force to request assistance in avoiding the necessity of such force and managing the conduct of inmates with mental illness;	OP 22.01 HS 19.08	07/20/18 Partial compliance	07/20/18 Partial Compliance
	ix. Develop a mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates;	OP 22.01 ADM 17.01 Employee Training Standards, SCDC Annual Training Plan HS 19.08	07/20/18 Partial compliance	07/20/18 Partial Compliance
	x. Collection of data and issuance of quarterly reports concerning the use-of-force incidents against mentally ill and non-mentally ill inmates; and	OP 22.01 HS 19.07	07/20/18 Substantial compliance (03/03/17)	07/20/18 Substantial Compliance (03/03/17)
	xi. The development of a formal quality management program under which use-of-force incidents involving mentally ill inmates are reviewed.	OP 22.01 HS 19.07	07/20/18 Partial compliance	07/20/18 Partial Compliance
3.	**Employment of a sufficient number of trained mental health Professionals:**			
	a. Increase clinical staffing ratios at all levels to be more consistent with guidelines recommended by the American Psychiatric Association, the American Correctional Association, and/or the court-appointed monitor;	Hiring Plan attached as Exhibit E to the Settlement Agreement	07/20/18 Noncompliance	07/20/18 Noncompliance
	b. Increase the involvement of appropriate SCDC mental health clinicians in treatment planning and treatment teams;	HS 19.05	07/20/18 Partial compliance	07/20/18 Partial Compliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	c. Develop a training plan to give SCDC mental health clinicians a thorough understanding of all aspects of the SCDC mental health system, including but not limited to levels of care, mental health classifications, and conditions of confinement for caseload inmates;	Mental Health Training Policy Addendum	07/20/18 Substantial compliance	07/20/18 Substantial Compliance
	d. Develop a plan to decrease vacancy rates of clinical staff positions which may include the hiring of a recruiter, increase in pay grades to more competitive rates, and decreased workloads;	Hiring Plan attached as Exhibit E to the Settlement Agreement	07/20/18 Substantial compliance 12/08/17	07/20/18 Substantial Compliance (12/08/17)
	e. Require appropriate credentialing of mental health counselors;	HS 19.04	07/20/18 Substantial compliance (03/03/17)	07/20/18 Substantial Compliance (03/03/17)
	f. Develop a remedial program with provisions for dismissal of clinical staff who repetitively fail audits; and	HS 19.07	07/20/18 Substantial compliance	07/20/18 Substantial Compliance
	g. Implement a formal quality management program under which clinical staff is reviewed.	HS 19.07	07/20/18 Substantial compliance	07/20/18 Substantial Compliance
4.	**Maintenance of accurate, complete, and confidential mental health treatment records:**			
	a. Develop a program that dramatically improves SCDC's ability to store and retrieve, on a reasonably expedited basis:	HS 200.7		
	i. Names and numbers of FTE clinicians who provide mental health services;		07/20/18 Substantial compliance (03/03/17)	07/20/18 Substantial Compliance (03/03/17)
	ii. Inmates transferred for ICS and inpatient services;		07/20/18 Substantial Compliance (7/14/17)	07/20/18 Substantial Compliance (7/14/17)
	iii. Segregation and crisis intervention logs;		07/20/18 Partial compliance	07/20/18 Partial Compliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	iv. Records related to any mental health program or unit (including behavior management or self-injurious behavior programs);		07/20/18 Partial compliance	07/20/18 Partial Compliance
	v. Use of force documentation and videotapes;		07/20/18 Substantial compliance (03/03/17)	07/20/18 Substantial Compliance (03/03/17)
	vi. Quarterly reports reflecting total use-of-force incidents against mentally ill and non-mentally ill inmates by institution;		07/20/18 Substantial compliance (03/03/17)	07/20/18 Substantial Compliance (03/03/17)
	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;		07/20/18 Substantial compliance (03/03/17)	07/20/18 Substantial Compliance (03/03/17)
	viii. Quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution;		07/20/18 Substantial compliance (03/03/17)	07/20/18 Substantial Compliance (03/03/17)
	ix. Quality management documents; and		07/20/18 Partial compliance	07/20/18 Partial Compliance
	x. Medical, medication administration, and disciplinary records.		07/20/18 Partial compliance	07/20/18 Partial Compliance
	b. The development of a formal quality management program under which the mental health management information system is annually reviewed and upgraded as needed.	HS 19.07	07/20/18 Partial compliance	07/20/18 Partial Compliance
5.	**Administration of psychotropic medication only with appropriate supervision and periodic evaluation:**		07/20/18 Noncompliance	07/20/18 Noncompliance
	a. Improve the quality of MAR documentation;	HS 18.16	07/20/18 Partial compliance	07/20/18 Partial Compliance
	b. Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs;	HS 18.16	07/20/18 Noncompliance	07/20/18 Noncompliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	c. Review the reasonableness of times scheduled for pill lines; and	HS 18.16	07/20/18 Partial compliance	07/20/18 Partial Compliance
	d. Develop a formal quality management program under which medication administration records are reviewed.	HS 18.16	07/20/18 Partial compliance	07/20/18 Partial Compliance
6.	**A basic program to identify. treat, and supervise inmates at risk for suicide:**			
	a. Locate all CI cells in a healthcare setting;	HS 19.03 OP RHU 22.38 Section 3.39	07/20/18 Partial compliance	07/20/18 Partial Compliance
	b. Prohibit any use for CI purposes of alternative spaces such as shower stalls, rec cages, holding cells, and interview booths;	HS 19.03 OP RHU 22.38 Section 3.39	07/20/18 Substantial compliance 12/08/17	07/20/18 Substantial Compliance (12/08/17)
	c. Implement the practice of continuous observation of suicidal inmates;	HS 19.03	07/20/18 Noncompliance	07/20/18 Noncompliance
	d. Provide clean, suicide-resistant clothing, blankets, and mattresses to inmates in CI;	HS 19.03	07/20/18 Partial compliance	07/20/18 Partial Compliance
	e. Increase access to showers for CI inmates;	HS 19.03	07/20/18 Partial compliance	07/20/18 Partial Compliance
	f. Provide access to confidential meetings with mental health counselors, psychiatrists, and psychiatric nurse practitioners for CI inmates;	HS 19.03	07/20/18 Noncompliance	07/20/18 Noncompliance
	g. Undertake significant, documented improvement in the cleanliness and temperature of CI cells; and	HS 19.03	07/20/18 Partial compliance	07/20/18 Partial Compliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	h. Implement a formal quality management program under which crisis intervention practices are reviewed.	HS 19.03	07/20/18 Partial compliance	07/20/18 Partial Compliance

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.

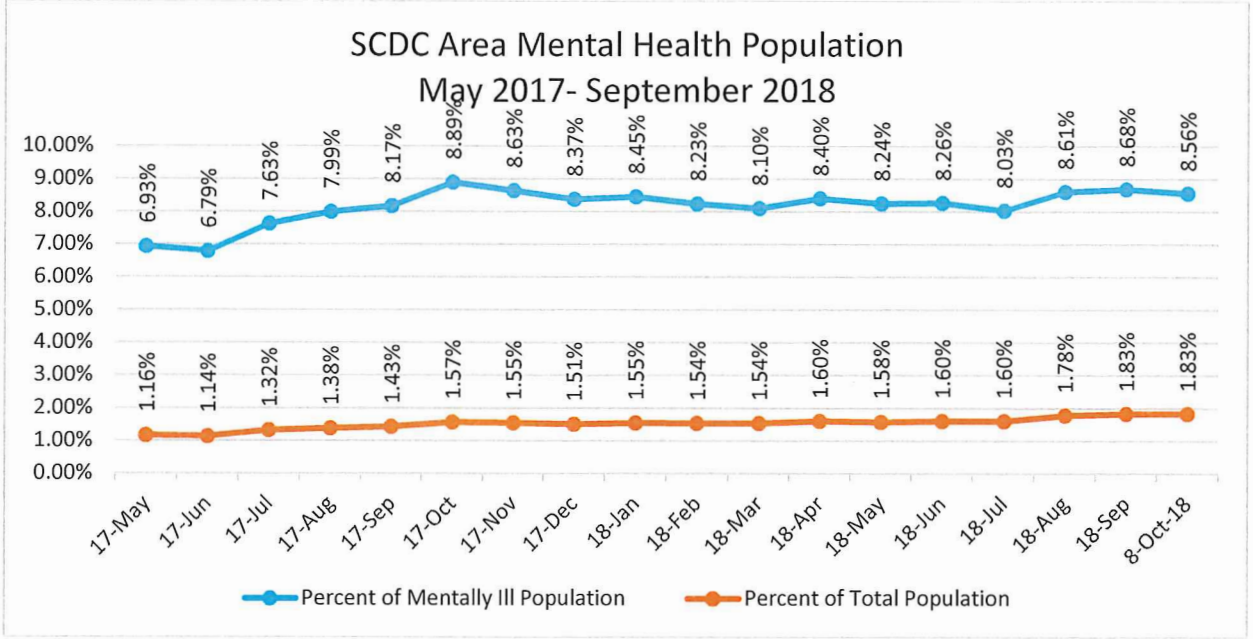
Although Leath Correctional Institution is not included in the current site visit, on August 16, 2018, the Division Director of BMHSAS verified through email that Leath CI no longer has a designated mental health dorm

