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

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

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

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

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

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

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 Collins 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

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

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 GPH Allotted FTE		**Staffing Plan 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

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)

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

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

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

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

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)

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

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

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

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

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)

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)

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)

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

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

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

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

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)

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

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

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

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)

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)

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)

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)

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)

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)

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

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

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

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

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)

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)

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)

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)

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

July 2018 Implementation 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

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

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

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

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

July 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.

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

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

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

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)

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

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

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

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

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

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

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. Frierson 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