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%

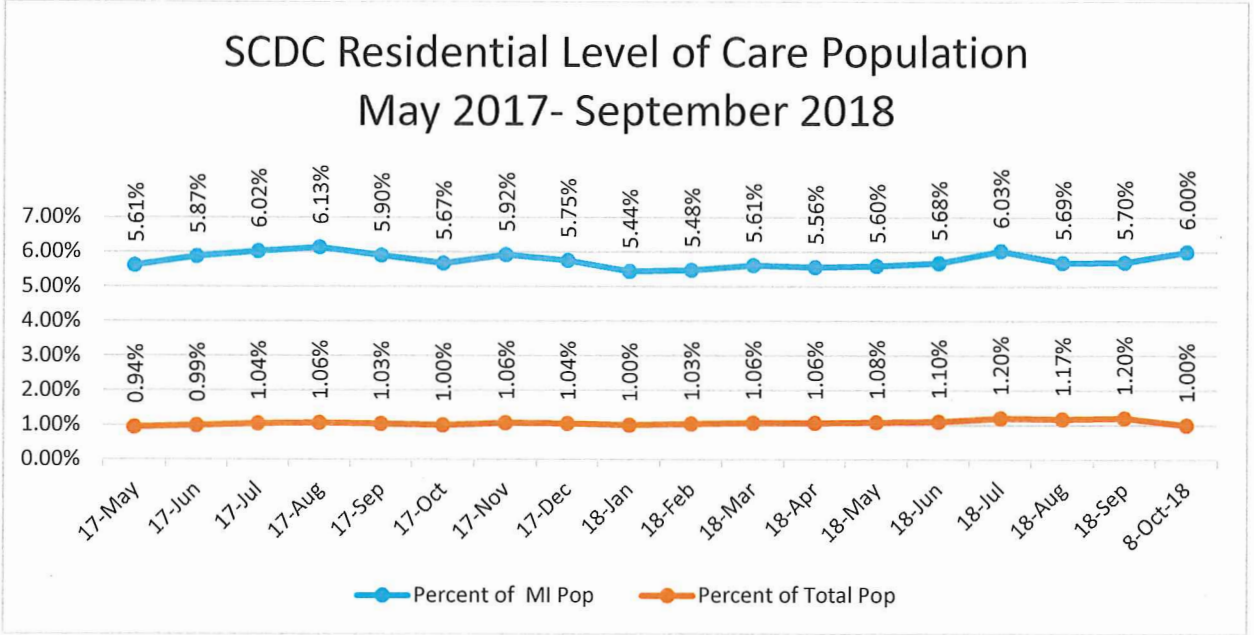
Data Source: Report Completed by Mental Health Staff

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.,)

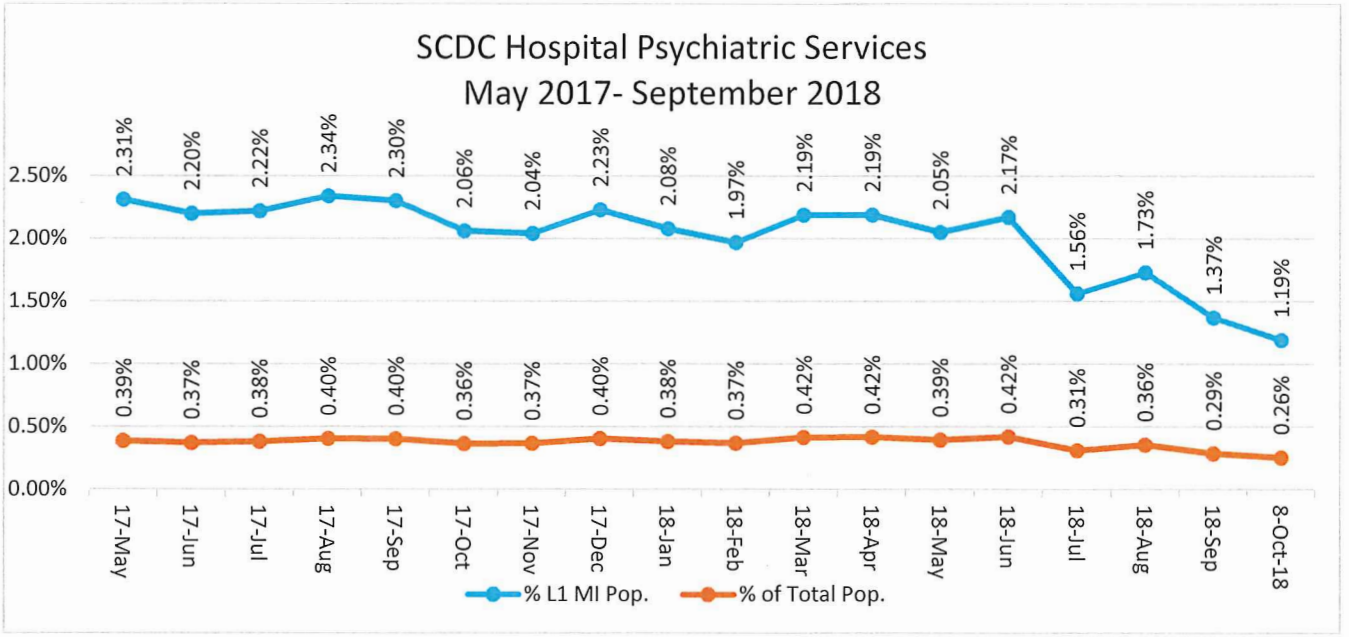
Per the report submitted by mental health staff, Inmates admitted and discharged during the month were deleted from the weeks they were not present. July 4th was holiday with limited staff and groups were not held on July 16 due to limited security personnel.

	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

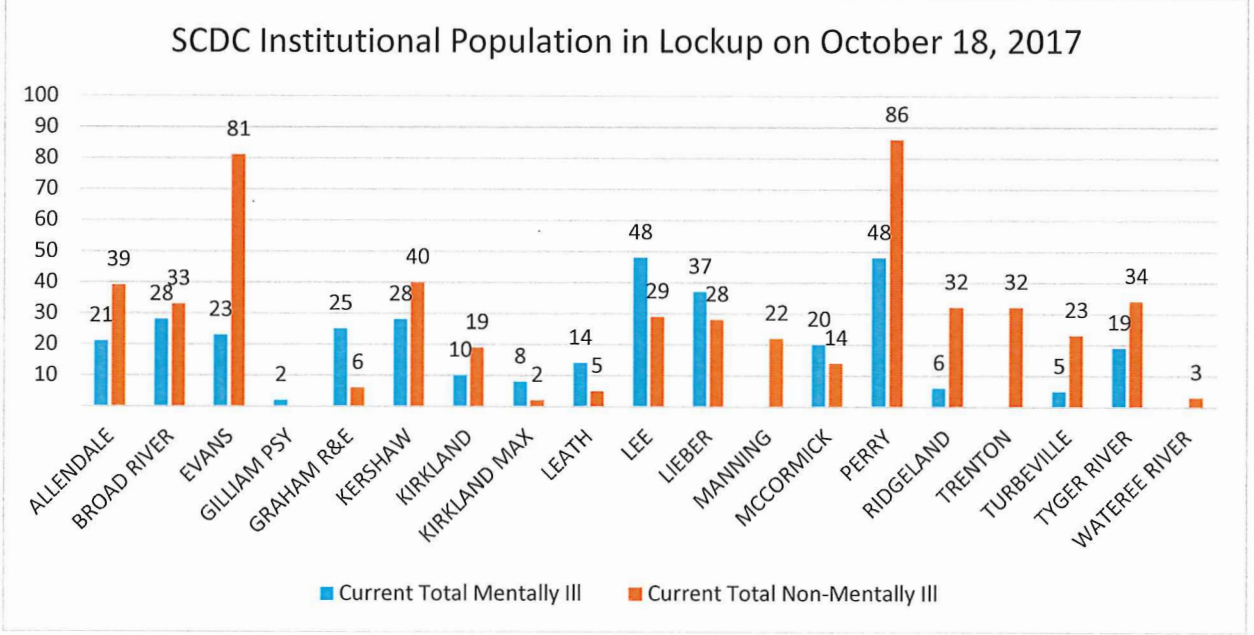
and procedure re: the Special Concerns Unit when it has been developed.

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.

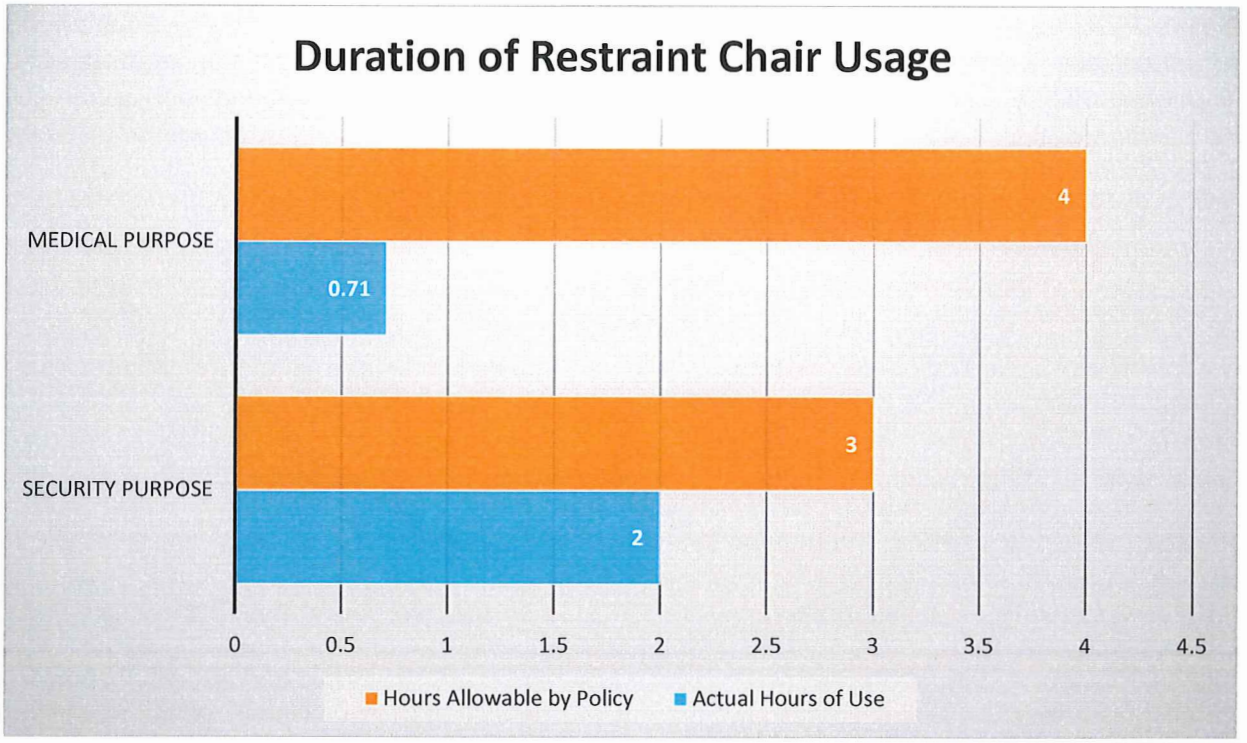


Table 2: A review by the Division of Quality Improvement & Risk Management identified one use of a restraint chair for medical purposes and one use for security purposes in SCDC Institutions during the period June 1, 2018 – August 31, 2018. The duration of the use of the medically ordered use was 43 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;

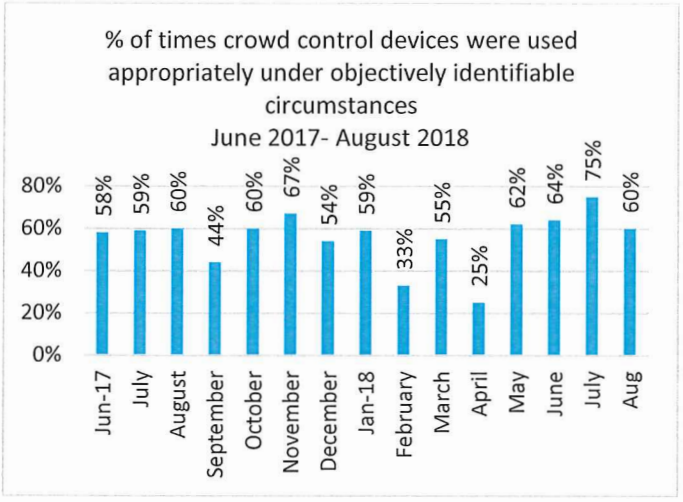
Implementation Panel November 2018 Assessment: partial compliance

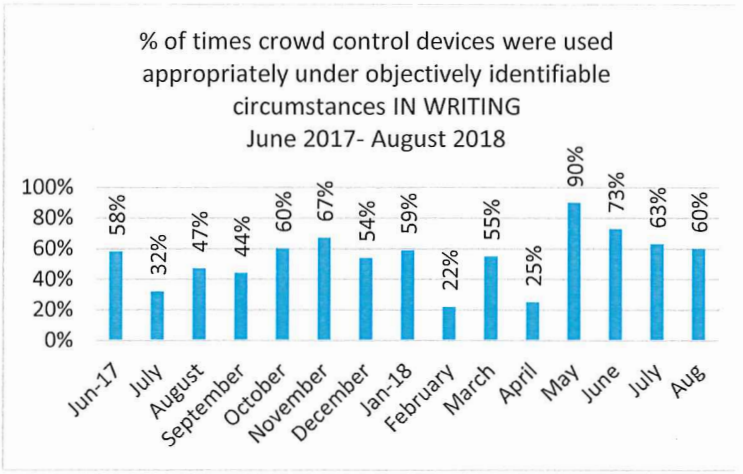
October 2018 SCDC Status Update:

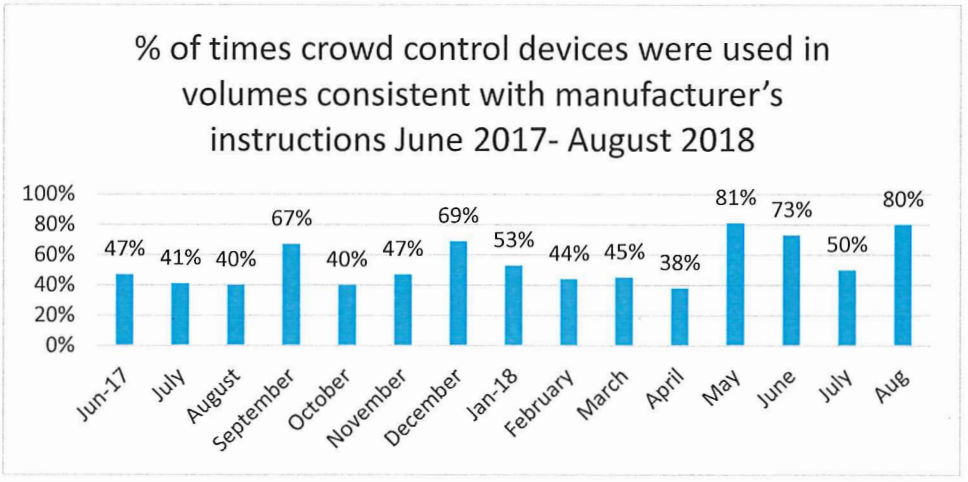
QIRM UOF reviewers continue to review daily MINS and documentation in the automated use of force system to assess appropriate use of crowd control canisters to include MK-9.

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.

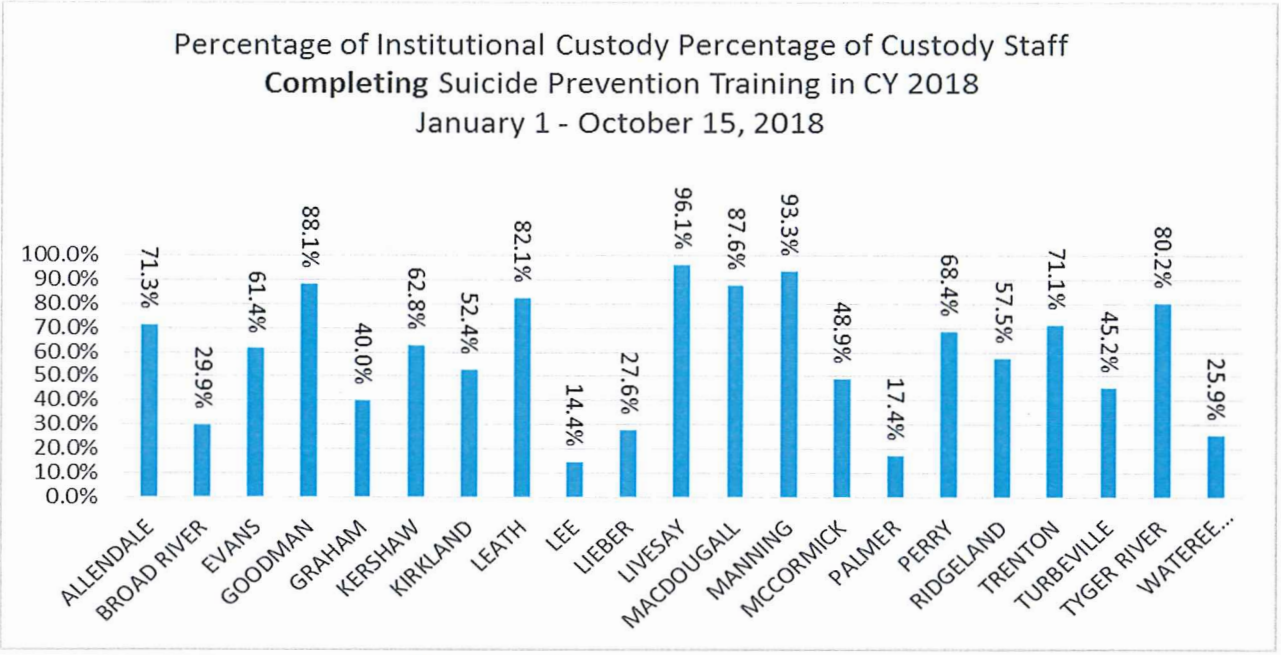
Managing Mentally Ill Offenders Curriculum

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:

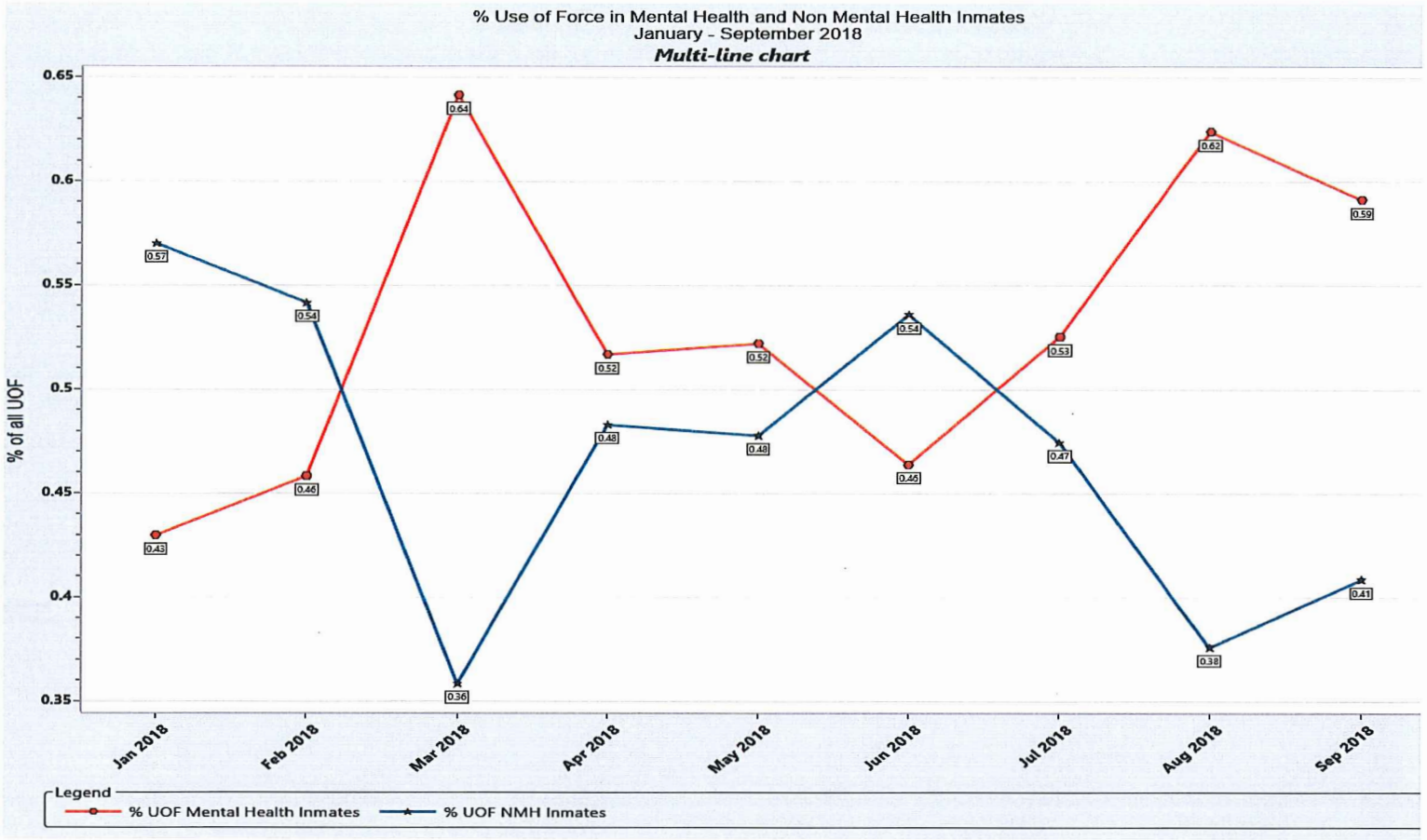
- Agency Use of Force by Type
- Video Review
- Grievances Related to Use of Force
- Grievances Filed by Inmates with a Mental Health Classification
- MINS: Mainframe vs Use of Force Application

- 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

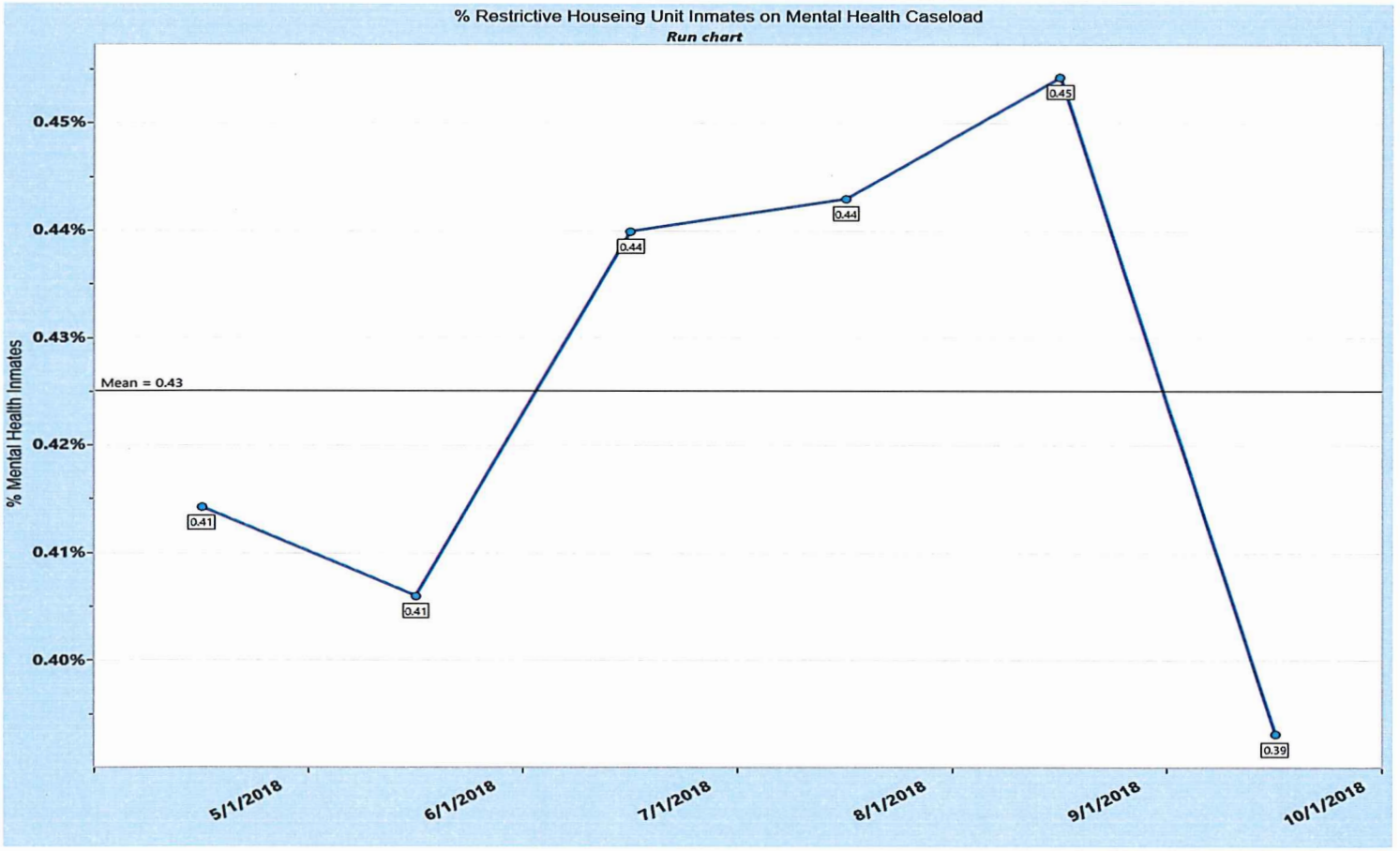
4.a.viii. Quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution;

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.

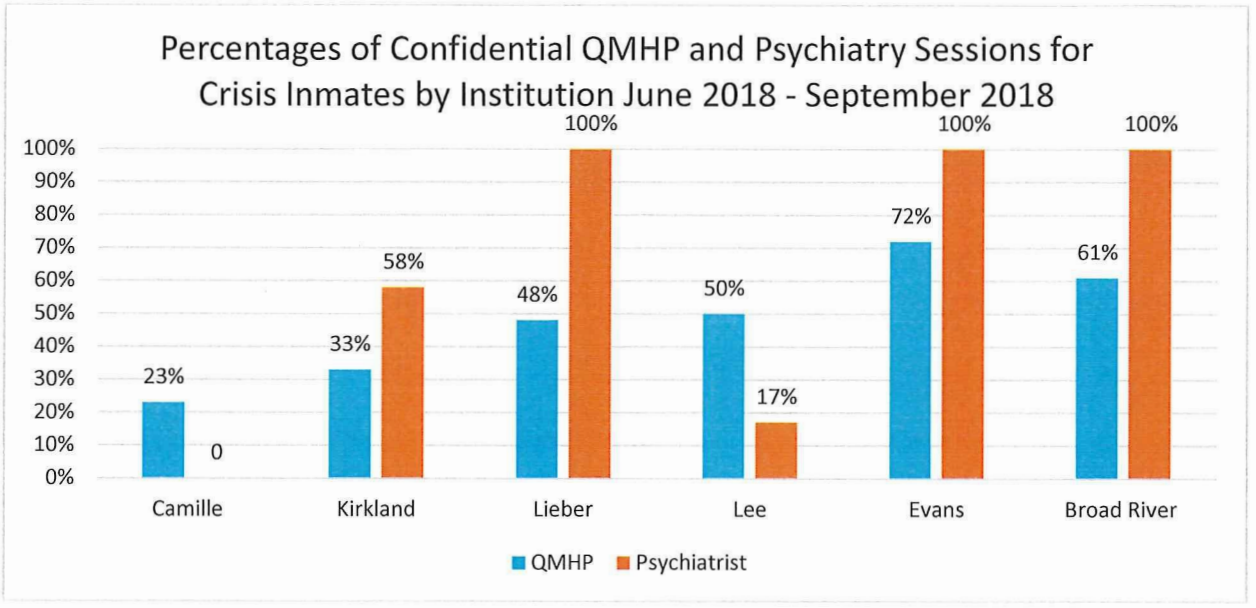
November 2018 Implementation Panel findings: As per status update section.

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

MEDIATOR REPORT OF COMPLIANCE WITH REMEDIAL GUIDELINES
NOVEMBER 2018 IP ASSESSMENT

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
1.	**The development of a systematic program for screening and evaluating inmates to more accurately identify those in need of mental health care:**			
	a. Develop and implement screening parameters and modalities that will more accurately diagnose serious mental illness among incoming inmates at R&E with the stated goal of referring inmates to the appropriate treatment programs. Accurately determine and track the percentage of the SCDC population that is mentally ill.	HS 19.10	11/16/18 Partial compliance	07/20/18 Partial Compliance
		HS 19.07	11/16/18 Substantial compliance	07/20/18 Partial Compliance
	b. The implementation of a formal quality management program under which mental health screening practices are reviewed and deficiencies identified and corrected in ongoing SCDC audits of R&E counselors;	HS 19.07	11/16/18 Partial compliance	07/20/18 Partial Compliance
	c. Enforcement of SCDC policies relating to the timeliness of assessment and treatment once an incoming inmate at R&E is determined to be mentally ill; and	HS 19.07 HS 19.10	11/16/18 Partial compliance	07/20/18 Partial Compliance
	d. Development of a program that regularly assesses inmates within the general population for evidence of developing mental illness and provides timely access to mental health care.	HS 19.07 HS 19.10	11/16/18 Partial compliance	07/20/18 Partial Compliance

[1] The Order components are for reference only and are to be used as references to identify those aspects of the Policies which apply to the Implementation.

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
2.	**The development of a comprehensive mental health treatment program that prohibits inappropriate segregation of inmates in mental health crisis, generally requires improved treatment of mentally ill inmates. and substantially improves/increases mental health care facilities within SCDC:**			
	a. Access to Higher Levels of Care:			
	i. Significantly increase the number of Area Mental Health inmates vis-a-vis outpatient mental health inmates and provide sufficient facilities therefore;	HS 19.04 HS 19.11	11/16/18 Noncompliance	07/20/18 Noncompliance
	ii. Significantly increase the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefore;[2]	HS 19.04, HS 19.07, HS 19.11	11/16/18 Partial compliance	07/20/18 Partial Compliance
	iii. Significantly increase the number of male and female inmates receiving inpatient psychiatric services, requiring the substantial renovation and upgrade of Gilliam Psychiatric Hospital, or its demolition for construction of a new facility;	HS 19.04, HS 19.07 HS 19.09	11/16/18 Partial compliance	07/20/18 Partial Compliance
		Gilliam Construction Plan	11/16/18 Partial compliance	07/20/18 Partial Compliance
	iv. Significantly increase clinical staffing at all levels to provide more mental health services at all levels of care; and	Hiring Plan attached as Exhibit E to the Settlement Agreement	11/16/18 Substantial compliance	07/20/18 Partial Compliance
	v. The implementation of a formal quality management program under which denial of access to higher levels of mental health care is reviewed.	HS 19.07	11/16/18 Substantial compliance (7/14/17)	07/20/18 Substantial Compliance (7/14/17)
	b. Segregation:			
	i. Provide access for segregated inmates to group and individual			

[2] The Parties agree that 10-15% of male inmates and 15-20% female inmates on the mental health case load should receive Intermediate Care Services.

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	therapy services;			
		OP RHU Policy _22.38 Section 3.23 H.S. 19.04	11/16/18 Partial compliance	07/20/18 Partial Compliance
	ii. Provide more out-of-cell time for segregated mentally ill inmates;	HS 19.12 OP RHU Policy 22.38 Section 3.14.4 & Section 3.25	11/16/18 Noncompliance	07/20/18 Noncompliance
	iii. Document timeliness of sessions for segregated inmates with psychiatrists, psychiatric nurse practitioners, and mental health counselors and timely review of such documentation;	HS 19.04 OP RHU Policy 22.38 Section 3.15	11/16/18 Noncompliance	07/20/18 Noncompliance
	iv. Provide access for segregated inmates to higher levels of mental health services when needed;	HS 19.04 HS 19.06	11/16/18 Partial compliance	07/20/18 Partial Compliance
	v. The collection of data and issuance of quarterly reports identifying the percentage of mentally ill and non-mentally ill inmates in segregation compared to the percentage of each group in the total prison population with the stated goal of substantially decreasing segregation of mentally ill inmates and substantially decreasing the average length of stay in segregation for mentally ill inmates;	HS 19.07 OP RHU Policy 22.38 Section 1 and Section 2	11/16/18 Substantial compliance (11/04/16)	07/20/18 Substantial Compliance (11/16)
	vi. Undertake significant, documented improvement in the cleanliness and temperature of segregation cells; and	To be determined	11/16/18 Partial compliance	07/20/18 Partial Compliance
	vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.	HS 19.07	11/16/18 Partial compliance	07/20/18 Partial Compliance
	c. Use of Force:			
	i. Development and implementation of a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness;	OP 22.01 HS 19.08	11/16/18 Partial compliance	07/20/18 Partial Compliance
	ii. The plan will further require that all instruments of force, (e.g., chemical agents and restraint chairs) be employed in a manner fully consistent with manufacturer's instructions, and track such use in a way to enforce such compliance;	OP 22.01 HS 19.08	11/16/18 Partial compliance	07/20/18 Partial Compliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	iii. Prohibit the use of restraints in the crucifix or other positions that do not conform to generally accepted correctional standards and enforce compliance;	OP 22.01 HS 19.08	11/16/18 Substantial compliance (7/14/17)	07/20/18 Substantial Compliance (7/14/17)
	iv. Prohibit use of restraints for pre-determined periods of time and for longer than necessary to gain control, and track such use to enforce compliance;	OP 22.01 HS 19.08	11/16/18 Substantial compliance (03/24/18)	07/20/18 Substantial Compliance
	v. The collection of data and issuance of quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs;	HS 19.07 OP Use of Force 22.01 Section 13	11/16/18 Substantial compliance (12/08/17)	07/20/18 Substantial Compliance
	vi. Prohibit the use of force in the absence of a reasonably perceived immediate threat;	OP 22.01 HS 19.08	11/16/18 Partial compliance	07/20/18 Partial Compliance
	vii. Prohibit the use of crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions;	OP 22.01 HS 19.08	11/16/18 Partial compliance	07/20/18 Partial Compliance
	viii. Notification to clinical counselors prior to the planned use of force to request assistance in avoiding the necessity of such force and managing the conduct of inmates with mental illness;	OP 22.01 HS 19.08	11/16/18 Partial compliance	07/20/18 Partial Compliance
	ix. Develop a mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates;	OP 22.01 ADM 17.01 Employee Training Standards, SCDC Annual Training Plan HS 19.08	11/16/18 Partial compliance	07/20/18 Partial Compliance
	x. Collection of data and issuance of quarterly reports concerning the use-of-force incidents against mentally ill and non-mentally ill inmates; and	OP 22.01 HS 19.07	11/16/18 Substantial compliance (03/03/17)	07/20/18 Substantial Compliance (03/03/17)
	xi. The development of a formal quality management program under which use-of-force incidents involving mentally ill inmates are reviewed.	OP 22.01 HS 19.07	11/16/18 Partial compliance	07/20/18 Partial Compliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
3.	**Employment of a sufficient number of trained mental health Professionals:**			
	a. Increase clinical staffing ratios at all levels to be more consistent with guidelines recommended by the American Psychiatric Association, the American Correctional Association, and/or the court-appointed monitor;	Hiring Plan attached as Exhibit E to the Settlement Agreement	11/16/18 Partial compliance	07/20/18 Noncompliance
	b. Increase the involvement of appropriate SCDC mental health clinicians in treatment planning and treatment teams;	HS 19.05	11/16/18 Partial compliance	07/20/18 Partial Compliance
	c. Develop a training plan to give SCDC mental health clinicians a thorough understanding of all aspects of the SCDC mental health system, including but not limited to levels of care, mental health classifications, and conditions of confinement for caseload inmates;	Mental Health Training Policy Addendum	11/16/18 Substantial compliance (03/23/18)	07/20/18 Substantial Compliance
	d. Develop a plan to decrease vacancy rates of clinical staff positions which may include the hiring of a recruiter, increase in pay grades to more competitive rates, and decreased workloads;	Hiring Plan attached as Exhibit E to the Settlement Agreement	11/16/18 Substantial compliance (12/08/17)	07/20/18 Substantial Compliance (12/08/17)
	e. Require appropriate credentialing of mental health counselors;	HS 19.04	11/16/18 Substantial compliance (03/03/17)	07/20/18 Substantial Compliance (03/03/17)
	f. Develop a remedial program with provisions for dismissal of clinical staff who repetitively fail audits; and	HS 19.07	11/16/18 Substantial compliance (07/20/18)	07/20/18 Substantial Compliance
	g. Implement a formal quality management program under which clinical staff is reviewed.	HS 19.07	11/16/18 Substantial compliance (07/20/18)	07/20/18 Substantial Compliance
4.	**Maintenance of accurate, complete, and confidential mental health treatment records:**			
	a. Develop a program that dramatically improves SCDC's ability to store and retrieve, on a reasonably expedited basis:	HS 200.7		

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	i. Names and numbers of FTE clinicians who provide mental health services;		11/16/18 Substantial compliance (03/03/17)	07/20/18 Substantial Compliance (03/03/17)
	ii. Inmates transferred for ICS and inpatient services;		11/16/18 Substantial Compliance (7/14/17)	07/20/18 Substantial Compliance (7/14/17)
	iii. Segregation and crisis intervention logs;		11/16/18 Partial compliance	07/20/18 Partial Compliance
	iv. Records related to any mental health program or unit (including behavior management or self-injurious behavior programs);		11/16/18 Partial compliance	07/20/18 Partial Compliance
	v. Use of force documentation and videotapes;		11/16/18 Substantial compliance (03/03/17)	07/20/18 Substantial Compliance (03/03/17)
	vi. Quarterly reports reflecting total use-of-force incidents against mentally ill and non-mentally ill inmates by institution;		11/16/18 Substantial compliance (03/03/17)	07/20/18 Substantial Compliance (03/03/17)
	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;		11/16/18 Substantial compliance (03/03/17)	07/20/18 Substantial Compliance (03/03/17)
	viii. Quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution;		11/16/18 Substantial compliance (03/03/17)	07/20/18 Substantial Compliance (03/03/17)
	ix. Quality management documents; and		11/16/18 Partial compliance	07/20/18 Partial Compliance
	x. Medical, medication administration, and disciplinary records.		11/16/18 Partial compliance	07/20/18 Partial Compliance
	b. The development of a formal quality management program under which the mental health management information system is annually reviewed and upgraded as needed.	HS 19.07	11/16/18 Partial compliance	07/20/18 Partial Compliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
5.	**Administration of psychotropic medication only with appropriate supervision and periodic evaluation:**		11/16/18 Noncompliance	07/20/18 Noncompliance
	a. Improve the quality of MAR documentation;	HS 18.16	11/16/18 Partial compliance	07/20/18 Partial Compliance
	b. Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs;	HS 18.16	11/16/18 Noncompliance	07/20/18 Noncompliance
	c. Review the reasonableness of times scheduled for pill lines; and	HS 18.16	11/16/18 Partial compliance	07/20/18 Partial Compliance
	d. Develop a formal quality management program under which medication administration records are reviewed.	HS 18.16	11/16/18 Partial compliance	07/20/18 Partial Compliance
6.	**A basic program to identify. treat, and supervise inmates at risk for suicide:**			
	a. Locate all CI cells in a healthcare setting;	HS 19.03 OP RHU 22.38 Section 3.39	11/16/18 Partial compliance	07/20/18 Partial Compliance
	b. Prohibit any use for CI purposes of alternative spaces such as shower stalls, rec cages, holding cells, and interview booths;	HS 19.03 OP RHU 22.38 Section 3.39	11/16/18 Substantial compliance 12/08/17	07/20/18 Substantial Compliance (12/08/17)
	c. Implement the practice of continuous observation of suicidal inmates;	HS 19.03	11/16/18 Noncompliance	07/20/18 Noncompliance
	d. Provide clean, suicide-resistant clothing, blankets, and mattresses to inmates in CI;	HS 19.03	11/16/18 Partial compliance	07/20/18 Partial Compliance
	e. Increase access to showers for CI inmates;	HS 19.03	11/16/18 Partial compliance	07/20/18 Partial Compliance

	Components as Identified in Order[1]	Relevant Policies, Plans and Standards	Implementation Panel Assessment	Mediator Assessment
	f. Provide access to confidential meetings with mental health counselors, psychiatrists, and psychiatric nurse practitioners for CI inmates;	HS 19.03	11/16/18 Noncompliance	07/20/18 Noncompliance
	g. Undertake significant, documented improvement in the cleanliness and temperature of CI cells; and	HS 19.03	11/16/18 Partial compliance	07/20/18 Partial Compliance
	h. Implement a formal quality management program under which crisis intervention practices are reviewed.	HS 19.03	11/16/18 Partial compliance	07/20/18 Partial Compliance

South Carolina Department of Corrections
Implementation Panel Report of Compliance
March 2019

Executive Summary

This is the 9th report presented by the Implementation Panel (IP) regarding the South Carolina Department of Corrections' (SCDC's) compliance with the Settlement Agreement enacted in May 2016. The IP was created by the Court based on agreement by the parties with oversight by the mediator, Judge William Howard. In our previous site visits, the IP has reviewed the SCDC compliance with the Settlement Agreement (SA) by review of systems, documents and onsite visits to specific SCDC facilities. The terms of the SA require that there be three visits for the first three years and two visits for the last year of the four year term of the Settlement Agreement. At the end of that term, if full substantial compliance has not been met in the designated criteria, the parties are to follow the Settlement Agreement directives with regard to further action.

This report will differ from past reports in that the IP, based on discussions and agreement by the parties, conducted an intensive review of inmates with a mental health designation housed in Restrictive Housing Units (RHUs) at the Broad River Correctional Institution (BRCI) and Lee Correctional Institution (LCI). Also by agreement of the parties, SCDC was not required to submit the full volume of documents and materials usually requested prior to this particular site visit but rather to select submission of those documents for which SCDC believed it was recommending change in compliance from non-compliance to partial or substantial compliance and/or from partial compliance to substantial compliance. SCDC submitted one clinical/mental health item in which they believed there has been improvement in their level of compliance, and several items from operations/security. These items were reviewed and their levels of compliance will be detailed further in this report.

The Implementation Panel (IP) reviewed Restrictive Housing Unit (RHU) operations for the South Carolina Department of Corrections (SCDC) Broad River Correctional Institution (BRCI) and Lee Correctional Institution (LCI) focusing on inmates with a mental health designation during the site visit. The operations review was conducted with the assistance of SCDC QIRM (Quality Improvement and Risk Management) staff. IP and QIRM interviews conducted with BRCI and LCI RHU inmates with a mental health designation revealed the majority are inappropriate for RHU confinement. Inmates are being held in Security Detention (SD) for reasons that do not require RHU confinement for more than 60 days. Inmates are held in Short Term (ST) Status without the required justification and for longer than the mandatory (60) days. Inmates recommended for alternative RHU residential programs (Awaiting Placement-AP) are remaining in RHU for months after an alternative program is recommended. The RHU and SD Behavior Level System has not been implemented. BRCI and LCI inmates with a mental health designation confined in RHU are subjected to unacceptable and harsh conditions of confinement. Inmates self-reported receiving weekly showers; however, SCDC documentation indicated showers are not provided to inmates the required (3) times per week. Staff and inmates reported inmates do not receive out of cell recreation (1) hour per day (5) days a week. In fact, the majority of inmates have not received out of cell recreation since their RHU placement. Both

BRCI and LCI routinely fail to conduct the required RHU 30-minute inmate welfare checks and the time between welfare checks far exceeded 30-minutes. BRCI is not providing RHU inmates with laundry services. BRCI and LCI are not providing inmates the opportunity to clean their cells 2 times a week as required by policy. Since the last site visit conducted in November 2018, there has been one reported completed suicide within SCDC which was reviewed on-site. Recommendations were made by the IP with regard to the mortality and morbidity review process regarding the death of this inmate.

The mental health review of the RHUs at BRCI and LCI consisted of 83 inmates who were examined clinically by the four examiners. Of the 83 inmates, 33 (40%) were SMI, 47 (57%) were not SMI and 3 (4%) were unclear. Thirty-three inmates (40%) were recommended for a higher LOC classification and 2 (3.4%) were recommended for a lower LOC classification. Seven referrals (8.4%) were made, each to GPH/CSU or ICS(HAB), and 16 (19.3%) to BMU's. These numbers are striking as indicators of the excessive number of inmates in need of mental health services not being provided by SCDC.

The Kirkland Correctional Institution (KCI) and Camille Graham Correctional Institution (CGCI) were also reviewed during this site visit. The improvements at KCI and CGCI appear to be largely because of administrative leadership's efforts to implement requirements of the Settlement Agreement as well as recommendations that have been made by the Implementation Panel. Many of these recommendations have also been made by QIRM and Health Services internally for improvement of services to persons on the mental health caseload. It appears that when those recommendations (made both internally and externally) have been supported by administrative leadership at the local and regional levels, improvements have been accomplished. However, it cannot be overstated that the need for increased correctional officer staffing as well as mental health staffing and nursing staffing is essential for SCDC to come into compliance with the Settlement Agreement requirements for adequate mental health care for their inmates. There is no "magic" to these necessities but rather identification of the necessary staffing requirements and commitment by SCDC leadership to identify and obtain the budgetary and other resources necessary to implement the requirements of the Settlement Agreement. The requirements are for basic mental health services and do not include excessive or unnecessary service provisions.

Unfortunately, despite repeated recommendations regarding mechanisms to achieve compliance with the Settlement Agreement, at the end of three years of monitoring SCDC has not achieved substantial compliance as required in the majority of criteria. Inmates housed in SCDC living with mental illness continue to suffer harm, much of which was identified during trial, and has been continuously identified for the past three years.

The findings of the IP with regard to compliance on the various components as of March 8, 2019 are as follows:

1. Substantial compliance—21
2. Partial Compliance—33
3. Non-Compliance—5

Introduction

The Implementation Panel (IP) reviewed Restrictive Housing Unit (RHU) operations for the South Carolina Department of Corrections (SCDC) Broad River Correctional Institution (BRCI) and Lee Correctional Institution (LCI) March 4, through 6, 2019 focusing on inmates with a mental health designation. The operations review was conducted with the assistance of SCDC QIRM staff. SCDC provided the IP with background information for all inmates with a mental health designation confined in the BRCI and LCI RHUs. The background information included:

- Inmate Name and SCDC Number
- Medical Classification
- Mental Health Classification
- Date of Last Annual Classification Review
- Reason for RHU Placement
- RHU Status
- Date of Placement
- RHU Supervision Plan
- Days in RHU
- RHU Behavior Level
- RHU Disciplinary History
- Number of Use of Force Incidents
- Number of Management Information Notes (MINS)

Prior to the March IP Site Visit, SCDC QIRM compiled information for the identified inmates regarding their access to showers, out of cell recreation and whether the required 30 minute RHU welfare checks were being conducted. The responsible IP Member and QIRM staff interviewed BRCI and LCI inmates during the site visit to determine their appropriateness for RHU confinement. Once the interview with each inmate was completed, QIRM staff conducted an inspection of each inmate's cell and personal property and made a determination if the evaluated items were acceptable or unacceptable and if cell fixtures were operational.

The interview with each inmate consisted of obtaining self-reported information on why the individual was in RHU, his RHU adjustment, and access to staff, services and programs. The interviewer then assessed the available information and made a determination if the inmate was appropriate or inappropriate for his present RHU Status.

Findings

The responsible IP member and QIRM staff interviewed 70 RHU inmates with a mental health designation at BRCI (43 inmates) and LCI (27 inmates). Documentation revealed the majority of the inmates in RHU with a mental health designation were inappropriate. BRCI had 26 inmates with a mental health designation in RHU that were inappropriate and 17 that were appropriate. LCI had 13 inmates with a mental health designation in RHU that were inappropriate and 14 that were appropriate. Interviews revealed 17 of the 31 inmates assessed as appropriate had been in RHU for over 60 days. The Settlement Agreement and SCDC Policies

prohibit inmates with a mental health designation from remaining in RHU for over 60 days; therefore, the actual number identified as inappropriate for RHU was 56 of the 70 inmates. [1]

(Documentation and Inmate Interviews)
The SCDC Form 19.67 is used to provide an inmate notice of placement in RHU and extend his RHU stay. The form does not provide the necessary details on why an inmate is being placed in RHU. The RHU Extension Section only requires the extension reason and the length of the extension (up to 10 days). Notice of RHU Placement only requires one or more of the following reasons:

- Current Escape Risk
- Maintain the Integrity of an Investigation
- Protective Concerns
- Threat to the Physical Safety of Other Inmates or Staff
- Inmate's Presence in the Population Would Create a Threat to the Safety and/or Order of the Institution

SCDC Form 19.67 fails to identify the institution, custody, medical and mental health classification of an inmate placed in RHU. Neither the Notice of RHU nor RHU Extension has a section to document details on why an inmate is or has been placed in RHU. The inmate can remain in RHU for (7) days before he/she appears before an Institutional Classification Committee (ICC). The form does not have a section for medical and mental health authorities to indicate whether the inmate is appropriate for RHU placement based on his medical and mental health condition.

IP and QIRM interviews conducted with BRCI and LCI RHU inmates with a mental health designation revealed the majority are inappropriate for RHU confinement. Inmates are being held in Security Detention (SD) for reasons that do not require RHU confinement for more than 60 days. There were inmates in RHU on SD Status for almost a year to investigate their involvement in the April 2018 Lee CI Incident that resulted in multiple assaults and seven (7) inmate deaths. It appears from inmate interviews and SCDC records the inmates have not been interviewed by investigators and do not understand why they remain in RHU. Inmates are held in Short Term (ST) Status without the required justification and for over the mandatory (60) days. Inmates recommended for alternative RHU residential programs (Awaiting Placement-AP) are remaining in RHU for months after an alternative program is recommended. The RHU and SD Behavior Level System has not been implemented. There were inmates found to have an RHU Behavior Level; however, staff and inmates are not familiar with the behavior level system. Failure to utilize the SCDC RHU and SD Behavior Level impacts the safety and security of staff and inmates. Positive behavior is not rewarded and there are no consequences for negative behavior. Most concerning was a finding that Wardens have the authority to disregard a Classification and/or Mental Health official's recommendation and continue an inmate in RHU without the necessary justification. A QIRM Study revealed system-wide the Institution Mental

[1] Appendix A documents the individual findings for each of the BRCI and LCI inmates interviewed and confined in RHU with a mental health designation.

Health Disciplinary Treatment Teams (MHDTT) rarely mitigate the RHU Disciplinary Detention (DD) time assessed by the SCDC Disciplinary Hearing Officer (DHO) for inmates with a mental health designation. A review of records revealed that Classification Counselors make rounds in RHU; however, sessions with RHU inmates are conducted cell front and are not recorded in the inmate's individual record. A significant number of inmates were found without a current annual classification review.

(Conditions of Confinement)
BRCI and LCI inmates with a mental health designation confined in RHU are subjected to unacceptable and harsh conditions of confinement. Inmates self-reported receiving weekly showers; however, SCDC documentation indicated showers are not provided to inmates the required (3) times per week. Staff and inmates reported inmates do not receive out of cell recreation (1) hour per day (5) days a week. The majority of inmates have not received out of cell recreation since their RHU placement. Both BRCI and LCI routinely fail to conduct the required RHU 30-minute inmate welfare checks and the time between welfare checks far exceeded 30 minutes. BRCI is not providing RHU inmates with laundry services. BRCI and LCI are not providing inmates the opportunity to clean their cells 2 times a week as required by policy. It was discovered BRCI recently started issuing powdered bleach to RHU inmates. Inmates possessing powdered bleach without direct staff supervision is a serious breech of security and a safety concern, particularly in a high security housing unit. It was reported this practice was discontinued prior to end of the IP site visit. QIRM's BRCI and LCI RHU cell inspections during the IP site visits and while inmate interviews were being conducted revealed serious deficiencies.

BRCI MH Inmate Cell Findings:
Lights 52% non-operational
Walls 76% unacceptable
Vents 81% Unacceptable

LCI MH Inmate Cell Findings:
Lights 59% non-operational
Walls 93% unacceptable
Vents 72% unacceptable

Previously, SCDC began an initiative to provide inmates in RHU with crank radios. Officials acknowledged issues maintaining accountability of the RHU crank radios and do not have the means to order additional crank radios. RHU cell inspections found 38 percent of the BRCI MH inmates had a crank radio. The LCI RHU cell inspections found 42 percent of the RHU inmates had a crank radio.[2]

BRCI RHU inmates complained the RHU Law Library computer was not operational from April 2018 until February 2019. SCDC officials investigated the complaint and confirmed the Law Library computer was not operational for several months. This restricted BRCI RHU inmates' access to the Courts. The IP also has a serious concern regarding the SCDC Inmate Grievance System. Frequently, inmate grievances are returned to inmates for minor technicalities without

[2]Appendix B RHU Conditions of Confinement.

meeting with the inmate. Inmates are required to attempt an informal resolution before submitting a grievance. Access to the housing unit kiosk is necessary for general population inmates to meet the informal resolution exhaustion requirement. When SCDC is on lockdown, inmates do not have access to the kiosk. Since April 2018, a number of SCDC institutions have been on extended lockdown.

A Lee CI RHU inmate complained the RHU cell tray slots were a safety hazard because the design did not have a mechanism to prevent the closure from dropping while open to provide services. The closure dropping could cause serious injury to a staff and/or inmate's arm and hand. The responsible IP member and Operations Assistant Deputy Director verified the safety hazard existed.

Recommendations:

1. Immediately remove SD, AP and SP and any other inmates over 60 days in RHU with a mental health designation beginning with the higher levels of care.
2. Establish additional quality controls to prevent placement of inmates in SD status that do not meet the criteria.
3. Establish quality controls to prevent housing of inmates in ST status over 60 days.
4. Establish quality controls to ensure policies and procedures are followed when placing, retaining and releasing inmates from RHU. Revise the SCDC Form 19.67 Inmate RHU Placement and Inmate RHU Extension.
5. Establish that Mental Health and Classification is the authority for placement and removal of inmates in RHU with a mental health designation.
6. Fully implement the RHU and SD Inmate Behavior Level System. Provide training to staff and orientation to the RHU inmates to ensure both understand and are familiar with the RHU and SD Behavior Level System.
7. Develop and Implement the RHU SD Step Down Policy. Provide training to staff and orientation to the RHU inmates to ensure both understand and are familiar with the RHU SD Step Down Policy.
8. Establish controls to ensure the Mental Health Disciplinary Treatment Teams (MHDTT) appropriately review and, where warranted, mitigate Disciplinary Detention time for inmates with a mental health designation.
9. Develop and implement a Corrective Action Plan to address the identified RHU Conditions of Confinement and Cell Physical Plant deficiencies. Develop and implement a Preventive Maintenance Plan to ensure RHU physical plants are maintained.

Review of Select Components of the Settlement Agreement:

Use of Force

The main focus of the March 2019 IP Site Visit was to review BRCI and Lee CI RHU inmates with a mental health designation. However, a limited review of Settlement Agreement Use of Force provisions was also completed.

2.c. Use of Force:

2.c.i. Development and implementation of a master plan to eliminate the disproportionate

use of force, including pepper spray and the restraint chair, against inmates with mental illness;

Implementation Panel March 2019 Assessment: partial compliance

March 2019 Implementation Panel findings: The MH UOF Coordinator is conducting 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 utilizes Excel spreadsheets to track Qualified Mental Health Professional follow-up (or lack thereof) on uses of force involving inmates on the Mental Health Caseload. Operations is developing a process to conduct and document an After-Action Debriefing after a use of force. The plan is to implement this process in April 2019.

March 2019 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. Provide Training to Division of Mental Health Staff on the policy regarding review of inmates with a mental health designation involved in use of force incidents once the policy is finalized.

2.c.ii. The plan will further require that all instruments of force, (eg., chemical agents and restraint chairs) be employed in a manner full consistent with manufacturer's instructions, and track such use in a way to enforce such compliance.

Implementation Panel March 2019 Assessment: partial compliance

March 2019 Implementation Panel findings: QIRM staff continues to meet weekly with Operations leadership to discuss UOF and other relevant issues. QIRM UOF Reviewers continue to produce and distribute a monthly report detailing:

- Agency Use of Force by Type
- Automated Use of Force Review
- Grievances Related to Use of Force
- Grievances
- Grievances Filed by Inmates with a Mental Health Classification
- Exception Reports which includes those Use of Force MINS that have been entered into the mainframe but have not been entered into the automated use of force application.

QIRM prepared a UOF Report using the months September 2018 through December 2018. The UOF Report was provided the IP prior to the March 2019 Site visit. SCDC has revised the MINs Electronic Form to include the Mental Health Classification of inmates involved in UOF.

March 2019 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 are 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. RIM include a canine use of force incident category in existing use of force reports.
6. Revise the SCDC UOF policy and require an annual review of the Agency List of approved UOF instruments and munitions;
7. All 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 March 2019 Assessment: compliance 7/14/17

March 2019 Implementation Panel findings: There were no documented reports from September- December 2018 of inmates being placed in the crucifix or other positions that do not conform to generally acceptable correctional standards.

March 2019 Implementation Panel Recommendations:
Operations and QIRM staff continue to review and monitor use of force incidents through the automated system to ensure restraints are not used to place inmates in the crucifix or other positions that do not conform to generally accepted correctional standards. Pursue corrective action when violations and/or issues are identified.

2.c.iv. Prohibit use of restraints for pre-determined periods of time and for longer than necessary to gain control, and track such use to enforce compliance;

Implementation Panel March 2019 Assessment: compliance

March 2019 Implementation Panel findings:
There was one identified restraint chair incident in SCDC Institutions during the period of 1 September-31 December 2018. This incident involved the Restraint Chair at the Broad River Correctional Institution. The Restraint Chair use followed required guidelines except minor documentation issues. The inmate was in the restraint chair for less than one hour. QIRM conducted a review of the incident and prepared a Restraint Chair Report (SCDC Appendix I). An SCDC report on the use of hard restraints was not included in the SCDC provided documentation.

March 2019 Implementation Panel Recommendations:
QIRM continues 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 before release.

2.c.v. The collection of data and issuance of quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs;

Implementation Panel March 2019 Assessment: compliance 12/08/17

March 2019 Implementation Panel findings: See above 2.c.iv.

March 2019 Implementation Panel Recommendations:
QIRM continues to prepare a Restraint Chair Report for each monitoring period.

2.c.vi. Prohibit the use of force in the absence of a reasonably perceived immediate threat;

Implementation Panel March 2019 Assessment: partial compliance

March 2019 Implementation Panel findings:
SCDC Use of Force MINS for October 2018 through January 2018:

October 2018	128
November 2018	101
December 2018	118
January 2019	102

(Inmate UOF Grievances)
In October and November 2018, 162 grievances related to UOF were filed across SCDC institutions. The grievances involved alleged physical abuse (28 or 17% of grievances), excessive UOF (27 or 17% of grievances) and unprofessional conduct (107 or 66% of grievances). Thirty-three percent (33%) of 162 filed Grievances during October and November were processed as active grievances. Sixty-three percent (63%) of Grievances were processed and returned to inmates for reasons allowed in policy. QIRM made recommendations based on their Inmate Grievance CQI Study:

1. The Grievance Branch audit should review a sample of inmate grievances to evaluate if appropriate grievance determinations are being made.
2. Evaluate whether the informal resolution attempt requirement before an inmate can submit a grievance is negatively impacting the grievance process.
3. Conduct inmate focus groups to improve the inmate grievance process.

(QIRM Identified Policy Violations related to UOF)
QIRM identified 66 policy violations, with 75 recommendations/actions taken by the Office of Operations. The recommendations/actions were:

- Use of Force training for Staff (34 instances).
- Corrective Action (5 instances), one of which the Warden initiated prior to compliance review.
- Discussion with the Warden/Institutional Executive Staff (19 instances).
- Concurrence with findings of Use of Force reviewer but action not documented in Automated Use of Force System (AUOF) (12 instances).
- Inmate discipline (2 instances).
- As of 8 February 2019, 3 instances have not been reviewed.
- Two actions were taken/recommended by the Office of Operations (9 instances).

(Police Services Referrals)
There were a total of 28 referrals to SCDC Police Services related to use of force and assault of an inmate by employee during the reporting period.

14 were opened for an investigation
14 were referred back to the Inmate Grievance Branch

The responsible IP member met with the SCDC Director of Police Services to discuss tracking of grievances referred to Police Services.

March 2019 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. Implement the QIRM recommendations to improve the Inmate Grievance System;
9. Remedy the high percentage of employees not receiving annual Use of Force Training; and
10. 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 March 2019 Assessment: partial compliance

March 2019 Implementation Panel findings:
The QIRM Use-of-Force staff reviewed 239 use-of-force incidents that involved MK-9 use from June 1, 2017 through December 31, 2018:

- There were 139 (58%) use of force incidents in which the officer's actions were justifiable based on circumstances set forth in agency policy OP-22.01 Use of Force.
- There were 138 (58%) incidents where the crowd control devices were used appropriately under objectively identifiable circumstances in writing.
- There were 144 (60%) incidents where the crowd control devices were used consistent with manufacturer's instructions.

SCDC officials are addressing staff MK9 use issues; however additional improvement is needed.

March 2019 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 March 2019 Assessment: partial compliance

March 2019 Implementation Panel findings: SCDC institutions contacting a clinical counselor prior to planned use of force to request assistance in avoiding force and managing the conduct of inmates with a mental illness remains problematic. The MH Reviewer and QIRM Reports on the number of times attempts were made to contact a mental health counselor prior to a planned use of force provided different findings. Nevertheless, in December 2018, the MH Reviewer and QIRM reported that QMHPs were contacted less than 50 percent of the time before a planned UOF.

March 2019 Implementation Panel Recommendations:
As identified in previous reports, additional training of 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.xi. The development of a formal quality management program under which use of force incidents involving mentally ill inmates are reviewed.

Implementation Panel March 2019 Assessment: partial compliance

March 2019 Implementation Panel findings:
See 2.c.i. The provision remains in partial compliance. The policy regarding review of inmates with a mental health designation involved in use of force has not been finalized. The policy is a critical component of having a formal quality management program under which use of force incidents are reviewed. Substantial compliance cannot be obtained until the policy is finalized and successful implementation is verified with conducting CQI studies.

March 2019 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's 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.

Further this site visit was managed differently in that the first three and one-half days were spent by the IP reviewing the SCDC recommendations regarding changes since the last site visit, and the in-depth interviews in the RHUs as described above. The fourth day was spent in reviewing specific programs at Kirkland Correctional Institution and Camille Graham Correctional Institution which will be described further below.

5.b Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs;

Implementation Panel March 2019 Assessment: partial compliance

March 2019 Implementation Panel findings: SCDC recommended that because they were no longer administering medications under the doors of inmates housed in specific housing units, the rating of medication compliance with component 5(b) should be elevated from non-compliance to partial compliance. Based on this recommendation and observations on-site, and despite there being ongoing difficulties with medication administration and medication management, including (a) the writing of 180 days rather than 90 days medication orders for psychotropic medications, (b) delays in medications because of inadequate nursing staffing and (c) failure to implement system-wide administration of hs (hour of sleep) medications at reasonable hours rather than at three or four p.m. in the afternoon, the IP is changing the assessment to partial compliance because the component relates to issues under the control of nurses ("clinicians responsible for completing and monitoring MARs") and the problems identified above are not under their control.

Conclusions and Recommendations

There have been very clear demonstrations of improvement at KCI and CGCI in specific areas and in response to prior recommendations internally by administration and staff, QIRM, and by the IP. The staff at both facilities beginning with the Wardens and their administrative staff and continuing with the treatment and custodial staff as well as support services, certainly deserve recognition for their sustained efforts to improve services in those areas identified in the body of this report.

In summary, the IP is extremely concerned about the very serious deficiencies in mental health care specifically with regard to inmates who are housed in RHUs and the resultant very serious and continuing harm. The very basis of the Settlement Agreement has largely to do with the mistreatment or lack of treatment of inmates who are housed in RHUs and there has been development of policies and procedures as well as post orders to attempt to remedy these conditions. The IP psychiatrists, Drs. Raymond Patterson and Jeffrey Metzner, Chief Psychiatrist for SCDC Dr. [redacted] and Psychiatric Consultant to SCDC Dr. Sally Johnson conducted evaluations referenced in this report as detailed in the appendices. The results of these interviews indicate SCDC has not achieved substantial compliance with the majority of the Settlement Agreement criteria.

The failures to achieve sustained substantial compliance have been fundamentally based on inadequate resources, including security, mental health and nursing staffing as well as space constraints for mental health programs. The other problematic areas of concern have been identified in this and past reports, including the impact of the conditions of confinement and lack of basic services. The IP acknowledges the improvements at several institutions in specific areas, however the systemic failures continue and require implementation of the recommendations made by SCDC staff, consultants and the Implementation Panel.

Sincerely,

Raymond F. Patterson, MD

Implementation Panel Member

On behalf of himself and:

Emmitt Sparkman

Implementation Panel Member

Attached Appendices:
Appendix A--Individual findings for each of the BRCI and LCI inmates interviewed and confined in RHU with a mental health designation.
Appendix B--RHU Conditions of Confinement
Appendix C1—Notes of [redacted] MD regarding interviews at BRCI and LCI
Appendix C2—Notes of Sally Johnson, MD regarding interviews at BRCI and LCI
Appendix C3—Notes of Jeffrey Metzner, MD regarding interviews at BRCI and LCI
Appendix C4—Notes of Raymond Patterson, MD regarding interviews at BRCI and LCI
Appendix D—Summary chart regarding findings of clinical reviewers